VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 42

(Pages 2289-END)

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

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

OCTOBER-DECEMBER 1990

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CITE AS

42 Van Natta ____ (1990)

In the Matter of the Compensation of
YOLANDA CARRASCO, Claimant
WCB Case Nos. 89-23967, 90-01087, 89-23968 & 90-01088
ORDER ON REVIEW (REMANDING)
Quintin Estell, Claimant Attorney
Meyers & Radler, Defense Attorneys
Daryll Klein, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

United Foods, a self-insured employer, requests review of that portion of Arbitrator Quillinan's order which: (1) set aside its denial of claimant's "new injury" claim for a low back and neck condition; and (2) upheld United States Fidelity & Guaranty Company's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We remand.

We review the arbitrator's order solely on questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989). We, therefore, accept the Arbitrator's Findings of Fact.

In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court held that if work activities at the later employer/insurer independently contribute to the worker's disability (i.e., causes a worsening of the underlying condition) then the second employer/insurer is responsible for the worsening. But where the worker has sustained a mere recurrence of symptoms, the earlier employer/insurer remains responsible. See CECO Corp. v. Bailey, 71 Or App 782 (1985).

The Arbitrator concluded that claimant's work activities at the self-insured employer's did not cause a pathological worsening of her underlying back condition, but rather contributed to an acute symptomatic flare-up of claimant's previously accepted low back condition. The Arbitrator then concluded that this symptomatic flare-up represented a new injury and shifted responsibility for claimant's low back condition to the self-insured employer.

The Arbitrator's conclusion is not consistent with the applicable law and is therefore in error. Accordingly, we remand for the proper application of law. See ORS 656.307(2); ORS 656.295(5).

ORDER

The Arbitrator's order dated April 9, 1990, is vacated. This matter is remanded to Arbitrator Quillinan for further action consistent with this order.

In the Matter of the Compensation of
GLORIA HUNTER, Claimant
WCB Case No. 89-04943
ORDER ON REVIEW (REMANDING)
Burt, et al., Claimant Attorneys
Debra Ann Kronenberg (Saif), Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Howell's order that dismissed claimant's request for hearing because claimant failed to appear at hearing. On review, claimant contends that the dismissal order should be vacated and the

matter remanded to the Hearings Division for a hearing on the merits. We remand.

FINDINGS OF FACT

On March 17, 1989, the parties were notified that this case was scheduled for hearing on June 7, 1989 at 1:00 p.m. On the appointed date, claimant's attorney appeared. Claimant did not appear. Claimant's attorney had not heard from claimant recently and had no knowledge why claimant did not appear at hearing. By order dated June 13, 1989, the Referee dismissed claimant's request for a hearing for failure to appear.

CONCLUSIONS OF LAW AND OPINION

The Referee relied on former OAR 438-06-071 which authorized the Referee to dismiss a request for a hearing for "failure of a party, or the parties' representative to appear at the time and place scheduled for a hearing." Claimant personally failed to appear. However, claimant did appear by counsel. We have recently stated that the dicta regarding the application of OAR 438-06-071 in Williams v. SAIF, 99 Or App 367 (1989), reversed and remanded 310 Or 320 (1990) is that correct interpretation of the rule and we continue to follow that interpretation. See Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990). It follows that OAR 438-06-071 does not provide authority for dismissal for failure of a claimant to appear at hearing if claimant's attorney does appear at hearing. Accordingly, the Referee was without authority to dismiss. We remand to the Hearings Division for further proceedings.

Instructions on Remand

We are unable to determine whether claimant waived her right to testify at hearing because the record is not sufficiently developed to determine whether a postponement should be granted. See Mark S. Lesowske, 42 Van Natta 2154 (1989). We remand to the Hearings Division for a hearing on that matter.

The Presiding Referee shall refer this case to another Referee. If the Referee determines that postponement of the June 7, 1989 hearing should have been granted, he can proceed with a hearing on the merits. If the Referee determines a postponement should not be granted, then he should proceed with a hearing on the merits, but shall not receive any exhibit which was not submitted in connection with the prior hearing, nor allow any witness, including claimant, to testify who was not available and planning to testify at the prior hearing or under subpoena to testify at the hearing.

ORDER

The Referee's order dated June 13, 1989 is vacated. This case is remanded to the Presiding Referee for further proceedings consistent with this order.

In the Matter of the Compensation of
RONALD L. SCHILLING, Claimant
WCB Case No. 87-09708
SECOND ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
John D. McLeod, Attorney
Gary T. Wallmark (Saif), Defense Attorney

Claimant has requested reconsideration of that portion of our September 13, 1990 Order on Reconsideration that reduced his assessed attorney fee

award for services provided at hearing from $5,000 to $250. In our Order on Reconsideration, we concluded that a reduction was appropriate considering the factors set forth in OAR 438-15-010(4). In reducing claimant's attorney fee, we particularly considered the minimal value of the interest secured for claimant.

On reconsideration, claimant argues that his counsel has secured permanent partial disability and other benefits in his behalf in various claims originally consolidated with the present one and in a prior stipulation. Claimant also contends that the value of the interest secured in the present case stems from its potential value in the future.

We disagree with claimant's assessment of the value of the present case. In this case, claimant received merely a determination of compensability of an injury for which the employer (Sunnyside) has not been responsible for eight years. As a result of our Order on Reconsideration finding that claimant had agreed to allow the SAIF Corporation (on behalf of the noncomplying employer) to use the last injurious exposure rule defensively, claimant was unable to prevail on the issue of responsibility against the noncomplying employer. Claimant therefore failed to secure any benefits as to this claim, due since his 1978 injury. Rather, claimant obtained only confirmation of his established right to receive benefits to which he was previously entitled under the separate, accepted 1982 claim.

In addition to our finding that the present case involved minimal value to claimant, we also decline to consider the value secured for claimant in proceedings other than the case currently before us. Therefore, after considering the factors set forth in OAR 438-15-010(4) and particularly considering the minimal value of the interest to claimant derived through this order and the related proceedings, we continue to conclude that a $250 reasonable assessed attorney fee is appropriate.

Accordingly, our September 13, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 13, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

October 2, 1990 Cite as 42 Van Natta 2291 (1990)

In the Matter of the Compensation of
PAUL DAVIS, Claimant
WCB Case No. 86-17953
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Scavera's order which: (1) declined to award claimant interim compensation; and (2) which awarded an assessed attorney fee of $300 in association with a penalty for late payment of interim compensation. We affirm.

ISSUES

Claimant contends that the Referee erred in not requiring the self-insured employer to pay interim compensation from July 21, 1988 through December 5,

1988. Claimant also contends that the attorney fee which the Referee ordered was not adequate.

The employer contends that claimant is not entitled to interim compensation because he did not raise that issue at hearing. It further contends that the penalty and attorney fee which the Referee ordered were raised by the Referee sua sponte. Consequently, although it does not seek to reverse the Referee's order, it argues that claimant's attorney fee should not be raised.

FINDINGS OF FACT

In a specification of issues submitted to the Hearings Division on July 12, 1988 and in another specification of issues submitted December 12, 1988, claimant raised as an issue penalties and attorney fees for failure to pay time loss within 14 days. However, at hearing claimant's attorney framed the issues as: "The issues are the denial of aggravation and extent of disability to and including permanent total, I believe." In his opening statement, the attorney again referred only to the issues of the denied aggravation and extent of disability.

In his Opinion and Order, the Referee listed the unscheduled disability and aggravation issues; he also listed "Penalty and attorney fees for failure to pay time loss within 14 days." The Referee concluded that the employer was late in paying time loss and assessed a 5 percent penalty and an associated attorney fee of $300. The employer requested reconsideration arguing that the penalty and fee issue and any time loss issue had not been raised by claimant at hearing. It argued that it did not seek to elicit evidence on these issues because claimant had not raised them. The Referee denied the motion.

CONCLUSIONS OF LAW AND OPINION

On review, we will not consider issues not raised at hearing. Although claimant had listed a penalty issue for late payment of time loss in his pleadings, when asked to frame the issues at the outset of the hearing, he listed only the aggravation and extent of disability issues. He did not list any penalty issues or any issues related to entitlement to time loss. The accepted practice in workers' compensation hearings is for the parties to state the issues for resolution on the record at the outset of the hearing. Thus, we conclude that claimant did not raise the penalty and fee issue or the issue of entitlement to interim compensation. Claimant is entitled to no relief sought on review.

Because the Referee raised the penalty and fee issue sua sponte, we conclude that he erred. Nonetheless, because the employer does not seek reversal on this basis, we will not disturb the Referee's order.

ORDER

The Referee's order dated August 28, 1989 is affirmed.

In the Matter of the Compensation of
ROBERT L. HEZELTINE, Claimant
WCB Case No. 89-02899
ORDER ON REVIEW
Yturri, Rose, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Knapp's order that: (1) increased claimant's unscheduled permanent disability award for a skin condition from 22 percent (70.4 degrees) to 40 percent (128 degrees); (2) reduced claimant's scheduled permanent disability for loss of binocular vision from 7.5 percent (22.5 degrees) to 2 percent (6 degrees); (3) upheld the insurer's denial of medical services; and (4) declined to assess penalties and related attorney fees for alleged unreasonable claims processing. On review, the issues are extent of permanent disability, scheduled and unscheduled, medical services and penalties and related attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

The position which claimant successfully performed in the ten years preceding the date of determination, which has the highest specific vocational preparation (SVP) figure, was a mechanic (DOT # 620.281-050), with an SVP of 7. He has demonstrated competence in a specific vocational pursuit.

Claimant does not suffer loss of central vision or loss of ocular motility. He has suffered a 7 percent loss of peripheral vision in his left eye and a 9 percent loss of peripheral vision in his right eye.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

We adopt the Referee's "Conclusions of Law and Opinion" regarding this issue.

Extent of Scheduled Permanent Disability

The Referee reduced claimant's scheduled permanent disability for the loss of binocular vision from 7.5 percent to 2 percent. We disagree.

Permanent loss of binocular vision is ratable under the standards. OAR 436-35-260(6) & (7). Claimant's total rating for monocular loss is found by combining the ratings for loss of central vision, loss of peripheral visual field, and loss of ocular motility. OAR 436-35-260(6). Then, after determining the percent of monocular loss for each eye, the total binocular loss is determined by multiplying the percent of loss in the better eye by three, adding that result to the percent of monocular loss in the other eye, and then dividing that result by four. OAR 436-35-260(7).

Claimant does not suffer loss of central vision or loss of ocular motility. (Ex. 25). His loss of peripheral vision is 7 percent in the left eye and 9 percent in the right eye. After combining the ratings for loss of central vision (0) and peripheral vision (7 and 9 percent, respectively) for each eye, we find that claimant's total loss of monocular vision in his left eye is 7 percent and the loss of monocular vision in his right eye is 9 percent. OAR 436-35-260(6).

After multiplying the monocular loss in the better eye (7 percent) by three, the result is 21. After adding that result with the monocular loss in the other eye (9 percent), the sum is 30. After dividing this sum by 4, the result is 7.5 percent, the total percentage of binocular loss. OAR 436-35-260(7).

Compensability of Medical Services, Penalty and Related Attorney Fee for Alleged Unreasonable Denial

We adopt the Referee's "Conclusions of Law and Opinion" regarding the compensability of medical services and the penalty and related attorney fee issue therewith.

Penalty and Related Attorney Fee - Failure to Accept or Deny

The Referee did not address claimant's contention that he was entitled to a penalty and related attorney fee for the insurer's failure to accept or deny medical services within 60 days pursuant to ORS 656.262(10). We turn to that issue now.

Claimant submitted several medical bills to the insurer for payment. The insurer had notice of those bills by a letter dated December 7, 1987. There has never been an acceptance or denial of those medical bills, at least until the date of hearing.

We further note that the insurer has provided no justification for its failure to accept or deny. Consequently, we conclude that claimant is entitled to a penalty pursuant to ORS 656.262(10). However, because we have earlier found that the medical services at issue are not compensable, there are no amounts "then due" upon which we might base a penalty for the insurer's delay. ORS 656.262(10). Further, we do not find any unreasonable resistance to the payment of compensation under ORS 656.382. Therefore, we do not assess an attorney fee on the untimely denial issue. See Lloyd L. Cripe, 41 Van Natta 1774 (1989).

Penalties and Attorney Fees - Claims Information, Failure to Pay Temporary Disability

We adopt the Referee's "Conclusions of Law and Opinion" regarding penalties and attorney fees for the insurer's failure to provide claims information timely and failure to pay temporary disability benefits within 14 days.

Attorney Fees - Request for Increase in Carrier-paid Fees

Claimant contends entitlement to a larger carrier-paid attorney fee for the insurer's claims processing violations. We disagree.

ORS 656.262(10) provides authority for assessing a penalty and related attorney fee for claims processing violations. The Referee assessed a penalty of 25 percent of the amounts then due, pursuant to ORS 656.262(10), and a $150 related attorney fee for each failure to timely supply claims information and failure to pay interim compensation within 14 days. The statute allows for a penalty of "up to" 25 percent and any attorney fees which may be assessed under ORS 656.382.

Under the circumstances, we conclude that the Referee's $300 attorney fee award and 25 percent penalty are appropriate for the insurer's unreasonable claims processing.

ORDER

The Referee's order dated August 1, 1989 is affirmed in part and reversed in part. That portion of the Referee's order that reduced claimant's scheduled permanent disability award is reversed. That portion of the Determination Order which awarded claimant 7.5 percent (22.5 degrees) scheduled permanent disability is reinstated and affirmed. The remainder of the order is affirmed.

October 2, 1990 Cite as 42 Van Natta 2295 (1990)

In the Matter of the Compensation of
DANIEL R. JORDISON, Claimant
And, in the Matter of the Complying Status of DEAN T. CATES, dba
CATES CONSTRUCTION, Employer
WCB Case Nos. 89-01966 & 89-01967
ORDER ON RECONSIDERATION
Goldberg, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Sharon R. Schooley, Assistant Attorney General

Claimant requests reconsideration of our September 7, 1990 order which dismissed the noncomplying employer's request for review of a Referee's order that affirmed a proposed order of noncompliance. Specifically, claimant seeks an assessed attorney fee for services rendered on Board review under OAR 438-15-070.

Following our review of claimant's motion, we decline to award an attorney fee. The Board may assess a reasonable attorney fee where an employer initiates a request for review and the Board finds that compensation awarded to a claimant should not be disallowed or reduced. See ORS 656.382(2); OAR 438-15-070; Kordon v. Mercer Industries, 308 Or 290, 295-296 (1989).

As noted in the Order of Dismissal the sole issue at hearing was the validity of a Proposed and Final Order issued by Department of Insurance and Finance. Because the matter before the Referee did not concern a claim, we did not have jurisdiction and dismissed the request for review. Claimant's entitlement to compensation was never in issue on Board review. Moreover, we made no finding that claimant's compensation should not be disallowed or reduced. Under such circumstances, claimant is not entitled to an attorney fee under ORS 656.382(2). Liberty Northwest Ins. Corp. v. McKellips, 100 Or App 549, 550 (1990); Agripac, Inc. v. Kitchel, 73 Or App 132 (1985); Matthew W. Johnson, 40 Van Natta 393 (1988).

Accordingly, our September 7, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 7, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAROLD W. MILLER, Claimant
WCB Case No. 89-05899
ORDER ON REVIEW
Brothers, Drew, et al., Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of those portions of Referee Peterson's order which: (1) reclassified claimant's 1983 low back injury claim from nondisabling to disabling; (2) set aside SAIF's denial of claimant's aggravation claim for a low back condition; and (3) awarded temporary disability compensation commencing in May 1988. On review, the issues are aggravation and entitlement to temporary disability compensation. We reverse.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

Claimant did not initially lose time from work, receive temporary disability benefits or sustain permanent disability as a result of his low back injury.

Claimant did not request reclassification of his injury from nondisabling to disabling within one year of injury.

Claimant did not file his aggravation claim within five years of injury.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's low back injury was misclassified as nondisabling from the outset and had never been closed, the Referee concluded that claimant's aggravation rights had not begun to run. The Referee further concluded that claimant is entitled to time loss compensation commencing May 1988 when he was last able to work. We disagree and reverse.

Classification of Claim

A "disabling compensable injury" is one which entitles the worker to compensation for disability or death. Former ORS 656.005(7)(b). A "nondisabling compensable injury" is any injury which requires medical services only. Former ORS 656.005(7)(c).

We find that claimant's injury initially only required medical services. During the first year after claimant's September 29, 1983 injury, claimant continued to work for the insured with no time loss due to his injury. Claimant continued to receive periodic medical treatment, and Dr. Ries, claimant's treating chiropractic physician, immediately released claimant to return to modified work with a temporary 30 pound lifting restriction. This temporary restriction did not affect claimant's wages. However, Ries did not indicate that claimant had any permanent disability at that time.

Moreover, there is no evidence of permanent disability within one year of the injury. Dr. Ries referred claimant to Dr. Kendrick, neurosurgeon, in December 1984. Kendrick reported that claimant's condition was improving but that a CT scan revealed a mild bilateral disc bulge not requiring surgical intervention. The presence of a disc bulge alone is not persuasive evidence of permanent disability. Furthermore, even after the CT scan revealed the presence of a

disc bulge, Dr. Ries still did not indicate that claimant had any permanent disability.

Inasmuch as claimant sustained neither time loss nor permanent disability, we find that claimant's injury claim was not misclassified as nondisabling from the outset.

Aggravation

At the time of claimant's September 29, 1983 injury, ORS 656.268(3) provided that claims for nondisabling injuries could be closed either through a Notice of Closure or by means of a Determination Order. In any event, closure of a claim was required, whether disabling or nondisabling. See Webb v. SAIF, 83 Or App 386, 390 (1987). As the Referee noted, SAIF did not close this claim with a Notice of Closure, and a Determination Order was not issued. Therefore, the claim is still in open status.

Claimant contends that, as his claim continues in open status, his aggravation rights have never run. If claimant's injury had been misclassified from the outset, and in truth was always disabling, then claimant's contention would be correct. See Davison v. SAIF, 80 Or App 541, modified on recon, 82 Or App 546 (1986). However, we have concluded that claimant's injury was not disabling at the outset.

SAIF's failure to close a nondisabling claim has no effect on claimant's aggravation rights. If the claim that a nondisabling injury has become disabling is made more than one year after the date of injury, the claim is to be treated as an aggravation claim pursuant to ORS 656.273. Former ORS 656.262(11) (renumbered ORS 656.262(12)). If the injury was nondisabling and no determination has been made, a claim for aggravation has to be filed within five years after the date of injury, not the date of closure. Former ORS 656.273(4)(b).

SAIF initially accepted this claim as nondisabling, and claimant did not seek reclassification of his injury from nondisabling to disabling within one year of injury. See former ORS 656.262(11) (renumbered ORS 656.262(12)). Therefore, claimant's claim must be treated as an aggravation claim under ORS 656.273, because it is made on the basis that his previously nondisabling injury has become disabling more than one year after the date of injury. Smith v. Ridgepine, Inc., 88 Or App 147, 149 (1987). The crucial question, then, is did claimant file his claim within five years of September 29, 1983, that is, by September 29, 1988.

Dr. Ries completed a Form 828 on May 17, 1988, and noted that claimant was medically stationary and released to work. He additionally noted that claimant was experiencing increased back and leg pain and required more frequent treatment. The doctor again noted claimant's increased back and leg pain on a Form 828 filed on June 20, 1988, while continuing to indicate that claimant was medically stationary and released for work. On December 13, 1988, Dr. Ries wrote to SAIF requesting that claimant's injury claim be reopened and that time loss benefits be paid retroactive to May 1988.

On this record, we find that these 828 Forms constituted a claim for additional medical services. We further find that 828 Forms that indicate claimant is medically stationary and released to work, while simultaneously requesting additional medical services, are not sufficient to put an insurer on notice that an aggravation claim is being filed. See Krajacic v. Blazing Orchards, 84 Or App 127 (1987); Haret v. SAIF, 72 Or App 668, rev den 299 Or 313 (1985); Joanne C. Krause, 42 Van Natta 1021 (1990).

Dr. Ries' letter of December 13, 1988, received by SAIF on December 19, 1988, clearly was an aggravation claim. However, this was the first notice of the claim received by SAIF. Consequently, as this notice was not filed within five years of claimant's injury, the claim is barred. See ORS 656.273(4)(b).

Temporary Disability Compensation

As we have found that claimant's claim was not filed within the statutory five-year aggravation period, claimant has no aggravation rights from his September 1983 injury for which time loss compensation can be paid.

ORDER

The Referee's order dated July 6, 1989 is reversed. The SAIF Corporation's Notice of Claim Acceptance is reinstated and upheld. Claimant's low back injury claim shall remain classified as "nondisabling." Claimant is not entitled to time loss compensation beginning May 1988. The award of an attorney fee equal to 25 percent of the increased time loss compensation payable to claimant's counsel is reversed.

In the Matter of the Compensation of
BOBBIE D. OWENS, Claimant
Own Motion No. 90-0482M
OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
Vick, et al., Claimant Attorneys
SAIF Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his October 7, 1982, industrial injury. Claimant's aggravation rights expired July 11, 1989. The insurer accepts responsibility for the proposed surgery and recommends that claimant's 1982 injury claim be reopened for the payment of temporary disability benefits.

The parties apparently agree that claimant's cervical condition has worsened requiring surgery; however, responsibility for that condition has not yet been resolved. There is pending litigation regarding whether claimant's condition is related to his October 7, 1982, injury or his June 11, 1989 injury. (WCB Case Nos. 90-16115 and 90-17879). SAIF is responsible for both injuries. However, because only the 1982 injury is subject to the Board's own motion authority, we conclude that it would be in the best interest of the parties to consolidate this own motion matter with the pending litigation.

SAIF will pay the claim no matter what the outcome. It appears to the Board that SAIF is at minimal, if any, risk if it voluntarily pays the claim pending resolution of the responsibility issue. We are unwilling to further complicate the situation by issuing an order that may require alteration when there is an obvious solution to the problem within the unilateral reach of SAIF.

The hearing is presently set before Referee Crumme on December 27, 1990. At that hearing, the Referee shall take evidence on whether claimant's need for cervical surgery is related to the 1982 injury and, if so, whether claimant qualifies for own motion relief under ORS 656.278(1)(a). At the conclusion of the hearing, the Referee shall forward to the Board a recommendation with respect to the own motion matter and a copy of the appealable order issued in WCB Case Nos. 90-16115 and 90-17879.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHERYL A. PATTEN, Claimant
WCB Case No. 89-07327
ORDER ON REVIEW
Robert L. Philmon, Claimant Attorney
Cooney, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Galton's order that reduced her scheduled permanent disability award for a right forearm injury from 28 percent (42 degrees), as awarded by a Determination Order, to 5 percent (7.5 degrees). On review, the issue is extent of scheduled disability. 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 "Conclusions and Opinion," with the following supplementation.

Disabling pain

We note that, under the current version of OAR 436-35-001 et seq, the rules in effect at the time of the February 27, 1989 Determination Order, no provision has been made for an impairment value for pain. OAR 436-35-010(2)(b). Accordingly, under the standards for rating disability, the issue of whether or not claimant's pain is disabling is moot.

Loss of grip strength

Claimant contends that a report from Medical Consultants Northwest indicates that she has sustained lost grip strength on the right. However, the exhibit cited to by claimant was not admitted at hearing. Under the circumstances, we decline to consider claimant's argument as it is based upon evidence not in the record. See ORS 656.295(5).

ORDER

The Referee's order dated August 4, 1989 is affirmed.

In the Matter of the Compensation of
BRYAN THOMPSON, Claimant
WCB Case No. 88-20553
ORDER DENYING RECONSIDERATION
Gatti, Gatti & Maier, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Claimant has requested reconsideration of our July 5, 1990 Order on Review. Contending that his counsel did not receive a copy of the Board's order, claimant seeks reconsideration of our order. We deny the request.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for

judicial review. ORS 656.295(8). The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

The Board may republish an order if it finds that it failed to mail a copy of its prior order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988); Mary J. Gates, 42 Van Natta 1813 (August 21, 1990). An attorney is not a party. ORS 656.005(19); Berliner, supra, page 266, n. 1; Frank F. Pucher, Jr., 41 Van Natta 794, 795 (1989).

Here, claimant asserts that his counsel did not receive a copy of the Board's July 5, 1990 order. Yet, the Board's file indicates that a copy of the order was mailed to claimant's counsel to his firm's branch office and the copy has not been returned to the Board as undeliverable by the postal service.

In any event, even assuming that claimant's counsel did not receive a copy of the Board's order, that does not invalidate the order. See Berliner, supra; Pucher, supra. Rather, to prompt the reissuance of our order as claimant requests, he must establish that a copy of the order was not mailed to him. The record does not support such a finding.

To begin, the Board's order and file indicates that copies of the order were mailed to all parties, as well as their representatives. Moreover, there has been no contention from either claimant, the employer, or its insurer that this mailing to the parties was defective. Such circumstances persuade us, at a minimum, that copies of the Board's July 5, 1990 order were mailed to all parties to the proceeding.

Based on the foregoing reasoning, we are persuaded that a copy of our July 5, 1990 order was mailed to claimant and all other parties to the proceeding. Inasmuch as our order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties, it has become final. See ORS 656.295(8); Berliner v. Weyerhaeuser Company, supra; International Paper Co. v. Wright, supra; Fischer v. SAIF, supra. Consequently, we are without authority to reconsider our order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES M. KEPFORD, Claimant
WCB Case No. 87-02846
THIRD ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Claimant requests reconsideration of our September 18, 1990 Second Order on Remand that declined to grant his request for an award of attorney fees for services rendered on appeal which eventually resulted in our August 24, 1990 Order on Remand that reinstated a Referee's assessment of a penalty and an associated attorney fee for the self-insured employer's unreasonable conduct in failing to timely submit a claim for closure. Specifically, claimant contends that he is entitled to an employer-paid attorney fee under ORS 656.386(1) and 656.388(1). We disagree for the following reasons.

There are three prerequisites to the applicability of ORS 656.386(1): (1) claimant must initiate the process by requesting review from an order or

decision denying the claim; (2) claimant must prevail finally on the issue of compensation (before the forum in which the claimant is the initiating party); and (3) the decision of the referee, board or court in which the claimant prevails finally must be from an earlier decision or order denying, rather than allowing, the claim for compensation. Greenslitt v. City of Lake Oswego, 305 Or 530 (1988); Shoulders v. SAIF, 300 Or 606, 611-12 (1986).

The facts presented in this case do not satisfy the requirements of ORS 656.386(1). If for no other reason, claimant neither requested Board review nor petitioned for judicial review. Thus, he was not the initiating party. Moreover, he did not prevail finally before a forum in which he was the initiating party. Instead, assuming our present order becomes final, claimant will have prevailed against the employer's requests for review by the Board and the Court of Appeals.

ORS 656.388(1) provides for the approval or allowance of a reasonable attorney fee before every prior forum. However, the provision is expressly applicable to those cases "in which a claimant finally prevails after remand."

As discussed in our prior order, except with respect to the penalty and attorney fee assessment, claimant did not finally prevail after remand to the Board. Rather, he prevailed at the hearings level and successfully defended the Referee's temporary disability award before the Board and the Court of Appeals. (Our mandate from the court did not include the award of an attorney fee for claimant's successful defense of the temporary disability award). Thus, claimant prevailed finally before the Court of Appeals with respect to the entitlement to temporary disability compensation.

Finally, to the extent that claimant is seeking an award for efforts expended at the Board and court level for successfully defending against the employer's appeals on the penalty issue, we find that there would be no such entitlement. ORS 656.382(2); Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). [Such penalties and attorney fees are not "compensation" under ORS 656.382(2).] In reaching this conclusion, we find no logical reason why a claimant would be entitled to an attorney fee for services which result in the reinstatement of a penalty after remand under ORS 656.388(1), when those same services would not justify an attorney fee award under ORS 656.382(2) had the appellate court affirmed the identical penalty and attorney fee assessment.

Thus, we conclude that ORS 656.388(1) envisions the award of an attorney fee for services rendered before every prior forum where claimant has requested Board review or petitioned for judicial review and "finally prevails" at a lower forum after remand. We draw further support for this holding from ORS 656.386(1), which we note also uses the term "finally prevails" in providing for a carrier-paid attorney fee as awarded by the Referee, Board or appellate court where claimant "finally prevails" before that particular forum from an order or decision denying a claim for compensation.

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 18, 1990 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT A. PETERSON, Claimant
And, in the Matter of the Complying Status of ANDREW J. THOMAS,
dba, GOLDEN RULE PAINTING, Noncomplying Employer
WCB Case Nos. 89-08481, 89-08480, 89-08479, 89-00446, 89-00445 & 88-12801
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Cooney, et al., Defense Attorneys
Parker & Bush, Defense Attorneys
Jerry Larkin (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Peterson's order which: (1) upheld the noncomplying employer's denial of compensability of claimant's low back injury claim; (2) affirmed a corrected Proposed and Final Order issued by the Department of Insurance and Finance finding claimant to be a nonsubject employee; and (3) declined to assess penalties and associated attorney fees for an alleged unreasonable denial of claimant's claim and for the employer's alleged failure to pay interim compensation 14 days after receiving notice of claimant's injury. In his brief, claimant contends that a noncomplying employer does not have standing to challenge the SAIF Corporation's acceptance of a claim nor can the Department challenge SAIF's acceptance of a claim. On review, the issues are subjectivity, compensability, jurisdiction, and penalties and associated attorney fees. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions of Law and Opinion" with the following comments.

Claimant, citing Stephen L. Dokey, 38 Van Natta 1560 (1986), contends that a noncomplying employer may not challenge the compensability of an accepted claim. On judicial review in Dokey, the court affirmed. Derryberry v. Dokey, 91 Or App 533 (1988). We note, however, that that portion of Derryberry v. Dokey, which suggests a contrary result has subsequently been disapproved. Clark v. Linn, 98 Or App 393 (1989); ORS 656.283. In Clark v. Linn, the court held that an alleged noncomplying employer which requests a hearing on compensability is entitled to such a determination, whether or not the employer denied the claim pursuant to ORS 656.262. Here, moreover, the noncomplying employer requested review of SAIF's acceptance of the claim less than 60 days from referral to SAIF and, thus, is not confined to proving fraud, misrepresentation, or other illegal activity in order to defeat compensability of the claim. See Kristi L. Chase, 42 Van Natta 1247 (1990).

Claimant next contends that the noncomplying employer is subject to a penalty and associated attorney fee for failing to pay interim compensation 14 days after receiving notice of claimant's injury. We disagree. The noncomplying employer has no obligation to pay interim compensation. SAIF is solely responsible for any such payments. See Kenneth R. Derrick, 42 Van Natta 274 (1990). See ORS 656.054(1).

Finally, claimant contends that the "Department" may not deny the compensability of an accepted claim after issuing a Proposed and Final Order of Noncompliance. We note that the Department's order concerns only the compliance

of an employer under the context of ORS 656.052 and ORS 656.735. The claimant is not a party to the order and proceeding concerning compliance of an employer. ORS 656.017. See ORS 656.003 and 656.005(19). The Proposed and Final Order of Noncompliance has no binding effect on the compensability of a claim.

ORDER

The Referee's order dated July 25, 1989 is affirmed in part, reversed in part and modified in part. That portion of the Referee's order that upheld the employer's denial is reversed. The employer's denial is a nullity. The SAIF Corporation's acceptance of the claim is set aside. The remainder of the order is affirmed.

October 3, 1990 Cite as 42 Van Natta 2303 (1990)

In the Matter of the Compensation of
TAMIRAH R. ROGERS, Claimant
WCB Case No. TP-90053
THIRD PARTY ORDER
Dixon & Friedman, Claimant Attorneys
J. David Thurber (Saif), Defense Attorney

Claimant has petitioned the Board for resolution of a dispute concerning a proposed settlement of a third party action. See ORS 656.587. We approve the settlement.

FINDINGS OF FACT

In June 1989, claimant sustained a compensable injury as a result of a motor vehicle accident. Specifically, the vehicle claimant was operating was struck from behind by another vehicle. The SAIF Corporation, as insurer for claimant's employer, has accepted the claim and provided compensation.

As a result of the accident, claimant has suffered headaches, as well as neck, back, and right arm complaints. Her condition has been diagnosed as cervical sprain and strain. She has received conservative treatment for these problems, primarily consisting of physical therapy and medication.

Claimant has not returned to her job as a driver for a catering company. Her condition became medically stationary in November 1989. At that time, the Western Medical Consultants concluded that no additional treatment was needed and that there was no objective reason why she could not return to her prior work activities. Dr. Klubert, claimant's treating physician, concurred with the Consultants' report.

In January 1990, a Determination Order issued. Claimant was awarded approximately 5 months of temporary total disability. In addition, she was granted 17 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the right arm. The Evaluator's Worksheet noted that the Consultants' report had not been received until just prior to the evaluation.

To date, SAIF, as paying agency, has incurred actual claim costs totalling $12,651. These costs include medical expenses and temporary disability compensation, as well as the aforementioned unscheduled permanent disability awards.

Claimant has engaged legal representation to pursue a cause of action for negligence against the driver of the other vehicle. The third party insurer and claimant have agreed to settle the action for $12,000. SAIF has declined to

approve the settlement, contending that such a recovery would result in it receiving less than 50 percent of its actual claim costs.

FINDINGS OF ULTIMATE FACT

The third party settlement offer of $12,000 is reasonable.

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Dorotha M. Clarke, 40 Van Natta 1125 (1988); Kathryn I. Looney, 39 Van Natta 1140 (1987).

After reviewing the parties' respective positions, as well as the medical assessments concerning the lack of objective permanent impairment, and considering the aforementioned standard, we conclude that a settlement offer of $12,000 is reasonable. Consequently, we approve the settlement. Accordingly, proceeds of the settlement shall be distributed in accordance with ORS 656.593(3).

IT IS SO ORDERED.

October 4, 1990 Cite as 42 Van Natta 2304 (1990)

In the Matter of the Compensation of
CURTIS E. DEHAVEN, Claimant
WCB Case No. C0-00070
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Unrepresented Claimant
Gail Jacobs, Defense Attorney

Reviewed by Board Members Cushing and Myers.

On September 7, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $7,000 by Liberty Northwest Insurance Corporation, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

We shall not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, a reasonable fact-finder could only conclude that the agreement is unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Here, the disposition agreement provides: "By signing this Agreement, claimant certifies ... that claimant's questions ... have been fully and completely answered by claimant's attorney, and that no further questions remain." This certification is puzzling because it is not evident from the settlement documents or accompanying correspondence that claimant was ever represented by counsel during the negotiation or execution of this claim disposition agreement. Absent such evidence, a reasonable fact-finder could only conclude that the above certification is false and, consequently, that the entire agreement is unreasonable as a matter of fact.

Accordingly, we find that the proposed disposition is unreasonable as a matter of law and set it aside. See ORS 656.236(2).

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

IT IS SO ORDERED.

October 4, 1990 Cite as 42 Van Natta 2305 (1990)

In the Matter of the Compensation of
SUSAN J. FROMAN, Claimant
WCB Case No. 89-00485
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Baker's order which increased claimant's unscheduled permanent disability for her back injury from 28 percent (89.6 degrees), as awarded by the Determination Order, to 40 percent (128 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant compensably injured her low back on January 5, 1988. Claimant has been released for modified work, but has not returned to work.

Claimant's claim was closed by a March 10, 1989 Determination Order, awarding her 28 percent (89.6 degrees) unscheduled permanent partial disability.

Claimant, 37 years of age at hearing, has a GED. Claimant has successfully worked as a floral arranger. During that period she underwent specific training for that position. Claimant has successfully performed work as a floral designer during the ten years prior to the date of determination. The specific vocational preparation (SVP) for that position is +6. Claimant's highest SVP during the ten years prior to the Determination Order is +6. She has competence as a floral designer.

The physical capacity required to perform her work-at-injury was in the medium category. Claimant is now capable of performing work in the sedentary/light category.

Claimant suffers permanent ratable loss of range of motion in her back, and an unoperated disc derangement. Claimant suffers permanent loss of earning capacity resulting from her compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability for her back from 28 percent to 40 percent. We modify.

Because claimant's condition became medically stationary on January 30, 1989, and her claim was closed by Determination Order on March 10, 1989, the "standards" adopted effective January 1, 1989 (OAR 436-35-001 et seq), apply to the rating of claimant's permanent partial disability. OAR 436-35-270 through

436-35-440 apply to the rating of unscheduled permanent partial disabilities. OAR 436-35-270(1).

Age and Education

The appropriate value for claimant's age of 37 years is 0. OAR 436-35-290. Claimant has a GED. (Tr. 24). Therefore, the appropriate value for her formal education is 0. OAR 436-35-300(3). The highest SVP level demonstrated by claimant during the ten years prior to the date of determination was a +6, for working as a floral designer (DOT # 142-081-010). Therefore, the appropriate value for skills is +2. OAR 436-35-300(4). Claimant has demonstrated competence in some specific vocational pursuit, i.e. floral arranging. Therefore, the appropriate value for training is +0. OAR 436-35-300(5).

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

Adaptability

Neither party disputes claimant's adaptability factor of +6. Accordingly, we conclude the appropriate value is +6.

Impairment

The Referee found that claimant's impairment resulting from the compensable injury totalled 16 percent. We modify.

In rating claimant's impairment, we rely on Dr. Woolpert's report of April 19, 1989, as it is the most current medical report which includes range of motion findings. See Darlene J. Byrd, 42 Van Natta 1029 (1990).

Claimant's ratable loss of range of thoracolumbar motion includes: 28 degrees retained flexion (for a value of 6), zero degrees retained extension (for a value of 3), 18 degrees retained right flexion (for a value of 2), and 21 degrees retained left flexion (for a value of 2). OAR 436-35-360(6)(7)(8)(9). Claimant's total loss of thoracolumbar motion therefore, is 13.

The parties agree that claimant suffers from an unoperated disc bulge, for an impairment value of 4 percent. OAR 436-35-350(2).

After combining claimant's disc bulge value (4) with the lost range of motion value (13), we find that claimant's total impairment value is 16.48. OAR 436-35-320(1)(a) and 436-35-360(11).

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (0) is added to his education value (2) the sum is 2. When that value is multiplied by claimant's adaptability value (6), the product is 12. When that value is added to the impairment value (16.48), the sum is 28.48. This figure is then rounded to the next highest whole number. OAR 436-35-280(7). Therefore, claimant's total unscheduled permanent partial disability is 29 percent (92.8 degrees).

ORDER

The Referee's order dated July 17, 1989, is modified. In lieu of the Referee's increased award, and in addition to the Determination Order award, of 28 percent (89.6 degrees) claimant is awarded 1 percent (3.2 degrees) unscheduled permanent partial disability, giving him a total award to date of 29 percent (92.8 degrees).

In the Matter of the Compensation of
KENNETH D. McDONALD, Claimant
WCB Case No. C0-00076
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Richard A. Sly, Claimant Attorney
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

On September 7, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $10,000 by the SAIF Corporation, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

We shall not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). The lifetime right to medical services under ORS 656.245 is specifically excluded from matters which may be disposed under ORS 656.236 and rules promulgated thereunder. See OAR 436-60-145(1), 438-09-001(1). Compensable medical services include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services. See 1990 Or Laws, Ch.2, 10(1)(c).

Here, the proposed disposition purports to release claimant's claim for compensation and payments of any kind due or claimed for the past, the present, and the future, except compensable medical services. The disposition then provides: "Compensable medical services for this claim includes orthopedic footwear and braces that are reasonable and necessary as well as medications determined to be reasonably and necessarily related to the claim." That language could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245. Any limitation on that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). Accordingly, we find that the proposed disposition is unreasonable as a matter of law and set it aside. See ORS 656.236(2).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement which does not contain provisions exceeding the bounds of the statute and rules.

IT IS SO ORDERED.

In the Matter of the Compensation of
NEWTON W. ORR, Claimant
WCB Case No. 84-05108
ORDER ON REMAND
Michael B. Dye, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Orr, 101 Or App 612 (1990). Relying on SAIF v. Stephen, 308 Or 41 (1989), the court concluded that our prior order, which affirmed a Referee's

award of permanent total disability, Newton W. Orr, 41 Van Natta 966 (1989), failed to make "findings concerning whether, but for the compensable injury, claimant would have been willing to seek regular, gainful employment." The court has remanded the case to us to make findings concerning this requirement.

FINDINGS OF FACT

Claimant was 63 years of age at the time of hearing. His formal education is through the eighth grade. He had worked as an electrician at a mill for 18 years prior to his 1982 compensable injury.

On June 21, 1982, claimant compensably injured his low back and left knee when he fell about 15 feet down a stairway. He subsequently underwent surgery for both injuries. Dr. Buza, claimant's back surgeon, felt that claimant would not be able to return to any type of employment.

Claimant has no transferable skills. His physical restrictions resulting from the compensable injury preclude him from regularly performing any gainful and suitable occupation for which he has training and experience. Vocational rehabilitation services will not enable a return to work. Claimant attempted to return to work, but could not continue because of his physical disabilities attributable to the compensable injury. It is futile for claimant to seek work.

If not for the effects of his compensable injury, claimant would be willing to seek regular gainful employment. At hearing, claimant was asked whether he wanted to work and he responded, "yes, absolutely," and was sure he would still be working at the employment at injury if he had not been injured. (Tr. 63). This testimony is uncontradicted.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was permanently totally disabled because of his physical disabilities alone. 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 a work search futile, SAIF v. Scholl, 92 Or App 594, 597 (1988), he must also establish that he has made reasonable efforts to obtain regular gainful employment. ORS 656.206(3). Moreover, even if a work search would be futile, he must further establish that, but for the compensable injury, he would have returned to work. SAIF v. Stephen, 308 Or 41, 47-48 (1989).

Here, claimant compensably injured his low back and left knee. He has had surgery for both injuries, but continues to experience constant pain. The pain prevented him from continuing to work at a light duty job repairing electric motors, which a vocational counselor had found for claimant.

Claimant was 63 years old at the time of hearing. He has only an eighth grade education and no transferable skills. Vocational testing revealed limited adaptability and slow reactions. Severe pain, and subsequent back surgery, forced claimant to discontinue an authorized training program. Claimant's treating physician, Dr. Buza, stated that claimant would not be able

to return to any type of employment because of his physical limitations, combined with his psychological reaction to the compensable injury.

Considering the above-mentioned medical and vocational evidence, we conclude that claimant is no longer able to obtain and hold gainful employment in the broad field of occupations. Moreover, any efforts to obtain employment would be futile. Finally, claimant has established that, but for his compensable injury, he is willing to work, and would probably still be working at the employment he has held for over 18 years.

In reaching this latter conclusion, we rely upon claimant's uncontradicted testimony that he enjoyed his work and would be working at that previous employment had he not been injured, and his statements made to a pain center psychologist that he would like to return to work, but does not feel capable due to his physical problems. (Tr. 63; Ex. 29-5). Accordingly, we conclude that claimant has sustained his burden of establishing that he is permanently and totally disabled. Consequently, the Referee's order dated October 7, 1987 is affirmed.

IT IS SO ORDERED.

October 4, 1990 Cite as 42 Van Natta 2309 (1990)

In the Matter of the Compensation of
BASALISA RIOS, Claimant
WCB Case No. 89-11013
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Brazeau's order which declined to award temporary total disability compensation after April 25, 1989. On review, the issue is temporary disability benefits. We reverse.

FINDINGS OF FACT

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

The employer's office policy directs all supervisors to notify the personnel office of any worker's change of address if the worker gives the change of address to the supervisor. (Tr. 29).

Following her compensable injury, claimant went to the plant and told her immediate supervisor that she had moved and gave the supervisor her new address but not in writing. (Tr. 10, 11, 14, 17). The supervisor did not give claimant's new address to the office. Claimant's daughter-in-law, who speaks some English, called the insurer and gave the it the new address. (Tr. 17). Claimant's disability checks and other medical papers from the insurer were sent to claimant's new address. (Tr. 17, 18)

Claimant did not receive the employer's offer of light duty work.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's failure to respond to the employer's offer of wage earning employment allowed the employer to lawfully terminate claimant's temporary disability compensation. We disagree.

An injured worker is entitled to continued payment of temporary disability compensation for a disabling injury until the worker is both medically stationary and released by the attending physician to return to regular work. Former ORS 656.268(1) & (2); Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). However, an insurer/employer may reduce temporary total disability benefits to temporary partial disability benefits upon the worker's return to work. ORS 656.212; former OAR 436-60-030(3).

Additionally, the employer may pay only temporary partial disability benefits when the worker "refuses" wage earning employment under specified conditions. ORS 656.325(5); former OAR 436-60-030(5). However, before an employer can terminate temporary total disability benefits, strict compliance with former OAR 436-60-030(5) is necessary. Eastman v. Georgia-Pacific Corp., 79 Or App 610 (1986).

In this case, as of April 25, 1989, claimant's claim was not closed nor had claimant been found to be medically stationary. Therefore, claimant was entitled to continued temporary total disability benefits unless she refused the employer's offer of wage earning employment. Former OAR 436-60-030(5)(c) requires that "the employer has provided the injured worker with a written offer of the employment...." Subsequent to her compensable injury, while she was receiving temporary total disability benefits, claimant changed her address. Claimant informed her supervisor of her address change. Claimant informed the insurer of her address change. The employer twice mailed the wage earning employment offer to claimant's former address and twice it was returned to the employer undelivered by the post office. Claimant did not receive the employer's wage earning employment offer. Accordingly, we hold that the employer in this case has not "provided" claimant with a written wage earning employment offer. Furthermore, even if we were to agree with the Referee, that the employer did "provide" claimant with an offer of work, we could not find that claimant "refused" the offer. See ORS 656.325(5); former OAR 436-60-030. Claimant could not have "refused" an offer of which she had no knowledge.

Claimant is entitled to be compensated for temporary disability from April 25, 1989, the date that the employer terminated claimant's temporary disability benefits, until termination is authorized by ORS 656.268.

ORDER

The Referee's order dated July 11, 1989, as reconsidered on July 26, 1989, is reversed. Claimant is awarded temporary disability compensation as set forth above. Claimant's attorney is awarded 25 percent of the increased compensation resulting from this order as a reasonable attorney fee, not to exceed $3,800, payable directly to claimant's attorney.

In the Matter of the Compensation of
EDDIE BORREGO, Claimant
And, in the Matter of the Complying Status of
MORRIS SALTER, Employer
WCB Case Nos. 88-18220 & 88-18219
ORDER ON REVIEW (REMANDING)
Garrett, et al., Defense Attorneys
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Nichols' order which: (1) upheld the noncomplying employer's denial of claimant's back injury claim; (2) denied claimant's motion to exclude the noncomplying employer's testimony; and (3) declined to address the issue of untimely claim filing. On review the issues are jurisdiction, compensability, and evidence. We vacate.

FINDINGS OF FACT

Claimant filed an "801" claim form on August 22, 1988. (Ex. 1A).

On September 26, 1988, the Compliance Section of the Workers' Compensation Division issued its Proposed and Final Order; Notice finding that claimant was a subject worker in May 1988, and his employer was a noncomplying employer from November 1, 1987 to August 8, 1988. (Ex. 3).

Also, on September 26, 1988, the Department of Insurance and Finance referred claimant's back injury claim to the SAIF Corporation. (Ex. 2).

On September 30, 1988, the noncomplying employer filed his request for a hearing challenging the Proposed and Final Order; Notice which found him to be a noncomplying employer. (Ex. 5).

The SAIF Corporation issued a denial of claimant's back injury claim on October 10, 1988, on the grounds that claimant had not received medical services. (Ex. 6). Claimant has not requested a hearing from SAIF's denial.

On December 9, 1988, the noncomplying employer sent claimant a "denial" of claimant's back injury claim. (Ex. 8).

On December 22, 1988, claimant requested a hearing from the noncomplying employer's "denial."

On January 10, 1989, SAIF issued a rescission of its denial because it had received medical information that claimant had received medical treatment. (Ex. 10).

A hearing was held on January 26, 1989, which was continued to March 31, 1989 for the testimony of the noncomplying employer. The only issues presented at hearing were the noncomplying employer's challenge of the Proposed and Final Order; Notice of September 26, 1988, finding him noncomplying; claimant's challenge of the noncomplying employer's December 9, 1988 "denial" of claimant's back injury claim; and the noncomplying employer's affirmative defense that claimant failed to timely file his claim. (Tr. 1-12).

CONCLUSIONS OF LAW AND OPINION

Although the hearing requests are not part of the record, they are present in our Hearings Division files. Therefore, we take administrative

notice of the noncomplying employer's September 30, 1988 request challenging the Proposed and Final Order; Notice, and claimant's December 22, 1988 request from the noncomplying employer's denial. See Susan K. Teeters, 40 Van Natta 1115, 1118 (1988) (The Board may take administrative notice of a hearing request in its files).

The Referee held that claimant had not sustained his burden to establish that his work activities were a material contributing cause of his back condition or need for medical services. Claimant requested Board review. No briefs were submitted. The threshhold issue in this matter on review, however, is one of jurisdiction. See Southwest Forest Ind. v. Anders, 299 Or 205, 208 (1985); Davis v. Aetna Casualty Co., 102 Or App 132 (1990). We conclude that the Referee did not have jurisdiction to decide compensability.

There are two requests for hearing in this matter. Claimant requested a hearing from the noncomplying employer's denial of December 9, 1988. 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 656.740(1); Clark v. Linn, 98 Or App 393 (1989); Kristi L. Chase, 42 Van Natta 1247 (1990). Therefore, claimant's request from the noncomplying employer's "denial" does not raise a question concerning a claim since the noncomplying employer's "denial" is legally invalid and without effect. The Referee lacked jurisdiction to address claimant's request for hearing.

The other request for a hearing is the noncomplying employer's September 30, 1988 request from the Proposed and Final Order; Notice. Compensability was not determined by the order nor placed in issue by the request for hearing. Moreover, the noncomplying employer did not request a hearing from SAIF's subsequent acceptance of claimant's claim. See ORS 656.283(4); Clark v. Linn, supra; Kristi L. Chase, supra. As we held in Kristi L. Chase, supra, if the noncomplying employer had requested a hearing challenging compensability of SAIF's acceptance within 60 days of the referral to SAIF, then a litigation order finding the claim noncompensable would have operated to relieve SAIF of the duty to pay. Finally, claimant had not requested a hearing from SAIF's earlier denial of the claim.

Therefore, the only valid request for a hearing before the Referee was the September 30, 1988 request by the noncomplying employer from the Proposed and Final Order; Notice raising the issue of subjectivity/compliance, which the Referee did not address. In this situation, where the noncomplying employer is challenging the order of noncompliance from the Department, the request for a hearing is considered to be unrelated to a claim. The Board's only involvement in the case is to appoint a Referee to hold a hearing. ORS 656.283(4); Heinz J. U. Sauerbrey, 37 Van Natta 1512 (1985). 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 656.740(4); ORS 183.480(1)(2); see Stanley Wilson, 40 Van Natta 387 (1988). Consequently, because the Referee did not issue an order addressing subjectivity or compliance, and because the Board does not have de novo jurisdiction, we remand the matter to the Hearings Division for the appropriate proceedings and order.

ORDER

The Referee's order dated June 29, 1989 is vacated. The noncomplying employer's request for a hearing from the September 26, 1988 Proposed and Final Order; Notice is remanded to the Presiding Referee. The Presiding Referee shall appoint a referee who shall conduct further proceedings consistent with this opinion. Claimant's request for a hearing from the noncomplying employer's denial is dismissed.

In the Matter of the Compensation of
JACQUELINE D. HANES, Claimant
WCB Case Nos. 89-00305 & 89-00047
ORDER DENYING RECONSIDERATION
Ronald A. Fontana, Claimant Attorney
Davis & Bostwick, Defense Attorneys
Randolph Harris (Saif), Defense Attorney

Claimant requests reconsideration of our July 20, 1990 Order on Review. Specifically, claimant seeks an attorney fee for successfully defending the Referee's responsibility decision. We deny the request.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal a 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).

Inasmuch as our order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its issuance, it has become final. See ORS 656.295(8); International Paper Co. v. Wright, supra; Fischer v. SAIF, supra. 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 Theron Stiehl, 42 Van Natta 31 (1990). In order to do so, our prior order must not have addressed either the entitlement to, or the amount of, an attorney fee. Id.

Here, our July 20, 1990 order neither addressed the entitlement to, nor the amount of, an assessed fee for services on review. Thus, we have jurisdiction to consider claimant's request. However, claimant has provided no explanation for her failure to submit her request during the 30 day period immediately following the issuance of our order, while we still retained jurisdiction over the merits of the case. Instead, she has merely submitted her request for an attorney fee, some 65 days after our order issued. Under these circumstances, we decline to reconsider our order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSE E. SANCHEZ, Claimant
WCB Case No. 89-00986
ORDER ON RECONSIDERATION
Wilbur C. Smith, Jr., Claimant Attorney
Dennis S. Martin (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our September 19, 1990 Order on Review that reduced a Determination Order award of 42 percent (134.4 degrees) unscheduled permanent disability to 38 percent (121.6 degrees) unscheduled permanent disability. Specifically, SAIF requests authorization to offset overpaid permanent partial disability against future permanent disability awards.

A Determination Order awarded claimant 42 percent (134.4 degrees) unscheduled permanent disability. Claimant requested a hearing, alleging that he

was permanently totally disabled or, in the alternative, that his award of permanent partial disability should be increased. SAIF filed a supplemental response to claimant's hearing request, contending the award should be decreased. The issue of reducing permanent partial disablity benefits was before the Referee, but the Referee affirmed the Determination Order award.

Claimant requested Board review. SAIF cross-requested review, again asking that the award be reduced. In its brief, SAIF argued that it was entitled to an offset of overpayment of permanent partial disability compensation. Entitlement to an offset did not arise until after the Board reviewed the case and reduced the award. It is clear that SAIF did not intend to waive the issue. See V. W. Johnson & Sons v. Johnson, 103 Or App 355 (1990). Consequently, we authorize SAIF to offset permanent partial disability benefits overpaid as a result of the Determination Order against any future permanent partial disability awards.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, the Board adheres to and republishes our September 19, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

October 9, 1990 Cite as 42 Van Natta 2314 (1990)

In the Matter of the Compensation of
GUY M. GABEL, Claimant
WCB Case No. 89-08822
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) affirmed a Determination Order that awarded no unscheduled permanent partial disability for injury to the right shoulder; and (2) declined to award additional temporary total disability, finding that the SAIF Corporation had correctly calculated the temporary total disability rate. On review, the issues are extent of permanent disability and rate of temporary total disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt findings numbered 1-6 and 8 of the Referee's Findings of Fact and make the following additional findings:

Claimant was hired to work a regular shift beginning at 7:00 a.m. and ending at 3:30 p.m., for a total of eight hours of work. He was also expected to work overtime as required. Claimant was hired in September 1988, during the employer's busy season. During his employment, claimant, along with other employees, was frequently called to begin work before the regular shift and to work more than eight hours in a day and to work more than 40 hours in a week.

Overtime pay was paid for all hours worked in excess of 40 hours per week.

FINDINGS OF ULTIMATE FACT

Claimant has suffered no impairment of the right shoulder due to his compensable injury. He has suffered no loss of earning capacity due to injury to the shoulder.

Claimant was regularly employed five days per week. His remuneration was not based solely on daily wages. His hours of worked varied. He regularly performed overtime work.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

We affirm and adopt the Referee's order on this issue. Although claimant experiences pain in the shoulder, that pain is apparently related to a bilateral, noncompensable condition. Moreover, claimant's treating physician has opined that claimant suffers no shoulder impairment related to the compensable injury. Consequently, claimant is entitled to no unscheduled award.

Rate of Temporary Total Disability Compensation

The Referee concluded that SAIF correctly calculated claimant's temporary disability compensation based solely on his wages for his regularly scheduled shift, without regard to wages earned for overtime work.

On review, claimant contends that he is entitled to a higher rate of temporary total disability for two reasons. First, he contends that he is entitled to temporary disability compensation based on a six-day workweek, rather than a five-day workweek, because he is required to be available for work on Saturdays as well as Monday through Friday. Second, he contends that he is entitled to an adjustment of the rate in light of his overtime work. We agree with the second contention only.

ORS 656.210 provides that a regularly employed worker whose compensation is based solely on daily wages shall be entitled to temporary disability compensation based on the number of days in his or her workweek. A worker is regularly employed if he or she is actually employed or available for employment. We are persuaded that claimant was regularly employed on five days per week, the days when he was regularly scheduled to work. We are not persuaded that claimant was employed on a six-day per week basis. Claimant was employed to work five days and overtime as necessary. The employer apparently notified claimant in advance if he was expected to work on Saturday. It does not appear that he was required to be available for work unless so notified. Were we to conclude that claimant was regularly employed on Saturdays by virtue of the fact that the employer sometimes required employees to do Saturday overtime, we would also conclude that any employee who is employed under a contract providing for mandatory overtime is regularly employed around the clock. Such an interpretation of the statute would, we believe, be inconsistent with its intent.

Consequently, we treat claimant as regularly employed for five days per week and reject claimant's first argument.

We are persuaded, however, that claimant, while regularly employed, is not compensated solely on daily wages. Consequently, OAR 436-60-020(7) applies. See Lowry v. Du Log, Inc., 99 Or App 459 (1989). Under OAR 436-60-020(7)(i), the rate for workers who regularly work a 40 hour week but also regularly work overtime must be calculated based upon average overtime earnings as well as the

worker's regular earnings. See Roger A. Bailey, 42 Van Natta 1659 (1990). See also, Donna J. Russell, 40 Van Natta 568 (1988), affd mem, 95 Or App 219 (1989).

A worker regularly works overtime if the worker frequently works overtime--that is, if his overtime work is not sporadic. See Cecilia A. Herrington, 42 Van Natta 1766 (1990). In this case, claimant was hired precisely because the employer was working a significant amount of overtime. He frequently worked hours outside his regularly scheduled hours. Therefore, we have found that he regularly worked overtime.

Accordingly, under the rule, claimant is entitled to compensation based on his overtime as well as his regular wages.

ORDER

The Referee's order dated September 6, 1989 is affirmed in part and reversed in part. That portion of the order that declined to adjust claimant's temporary disability compensation rate is reversed. The claim shall be remanded to the SAIF Corporation to recalculate claimant's temporary disability compensation in accordance with this order. For services at hearing and review regarding the temporary total disability rate issue, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased compensation awarded by this order, not exceeding $3,800, payable by SAIF directly to claimant's attorney out of that compensation. The remainder of the order is affirmed.

October 9, 1990 Cite as 42 Van Natta 2316 (1990)

In the Matter of the Compensation of
DAVID S. MCELMURRY, Claimant
WCB Case No. 85-12308
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Quillinan's order that upheld the insurer's denial of medical benefits for a low back condition. On review, the issues are compensability, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant compensably injured his low back in Oregon in 1976. The injury resulted in a right sided laminotomy and removal of a disc fragment at L5-S1 in 1977. His aggravation rights expired on March 10, 1982.

Claimant became a seasonal farm hand in California, where he worked from 1981 until 1985. He had no incidents or injuries in this employment.

Claimant continued to consult in Oregon with Dr. Streitz, M.D., orthopedic surgeon and his treating physician, for recurrent low back symptoms. In 1984, he was hospitalized in Klamath Falls, Oregon after an acute onset of low back pain precipitated by non-work activity. At this time he had a narrowing of the left L5-S1 disc space. In May and again in July 1985 he was treated for flare-ups. In August 1985 Streitz performed a left-sided laminotomy at L5-S1. Claimant did not return to work after this surgery.

In September 1985 the Oregon insurer denied both compensability and responsibility, stating that claimant's subsequent employment in California materially contributed to his current condition. Claimant had not filed a claim in California.

Claimant filed a request for hearing in October 1985 on the issues of compensability, medical services, and penalties and attorney fees. In December 1985 the Board issued an order postponing action on an Own Motion request.

In December 1985 claimant again had low back, left hip and left leg pain associated with numbness and tingling in the left leg, which was aggravated by prolonged sitting, standing or walking. Dr. Campagna, surgical neurologist, diagnosed recurrent nerve root irritation S1 left secondary to the 1976 injury. Claimant had scarring at L5-S1, the site of the 1985 surgery, and an extruded disc at L5-S1 centrally. Claimant eventually underwent a discectomy in July 1986.

In an April 1986 order, the Referee found that both claimant's 1976 injury and 1985 work exposure in California materially contributed to his low back condition. She upheld the insurer's denial because claimant had not filed a claim in California.

In May 1986 claimant filed a request for review, and, on the advice of his attorney, filed a California claim. The California Workers' Compensation Appeals Board found that claimant did not sustain an injury to the back arising out of and in the course of employment and did not sustain a cumulative trauma injury to the back during the period of March 1981 to July 1985. This order was not appealed.

In response to claimant's motion, the Board, in December 1986, stayed review and remanded, limiting the scope of the remand to consideration of the evidence related to claimant's claim for workers' compensation under California law. The insurer maintained that the California claim had not been filed in good faith and that the Oregon claim was therefore not compensable.

The Referee affirmed the Oregon insurer's denial in a November 1987 order, stating that claimant's California claim was filed in bad faith and reiterating her initial opinion that claimant's California work activities were an "intervening off-job factor which [broke] the chain of compensability" in Oregon. Claimant filed a request for review of this order in December 1987.

FINDINGS OF ULTIMATE FACT

Claimant's current need for medical services is materially related to his compensable 1976 Oregon injury.

Claimant's out-of-state employment did not independently contribute to a worsening of his low back condition.

Claimant filed for benefits in California. Those benefits were denied and finally determined.

CONCLUSIONS OF LAW AND OPINION

This case is on review from both the April 1986 and the November 1987 orders. There are no briefs in the file.

Where claimant has a compensable claim in Oregon and thereafter experiences an injury or injurious exposure with an out-of-state employer, the Oregon

employer remains responsible for the condition if the Oregon injury remains a material contributing cause of that condition, just as it would where the alleged worsening occurred off the job. Grable v. Weyerhaeuser Co., 291 Or 387 (1981); Miville v. SAIF, 76 Or App 603 (1985). However, if it can be shown that the out-of-state employment or injury independently contributed to a worsening of the underlying condition, then claimant must show that he filed for benefits in the foreign jurisdiction, and that those benefits were denied and finally determined. Olson v. E.B.I. Co., 78 Or App 261 (1986); Miville, supra; Harry C. Clark, 38 Van Natta 1371 (1986). If claimant's out-of-state claim had been accepted and compensation awarded, or if claimant failed to file a claim in the foreign jurisdiction, the Oregon claim would be barred. Olson, supra; Miville, supra.

Independent Contribution

Based on the change in claimant's complaints in 1985 and his work activities in California between 1981 and 1985, the Referee found that those work activities resulted in an injury in California in 1985; that the injury was a material factor in claimant's 1985 ruptured disc; and that the out-of-state employment, therefore, independently contributed to claimant's condition. We disagree.

In order to break the chain of causation and potentially defeat compensability, the later California incident must independently contribute to a worsening of claimant's underlying condition. If the California incident independently contributes to the worsening of symptoms alone, compensability under the Oregon claim cannot be defeated. Harry C. Clark, supra. Claimant had a history of episodic increases in symptoms but no significant change until July 1985, when he reported pain down his left leg to the ankle. (Ex. 64-11, -12, -13). There is no evidence that an injury occurred in California. However, on the one hand, Dr. Streitz stated that the herniation and need for surgery related back to claimant's 1976 injury because it was in the same location as the original disc rupture and surgery, and may have been related to claimant's interim work. On the other hand, at deposition in answer to a hypothetical question, Streitz stated that it was medically probable that work as a farmhand contributed slightly to the herniation. (Ex. 64-33 & 34; see also ex. 59, 61). We give no weight to Streitz' answer to the hypothetical, because there is nothing in the record to establish what claimant in fact did in his California employment, i.e., that he did what was presented in the hypothetical. It is inadequate to show that the subsequent California employment merely "could have" contributed to claimant's condition. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). Consequently, we find no proof of an independent contribution to claimant's underlying condition as a result of his California employment. We further conclude that claimant's current need for medical services is materially related to his 1976 compensable injury.

Out-of-State Filing Requirement

The Referee found that claimant had not made a good faith effort to successfully litigate a claim with the California employer and thus concluded that claimant could not rely on Miville to obtain compensation from the Oregon employer. Because we find no independent contribution as a result of claimant's California employment, it is immaterial whether or not claimant filed a claim in California.

Nevertheless, assuming there was an independent contribution by claimant's California work, the claim was filed and finally denied in California. Claimant went to hearing in California and testified honestly as far as we know. It is not our position to decide how vigorously the out-of-state claim was

pursued. Consequently, claimant's claim against the Oregon employer remains compensable. Grable, supra.

Penalty and Related Attorney Fees

Claimant requested a penalty and attorney fees in his first request for hearing. The insurer's September 6, 1985 denial was timely. Therefore, we address the issue of unreasonable denial. At the time of denial the insurer had reports from Dr. Streitz stating that, although claimant's present symptoms related back to the 1976 injury, his interim work may have contributed to his current condition. Under these circumstances, the insurer's denial was not unreasonable. Accordingly, we decline to assess a penalty and related attorney fees.

Attorney Fee

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case, noting that no brief was filed on review, and the moderate complexity of the issues.

ORDER

The Referee's orders dated April 21, 1986 and November 30, 1987 are reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $2,000, to be paid by the insurer.

October 9, 1990 Cite as 42 Van Natta 2319 (1990)

In the Matter of the Compensation of
JON C. MILLET, Claimant
WCB Case No. 88-16759
ORDER OF ABATEMENT
Merrill Schneider, Claimant Attorney
Stafford Hazelett, Defense Attorney

The Board has received claimant's request for reconsideration and abatement of our Order on Review dated September 13, 1990.

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 10 days from the date of this order. Thereafter the Board shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
VERNON L. RICHARDSON, Claimant
WCB Case No. 89-02947
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
David Smith (Saif), Defense Attorney
John Snarskis, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Referee Tenenbaum's order that declined to award an assessed attorney fee for his attorney's services in obtaining an order setting aside a stipulation between the SAIF Corporation and Industrial Indemnity. Industrial Indemnity cross-requests review of that portion of the order that set aside the stipulation. On review, the issues are the validity of the stipulation and attorney fees. We affirm.

FINDINGS OF FACT

Claimant was compensably injured in 1983; the claim was accepted by Industrial Indemnity. Claimant was again compensably injured in 1985; the claim was accepted by SAIF.

In 1988, claimant apparently suffered additional low back difficulty. SAIF denied responsibility for claimant's current problems contending that Industrial Indemnity was responsible. Industrial Indemnity likewise denied responsibility. A .307 order issued on May 31, 1988, designating a paying agent and referring the matter to the Workers' Compensation Board for hearing. A hearing was set pursuant to the order.

Claimant received a copy of the hearing notice. The notice directed claimant to advise the insurers and the Hearings Division whether or not claimant would attend the hearing. Claimant did not advise anyone whether or not he would attend.

At the time set for hearing, claimant was enrolled in an inpatient pain center program. Nevertheless, he planned to take time off to attend the hearing. However, the morning of the hearing, the vocational counselor at the pain center advised him that the responsibility issue had already been settled.

Prior to the time set for hearing, it appears that SAIF and Industrial Indemnity agreed that SAIF would withdraw its denial and accept responsibility for claimant's condition; in return, Industrial Indemnity would pay SAIF $2,000. This stipulation was reduced to writing, executed by counsel for the insurers, and approved by a Referee. The request for hearing was dismissed. Claimant was not a party to the stipulation.

Thereafter, claimant conferred with an attorney and filed a request for hearing contending that the stipulation should be set aside and the dismissal order vacated.

CONCLUSIONS OF LAW AND OPINION

Referee Tenenbaum, after hearing, did set aside the stipulation and vacate the dismissal order. She reasoned that a claimant may elect to be a nominal party in a .307 proceeding in which event the insurers may settle the responsibility issue without the claimant's assent. She found, however, that claimant had not voluntarily relinquished his right to be more than a nominal party either by failing to notify the insurers and the forum that he intended to attend the hearing or by in fact failing to appear at hearing. Consequently,

she held that the insurers were not free to settle the responsibility matter without his assent.

On review, Industrial Indemnity has conceded that a claimant is a necessary party to a .307 proceeding, whether or not he is a nominal party. Nevertheless, it argues that claimant waived his right to be involved in the settlement by waiving appearance at hearing.

We agree with the Referee's conclusion that the stipulation was invalid absent claimant's agreement, but we do so for different reasons. We agree with Industrial Indemnity's contention that a claimant is a necessary party to a .307 proceeding, whether he participates as a nominal party or actively participates at hearing. Contrary to the Referee's understanding, OAR 438-14-025(1), which requires a claimant to advise the Referee whether or not he will attend the hearing, does not require a claimant to "opt in" to a .307 proceeding. The purpose of that rule is to avoid continuances for the purpose of obtaining claimant's testimony by ensuring that the insurers will know in advance of hearing whether or not claimant will appear at hearing without subpoena. The rule does not place any burden on claimant to elect party status.

We reject Industrial Indemnity's argument that a claimant's failure to appear at a .307 hearing leaves the insurers free to enter into bilateral agreements governing responsibility. The insurer's argument rests on former OAR 438-06-071. That rule provides for dismissal of a request for hearing if the party requesting hearing fails to appear at hearing either personally or through counsel. A .307 hearing is commenced not pursuant to a claimant's request for hearing but pursuant to the Director's order. Inasmuch as claimant did not request the hearing, his nonappearance at hearing would not warrant dismissal under the rule. The argument is without merit.

Once a .307 order has issued, a responsibility dispute cannot be settled unless all parties enter into the stipulation. Just as claimant cannot enter into an agreement with a single insurer (J.C. Compton Company v. DeGraff, 52 Or App 317 (1981)), the insurers alone cannot enter into an agreement. Inasmuch as a necessary party to the agreement was not a party thereto, the Referee correctly set aside the settlement agreement. See e.g., John A. Tallant, 42 Van Natta 939 (1990).

Claimant contends that the Referee erred by failing to award a carrier-paid fee for prevailing in this matter. Claimant describes the insurers' conduct as tantamount to a denial, characterizes the Referee's order setting aside the settlement agreement as an order setting aside a denial, and, apparently, relies on ORS 656.386(1) as authority for award of a fee. We disagree. Claimant, by prevailing in this matter, has simply returned the chess pieces where they were before the settlement and dismissal of the Director's hearing request. If claimant participates in the arbitration hearing which must now take place pursuant to the .307 order, his attorney may be entitled to a carrier-paid fee under ORS 656.307(5). There is no authority for award of a fee at this stage of the proceedings. See analogously, Peterson v. Compensation Department, 257 Or 369 (1971).

ORDER

The Referee's order dated August 24, 1989 is affirmed.

In the Matter of the Compensation of
AUDREY RUDD, Claimant
WCB Case No. 89-07280
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of those portions of Referee Podnar's order which: (1) declined to dismiss the request for hearing because of claimant's failure to appear; (2) declined to authorize a requested overpayment; and (3) assessed a 25 percent penalty and an attorney fee for alleged late submission of the claim for closure. On review, the issues are dismissal for failure to appear, overpayments, penalties and attorney fees.

FINDINGS OF FACT

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

Claimant appeared for hearing through his attorney. Claimant withdrew all her issues that she had requested a hearing on, except for penalties and attorney fees for late closure of the claim. Claimant does not rely upon her testimony to prove her claim for penalties and attorney fees.

CONCLUSIONS OF LAW AND OPINION

The Referee refused to dismiss claimant request for hearing on the issue of penalties and attorney fees, failed to authorize the self-insured employer's requested overpayment, and assessed a penalty and attorney fee for late closure of the claim. We affirm in part, reverse in part, and modify in part.

Motion to Dismiss

Claimant did not attend the scheduled hearing and the employer moved to dismiss her request for hearing under OAR 438-06-071(2). The Referee denied the request and proceeded to the merits of claimant's penalty and attorney fee issue. We agree.

In Williams v. SAIF, 99 Or App 367 (1989) reversed and remanded 310 OR 320 (September 20, 1990), the Court of Appeals, in dicta, stated that OAR 438-06-071 did not require the claimant to personally attend the hearing. The court reasoned that it would be error to dismiss the request for hearing because claimant did not personally attend the hearing, especially when claimant's attorney did attend the hearing and was prepared to proceed without the benefit of claimant's testimony. We have specifically adopted the Court of Appeals' interpretation of the rule. Gloria Hunter, 42 Van Natta 2289 (1990); Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990)

Here, because claimant's attorney appeared and was prepared to proceed, the Referee acted appropriately by not dismissing the request for hearing and proceeding to the merits.

Overpayment

The employer requested that the Determination Order be modified to reflect a medically stationary date of July 12, 1988 instead of February 7, 1989. The

employer also requested that it be granted an overpayment for the sums of temporary disability paid between the July 12, 1988 and February 7, 1989 if the Referee did modify the Determination Order. The Referee modified the Determination Order as requested, but failed to award the employer its overpayment. We authorize the overpayment.

Claimant is substantively entitled to temporary disability benefits only through the medically stationary date. Julie A. Trujillo, 40 Van Natta 1892 (1988). Sums that are paid after that date are recoverable, upon authorization, as an overpayment.

There is no dispute that the employer paid claimant temporary disability during the time from July 12, 1988 through February 7, 1989. Consequently, the employer is entitled to an overpayment of the temporary disability paid during that period of time. This overpayment may only be recovered against future awards of permanent disability.

Late Closure

The Referee assessed a penalty and attorney fee because he found that the employer had unreasonably delayed the closure of this claim. We agree that there was an unreasonable delay, but modify the amount of the penalty.

The administrative rules require the employer to procure information requested by the Evaluation section. The employer has 60 days from an Evaluation Section's request to procure additional information to submit it to them or explain why it cannot. Former OAR 436-30-030(5). This rule covers the employer's obligation to respond to an 873 form requesting an evaluation for the purposes of rating disability.

Here, the employer timely responded to the first 873 form requesting information, but the information supplied was insufficient to close the claim. A second 873 form, this time requesting an evaluation of physical findings, was received by the employer on August 25, 1988. The next action by the employer contained in this record was a letter to claimant, dated November 15, 1988, requesting that she see her doctor so that the necessary information could be procured. There is a lapse of 81 days between this 873 request form and the employer's action. Although the letter to claimant indicates that the employer had previously tried to contact her doctor, there is no evidence in this record that the attempt was made prior to the 60 day limit. We conclude that claimant has proven that the employer unreasonably delayed the closure of claim.

In setting the amount of the penalty, we consider the fact that after claimant was asked to assist in gaining the information to close the claim in November 1988, she did not cooperate. Claimant did not return to her doctor until she was ordered to in December. This lack of cooperation by claimant further delayed the closure of the claim and was outside the control of the employer.

Consequently, we view claimant's action as mitigating the employer's unreasonableness. Thus, we assess a penalty of 15 percent of the permanent disability awarded by the Determination Order.

ORDER

The Referee's order dated August 21, 1989 is affirmed in part, reversed in part, and modified in part. That portion of the order that declined to authorize the employer's request for an overpayment is reversed and the overpayment is granted. That portion of the order that granted claimant a 25 percent penalty is modified to grant a 15 percent penalty instead. The remainder of the order is affirmed.

In the Matter of the Compensation of
CARLA J. SCHROCK, Claimant
WCB Case No. 89-09148
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham and Crider.

Claimant requests review of Referee Howell's order that: (1) upheld the SAIF Corporation's denial of chiropractic treatment for claimant's bilateral carpal tunnel syndrome; and (2) declined to award claimant's counsel an attorney fee for efforts regarding SAIF's rescission of its denial of ultrasound treatment. On review, the issues are medical treatment and attorney fees.

We affirm the order of the Referee with the following comment.

The Referee relied on OAR 438-15-030(1) for the proposition that an attorney fee may be approved or assessed when the attorney was instrumental in obtaining compensation for a claimant without a hearing, and found that claimant's attorney was not instrumental in obtaining compensation for ultrasound treatments. On review, claimant contends that her attorney should receive a fee for taking the ultrasound issue to hearing. We affirm the Referee on this issue, but with different reasoning. Here, SAIF's rescission of that portion of its denial that dealt with ultrasound treatment occurred at hearing and on the record. However, claimant must not only take an issue to hearing; she must finally prevail before a Referee. Dorothy J. Hayes, 42 Van Natta 1311 (1990); Duane L. Jones, 42 Van Natta 875 (1990). Furthermore, the Referee's order upheld SAIF's amended denial. Accordingly, claimant did not "finally prevail" in overcoming SAIF's denial of compensability and, therefore, SAIF is not liable for claimant's attorney fees under ORS 656.386(1). Dorothy J. Hayes, supra; Duane L. Jones, supra.

ORDER

The Referee's order dated August 30, 1989 is affirmed.

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

I concur in that portion of the order that upheld the denial of chiropractic treatment.

I dissent from that portion of the order which holds that claimant's attorney is not entitled to a carrier-paid fee for services requesting a hearing on the denial of ultrasound treatment, preparing for that hearing, and prevailing when SAIF rescinded its denial at hearing.

Claimant's attorney was clearly instrumental in obtaining rescission: The denial issued May 2, 1989; a request for hearing was filed by claimant's attorney on May 10, 1989; a paralegal for SAIF, apparently in connection with preparation of the case for hearing, sought reports from Drs. Nathan and Mayhall; Dr. Mayhall's report supported compensability of ultrasound treatment; and, thereupon, the denial was withdrawn by SAIF's attorney at hearing. It is quite evident that Dr. Mayhall's opinion would not have been sought nor the denial withdrawn had claimant's attorney not challenged the denial. Therefore, his services were instrumental in obtaining acceptance of a rejected claim.

Moreover, claimant got what she wanted--acceptance of her claim for treatment. For the reasons stated in my dissenting opinion in Duane L. Jones, 42 Van Natta 875 (1990), the majority errs in holding that claimant does not finally prevail within the meaning of ORS 656.386(1) simply because an insurer withdraws its denial and no Referee passes on the compensability issue.

In the Matter of the Compensation of
THOMAS N. THORN, Claimant
WCB Case Nos. 89-00864, 89-04139, 89-02110 & 89-04140
ORDER ON REVIEW (REMANDING)
Emmons, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Siltec Corporation requests review of Arbitrator Brazeau's order that found it responsible for claimant's low back condition. On review, the issue is responsibility. We remand.

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

The Arbitrator concluded that the standard to be applied in this particular responsibility case is that pronounced in Champion International v. Castilleja, 91 Or App 556 (1988). In Castilleja, the court stated that the "last injurious exposure rule" principles of Bracke v. Baza'r, 293 Or 239 (1983) applied to successive injuries cases, as well as successive occupational disease cases. The "last injurious exposure rule" places responsibility on the last employment which could have contributed to the worker's disability.

However, since the Arbitrator's order, the Board has issued Linda L. Wise, 42 Van Natta 115 (1990), which held that Castilleja does not apply where there is an accepted compensable injury or occupational disease, followed by an increase in disability during or after employment with the later employer/insurer. In such cases, the original employer/insurer has the burden of proving affirmatively that a later employment independently contributed to a pathological worsening of the accepted condition. See Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81, 86 (1985).

The dispute in this case involves only Aetna and Siltec. Aetna accepted claimant's back condition in 1984. Claimant then suffered either an increase in symptoms or a pathologic worsening during employment with Siltec. The Arbitrator concluded that responsibility lies with Siltec, as the last employer whose working conditions "could have" contributed to claimant's disc extrusion.

The Arbitrator's conclusion is not consistent with Wise and is therefore in error. Accordingly, we remand for proper application of law. See ORS 656.307(2); ORS 656.295(5); Yolanda R. Carrasco, supra.

As we do not review an arbitrator's order on issues of fact, we find that the Arbitrator's Findings of Fact are adequate to determine the responsibility issue before him. Therefore, we remand to Arbitrator Brazeau for Conclusions of Law consistent with ORS 656.307(2) and Linda L. Wise, supra.

ORDER

The Arbitrator's order dated June 30, 1989, is vacated. This matter is remanded to Arbitrator Brazeau for further action consistent with this order.

In the Matter of the Compensation of
JAMES C. BALES, (DECEASED)
CHAROLLET K. BALES, Claimant
Own Motion No. 84-0052M
OWN MOTION ORDER OF ABATEMENT
Burt, Swanson, et al., Claimant Attorneys

Claimant has requested that the Board reconsider its September 10, 1990, 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.

In the Matter of the Compensation of
VERNON E. CARPENTER, Claimant
WCB Case Nos. 88-06305, 88-08390, 88-13516, 88-13517 & 88-13518
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
James Dodge (Saif), Defense Attorney
Arden Olson (Saif), Defense Attorney
Atherly, Butler, et al., Defense Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Higashi's order that upheld the SAIF Corporation's denials, as insurer for R.J. Hehn, L.H. Broyhill, and Cliff Brown Logging, of claimant's claim for a carpal tunnel syndrome condition. The issues on review are compensability and responsibility. We affirm.

FINDINGS OF FACT

Claimant had accepted claims with C&D Logging and with Counts & Brown in 1981 and 1985 respectively. The 1981 claim was for low back problems. The 1985 claim was for a ruptured right biceps muscle. The arm claim was closed by notice of closure in August 1985 with no award for permanent disability. Claimant subsequently returned to work as a yarder operator. After he left work with Counts and Brown, he worked with R.J. Hehn from February to June 1987, then with L.H. Broyhill from June to September 1987, and finally with Cliff Brown Logging from September to November 1987. His work as a yarder operator was similar with all these employers, with slight differences based on the type of equipment he operated.

In January 1988, claimant was seen by Dr. Freeman for shoulder, arm, neck, low back and leg pain. Nerve conduction studies were performed in February 1988, at the request of Dr. Freeman, for the carpal tunnel condition. An independent medical examination was performed by Dr. Phipps, neurologist, and Dr. Hopkins, orthopedist, in February 1988. Claimant saw Dr. Freeman a second time in July 1988.

Claimant's attorney filed a claim with L.H. Broyhill/SAIF for development or worsening of his cervical radiculopathy, bilateral carpal tunnel disease and LS radiculopathy. That claim was denied on May 10, 1988 as not related to the work at Broyhill and as not timely filed.

Denials were subsequently issued by SAIF in behalf of R.J. Hehn and Cliff Brown for these conditions.

CONCLUSIONS OF LAW AND OPINION

SAIF denied both compensability and responsibility on behalf of all three employers. The Referee found that claimant had failed to prove that there was a causal relationship between the denied carpal tunnel condition and his work exposure. Claimant argues that the reports of Dr. Freeman prove that his work experience was the major contributing cause of the development of his carpal tunnel condition, but because the doctor cannot determine which work exposure was the cause, and all of the work exposures were of a similar nature and could cause the condition, the last employer is responsible under Boise Cascade v. Starbuck, 296 Or 238, 244 (1984). We disagree.

When both compensability and responsibility have been denied, we address the issue of compensability first. Since claimant's last exposure occurred in 1987, he is required to prove that the work activity was the major contributing factor to the development of his carpal tunnel disease. Donna E. Aschbacher, 41 Van Natta 1242, 1243-1244 (1989).

Claimant relies on the medical reports of Dr. Freeman to prove his claim. Dr. Freeman diagnosed carpal tunnel in January 1988. Nerve conduction studies done in February 1988 were consistent with a clinical diagnosis of carpal tunnel. Dr. Freeman issued a report in July 1988 in which he stated that he was unable to comment on the cause of the carpal tunnel. In January 1989, Dr. Freeman reported that the frequent and rapid heavy jerking of levers required in yarder operation is indeed trauma sufficient to bring about carpal tunnel disease.

The evidence of claimant's work activities does not support Dr. Freeman's basis for his conclusion on causation. There is no indication that claimant's job required heavy jerking of levers. Since Dr. Freeman's opinion of causation is based on an understanding of claimant's work activities that is inaccurate, we do not find his opinion on causation to be persuasive. There is no other medical opinion upon which claimant can rely to carry his burden of proof. This is particularly important because the doctors who performed the independent medical examination were under the impression that claimant's wrist and hand complaints were related to radicular problems from his degenerative cervical condition. Therefore, we affirm the decision of the Referee.

ORDER

The Referee's order dated June 15, 1989 is affirmed.

In the Matter of the Compensation of
JOSE CURIEL, Claimant
WCB Case No. 89-06338
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Perry and Speer.

Claimant requests review of Referee McWilliams' order that dismissed his request for hearing for lack of jurisdiction. On review, the issue is dismissal. 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 conclusions and opinion, as set forth in the "Motion to Dismiss" section of the order, with the following supplementation.

The Referee concluded that the prior Referee was without jurisdiction to extend claimant's statutory time limits for filing a request for hearing. We agree.

ORS 656.319(1) sets the time within which a claimant must request a hearing on a denial of a claim. Time limitations prescribed by the law are limitations upon the right to obtain compensation and are not subject to exceptions contained within the general statute of limitations. Neither the Board nor the Court may waive these requirements. See Nelson v. SAIF, 43 Or App 155, 159 (1979); Naught v. Gamble Inc., 87 Or App 145 (1987).

ORDER

The Referee's order dated August 30, 1989 is affirmed.

In the Matter of the Compensation of
BARRY DUNN, Claimant
And, in the Matter of the Complying Status of
FRANK STANLEY WOOD and MIKE HERMELING, dba, HERWOOD, Noncomplying Employer
WCB Case Nos. 89-05827, 89-05826, 89-03292 & 88-16769
ORDER ON RECONSIDERATION
Brothers, et al., Claimant Attorneys
Carl William Hopp, Jr., Attorney
Bonnie Laux (Saif), Defense Attorney
Atherly, et al., Defense Attorneys

The alleged noncomplying employer, Herwood, requests reconsideration of our September 13, 1990 Order on Review that affirmed a Referee's order that: (1) set aside its denial of claimant's hand injury claim; and (2) declined to assess penalties and attorney fees for an alleged unreasonable and untimely denial.

Specifically, the employer contends that we did not address its argument that, when read as a whole, ORS 656.029 provides that when an exempt individual, such as a sole proprietor, hires workers to assist him, that individual becomes responsible for workers' compensation coverage. We do not agree that claimant falls within the description of a sole proprietor as defined by the statute.

ORS 656.029 provides for the obligation of persons letting a contract to provide coverage for workers under the contract, exceptions to that obligation and the effect of the failure to provide coverage. ORS 656.029(2) provides:

> "If a person to whom the contract is awarded is exempt from coverage under ORS 656.027, and that person engages individuals who are not exempt under ORS 656.027 in the performance of the contract, that person shall provide workers' compensation insurance coverage for all such individuals. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person to whom the contract is awarded, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in ORS 656.001 to 656.794 for the payment of benefits to the worker of a noncomplying employer."
>
> ORS 656.029(4) provides that, as used in this section:
>
> (a) "Person" includes partnerships, joint ventures, associations, corporations and sole proprietorships.
>
> (b) "Sole proprietorship" means a business entity or individual who performs labor without the assistance of others."

We agree with the Referee's reasoning that the only definition that could arguably render claimant a "person" under ORS 656.029(2) is that of sole proprietorship. See ORS 656.029(4)(a). We conclude that for claimant to be a "person" within the meaning of ORS 656.029(2), he must therefore meet the definition of a sole proprietorship under ORS 656.029(4)(b). Because claimant hired other individuals to assist him in the contracted work, claimant does not meet the definition of a sole proprietor and accordingly, ORS 656.029(2) is not applicable.

The employer also disagrees with our finding that it did not timely request a hearing on the issue of compensability. In our order, we found that the SAIF Corporation received notice of claimant's injury claim by at least August 12, 1988, the date on which its representative signed claimant's 801 form. The employer now contends that the 801 form in issue was filed against Stan's Wood Products, not against Herwood.

The employer also argues that Kristi L. Chase, 42 Van Natta 1247 (1990), the case we relied upon in our order, was not in effect at the time when SAIF accepted the claim. The employer contends that SAIF's December 13, 1988 letter provided that it had 60 days in which to request a hearing on the issue of compensability.

We conclude that, even if SAIF did not have notice of a claim against Herwood as a result of signing the 801 form in August 1988, the employer's request for hearing on the issue of compensability was nonetheless untimely. The Department of Insurance and Finance, by letter of October 31, 1988, requested that SAIF, on behalf of Herwood, process claimant's injury claim. The Department's letter was received by SAIF on November 1, 1988. Because Herwood did not request a hearing from SAIF's acceptance until February 7, 1989, its request was more than 60 days from the time SAIF had notice of a claim against it. See ORS 656.054.

Finally, although we agree that the Chase case had not been issued at the time SAIF accepted the claim, we do not find that Chase imposes a new rule or additional requirements upon the employer in regard to requesting a hearing on the issue of compensability. We are also not convinced that the employer could rely upon a letter from SAIF providing information pertaining to rights which are controlled by statute and prior case law. See Chase, supra; Gary D. Soderstrom, 35 Van Natta 1710 (1983).

Accordingly, our September 13, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 13, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES D. HARRIS, Claimant
WCB Case Nos. 88-12443, 88-07317 & 88-07316
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Acker et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Seymour's order that: (1) upheld Liberty Northwest Insurance Corporation's (Carriers West) denial of his "new injury" claim for his current left leg (knee) condition; (2) set aside Liberty Northwest's (TAMC) "de facto" denial of claimant's claim for the same condition; and (3) declined to assess penalties and attorney fees for alleged improper claims processing. Claimant also requests review of that portion of the Referee's order that found that he had waived his right to appeal a 1988 Determination Order award of temporary total disability. On review, the issues are responsibility, penalties and attorney fees and temporary total disability. We affirm.

FINDINGS OF FACT

Claimant is a truck driver who first injured his left knee in 1982. On March 12, 1986, claimant injured his left knee while working as a driver for TAMC (insured by Liberty Northwest). Claimant's left knee condition was treated by Dr. Shaw who performed a patellar shave.

An August 20, 1987 disputed claim settlement (DCS) held that claimant's then current back condition was not the result of the accepted knee

condition. At the time of the DCS, claimant was not working because of his back problems, rather than due to any residuals of his left knee condition.

From the time of his March 1986 injury until December 15, 1987, claimant was not employed. On December 15, claimant began work for Carriers West (also insured by Liberty Northwest). At that time, his left knee claim with TAMC was still in open status.

In a January 13, 1988 chart note, Dr. Shaw reported that claimant was experiencing swelling in his knee with driving. A "wrip wrap" brace was prescribed. On January 18, 1988, claimant phoned Dr. Shaw to report that his brace was aggravating the pain on the side of his knee.

Claimant's first report of a reinjury of his left knee was on January 26, 1988, when he phoned Dr. Shaw's office and made an appointment. On that same day, claimant was treated at a hospital in California for complaints of left knee pain. Dr. Walters, who examined claimant, reported that he denied fever, chills and recent trauma other than driving.

On February 3, 1988, claimant saw Dr. Shaw in person for the first time since September 11, 1987. At that time, claimant related to Dr. Shaw that he had injured his left knee at work on December 28, 1987.

Dr. Shaw filled out a Form 827 on February 28, 1988 and indicated that claimant had injured his left knee on December 28, 1987. The form listed claimant's employer as Carriers West.

Upon receiving the Form 827, the claims examiner called Dr. Shaw's office for clarification and was informed that claimant's knee problem was a continuation of the accepted March 1986 injury, which was still in open status. The insurer did not commence payment of time loss, as time loss had not been authorized by Dr. Shaw.

On May 3, 1988, claimant filed a request for hearing indicating that the employer was TAMC/Carriers West and the insurer was Liberty Northwest. A Hearings Division file was set up only for TAMC and its insurer, Liberty. No file was set up for a claim against Carriers West and Liberty. At the July 22, 1988 hearing on TAMC's "de facto" denial of the December 28, 1987 injury claim, the Referee determined that not all parties were present. The hearing was continued until October 17, 1988, with a new hearing file set up for a claim against Carriers West and outside counsel assigned for Liberty.

In the interim, claimant's 1986 injury claim with TAMC was closed by an August 9, 1988 Determination Order. The Determination Order awarded temporary total disability benefits through December 26, 1986 and awarded 24 percent scheduled permanent partial disability. Claimant requested and received a lump sum payment of all amounts awarded by the Determination Order.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee concluded that claimant's knee condition was all related to his 1986 injury and was not worsened by the 1987 incident. We agree that Carriers West is not responsible for claimant's left knee condition, but we base our conclusion upon the following reasoning.

Claimant testified that, on December 28, 1987, he fell at work and struck his knee. On January 13, 1988, claimant received treatment in the form

of a "wrip wrap" brace. Dr. Shaw's chart notes on that day indicate that claimant had swelling in the knee with driving. It was not until January 26, however, that claimant called Dr. Shaw's office to report that he had reinjured his left knee. On the same day that claimant reported his injury to Dr. Shaw, he was seen at a hospital in California for complaints of left knee pain. Dr. Walters, M.D., examined claimant and reported that claimant denied recent trauma, other than driving.

On February 3, 1988, claimant was examined by Dr. Shaw, who reported findings of tenderness over the medial edge of the quadriceps tendon and the medial superior corner of the patella. Dr. Shaw reported that claimant's examination revealed no swelling or effusion in the left knee and he opined that claimant had full range of motion in the knee. Dr. Shaw diagnosed severe contusion to the medial edge of the quadriceps tendon and patella.

In August 1988, Dr. Shaw reported that the injury claimant sustained to his left knee in the incident of December 28, 1987, was a bruise to the knee. Dr. Shaw did not find that the bruise had worsened the underlying knee condition.

Dr. Shaw later testified that, had claimant fallen to the ground the way he described, he (Shaw) would have expected pain in a different area, along with other symptoms that claimant did not have upon examination. Dr. Shaw also testified that (as they related to his injury) claimant's subjective complaints were out of proportion and lasted longer than expected for the type of injury claimant had reported.

We are not convinced that claimant sustained a new injury on December 28, 1987. Claimant contacted Dr. Shaw's office three times regarding his knee condition, before he reported that he had reinjured his knee. Claimant also denied a new injury when he was examined by Dr. Walters. Finally, claimant's treating physician has not documented any objective physical findings of a new injury.

Furthermore, a worsening of claimant's underlying condition, as opposed to symptoms, has not been shown. We therefore conclude that because there was no contribution from claimant's subsequent work activities, TAMC remains responsible for his current left knee condition.

Temporary total disability

The Referee held that, by accepting a lump sum payment for the amount awarded by the 1988 Determination Order, claimant was precluded from contesting that order. We disagree.

ORS 656.304 provides that:

> "A claimant may accept and cash any check given in payment of any award or compensation without affecting the right to a hearing, except that the right of hearing on any award shall be waived by acceptance of a lump sum award by a claimant where such lump sum award was granted on the claimant's own application under ORS 656.230."

ORS 656.230(1), provides in part:

> "Where a worker has been awarded compensation for permanent partial disability, and the award has become final by operation of law or waiver of the right to appeal its adequacy, the director may, in the director's discretion, upon the worker's application order all or any part of the remaining unpaid award to be paid to the worker in a lump sum.

We conclude that the statutes cited by the Referee do not apply to the lump sum payment of temporary disability. Also see OAR 436-60-60. In the present case, claimant has challenged the Determination Order award of temporary total disability. We therefore find that the issue of temporary disability has not been waived by his acceptance of a lump sum payment and we proceed to address claimant's argument on the merits.

Claimant contends that he is entitled to temporary total disability from February 3, 1988 to June 8, 1988. Whether claimant is entitled to temporary disability depends on whether a preponderance of the evidence indicates that he was disabled during that time due to the compensable claim. Botefur v. City of Creswell, 84 Or App 627 (1987).

We conclude that claimant is not entitled to additional temporary disability. In an October 7, 1988 letter, Dr. Shaw reported that the December 1987 injury had caused claimant to remain off work until March 1988. In a letter dated October 14, 1988, Dr. Shaw stated that he had released claimant to return to work on June 8, 1988. Dr. Shaw again indicated that claimant had sustained a "new injury."

As we have found that claimant did not sustain a new injury on December 28, 1987, we conclude that the evidence does not show that claimant was disabled between February 3, 1988 and June 8, 1988, due to the compensable condition. Claimant has not established by a preponderance of the evidence that he is entitled to additional temporary disability.

Penalties and attorney fees

The Referee found that all claims processing was reasonable. Claimant conceded in his closing argument, that, as far as TAMC was concerned, the failure to accept or deny any claim in 1988 "may have been appropriate in light of the lack of medical verification for an aggravation claim." We affirm the Referee's conclusion that the claims processing was reasonable.

ORDER

The Referee's order dated April 17, 1989 is affirmed.

October 10, 1990 Cite as 42 Van Natta 2333 (1990)

In the Matter of the Compensation of
BARBARA M. LABREE, Claimant
WCB Case No. 89-05001
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Nichols' order that: (1) upheld the SAIF Corporation's denial of lumbar surgery; and (2) declined to assess penalties and related attorney fees for alleged unreasonable delay in issuing its denial. The issues on review are medical services and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

It is apparent from the record as a whole that the parties were litigating a denial of the facet denervation proposed by Dr. Smith, rather than the SAIF Corporation's failure to authorize a laminectomy.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion and Conclusions" with the following comments and supplementation.

Claimant asserts that the Referee erroneously sustained SAIF's denial of a laminectomy which was never a suggested or requested procedure. Claimant therefore requests that SAIF be ordered to authorize the treatment which has been recommended and which SAIF has not heretofore denied. We disagree with this analysis.

Although the February 1, 1989 denial letter says "laminectomy," it is evident from the record as a whole that the parties were litigating the denial of the facet denervation surgical procedure proposed by Dr. Smith. In fact, claimant did not raise at the hearing the issue of the apparent clerical "error" in SAIF's denial letter, and there is no other indication in the record that either party or the trier of fact were confused on this point.

Next, claimant argues that the Referee should have accorded Dr. Smith the status of attending physician, instead of placing greater credence on the reports of physicians who "misdiagnosed" her condition. We conclude that Dr. Smith does not have treating physician status for purposes of evoking the treating physician presumption. See Ward Neihart, 38 Van Natta 1418 (1986); Weiland v. SAIF, 64 Or App 810 (1983).

An "attending physician" is one who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005 (12). In Neihart, supra, we held that a physician who sees a claimant primarily for diagnostic purposes is not the attending physician. Here, claimant was referred to Dr. Smith by claimant's attorney for a medical consultation. Dr. Smith saw claimant only three times and essentially performed diagnostic procedures. His role in examining claimant is consistent with the definition of "Consulting physician" as described in ORS 656.005(12). We are not persuaded that Dr. Smith's opportunity to evaluate claimant's condition substantially exceeded that of the other physicians who treated or examined claimant. Therefore, it was appropriate for the Referee not to accord "special consideration" to Dr. Smith's opinions.

The Referee concluded that claimant failed to meet her burden of proof that the surgery requested by Dr. Smith is reasonable and necessary treatment for the compensable injury. We argue.

Claimant sustained a compensable low back injury in October 1987. A full array of diagnostic tests ruled out a disc problem and claimant's condition was diagnosed as back strain. Conservative treatments, while under the care of Dr. Sharrer and Dr. Rockey, allegedly provided little relief to claimant and she continued to complain of low back pain with radiation to lower extremities. Claimant's attorney referred her to Dr. Smith who diagnosed a facet impingement syndrome. After performing two facet injections, which relieved claimant's discomfort, Dr. Smith requested authorization to perform a lumbar laminotomy at L5-S1 for decompression with a facet denervation. Initially, SAIF gave verbal

authorization for the surgery but later retracted it after receiving second opinions on the necessity for surgical intervention.

Consulting surgeon, Dr. Serbu, opined that the requested surgery would unlikely change much and he did not recommend it. Claimant was also seen at the Northwest Pain Center for the purpose of assessing the benefit of the recommended laminotomy and facet denervation. Dr. McVay, orthopedic surgeon, and Dr. Davies, clinical psychologist, concluded that a denervation procedure would not provide long-term relief, and, because claimant has a psychological profile which magnifies pain symptoms, surgery would be contraindicated. Drs. Rockey and Serbu concurred with the Pain Center report. Dr. Smith disagreed.

Even if Dr. Smith were accorded "treating physician" status, we would give greater weight to the more persuasive opinions of the three consulting doctors (Serbu, McVay, and Davies) and claimant's previous treating physician (Dr. Rockey). Accordingly, we conclude that the preponderance of well-reasoned medical opinion does not support the finding that a laminotomy and facet denervation is a reasonable and necessary procedure for the treatment of claimant's compensable injury.

ORDER

The Referee's order dated July 14, 1989 is affirmed.

October 11, 1990 Cite as 42 Van Natta 2335 (1990)

In the Matter of the Compensation of
JOHN H. BEMENT, Claimant
WCB Case No. 88-13391
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
John Motley (Saif), Defense Attorney

Reviewed by Board Members Myers, Brittingham and Perry.

Claimant requests review of Referee Daron's order that affirmed a Determination Order that awarded no unscheduled permanent disability for a back injury. On review, the issue is extent of unscheduled permanent partial disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact and make the following additional findings. Claimant will sustain exacerbations, from time to time, depending upon his job and activities. Those exacerbations will cause periods of temporary disability.

Claimant is capable of working without restriction. He has been advised to exercise care when lifting. Since the January 1988 exacerbation, he has suffered dull back pain that worsens during a day of work and disappears with a night's rest. He also feels stabbing pain if he lifts "wrong." At the time of hearing, this pain did not interfere with his ability to work.

FINDINGS OF ULTIMATE FACT

Claimant has suffered a greater permanent loss of earning capacity than is indicated by the standards.

Claimant has suffered a loss of ten percent of his earning capacity as a result of the compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant has suffered no impairment that is ratable under the disability rating standards applicable to this case. See former OAR 436-35-001 et seq, in force from January 1, 1989 to October 1, 1990. The Referee apparently believed, as do we, based on Dr. Dahlstrom's opinion and the history of this claim, that claimant will suffer future exacerbations of his condition that will result in temporary disability. He nonetheless declined to make any permanent disability award to compensate claimant for the anticipated periods of temporary disability because the standards do not allow such an award when, as here, claimant has suffered no impairment ratable under the standards. Without explanation, he also declined to find that claimant's permanent disability was greater than the "0" indicated by the standards.

On review, claimant concedes that he has suffered no impairment ratable under the applicable standards for rating permanent disability. He contends that he is nevertheless entitled to a permanent disability award to compensate him for anticipated periods of increased disability due to exacerbations of his condition. We agree.

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

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

In this case, the "standards" in force from January 1, 1989 to October 1, 1990, apply to the rating of claimant's permanent partial disability. Those standards provide that "If there is no measurable impairment no award of unscheduled permanent partial disability shall be allowed." Former OAR 436-35-320. The standards expressly state that anticipated waxing and waning of a condition will be assumed to be taken into account by the adaptability (lifting) portion of the rating process:

> "To the extent that pain results in disability greater than that evidenced by the measurable impairment, including the disability due to expected periodic exacerbations of the worker's condition, this loss of earning capacity is considered and rated under OAR 436-35-310 and is included in the adaptability factor."

Former OAR 436-35-320(1). The process for determining a worker's adaptability, however, does not in fact provide for any consideration of medical evidence indicating that exacerbation of a worker's condition is anticipated from time to time; a worker's adaptability rating is based solely on the worker's lifting restrictions. Former OAR 436-35-310(3). Therefore, only when anticipated waxing and waning has been translated into a lifting restriction will the standards in fact consider that anticipation. Indeed, even limitations on a worker's ability

to lift results in no augmentation of a worker's award under the standards where, as here, the worker has returned to his former job after the injury. Former OAR 436-35-310(2)(a). Finally, under no circumstances is the worker entitled to any compensation for limitations on the worker's lifting ability if the worker has no "measurable impairment." Former OAR 436-35-320(1).

Impairment, under the applicable standards, is "a decrease in the function of a body part or system as measured by a physician according to the methods described in the American Medical Association Guides to the Rating of Permanent Impairment, 2nd Edition, copyright 1984.

Claimant, who has returned to his former job and has no measurable impairment under the standards, is entitled to no award compensating him for anticipated periods of temporary disability due to the compensable injury under the standards.

Although former ORS 656.283(7) requires the Board to apply the standards for rating permanent disability, it also provides that:

> "Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence 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."

To be "clear and convincing," 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).

When an adjudicator anticipates that post-closure exacerbations of claimant's physical condition will cause additional periods of temporary disability, the worker is entitled to compensation for that permanent condition via a permanent disability award. International Paper Company v. Turner, 91 Or App 91, 93 (1988). Only when periods of increased temporary disability exceed what was anticipated by the permanent disability award will the claim be reopened for additional temporary disability. Gwynn v. SAIF, 304 Or 345 (1987).

The record establishes, and we have found, that since claimant's initial injury and first return to work, claimant has suffered several exacerbations which have resulted in temporary disability. Moreover, the unrebutted opinion of claimant's treating physician is that although he is now medically stationary, he will continue to suffer periods of exacerbation depending on the nature of his work and other daily activities. Based on these facts, we conclude that it is highly probable that claimant will suffer periods of exacerbation.

Inasmuch as periods of temporary disability anticipated by the adjudicator at the time permanent disability is rated constitutes a permanent loss of earning capacity as defined by ORS 656.214(5), and inasmuch as we make no award to claimant for such permanent disability under the standards, we find, by clear and convincing evidence, that claimant's permanent disability is more than is indicated by the standards. Based on the foregoing evidence, we find that claimant has suffered a 10 percent loss of earning capacity due to the compensable injury.

ORDER

The Referee's order dated March 6, 1989, is reversed. Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for a low back

injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney.

Board Chair Perry, dissenting.

The majority awards claimant permanent disability compensation on the basis that claimant's disability exceeds that indicated by the "standards." See former ORS 656.295. I do not agree that claimant has established, by clear and convincing evidence, entitlement to a permanent disability award in excess of that indicated under the standards. Moreover, I would hold that claimant's entitlement to benefits, both temporary and permanent, for future exacerbations of his compensable condition is more appropriately addressed under the aggravation statutes. Accordingly, I dissent.

The majority, as well as the parties, agree that on the day of the hearing, claimant had no ratable impairment, no "disabling" pain, no vocational limitations, and had returned to work without restrictions. Generally, the combined effect of these findings would support an ultimate finding that claimant has not suffered any permanent loss of earning capacity, i.e. permanent disability, resulting from his compensable injury. Consequently, under the applicable administrative rules, claimant is not entitled to an award of permanent disability. Former OAR 436-35-270(2).

However, after finding that claimant suffers no permanent impairment at the time of hearing, the majority makes the additional finding that claimant will sustain exacerbations in the future that will cause periods of temporary disability. Based on this finding, the majority concludes that claimant has proven by clear and convincing evidence that he will suffer future periods of exacerbation which will cause temporary disability, thereby entitling him to a current award of permanent disability.

I do not agree that claimant has clearly and convincingly established entitlement to an award of permanent disability, where such an award is based on future exacerbations which may, or may not, result in additional temporary disability. To be "clear and convincing," 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); Daniel M. Alire, 41 Van Natta 752 (1989). Claimant's treating physician opined that, from time to time, claimant will "probably" sustain exacerbations depending upon his job and daily activities. The evidence also shows that, since his injury, claimant has lost time from work due to back symptoms. However, as of the date of hearing, claimant had worked for several months without losing time from work. Such evidence, I submit, does not make it highly probable that claimant will experience future exacerbations causing additional temporary disability justifying an award in excess of the standards. Accordingly, claimant has not met his burden of proving by clear and convincing evidence that he suffers permanent disability exceeding that indicated by the standards.

The case law cited by the majority does not support its position. The majority cites International Paper Company v. Turner, 91 Or App 91, 93 (1988) and Gwynn v. SAIF, 304 Or 345 (1987), on remand 91 Or App 84 (1988). In both cases, the central issue is aggravation, not extent of permanent disability. Neither of these cases is legally or factually on point with the present case.

Turner is cited by the majority for the proposition that an adjudicator can anticipate that post-closure exacerbations of claimant's physical condition will cause additional periods of temporary disability. However, the holding in Turner does not direct a fact finder to consider evidence concerning claimant's

anticipated permanent disability when determining extent of permanent disability. In Turner, the court said:

> "We assume, however, in the absence of an indication to the contrary, that all relevant evidence concerning claimant's anticipated permanent disability which was before the referee was considered in making the award of ten percent permanent loss of use of the left leg." Turner, 91 Or App at 93. (Emphasis added.)

It was only after making the initial finding as to whether relevant evidence of anticipated permanent disability was or was not considered, that the court could make its determination of whether or not claimant had established a compensable aggravation. The Turner court was not determining extent of permanent disability, but instead was only determining whether a compensable aggravation had occurred. Turner cannot be read as conclusive on the issue of whether anticipated future exacerbations should or should not be considered in determining extent of permanent disability.

In Gwynn, the Court remanded to the Court of Appeals to determine whether "waxing and waning" was anticipated and included in arriving at the permanent disability award. Subsequently, on remand the court made the finding that the disability award, which was made by stipulation, was based partly on an expectation of future exacerbations. Gwynn v. SAIF, 91 Or App 84 (1988). Thus, the Gwynn case did not hold that the evaluator should or should not consider future exacerbations in determining extent of permanent disability. The Supreme Court merely ordered the Court of Appeals to make a finding as to what was considered in the stipulation. Then, based on that finding, the Court of Appeals was to determine whether claimant had established a compensable aggravation. I would interpret the Supreme Court's decision in Gwynn to mean that if no permanent disability award was allowed for anticipated exacerbations, then assuming the relevant conditions are met, reopening for periods of increased disability should be allowed because it would not result in double compensation. See Krajacic v. Blazing Orchards, 90 Or App 593 (1988).

Furthermore, the aggravation cases relied upon by the majority were not decided under the law applicable to this case. Here, claimant's entitlement to permanent disability is initially determined under the disability rating standards adopted by the Director. As noted by the majority, those rules expressly provide that "expected periodic exacerbations" are considered and rated under the adaptability factor. Former OAR 436-35-320(1). The fact that claimant is not entitled to an adaptability value because his physician did not impose lifting limitations is not, as the majority states, a reason to rate claimant's disability outside the standards. Rather, the lack of a comfortable "fit" between this case and permanent disability concepts should serve as an indication that the majority's focus is misplaced.

I believe that claimant's entitlement to benefits for future exacerbations of his compensable condition initially arises under the aggravation statutes rather than the permanent disability statutes. In this regard, the statutory framework suggests a legislative intent to treat disability cases separately from aggravation cases. The statutory and regulatory framework provides claimant, by way of the statutes regulating aggravation claims, with appropriate remedies should he experience future exacerbations. By contrast,

the permanent disability standards were adopted, pursuant to legislative mandate, as a means to rate permanent disability, if and when it occurs (including following a compensable aggravation if claimant can prove a permanent worsening of his condition.)

Moreover, but for the majority's decision, the statutory framework has, and would continue, to function properly and fairly in this case. In this regard, this matter is before us because claimant's claim has been reopened and subsequently closed as a result of a prior symptomatic exacerbation. Upon closing, claimant received temporary disability benefits as a result of time off work during that exacerbation. Claimant does not contest the amount of that temporary disability. However, because claimant has not established, either under the standards or by clear and convincing evidence outside the standards, any current permanent disability, he has properly received no permanent disability award.

Therefore, I would affirm the Referee's conclusion that claimant has failed to sustain his burden of proving entitlement to an award of permanent disability.

October 11, 1990 Cite as 42 Van Natta 2340 (1990)

In the Matter of the Compensation of
ASHWANI K. GROVER, Claimant
WCB Case No. 87-15229
ORDER ON REVIEW (REMANDING)
David Hollander & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Shultz' order which: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent disability award for a low back injury from 20 percent (64 degrees), as awarded by Determination Order, to 58 percent (185.6 degrees); (3) upheld the insurer's denial of claimant's impotency condition; and (4) declined to require the insurer to produce video tapes for possible inclusion in the record. The insurer cross-requests review of that portion of the Referee's order which set aside it's partial denial of claimant's neck and upper back condition. On review, the issues are remand, extent of permanent disability including permanent total disability and compensability. We remand.

FINDINGS OF FACT

At hearing, testimony was received from the insurer's claims examiner that the insurer had conducted a video tape investigation of claimant. Those tapes were not introduced into evidence.

At the hearing, claimant requested disclosure of the video tape, but the Referee ruled that the tapes were work product, not subject to discovery.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant learned of the existence of surveillance tapes which were prepared by the insurer at the request of its counsel. Claimant requested disclosure of the tapes but, in an evidentiary ruling, the Referee ruled that the tapes were work product and not subject to discovery. We disagree.

Just as the Oregon Rules of Evidence are not binding at a workers' compensation hearing, neither are the Rules of Civil Procedure. See ORS 656.283(7); ORCP 1(A). Consequently, we are not persuaded by the insurer's argument that the video tapes are not discoverable because they were prepared in anticipation of litigation. ORCP 36(B)(3).

Moreover, OAR 438-07-017 states in pertinent part:

> "Documents reasonably believed relevant and material only for purposes of impeachment of a witness need not be disclosed in advance of hearing and may be offered and admitted solely for impeachment. Documents so offered shall not be considered by the referee as substantive evidence. Upon request, all such documents shall be disclosed prior to the close of the hearing, whether or not offered, at which time the other party may offer the documents as substantive evidence."

The Board has 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. Such evidence which must be disclosed includes video tapes. William E. Wood, 41 Van Natta 2123 (1989).

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). Here claimant was not allowed discovery of the video tapes at the hearing in violation of OAR 438-07-017. Accordingly, we remand.

ORDER

The Referee's order dated June 5, 1989, as amended on June 20, 1989, and as corrected June 30, 1989, is vacated and the case is remanded to the Referee for further proceedings consistent with this order. The insurer is directed to disclose the requested video tape to claimant's attorney. 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 shall be received. The Referee shall then reconsider this case in light of the new evidence, if any is offered. If claimant chooses not to offer the tape into evidence, the Referee shall proceed to issue another final, appealable order.

October 11, 1990 Cite as 42 Van Natta 2341 (1990)

In the Matter of the Compensation of
VERNON W. MILLER, Claimant
Own Motion No. 90-0398M
OWN MOTION ORDER
Francesconi, et al., Claimant Attorneys

The insurer has submitted to the Board claimant's claim for an alleged worsening of his November 15, 1981, industrial injury. Claimant's aggravation rights expired May 14, 1989. The insurer has accepted responsibility for the surgery but opposes reopening of his claim for temporary disability benefits on the ground that claimant has withdrawn from the work force.

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.

We are persuaded that claimant's compensable injury has worsened requiring surgery. In addition, claimant has submitted a letter from his employer that he has been a permanent full-time employee since July 10, 1989. Accordingly, claimant's claim is reopened with temporary disability benefits to commence May 15, 1990, the date he was hospitalized for surgery. The insurer shall continue paying temporary total disability benefits until one of the following events first occurs: (1) claimant is medically stationary and claim is closed; (2) claimant returns to regular or modified work; (3) the attending physician gives claimant a written release to return to regular employment; or (4) the attending physician gives claimant a written release to return to modified work, such employment is offered in writing to claimant and claimant fails to begin such employment. Finally, claimant's counsel is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve a fee unless claimant's attorney files a retainer agreement. See OAR 438-15-010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved. 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.

In the Matter of the Compensation of
DONALD S. WINCER, Claimant
Own Motion No. 86-0406M
OWN MOTION DETERMINATION ON REMAND
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Independent Paper Stock v. Wincer, 100 Or App 625 (1990). The court has reversed our order, 40 Van Natta 1196 (1988), that granted claimant permanent total disability benefits. In so doing, the court concluded that the Board's authority to award permanent disability after January 1, 1988 ceased. 100 Or App at page 629. Consequently, the court has remanded.

After further consideration of this matter in light of the court's holding, we reach the following determination. Since we are without authority to grant permanent disability, claimant's request for such an award is denied. Finally, we adhere to and republish our prior determination which found that claimant was entitled to temporary total disability benefits from December 6, 1985 through January 19, 1988.

IT IS SO ORDERED.

In the Matter of the Compensation of
GAIL E. COLLINS, Claimant
WCB Case No. 90-08868
ORDER OF DISMISSAL
Cooney, Moscato, et al., Defense Attorneys

The self-insured employer has moved the Board for an order dismissing claimant's request for Board review of the Referee's August 17, 1990 Order of Dismissal on the grounds that the other parties did not timely receive notice of the request. The motion is granted.

FINDINGS OF FACT

The Referee's order issued August 17, 1990. On September 14, 1990, claimant mailed by certified mail her request for Board review of the Referee's order. The request did not indicate that copies had been provided to the parties.

On September 19, 1990, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review. That acknowledgment was received by the self-insured employer's counsel on September 20, 1990. Receipt of that acknowledgment constitutes the other parties' first notice of the request for review.

ULTIMATE FINDINGS

Claimant's request for review was received by the Board within 30 days of the Referee's order. However, the other parties to the proceeding did not receive notice of the request within 30 days of the Referee's order.

CONCLUSIONS OF LAW

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

Here, the 30th day after the Referee's August 17, 1990 order was September 16, 1990, a Sunday; therefore, the last day to file a request for review was Monday, September 17, 1990. ORS 174.120. Claimant's request was filed September 14, 1990, the date her request was mailed by certified mail. See ORS 438-05-046(1)(b). Consequently, claimant's request was timely filed with the Board.

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 the affidavit from the self-insured employer's counsel, their first notice of claimant's request occurred on September 20, 1990, when counsel received a copy of the Board's September 19, 1990 computer-generated letter. Under such circumstances, we conclude that notice of claimant's request was not received within 30 days of the Referee's August 17, 1990 order. Consequently, we lack jurisdiction to consider her request for review. ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra.

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

October 12, 1990 Cite as 42 Van Natta 2344 (1990)

In the Matter of the Compensation of
GREGORY D. MARSHALL, Claimant
WCB Case No. 88-18154
ORDER ON RECONSIDERATION
Francesconi & Associates, Claimant Attorneys
Cooney, et al., Defense Attorneys

On our own motion, we reconsider our September 19, 1990 Order on Review. We take this action to clarify the reasoning supporting our conclusion that claimant has failed to prove by clear and convincing evidence that he is entitled to a greater award of disability than indicated by the "standards." See former ORS 656.283(7) and 656.295(5).

In particular, we note our language to the effect that claimant's residual functional capacity restrictions "were already rated and thus do not, in and of themselves, constitute clear and convincing evidence of additional impairment" in excess of that indicated by the standards. On reconsideration, we wish to emphasize that a claimant is not limited to any specific evidence for purposes of proving entitlement to permanent disability in excess of that indicated by the standards. Claimant's burden in this regard is to prove clearly and convincingly by whatever evidence is adduced that his or her disability exceeds that indicated under the standards. Such evidence may, or may not, involve one or more of the factors addressed by the standards. Here, we continue to hold that claimant has failed to sustain that burden.

Accordingly, our September 19, 1990 Order on Review is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARTOLO RODRIGUEZ, Claimant
WCB Case No. C0-00067
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Robert J. Guarrasi, Claimant Attorney
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

On September 7, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $25,000 by the SAIF Corporation, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury.

We generally decline to acknowledge a claim disposition agreement which does not meet the prerequisites set forth in ORS 656.236 and the Director's rule. Louis R. Anaya, 42 Van Natta 1843 (1990). Although we acknowledged this agreement, upon further consideration, we find that it does not comply with the necessary prerequisites. Therefore, we withdraw our acknowledgement, refuse to approve the agreement and return it to the parties.

According to the terms of the claim disposition agreement, SAIF furnished claimant, who is unable to read or understand English, with a Spanish translation of the agreement and notice of rights in compliance with OAR 436-60-145(3). The translation is attached to the agreement as "Exhibit A" along with a translator's affidavit swearing to its accuracy. Claimant evidently relied on the translation in construing the meaning and effect of the agreement before signing it. Yet, on page three of the agreement, it provides that "Exhibit A does not constitute a part of the text of the agreement between the parties and, if there is a dispute as to the meaning of the stipulation, Exhibit A shall not be considered in resolving that dispute."

ORS 656.236(1) permits parties to dispose of any or all matters regarding a claim, except for medical services, "subject to such terms and conditions as the director [of the Department of Insurance and Finance] may prescribe." Correspondingly, our rules require that a claim disposition agreement contain the terms, conditions, and information as prescribed by the Director pursuant to OAR 436-60-145. See OAR 438-09-020(2)(a). An agreement which lacks those prerequisites must be returned to the drafter. 438-09-020(3). At the time the Board acknowledged this agreement, the Director required the following terms, conditions and information: (1) a complete identity of the worker; (2) a specific identification of all benefits, rights and obligations which are disposed and released under the agreement; (3) the amount of consideration to be paid the claimant; and (4) that the worker was provided the notice containing all of the appropriate information about claims disposition. See former OAR 436-60-145(6).

Implicit in the above requirements is that the claimant must understand the terms, conditions and information contained in the agreement. Indeed, the Director's rules provide that, if the claimant does not read or comprehend English, the insurer must provide the aforementioned notice in a manner which ensures the claimant understands the meaning of a claim disposition. See OAR 436-60-145(3). Though not expressly stated, it follows that the terms, conditions and information in the agreement must also be provided in a manner which ensures that the claimant understands them.

Here, because claimant does not understand English, the Spanish translation is necessary to and, in fact, embodies claimant's understanding of this

claim disposition. Without it, we cannot be certain that the terms and conditions contained in the English-written agreement are the same to which claimant has assented. To ensure that they are the same, the translation must constitute a part of the text of the agreement and be considered in any dispute as to its meaning and effect. By attempting to exclude the translation, the parties have failed to comply with ORS 656.236 and OAR 436-60-145. We conclude, therefore, that the proposed disposition should not have been acknowledged as submitted. See Louis R. Anaya, supra.

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

IT IS SO ORDERED.

October 12, 1990 Cite as 42 Van Natta 2346 (1990)

In the Matter of the Compensation of
HENRY L. SZWEBLIK, Claimant
WCB Case No. 89-02552
ORDER DENYING RECONSIDERATION
Charles S. Robinowitz, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Claimant requests reconsideration of our September 18, 1990 Order on Reconsideration that denied his request for an attorney fee for successfully defending the Referee's order which assessed a penalty and attorney fee for unreasonable claim processing. Claimant concedes that the holding of Saxton v. SAIF, 80 Or App 631 (1986), as well as our previous order which relied on Dotson v. Bohemia, Inc., 80 Or App 261 (1986), do not support an attorney fee award for such services under ORS 656.382(2). Yet, contending that he is also entitled to an attorney fee award under former ORS 656.262(10), claimant seeks further consideration.

This case is currently pending review before the Court of Appeals pursuant to the SAIF Corporation's petition for review. Despite such circumstances, we retain authority to reconsider our September 18, 1990 decision. SAIF v. Fisher, 100 Or App 288 (1990). However, we decline to exercise that authority in this case.

We reach such a conclusion primarily because the attorney fee awarded under former ORS 656.262(10) for SAIF's unreasonable conduct was assessed by the Referee. Our order merely affirmed that assessment. Had claimant challenged the amount of the Referee's penalty and/or attorney fee assessment and assuming the record supported a more substantial award, we could have modified the Referee's award under former ORS 656.262(10). Yet, those circumstances did not arise. Instead, claimant successfully sought affirmation of the Referee's penalty and attorney fee assessment. Thus, our authority to award attorney fees for such efforts is subject to ORS 656.382(2), which has been interpreted not to provide for such an award for defending a Referee's assessment of penalties and/or attorney fees. See Saxton v. SAIF, supra; Dotson v. Bohemia, Inc., supra.

Accordingly, claimant's request for reconsideration is denied. We adhere to our September 18, 1990 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRUCE W. HAMILTON, Applicant
WCB Case No. CV-90001
FINDINGS OF FACT, CONCLUSIONS AND FINAL ORDER (CRIME VICTIM ACT)
Thomas Ewing, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Kathryn A. Poland, special hearings officer, on Friday, August 24, 1990, at Klamath Falls, Oregon. Applicant, Bruce W. Hamilton, was present and was not represented by counsel. The Department of Justice Crime Victims' Compensation Program ("Department") was represented by Thomas Ewing, Assistant Attorney General. The court reporter was Mary Lynn Crebbin. The record was closed August 24, 1990.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated March 5, 1990. By its order, the Department denied applicant's claim for compensation filed pursuant to the Compensation of Crime Victims Act (Act). ORS 147.005 to 147.365. The Department based its denial on the applicant's failure to meet the eligibility requirements of ORS 147.015(5). At hearing, the Department also argued that applicant's injury was not the result of a compensable crime within the meaning of the Act.

ISSUES

Was applicant's injury substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim?

Was applicant the victim of a compensable crime under the Act, defined as an intentional, knowing or reckless act that resulted in serious bodily injury and which, if committed by a person of full legal capacity, would be punishable as a crime in this state?

EVIDENTIARY RULING

At hearing, counsel for the Department offered into evidence his oral recitation of applicant's prior criminal record, including a conviction for felony assault in 1977, a shoplifting conviction in 1974, and arrests for brawling and criminal trespass for which no charges were filed. Counsel offered this evidence as proof that applicant had the motive, opportunity and intent to do bodily harm to the alleged assailant, Mr. Bailey. In the alternative, counsel offered this evidence of applicant's prior record as proof that his testimony was not truthful. An immediate ruling on this matter was withheld, pending the issuance of this order.

The Board lacks authority to admit documentary evidence at a hearing that has not previously been considered by the Department. See ORS 147.155(5); OAR 438-82-040(3). Applicant's prior conviction and arrest record was not considered by the Department in reaching its decision.

Counsel for the Department argued at hearing that applicant's prior record can be considered by the Board because it was recited orally at hearing, and not offered as a written exhibit. I disagree. The fact the record was presented orally does not alter its character as documentary evidence. Accordingly, applicant's prior record will not be considered in determining whether he had motive, opportunity or intent to do Mr. Bailey bodily harm.

However, the prohibition against admission of new documentary evidence at hearing does not extend to the Department's use of applicant's prior record as proof that applicant did not testify in a truthful manner. I, therefore, consider applicant's prior record for this limited purpose.

FINDINGS OF FACT

At approximately 2:30 a.m. on April 2, 1989, applicant and a companion, Paul E. Padgett, were travelling on applicant's motorcycle, southbound on Washburn Way, Klamath Falls, Oregon. Washburn Way is an asphalt road running north and south. Applicant and Mr. Padgett were en route to Mr. Padgett's home. Both had been drinking, and applicant was intoxicated. The motorcycle ran out of gas and applicant pushed it onto the gravel shoulder of Washburn Way, in front of Sway Tamer Manufacturing Company (Sway Tamer), located at 5215 Washburn Way.

Sway Tamer is located on the east side of Washburn Way. A gravel driveway from the Sway Tamer property intersects the east side of Washburn Way. The alleged assailant, Mr. Bailey, operates Sway Tamer, and he and his invalid wife live in a trailer home on the property. The trailer home is accessed by the gravel driveway intersecting with the east side of Washburn Way. Several pieces of heavy equipment used in the Sway Tamer business are parked in the yard and driveway in front of the trailer home.

After running out of gas, applicant and Mr. Padgett entered the Sway Tamer property and searched a trash can for a section of rubber hose to use to siphon gas. A dog at the trailer home began to bark, awakening Mr. Bailey. He looked out of the trailer window and saw applicant and Mr. Padgett near the equipment parked in front of the trailer. Mr. Bailey reported a burglary in progress to the Oregon State Police, and then went outside the trailer carrying a loaded 22-250 caliber rifle.

Mr. Bailey confronted applicant and Mr. Padgett in the driveway in front of the trailer. Mr. Bailey told applicant and Mr. Padgett to put their hands in the air. Applicant asked Mr. Bailey if he could buy some gasoline. Mr. Bailey responded that he had no gasoline for sale. Mr. Bailey and applicant then entered into a somewhat heated verbal exchange, and Mr. Bailey ordered applicant and Mr. Padgett off the property.

Applicant and Padgett turned around and walked back down the driveway to the motorcycle. Mr. Bailey followed with the rifle. At the edge of Washburn Way, applicant turned back and rapidly approached Mr. Bailey. Applicant's right hand was behind his back, and the lighting in this area was poor. Mr. Bailey thought applicant was carrying a gun or a knife in his right hand. Mr. Bailey fired one shot at applicant's right hand when applicant was roughly 6 to 8 feet from Mr. Bailey. When the shot was fired, applicant was inside the Sway Tamer property line.

The shot ripped the front of applicant's jacket and struck his right hand, fracturing the thumb. After the shot was fired, applicant moved back toward Washburn Way, and he and Mr. Padgett placed themselves behind the motorcycle. Mr. Bailey returned to the trailer home, reported the shooting to the police, and unloaded his rifle. Applicant was taken to the hospital and surgical repair of his thumb was performed on four separate occasions.

Assault charges were initially brought against Mr. Bailey. Two grand jury proceedings were held, and all charges were dropped.

CONCLUSIONS OF LAW AND OPINION

The standard of review for cases appealed to the Board under the Act is de novo upon the entire record. ORS 147.155(5); OAR 438-82-030(1). Applicant is entitled to an award under the Act if, among other requirements, his injury "was

not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim." See ORS 147.015(5).

Applicant testified that he had no intention of harming Mr. Bailey and was only interested in purchasing gas. He further testified that there was no verbal confrontation between himself and Mr. Bailey prior to the shooting, and that he was standing by his motorcycle, outside of the Sway Tamer property line, preparing to push the motorcycle on down the road when he was shot. Applicant contends he did nothing to cause Mr. Bailey to shoot him.

I am not convinced that applicant actually intended to do Mr. Bailey bodily harm. However, I am persuaded that, as a result of applicant's actions, Mr. Bailey reasonably believed himself to be in danger. Accordingly, I conclude that applicant did substantially provoke the shooting.

In reaching this decision, I rely on Mr. Bailey's statement to police and his testimony at hearing. In particular, Mr. Bailey stated that he believed applicant and Mr. Padgett were in the process of committing a burglary; that applicant argued with Mr. Bailey when the latter refused to sell applicant gas; that immediately prior to the shooting, applicant had turned from the motorcycle and rapidly approached Mr. Bailey, with applicant's right hand behind his back; that the lighting was bad and Mr. Bailey believed applicant had a weapon in his right hand; that Mr. Bailey did not fire at applicant until he was 4 to 5 paces in front of Mr. Bailey; and that Mr. Bailey fired because he felt in danger of bodily harm, and was concerned about the safety of his invalid wife who lived with him in the trailer home.

I rely on Mr. Bailey's testimony for the following reasons. Mr. Bailey has consistently told the same story regarding the events surrounding the shooting. He testified in a straightforward and credible manner. State Police records corroborate Mr. Bailey's report of a burglary in progress and substantiate his statement that he believed applicant was on the premises for a criminal purpose. The fact Mr. Bailey shot applicant in the right hand is consistent with Mr. Bailey's statement that he believed applicant was carrying a weapon in that hand.

Further, the investigating officer reported that applicant was intoxicated when the officer arrived on the scene at approximately 3:26 a.m., shortly after the shooting. I am persuaded that applicant's memory of the events surrounding the shooting was clouded because he was intoxicated. Also, applicant did not initially tell the truth at hearing regarding his prior conviction and arrest record. He initially denied any prior involvement with the police; it was only after counsel for the Department recited applicant's prior record that he admitted the convictions and arrests had occurred.

In addition, the statement given by Mr. Padgett shortly after the shooting supports Mr. Bailey's version of events, rather than applicant's. In particular, Mr. Padgett stated that applicant and Mr. Bailey engaged in a verbal confrontation; that applicant had turned back toward Mr. Bailey and was within 6 feet of him when applicant was shot.

Finally, Mr. Bailey's testimony is consistent with physical evidence documented in the police records. The investigating officer retrieved a 22-250 cartridge lying in the Sway Tamer driveway, at a point 16 feet east of the eastern edge of the gravel shoulder along Washburn Way. Mr. Padgett and Mr. Bailey both stated that applicant was 6 to 8 feet from Mr. Bailey when he was shot. Therefore, it follows that applicant was roughly 10 feet into the Sway Tamer driveway when he was shot, not on Washburn Way as applicant testified.

For these reasons, I accept Mr. Bailey's account of events preceding the shooting incident on the morning of April 2, 1989. In summary, I am persuaded that applicant was on the property of Sway Tamer at the time of the shooting, and was moving rapidly toward Mr. Bailey with his right hand behind his body; that the lighting in the area was poor; that Mr. Bailey shot at applicant's right hand when applicant was roughly 6 feet from Mr. Bailey; and that Mr. Bailey did so because he feared for his personal safety and that of his invalid wife. I am further persuaded that applicant's actions substantially provoked Mr. Bailey to fire the shot. Consequently, I conclude that applicant is not entitled to an award under the Act. See ORS 147.015(5)

As I have determined applicant has not met the requirement of ORS 147.015(5), there is no need to address the Department's alternative theory that applicant was not a victim of a compensable crime under the Act.

ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Program, dated March 5, 1990, be affirmed.

October 9, 1990 Cite as 42 Van Natta 2350 (1990)

In the Matter of the Compensation of
SHEILA A. DAVISON, Claimant
WCB Case No. 89-06787
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Nichols and Crider.

Claimant requests review of those portions of Referee Brazeau's order which: (1) awarded 6 percent (19.2 degrees) unscheduled permanent disability for a back injury, whereas a Determination Order had closed claimant's claim as nondisabling; (2) upheld the self-insured employer's "de facto" denial of chiropractic treatment in excess of two times a month; and (3) declined to assess penalties and related attorney fees for the alleged unreasonable denial of chiropractic treatment. On review, the issues are extent of unscheduled permanent disability, medical services, penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following clarifications. Claimant was not performing her at-injury job as of the date of the hearing. However, claimant was released to and continued to perform her regular job without time loss until June 1989, when she accepted a promotion to an office job. In addition, we supplement with the following facts.

Claimant became medically stationary March 17, 1988.

The Determination Order issued March 6, 1989.

Claimant has normal muscle strength, sensation and reflexes of the upper and lower extremities. She retains the following cervical ranges of motion in degrees: forward flexion - 40 degrees; left and right lateral flexion - 40 degrees; left rotation - 70 degrees; and right rotation - 50 degrees. She

retains the following thoracolumbar ranges of motion in degrees: extension - 20 degrees; forward flexion - 70 degrees; and left lateral flexion - 20 degrees.

Claimant has chronic pain which limits her ability to do prolonged sitting.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 13 percent permanent loss of earning capacity as a result of her compensable low, mid and upper back injury.

Chiropractic treatment in excess of two times a month is not reasonable or necessary.

The employer's denial of treatment in excess of two times a month was reasonable.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

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

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

In this case, claimant became medically stationary March 17, 1988 and the Determination Order issued March 6, 1989. Therefore, we apply the current version of OAR 436-35-001 et seq., the rules in effect at the time of the March 6, 1989 Determination Order. OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. OAR 436-35-270(1).

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

Age, Education and Adaptability

We adopt the Referee's finding that claimant returned to regular work and supporting reasoning. Therefore, the age, education and adaptability factors are not applicable to this worker. OAR 436-35-290(2)(b); 436-35-300(2)(b); and 436-35-310(2)(b).

Impairment

The Referee awarded claimant 6 percent disability for impairment of the low back. On review, claimant contends that she is also entitled to an award for lost cervical range of motion and headaches. We agree with the Referee that

there is no evidence that claimant's headaches are a consequence of her compensable injuries. However, we find that claimant is entitled to an increased award for her loss of thoracolumbar range of motion and an additional award for her loss of cervical range of motion.

Cervical Spine

We find that the neck impairment that claimant suffers is related to her compensable injury. Neck pain was noted when claimant reported to Dr. Utter, her treating chiropractic physician, three days post injury.

Claimant retains 40 degrees forward flexion for a value of .33 percent; 40 degrees left lateral flexion for a value of .33 percent; 40 degrees right lateral flexion for a value of .33 percent; 70 degrees left rotation for a value of .5 percent; and 50 degrees right rotation for a value of 1.5 percent. OAR 436-35-360(2), (4), and (5). These values are added (not combined) for a total impairment value of 3 percent. OAR 436-35-360(10).

Thoracolumbar Spine

Relying on the Orthopaedic Consultants' report of May 23, 1989, the Referee allowed claimant 1 percent for loss of right lateral bending. On review, claimant contends that she is entitled to 5 percent for greater loss of range of motion, relying on the March 30, 1989 report of Dr. Michels, consulting chiropractic physician. We agree and rely on Dr. Michels' report. We find that his report is most consistent with claimant's testimony at hearing regarding her restricted activities of daily living and is concurred in by her treating physician.

Claimant retains 70 degrees forward flexion for a value of 2 percent; 20 degrees extension for a value of 1 percent; and 20 degrees left lateral flexion for a value of 2 percent. OAR 436-35-360(6), (7), and (8). These values are added (not combined) for a total impairment value of 5 percent. OAR 436-35-360(10).

We affirm the Referee's award of 5 percent for loss of repetitive use of the low back. OAR 436-35-320(4).

We combine (not add) the values of 5 percent for loss of range of motion and 5 percent for loss of repetitive use of the low back for a total impairment value of 9.75 percent for the thoracolumbar spine. OAR 436-35-360(11).

Claimant also contends that she is entitled to an award for spinal nerve plexus damage with resultant loss of strength. Claimant has established the existence of neither.

In addition, claimant also contends that the Referee erred in not assigning a value under the standards for disabling pain. We disagree. Under the standards as amended effective January 1, 1989, pain is considered to the extent it results in "measurable impairment." OAR 436-35-320(1). Thus, no separate award may be made for disabling pain under the standards.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. Claimant's age, education and adaptability values are motion (3 percent) is combined with her impairment value for the thoracolumbar spine (9.75 percent), the result is 12.46 percent unscheduled permanent disability. OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the "standards" is, therefore, 13 percent.

Compensability of Chiropractic Treatment in Excess of Twice a Month

We adopt the Referee's conclusions and opinion on this issue.

Penalties and Attorney Fees for Unreasonable Denial

Based on his conclusion that the employer's denial of treatment in excess of the guidelines was proper, the Referee found that this issue was moot. We agree and adopt the Referee's conclusions and opinion with the following comment. On review, claimant now asserts processing violations against the employer, alleging that no timely denial was issued, the denial was prospective, no copy was sent to claimant, and the letter contained no appeals language. Claimant did not make this argument at hearing. Issues not raised at hearing nor considered by the Referee will not be considered on Board review. See McNett v. Roy-Ladd Construction Co., 46 Or App 601, rev den 289 Or 588 (1980).

ORDER

The Referee's award of August 2, 1989 is modified in part and affirmed in part. In addition to the Referee's award of 6 percent (19.2 degrees) unscheduled permanent disability, claimant is awarded 7 percent (22.4 degrees), giving her a total award to date of 13 percent (41.6 degrees) unscheduled permanent disability for her low, mid and upper back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800. The remainder of the order is affirmed.

October 15, 1990 Cite as 42 Van Natta 2353 (1990)

In the Matter of the Compensation of
LARRY P. KARR, Claimant
WCB Case No. 89-09281
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Myzak's order that: (1) calculated the rate of his temporary disability benefits based on his status as a "regular employee" pursuant to OAR 436-60-020; and (2) declined to assessed a penalty and related attorney fee for an alleged unreasonable resistance to the payment of compensation. On review, the issues are the rate of temporary disability benefits and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Disability

We adopt the Referee's Conclusions of Law and Opinion, regarding the issue of rate of temporary disability benefits, with the following supplementation.

Since the issuance of the Referee's order, the Court of Appeals issued Lowry v. DuLog, Inc., 99 Or App 459 (1989), which held that even if a claimant is a "regular employee," as characterized in ORS 656.210(2), where that claimant works "varying" hours, rather than "regular" hours, his or her temporary disability benefits shall be calculated under the Director's rules, not under ORS 656.210.

Here, claimant essentially argues that because he is a "regular employee," his temporary disability benefits should be calculated under ORS 656.210. However, based on claimant's work history and representations, we find that he worked varying hours at an hourly wage.

Therefore, consistent with Lowry, we find that the Referee correctly concluded that claimant's temporary disability benefits should be calculated under the Director's rules. Lowry, supra; Doris M. Stark, 42 Van Natta 449 (1990).

Penalty and Related Attorney Fee

We adopt the Referee's Conclusions of Law and Opinion which found that the insurer's reduction of claimant's temporary total disability rate was not unreasonable.

ORDER

The Referee's order dated September 20, 1989, as reconsidered October 3, 1989, is affirmed.

October 15, 1990 Cite as 42 Van Natta 2354 (1990)

In the Matter of the Compensation of
RICK L. TARBOX, Claimant
WCB Case No. 89-01214
ORDER ON RECONSIDERATION
McNutt & Thrush, Claimant Attorneys
Roberts, et al., Defense Attorneys

On our own motion, we reconsider our September 14, 1990 Order on Review. We take this action to clarify the reasoning supporting our conclusion that claimant has failed to prove by clear and convincing evidence that he is entitled to a greater award of disability than indicated by the "standards." See former ORS 656.283(7) and 656.295(5).

In particular, we note our language to the effect that claimant's limited education, lack of technical training and employment history were already addressed under the "standards." Citing Richard L. Sproul, 42 Van Natta 1516 (1990), we concluded that those factors do not constitute clear and convincing evidence of additional impairment in excess of that indicated by the standards. On reconsideration, we wish to emphasize that a claimant is not limited to any specific evidence for purposes of proving entitlement to permanent disability in excess of that indicated by the standards. Claimant's burden in this regard is to prove clearly and convincingly, by whatever evidence is adduced, that his or her disability exceeds that indicated by the standards. Such evidence may, or may not, involve one or more of the factors addressed by the standards. Therefore, we disavow any interpretation of Richard L. Sproul, supra, which would exclude those factors considered under the standards in determining whether claimant has clearly and convincingly established disability in excess of that indicated by the standards. Here, we continue to hold that claimant has failed to sustain that burden.

Accordingly, our September 14, 1990 Order on Review is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

October 15, 1990 Cite as 42 Van Natta 2355 (1990)

In the Matter of the Compensation of
VERNON E. SUMMERS, Claimant
WCB Case Nos. 88-06496 & 88-06495
ORDER ON REVIEW (REMANDING)
Malagon, Moore, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

The SAIF Corporation requests review of Arbitrator Livesley's order that: (1) set aside its denial of claimant's "new injury" claim for a neck and low back condition; (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition; and (3) awarded claimant's counsel an assessed attorney fee for actively and meaningfully participating in the hearing. On review, the issues are responsibility and attorney fees. We remand.

We review the Arbitrator's order solely on questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989).

Responsibility

Citing Boise Cascade Corp. v. Starbuck, 61 Or App 631 (1983), the Arbitrator held that the burden is on claimant to prove that working conditions at the last employer contributed independently to claimant's disability. The Arbitrator also cited Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986), for the proposition that if the work conditions at the second employer could have caused claimant's worsened condition, responsibility shifts to the second employer. Relying on Dr. Knox's opinion and claimant's testimony, the Arbitrator held that SAIF had failed to establish that conditions at Liberty Northwest's insured were the sole cause or that it was impossible for conditions at SAIF's insured to have contributed to claimant's condition. The Arbitrator assigned responsibility to SAIF.

We conclude that the Arbitrator erred in failing to make clear which standard of law he applied in reaching his conclusion that responsibility lies with SAIF.

This case involves an accepted compensable injury with Liberty Northwest's insured followed by an increase in disability during later employment with SAIF's insured. Therefore, responsibility is fixed with Liberty Northwest, as the insurer which accepted the claim. In order to shift responsibility, Liberty Northwest must prove affirmatively that the later employment with SAIF's insured independently contributed to a pathological worsening of the accepted condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81 (1985); Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795 (1985); see Hensel Phelps v. Mirich, supra.

Because we are unable to determine which standard of law the Arbitrator applied, we remand for the Arbitrator to make findings of fact regarding whether

claimant's work activities at SAIF's insured independently contributed to his condition and to apply the appropriate legal standard to those findings.

Attorney Fees

The Arbitrator found that claimant's attorney actively and meaningfully participated in the hearing. Accordingly the Arbitrator awarded claimant's attorney an assessed attorney fee pursuant to ORS 656.307(5).

Although court decisions have relied upon language similar to that in ORS 656.307(5), none have interpreted or applied that provision. In a recent case, Daniel J. Bergman, 42 Van Natta 949 (1990), we interpreted the provisions of ORS 656.307(5). We found "active and meaningful" participation in an arbitration proceeding where claimant's attorney submitted exhibits "and was further involved in the preparation of the case and in achieving settlement." While we made no finding that claimant had actively asserted the prevailing view on the responsiblity issue, that finding was implicit in our decision. See Jean Novotny, 42 Van Natta 1060 (1990).

Here, the Arbitrator made no findings to support his conclusion that claimant's attorney had actively and meaningfully participated in the hearing. Therefore, we also remand this issue to the Arbitrator to make findings of fact regarding claimant's attorney's participation in the hearing and to apply the appropriate standard to those findings.

ORDER

The Arbitrator's order dated April 26, 1989 is vacated. This matter is remanded to Arbitrator Livesley to make findings and conclusions of law consistent with this order.

October 16, 1990 Cite as 42 Van Natta 2356 (1990)

In the Matter of the Compensation of
CATHERINE A. BARRINGER, Claimant
WCB Case No. 89-13132
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Foss, Whitty, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Quillinan's order that calculated the rate of her temporary disability benefits, based on her status as an "on-call" employee and pursuant to OAR 436-60-020. On review, the issue is rate of temporary disability benefits. We affirm on other grounds.

FINDINGS OF FACT

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

Claimant was "regularly employed" with the employer, yet worked varying hours for an hourly wage.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was a "permanent on-call" employee and concluded that the calculation of her temporary disability benefits was to be

based on OAR 436-60-020(7)(a). In making this determination, the Referee relied upon the holding in Richard R. D'Ostroph, 41 Van Natta 1050 (1989), in which the Board distinguished between a "regular" employee and an "on-call" employee.

Claimant contends, based on an D'Ostroph analysis, that she was a "regular" employee, and that the calculation of her temporary disability benefits should be based on ORS 656.210(2). We agree that claimant is a "regular employee," but do not agree that her disability benefits should be calculated pursuant to ORS 656.210(2).

In Richard D'Ostroph, the Board reiterated the distinction between an on-call employee and a regular employee, stating that a "regular" employee must be available as scheduled, whether or not the employer takes advantage of his or her availability, whereas an "on-call" employee's employment is sporadic, unscheduled employment by an employer with no right of reprisal if the employee is unavailable. Richard D'Ostroph, supra; citing Eldon Britt, 31 Van Natta 141, 142 (1981).

ORS 656.210(2)(a) provides:

> ". . . 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. *** As used in this (c) subsection, "regularly employed" means actual employment or availability for such employment." (Emphasis added).

Here, while claimant was required to call in every night to determine whether or not she was working the next day, and to determine what her hours would be, her employment was dependent upon her availability, i.e., subject to reprisal if she was unavailable. Furthermore, claimant's employment was not sporadic and unscheduled. In fact, claimant was regularly scheduled to work during the shrimp picking season, from mid-April through October of each year. During the peak season, claimant worked from 8 to 10 hours per day, seven days a week.

After our de novo review of the record, and our review of the relevant case law and statutes, we find that claimant was "regularly employed" at the time of injury. ORS 656.210; Richard R. D'Ostroph, supra.

However, since the issuance of D'Ostroph, the Court of Appeals issued Lowry v. DuLog, Inc., 99 Or App 459 (1989), which held that even if a claimant is a "regular employee," as characterized in ORS 656.210(2), where that claimant works "varying" hours, rather than "regular" hours, his or her temporary disability benefits shall be calculated under the Director's rules, not under ORS 656.210.

Here, claimant essentially argues that because she is a "regular employee," her temporary disability benefits should be calculated under ORS 656.210. However, based on claimant's work history and representations, we find that she worked varying hours at an hourly wage.

Therefore, consistent with Lowry, we find that the Referee correctly concluded tht claimant's temporary disability benefits should be calculated under the Director's rules. Lowry, supra; Doris M. Stark, 42 Van Natta 449 (1990).

ORDER

The Referee's order dated October 23, 1989 is affirmed.

In the Matter of the Compensation of
ALFREDO G. BUSTAMANTE, Claimant
WCB Case Nos. 89-09982 & 89-08171
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

St. Luke's Catholic Church (St. Luke's), a self-insured employer, requests review of Referee Irving's order that: (1) set aside its denial of claimant's "new injury" claim for his low back condition; (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition; and (3) assessed a penalty and related attorney fee for St. Luke's alleged unreasonable "back-up" denial. On review, the issues are the propriety of St. Luke's denial, and responsibility. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion and Conclusion" through the second full paragraph of page 5, with the following comments.

Standards of Review

The Referee referred to her opinion as an "Arbitrator's Decision." However, an order pursuant to ORS 656.307 (a ".307" order) was not issued. The Board did not appoint an arbitrator. Our review is of the Referee's Opinion and Order (not of an Arbitrator's application of the law). Accordingly, our review is de novo.

Notice of Acceptance on Form 801

The Referee concluded that St. Luke's had accepted compensability and responsibility on February 15, 1989, when its manager checked off the "accepted" box on the 801 form. We agree that a duly executed 801 form is a valid acceptance of responsibility. See U.S. Bakery v. Duval, 86 Or App 120 (1987); Nancy V. Storey, 41 Van Natta 1951 (1989). In Storey, supra, the Board concluded that checking the appropriate options on an 801 is one manner of accepting a claim. "'[A]cceptance' 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...." Storey, supra, at 1952-53. Similarly, in Patrick A. Getty, 42 Van Natta 1197 (1990), the Board considered a duly executed Form 801 to be a valid acceptance of responsibility so as to render a later denial letter an improper back-up denial.

Here, in item 57 of Form 801, St. Luke's had the option to accept, deny, or defer compensability and responsibility. The employer checked-off the "accepted" box. There was no attempt to qualify this acceptance and, in fact, on March 8, 1989 a follow-up letter was sent to claimant asking him to send unpaid medical bills to the employer and advising claimant that if no information was received within two weeks, his claim would be closed. (Ex. 72A). We conclude that these actions by St. Luke's constituted acceptance of responsibility for claimant's back injury.

Back-up Denial of Responsibility

The Referee concluded that St. Luke's was bound by its acceptance of compensability and responsibility issued on February 15, 1989, and that the May 4, 1989 attempt to deny responsibility was an impermissible "back-up denial" under Bauman v. SAIF, 295 Or 788 (1988). We concur.

Pursuant to former ORS 656.262(6), the insurer has 60 days after notice of a claim in which to accept or deny the claim. If, as in this case, the employer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days have elapsed, deny responsibility of the claim unless there is a showing of fraud, misrepresentation, or other illegal activity. Jeld-Wen, Inc. v. McGehee, 72 Or App 12, rev den 299 Or 203 (1985), citing Bauman, supra. We note parenthetically that the Bauman rule on retroactive denials was limited effective July 1, 1990 by amendment to ORS 656.262(6). See SAIF v. Abbott, 103 Or App 49, 53 n.1 (1990). An insurer or self-insured employer now has up to two years from the date of claim acceptance to revoke such acceptance; however, this change is not applicable to this matter.

Here, St. Luke's argues that even if a Form 801 is deemed sufficient to constitute an acceptance of responsibility, the Bauman principle on "back-up denial" does not apply. In support of its position, the insurer relies on Retchless v. Laurelhurst Thriftway, 72 Or App 729, rev den 299 Or 251 (1985) and Fred Shearer & Sons v. Stern, 77 Or App 607 (1986). The insurer's reliance on these cases is misplaced.

The Court of Appeals in Retchless held that the original accepting employer was required to continue paying compensation and could not deny the claim retroactively "at least until someone else is determined to be responsible." Retchless, supra, at 731. Similarly, in Fred Shearer & Sons, the Court of Appeals said that the original accepting employer was required to continue paying compensation and could not deny the claim retroactively "unless and until someone else is determined to be responsible." Fred Shearer & Sons, supra at 609. (Emphasis in original). The court considered it significant that there was a .307 (paying agent) order assuring that claimant's benefits would not be terminated and "[a]ccordingly, there is no reason to apply the Bauman rule." Fred Shearer & Sons, supra, at 610.

However, the Supreme Court has since rejected the argument that the Bauman rule is not applicable in "backup" denials of responsibility where the claimant's benefits are not affected. See Ebbtide Enterprises v. Tucker, 303 Or 459 (1987). The Court in Ebbtide was faced with the same broad issue as Retchless and its progeny: "After the Court of Appeals delivered its opinion in Retchless (citation omitted), EBI added a challenge to the applicability of the Bauman rule in this case." Ebbtide, supra, at 462. The Supreme Court then noted that the Court of Appeals affirmed the Board on the backup denial and "[w]e affirm the Court of Appeals on the issue of applicability of the Bauman rule to this case...." Id.

Although the Court in Ebbtide does not expressly overrule Retchless, it clarifies that the Bauman principle cannot be avoided simply by asserting that claimant's benefits are not in jeopardy. The Court framed the issue as:

> "whether the rule of Bauman v. SAIF, 295 Or 788 (1983), which prohibits 'backup' denials of the compensability of a claimant's injury, applies to backup denials of responsibility for a claimant's injuries where the claimant's benefits are not affected." Ebbtide, supra, at 461. (emphasis added).

The Court explained that the basis for the "backup" denial rule was not a perceived threat to claimant's benefits and, therefore, insurers could not be excepted from the Bauman principle simply because claimant's benefits are not affected:

> "In reaching the conclusion in Bauman that backup claim denials are impermissible under the Workers' Compensation Law, we relied not upon a perceived threat to claimant's benefits, but upon the institutional costs of permitting such denials." Ebbtide, supra, at 463.

Absent a showing of fraud, misrepresentation or other illegal activity, the carrier is not justified in issuing a backup denial. Ebbtide, supra, at 463. Thus, once a determination is made that a carrier was not justified in issuing a backup denial of responsibility, that carrier cannot seek to disclaim responsibility for an accepted injury, including for an aggravation claim. Id. at 465.

We note that, in March 1990, the Court of Appeals cited the general rule of Retchless. See Oak Crest Care Center v. Bond, 101 Or App 15, 18 (1990). However, the court did not rely on Retchless nor distinguish Ebbtide in arriving at its decision. We apply the Bauman/Ebbtide analysis to this claim.

Here, on February 15, 1989, St. Luke's issued an acceptance of responsibility by checking the boxes on the 801 form. This acceptance became final 60 days after the claim was filed on February 10, 1989. Thus, the employer's attempt to deny responsibility on May 4, 1989 is beyond the 60 days. Because St. Luke's has not established fraud, misrepresentation or other illegal activity capable of affecting its acceptance of the claim, the denial constitutes an unreasonable back-up denial. See Bauman, supra; Ebbtide, supra. Accordingly, the Referee's assessment of penalties and attorney fees for "back-up" denial is also correct.

Responsibility

The Referee set aside St. Luke's denial of responsibility as procedurally improper and then proceeded to discuss the merits. The Referee concluded that "but for" the acceptance issued by St. Luke's, SAIF would continue to be responsible for the aggravation of claimant's back condition. We agree that St. Luke's denial must be set aside as an unreasonable "back-up" denial; however, we find the Referee's subsequent analysis of the merits to be unnecessary. See Stephanie L. Vollendroff, 42 Van Natta 945 (1990).

ORDER

The Referee's order dated August 25, 1989 is affirmed.

October 16, 1990 Cite as 42 Van Natta 2360 (1990)

In the Matter of the Compensation of
PATRICIA E. CUSHMAN, Claimant
WCB Case No. 89-08706
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Davis & Bostwick, Defense Attorney

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Brazeau's order that: (1) upheld the insurer's denial of claimant's aggravation claim for a low back condition; (2) did not award interim compensation; and (3) declined to assess penalties and

attorney fees for an alleged unreasonable failure to timely accept or deny claimant's aggravation claim. On review, the issues are aggravation, interim compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee concluded that, because the symptomatic flareup that claimant experienced in January 1989 was of the type contemplated by the last arrangement of compensation, claimant had not sustained a compensable aggravation. We agree with the Referee's ultimate conclusion, but for different reasons.

To prove a compensable aggravation, claimant must show: (1) increased symptoms or a worsened underlying condition; and (2) a resultant diminishment of earning capacity since the last arrangement of compensation. In those cases in which the last award of compensation anticipated future exacerbations of the claimant's symptoms, the claimant must also show that the degree or duration of his or her reduced earning capacity is greater than that anticipated by the last arrangement of compensation. Gwynn v. SAIF, 304 Or 345 (1987); Edward D. Lucas, 41 Van Natta 2272 (1989). Here, the last award of compensation was a May 2, 1988 stipulation that awarded claimant an additional 20 percent unscheduled disability.

Claimant contends that her condition has worsened and relies on medical evidence of Dr. Ray, her treating chiropractor. The Board defers to the opinion of the treating physician absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons to do otherwise. Although Dr. Ray felt that claimant's condition had worsened, his report was not specific and he had long before concluded that she was permanently and totally disabled. Moreover, Dr. Tsai reported that claimant had no significant motor defect and recommended no additional diagnostic or curative treatment. The Orthopaedic Consultants, who examined claimant before and after the last award of compensation, found no basis for reopening the claim in January 1989. (Ex. 126). We do not find Dr. Ray's opinion persuasive.

Even if we accept Dr. Ray's opinion that claimant's condition has worsened, there is no evidence that she has suffered a diminishment of earning capacity. At the time of the last arrangement of compensation, claimant maintained that she was unable to work due to her injury and agreed that she was no longer a member of the work force. Thereafter, she has not returned to work and remains unemployed. The only evidence that she is less able to work is her testimony that the increased pain impairs her ability to make stuffed animals that she sells from time to time. We do not consider that testimony, standing by itself, persuasive evidence of a diminishment of earning capacity.

Finally, we note that the last arrangement of compensation expressly contemplated the waxing of claimant's symptoms without a worsening in claimant's underlying condition. There is no evidence that the degree of claimant's reduced earning capacity is greater than that anticipated by the last arrangement of compensation.

On this record, we find that claimant has failed to prove a compensable aggravation of her low back condition.

Interim Compensation and Penalties and Attorney Fees

We adopt the conclusions and reasons regarding the issues of interim compensation and penalties and attorney fees as set forth in the Referee's order.

ORDER

The Referee's order dated September 11, 1989 is affirmed.

October 16, 1990 Cite as 42 Van Natta 2362 (1990)

In the Matter of the Compensation of
DAVID E. FITZSIMONDS, Claimant
WCB Case No. 89-08966
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Snarskis, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Tenenbaum's order that: (1) increased his unscheduled permanent disability award for a left shoulder injury from 5 percent (16 degrees), as awarded by a Determination Order, to 13 percent (41.6 degrees); and (2) found that claimant was entitled to temporary total disability benefits based upon regular and overtime hours actually worked. On review, the issues are extent of unscheduled permanent disability and rate of temporary total disability. We modify in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's "Stipulations" and "Findings," with the following supplementation.

As a result of his compensable injury, claimant underwent a clavicle resection of the left shoulder. In addition, claimant has lost 5 percent of the strength in his left shoulder and has lost the ability to repeatedly use his left shoulder.

CONCLUSIONS OF LAW AND OPINION

Unscheduled permanent disability

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director pursuant to ORS 656.726(3)(f). See former ORS 656.283(7). Specifically, the Referee applied the version of OAR 436-35-001 et seq in force from January 1, 1989 until October 1, 1990, the rules in effect at the time of the July 5, 1989 Determination Order. These are the rules which we apply as well.

Explanation of "standards" equation for unscheduled disability

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

Age/Education/Adaptability

In the present case, the parties have stipulated that claimant is not entitled to a value for age or education. The parties have also stipulated to claimant's SVP as a glass repairer and have agreed that claimant has been released to and has returned to his regular work. We therefore discuss only the issue of impairment.

Impairment

Claimant argues, and the insurer concedes, that the Referee erred by not awarding claimant a stipulated impairment value of 5 percent for a clavicle resection. We agree. As a result of his industrial injury, claimant underwent a clavicle resection. He is therefore entitled to a value of 5 for the resection. Former OAR 436-35-330(13).

Claimant also argues that the Referee incorrectly awarded a value of 7.2 percent for loss of strength under former OAR 436-35-330(19). The Referee found that claimant was entitled to 15 percent of the 48 percent maximum for loss of strength, or 7.2 percent. Claimant argues that the value awarded should have been 15 percent, not 7.2 percent. We disagree.

We conclude that the Referee correctly awarded a percentage of the 48 percent maximum value allowed, as the rule provides for such a calculation where loss of strength is less than complete. However, we do not agree that claimant is entitled to 15 percent of the 48 percent maximum. Here, claimant's treating physician, Dr. Bald, calculated that claimant had some slight residual weakness. Dr. Bald opined that claimant's residual weakness was 5 percent. We find that opinion persuasive and, therefore, find that claimant is entitled to a value of 5 percent of 48, or 2.4, for his loss of shoulder strength. Former OAR 436-35-330(13).

The Referee found, and we agree, that as a result of his compensable injury, claimant was less able to repetitively use his left shoulder. We conclude that, for loss of repetitive use of his shoulder, claimant is entitled to a value of 5 percent. Former OAR 436-35-320(4).

Claimant's impairment values for his resection (5), loss of shoulder strength (2.4) and loss of repetitive use (5) are combined for a total impairment of 11.9. Because claimant is not entitled to any value for age or education, the total value remains 11.9 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 12 percent.

Finally, claimant contends that he is entitled to disability in addition to that awarded by the standards, because there is clear and convincing evidence that the standards do not adequately reflect his loss of earning capacity. See former ORS 656.283(7). In determining whether claimant has established clear and convincing evidence of entitlement to additional disability, we take into consideration such factors as claimant's age, education, impairment and adaptability to perform a given job. See former ORS 656.214(5). In the present case, the record does not provide evidence of those factors and we do not find other evidence sufficient for claimant to have proved by clear and convincing evidence that he is entitled to additional disability.

Although we have found that, under the standards, claimant is entitled to 12 percent unscheduled permanent disability, the insurer has not requested a reduction of the Referee's award of 13 percent unscheduled permanent disability.

Moreover, the insurer has requested that the Referee's order "be affirmed subject to an additional 5 percent unscheduled permanent partial disability consistent with the stipulation pursuant to OAR 436-35-330(13)". Based upon the insurer's concession, we conclude that claimant's total disability award, should be 18 percent unscheduled permanent partial disability.

Temporary total disability

The Board adopts the Referee's Conclusions and Opinion regarding the issue of temporary total disability.

ORDER

The Referee's order, dated August 23, 1989, as amended by the August 30, 1989 order, is modified in part and affirmed in part. That portion of the Referee's order that increased claimant's award to 13 percent unscheduled permanent disability is modified. Claimant is awarded an additional 5 percent (16 degrees), for a total award to date of 18 percent (57.6 degrees) unscheduled permanent partial disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney by the insurer, but not to exceed $3,000. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
EARL A. RUSSELL, Claimant
WCB Case No. 89-04339
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of that portion of Referee Myzak's order that: (1) found that claimant's current claim for an os trigone condition was not barred by res judicata; and (2) set aside its partial denial of claimant's os trigone condition. On review, the issues are res judicata and compensability, and alternatively, extent of scheduled permanent disability. We reverse on the issues of res judicata and compensability and affirm the Determination Order, which awarded claimant 10 percent (15 degrees) scheduled permanent disability for the loss of use or function of claimant's right ankle (leg).

FINDINGS OF FACT

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

The Opinion and Order dated May 24, 1988, which upheld the insurer's denial of surgery to excise the os trigone, was not appealed and that order is final.

On March 6, 1989, the employer denied claimant's os trigone condition, contending that the claim was barred by the operation of the doctrine of res judicata. Claimant requested a hearing.

The issue of compensability of claimant's os trigone condition has been adjudicated previously. There was an opportunity to litigate the compensability of the condition under an occupational disease theory at the earlier hearing.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee found that claimant's claim was for a fracture of the posterior process of the talus and concluded that that claim was not barred by the doctrine of res judicata. We disagree.

The insurer's March 6, 1989 denial specifically denied compensability of the os trigone condition, not a fracture of the posterior process of the talus. (Ex. 22).

"Preclusion by former adjudication" is a "doctrine of rules and principles governing the binding effect on a subsequent proceeding of a final judgment previously entered in a claim." Drews v. EBI Companies, 310 Or 134 (1990). "Claim preclusion" or "res judicata" is the rule that a party may not assert a claim arising from a transaction with respect to which he has already prosecuted such a claim to a valid and final judgment. See Restatement, (Second) of Judgments, Introduction 1 and 18 & 19 (1980); Dean v. Exotic Veneers, Inc., 81 Or 188 (1975); Carr v. Allied Plating Co., 81 Or App 306 (1986); Tana Wilson, 40 Van Natta 476 (1988); Jimmy M. Campoz, 42 Van Natta 903 (1990). Three key elements of "claim preclusion" are: (1) the same parties; (2) the same claim; and (3) a valid and final judgment of the first claim.

A worker who is aware that it is possible that his physical condition is the product of either an occupational disease or a job-related traumatic injury may not bring two successive compensation claims seeking the same relief for the same condition. Drews, supra, 310 Or at page 143. The failure to assert both theories in the first compensation claim precludes the second claim on the second theory where finality has attached to the first processed and there was an opportunity to litigate both claims at the time of the first claim. Id.

After our de novo review of the record, we find that the employer's January 15, 1988 denial of surgery, to excise the os trigone, and the employer's March 6, 1989 denial of an occupational disease claim, for the os trigone condition, deny the same condition. They both involve the same parties (which is uncontested), both involve the same condition (os trigone) and there has been a final judgment of the first claim. Finally, there was an opportunity to litigate the os trigone condition as an occupational disease at the time of the proceeding on the first claim.

Final Judgment on the First Claim

On July 27, 1987, claimant's treating physician, Dr. Whitney, requested authorization to remove a metal plate and to excise the "os trigone." (Ex. 7). The employer denied the request. By Opinion and Order, that portion of the denial for surgery to remove the plate was set aside, but that portion of the denial regarding excision of the os trigone was upheld. Specifically, Referee McCullough found and concluded that the need to excise the os trigone was not materially related to claimant's compensable 1985 ankle injury. Accordingly, the Referee concluded that portion of the surgery required to excise the os trigone was not compensable. (Ex. 12). That order was affirmed by a May 22, 1987 Order on Review. Neither party appealed that order to the Court of Appeals. Therefore, that order became a final order.

The Same Claim - Condition

Claimant's first claim was for the surgical excision of the "os trigone." As noted earlier, that portion of the denial for the excision of the "os trigone" was upheld, both by a Referee and by the Board on review. The excision of the "os trigone" is not compensable.

The Referee characterized claimant's current claim as a claim for a fracture of the posterior process of the talus and apparently based her characteri

zation on Whitney's March 1989 "check-the-box" form letter. Because she found the claim was for a fracture, rather than the os trigone, the Referee found that the claim was not barred by res judicata. We disagree.

We find, after our review of the record, that the two claims filed by claimant are for the same condition: the os trigone.

On February 13, 1989, Whitney, for the first time, reported that the "os trigone was probably a fracture at the time of injury." We note that again, Whitney refers to the condition as an "os trigone." It was this report that the insurer interpreted that a second claim was being filed.

On March 2, 1989, Whitney "checked-the-box" on a form letter which specified claimant's attorney's interpretation of Whitney's February 13, 1989 report. That letter stated, essentially, that the excised portion of claimant's foot was not an os trigone, but was the posterior process of the talus which had been fractured as a result of claimant's compensable injury. (Ex. 23).

While we generally give greater weight to the opinions of a treating physician, we 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). We find persuasive reasons not to defer to Whitney's March 1989 changed opinion as to the nature of claimant's condition which was excised.

On seven separate occasions, Whitney noted claimant's condition as an "os trigone." (Exs. 4, 6, 7, 8, 9, 14). Each of these instances refer to medical evaluations dated prior to claimant's actual surgery. Likewise, the surgical report authored again by Whitney noted "excision of the os trigone." (Ex. 15). And, again, in a post-operative report, Whitney refers to claimant's "os trigone" condition. (Ex. 17). We are persuaded by the consistency of these reports that the item excised was an os trigone.

Claimant's check-the-box response is not persuasive given the numerous prior characterizations of claimant's condition as an os trigone. Whitney merely checked-the-box. He did not expressly change his opinion. For these reasons, we do not rely on Whitney's alleged recharacterization of claimant's condition. Weiland, supra.

Because we find that the condition, at all times, remained an "os trigone," the excision of which is not compensable, we conclude that claimant's current occupational disease claim for that same condition, which claimant had the opportunity to litigate at the first proceeding, is barred. Drews, supra.

Given our finding that claimant's occupational disease claim for the os trigone condition is precluded by former adjudication, we do not address the compensability issue. We now turn to the issue of extent of scheduled permanent disability.

Extent of Scheduled Permanent Disability

Claimant's compensable condition was medically stationary on December 16, 1988. His claim was closed by Determination Order on January 23, 1989. Therefore, the "standards" adopted effective January 1, 1989, former OAR 436-35-001, et seq., apply to the rating of claimant's permanent partial disability. Specifically, we apply former OAR 436-35-000 through 436-35-260 to the rating of claimant's scheduled permanent partial disability.

Scheduled disability is rated on the permanent loss of use or function of a body part due to an injury connected with the job. former OAR 436-35-010(2). Pain is considered in these rules to the extent it results in measurable impairment. If there is no measurable impairment, no award of scheduled permanent partial disability is allowed. Former OAR 436-35-010(2)(b).

Claimant previously was awarded 10 percent scheduled permanent disability for the loss of use or function of his right ankle (leg) by a February 20, 1986 Determination Order. After claimant's surgery for removal of the metal plate, his claim was again closed, by a January 23, 1989 Determination Order which awarded no additional scheduled permanent disability.

There is no evidence in the record, medical or otherwise, to indicate that claimant suffers measurable impairment above that already awarded by the earlier Determination Order. Consequently, we do not increase claimant's scheduled permanent disability award and affirm the January 23, 1989 Determination Order.

ORDER

The Referee's order dated July 6, 1989 is reversed. The insurer's March 6, 1989 denial of claimant's occupational disease claim for an os trigone is reinstated and upheld. The Referee's $1,500 attorney fee award is reversed. The January 23, 1989 Determination Order is affirmed.

October 16, 1990 Cite as 42 Van Natta 2367 (1990)

In the Matter of the Compensation of
GREGORY F. STEVENS, Claimant
WCB Case No. 89-06512
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Gruber's order that awarded 4 percent (12.8 degrees) unscheduled permanent disability for his upper back, whereas a Determination Order had awarded no permanent disability. On review the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" but not his "Ultimate Findings of Fact" with the following supplementation.

Repetitive movements of claimant's cervical and upper thoracic spine, along with the physical strain he is exposed to while working, results in a symptomatic worsening of claimant's cervical condition. The discomfort experienced while symptomatic, limits the repetitive use of claimant's neck.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

The Referee awarded 4 percent unscheduled permanent disability for claimant's compensable injury. He did not, however, award a value for a chronic condition limiting repetitive use. Claimant contends that he is entitled to 5 percent for the chronic condition which limits his repetitive use and function of his neck. See former 436-35-320(4). The self-insured employer disagrees.

The parties do not dispute that claimant has returned to his usual and customary occupation. Therefore, no values are assigned to claimant's age, education and adaptability factors. Former OAR 436-35-290(1)(b), OAR 436-35-300(1)(b), and OAR 436-35-310(1)(b); Sharon A. Ipox, 42 Van Natta 1568 (1990). Consequently, we do not address these issues. The only dispute as to impairment is whether claimant is entitled to a value for a chronic condition under former OAR 436-35-320(4).

We turn to the issue of entitlement for a chronic condition resulting from the compensable injury. Claimant's treating chiropractor, Dr. Rabin, opined that repetitive movement of the upper spine which claimant is subject to while working contributes to a symptomatic worsening. (Ex. 29-2). When claimant is symptomatic, his limited movement interferes with his work activities. Id. There is no evidence to the contrary.

Based on this record, we are persuaded that claimant experiences a chronic condition which limits the repetitive use of his neck. Consequently, we find that claimant is entitled to 5 percent for the chronic neck condition caused by the compensable injury that results in loss of use or function of his neck. Former OAR 436-35-320(4).

Computation of Disability

Claimant's total impairment is his lost range of motion (4), combined with the chronic condition value (5) for a total impairment of 8.8 percent. As no values are assigned to age, education, and adaptability, his disability is based solely on his impairment rating.

Consequently, we conclude that under the standards, claimant is entitled to 8.8 percent unscheduled permanent disability. That disability figure is rounded to the next higher percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 9 percent.

ORDER

The Referee's order dated November 17, 1989 is modified. In addition to the Referee's award, claimant is awarded 5 percent (16 degrees) for a total award to date of 9 percent (28.8 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased unscheduled disability compensation created by this order. However, the total attorney fee awarded by the Referee and Board order shall not exceed $3,800.

October 16, 1990 Cite as 42 Van Natta 2368 (1990)

In the Matter of the Compensation of
ROBERTA R. TOIBERG, Claimant
WCB Case No. 88-20052
ORDER ON REVIEW
Douglas D. Hagen, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of those portions of Referee Neal's order that set aside its partial denial, as amended, of claimant's current hyperlordosis condition and medical services claim for chiropractic care. On review, the issues are compensability and medical services. We reverse.

FINDINGS OF FACT

On November 30 1987, claimant injured her low back while lifting a patient at work. The claim was accepted for "low back strain."

Claimant was initially treated by Dr. Henry.

Subsequently, claimant was seen by Dr. Chaser.

On February 17, 1988, claimant underwent an independent medical examination by the Western Medical Consultants.

Claimant began treating with Dr. Urban, a chiropractor, on May 16, 1988.

Claimant underwent a second independent medical examination with the Orthopaedic Consultants on June 9, 1988.

On November 7, 1988, the employer issued a partial denial denying chiropractic care rendered by Dr. Urban, and claimant's current "scoliosis" condition. On January 12, 1989, the partial denial was amended rescinding the "scoliosis" aspect of the partial denial, and in its stead denying compensability of claimant's "hyperlordosis" of the lumbar spine.

At the time of hearing claimant was receiving treatment from Dr. Urban three times a week for low back pain resulting from the hyperlordosis condition. Palliative treatment consisted of ultrasound, heat, and massage.

Claimant's "morbid obese" condition preexisted the compensable November 1987 injury. The obesity is unrelated to the compensable injury.

Claimant's hyperlordosis condition is preexisting, and was not worsened or made symptomatic by the compensable November 1987 injury.

ULTIMATE FINDINGS OF FACT

The compensable November 1987 injury is not a material contributing cause of claimant's current hyperlordosis condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

Procedural validity of the amended partial denial.

Without reaching the merits, the Referee set aside the employer's amended partial denial on procedural grounds. The Referee found that the amended partial denial was an impermissible "backup" denial, and alternatively, was also an improper preclosure denial. We disagree.

As a general rule, an insurer who accepts a claim for compensation may not later deny the same claim. Bauman v. SAIF, 295 Or 788 (1983). The rationale for this decision is based on policy considerations, specifically the prevention of instability, uncertainty and delay in the processing of compensable claims. Bauman, supra.

We find the employer was not attempting to revoke its original acceptance of the low back claim. An employer's acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6). The employer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies. It is improper to deny

those conditions which are a part of the acceptance. But it is not improper to deny separate aspects, i.e., conditions/injuries arising out of the same claim. Georgia Pacific v. Piwowar, 305 Or 494, 501-502 (1988); Johnson v. Spectra Physics, 303 Or 49, 58 (1987).

Per the 801 form the employer accepted a "low back strain." The medical evidence indicates that claimant's hyperlordosis condition preexisted the compensable low back injury, and was a separate infirmity. The scope of the acceptance did not encompass the hyperlordosis. As such, it was not procedurally improper for the employer to deny the hyperlordosis condition which was a separate aspect of that claim. See Piwowar, supra; Johnson, supra.

Nor do we find a preclosure denial. Where there is an accepted claim, the employer may not issue a denial which attempts to terminate future responsibility for that accepted condition where the extent of claimant's disability has not yet been determined. Roller v. Weyerhaeuser Co., 67 Or App 583 (1984). Here, the employer denied the compensability of claimant's hyperlordosis condition. As noted above, this is a separate condition from claimant's accepted low back strain. Accordingly, Roller does not apply in this situation. Roller, supra.

Merits of the amended partial denial.

As we find the amended partial denial procedurally valid, we proceed to the merits of claimant's current hyperlordosis condition and medical services claim. We find that claimant's current need for medical treatment is related to the hyperlordosis condition, and not the accepted low back strain. We further conclude that the hyperlordosis is not causally related to the compensable injury.

Claimant suffered a compensable injury on November 30, 1987, when she attempted to lift a patient. Her treating physician at that time Dr. Henry diagnosed "low back strain." Shortly thereafter claimant began seeing Dr. Chaser. By report dated January 12, 1988, Dr. Chaser identified, through x-ray, a "severe lumbar hyperlordosis" condition. He noted the complications caused by claimant's "morbid obesity." He also stated, "...obesity, poor postural habits, and general poor health have probably contributed to the continuance of her back condition..."

In February 1988, an independent medical examination was performed by the Western Medical Consultants. It was the opinion of the Consultants that claimant's low back strain had reached maximum improvement. They concluded that claimant's low back strain was medically stationary with no permanent residuals. No further treatment was recommended. In addition to her obesity, they also noted that claimant had a "marked postural hyperlordosis."

Dr. Chaser, claimant's treating physician at the time, essentially concurred, although he concluded claimant was not medically stationary as he predicted continued increased improvement. With regard to the hyperlordosis he commented, "Her obesity and marked lumbar lordosis are hindering her progress."

The Orthopaedic Consultants stated that claimant's hyperlordosis is preexisting and is probably a major factor in her continuing low back pain. They further stated that her current regimen of chiropractic care was inappropriate for her problem, and instead recommended a work hardening program.

Dr. Farris, an orthopedist and member of the Orthopaedic Consultant panel which examined claimant, testified that it was more likely than not that the

November 1987 injury was temporary and resolved without lingering residuals. He opined that her continuing low back pain was due to the hyperlordosis.

We also note that Dr. Urban has indicated that claimant's continuing problems are related to her hyperlordosis condition. He explains in his February 9, 1989 letter that the strain was probably temporary as the very nature of strains is that they are of short duration and do not reoccur.

A close reading of the opinions rendered by claimant's treating doctors as well as those by independent medical examiners, shows substantial agreement that claimant's current problem stems, not from a "strain," but rather the combining influence of claimant's preexisting hyperlordosis condition and obesity. Thus, we conclude that the preponderance of the medical record indicates that claimant's current need for medical care and treatment stems not from the compensable low back strain, but is related to claimant's preexisting hyperlordosis condition as complicated by her contemporaneous obesity.

Inasmuch as we find that claimant's current need for medical services is related to claimant's hyperlordosis condition, we consider the compensability of the hyperlordosis condition.

In an injury case, a worker must prove by a preponderance of the evidence that the industrial injury was a material contributing cause of her existing disability or need for medical treatment. Harris v. Albertson's Inc., 65 Or App 254 (1983). Claimant has failed to meet her burden of proof.

Dr. Urban concluded that claimant's hyperlordosis condition was related to the November 1987 injury. His conclusion was based upon the lack of symptoms prior to the injury, and his study of the two sets of x-rays taken in January and May of 1988 which showed a marked increase in hyperlordosis of the spine.

The independent medical examiners share a conclusion different from Dr. Urban. The Western Medical Consultants concluded that the hyperlordosis was preexisting and unrelated to the compensable injury. The Orthopaedic Consultants, although noting that claimant's need for a work hardening program and the injury's residuals were related, did not support a causal relationship between the hyperlordosis and the compensable injury. We find it noteworthy that they had in their possession for consideration and study no less than four sets of x-rays of claimant's hyperlordosis condition including those of Dr. Chaser, the Western Medical Consultants, Dr. Urban, and ones they had taken themselves. Despite this, they concluded there were no objective findings of impairment related to the injury.

Later, at hearing a member of the Orthopaedic Consultants panel, Dr. Farris, clarified that claimant's hyperlordosis condition was not related to her compensable low back strain. He could find no objective evidence which indicated that claimant's preexisting hyperlordosis condition had been worsened or made symptomatic by the November 30, 1987 injury.

In evaluating medical opinions, we give weight to those that are well reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986). We conclude that the opinions of the independent medical examiners were more persuasive. In reliance on their opinions, we are not persuaded that claimant's compensable November 1987 compensable low back strain was a material contributing cause of her existing hyperlordosis disability or need for medical services.

In conclusion, we find that claimant's current need for treatment is for claimant's preexisting hyperlordosis condition, not for her previously accepted

low back strain. We further find that claimant has failed to carry her burden of proof in demonstrating the necessary causal relationship between the accepted injury and the hyperlordosis.

ORDER

The Referee's order dated March 2, 1989, as amended March 7, 1989, is reversed. The self-insured employer's November 7, 1988, partial denial, as amended January 12, 1989, is reinstated and upheld. The Referee's attorney fee of $1,000 concerning the partial denial to claimant's counsel is reversed. The remainder of the Referee's order is affirmed.

October 16, 1990 Cite as 42 Van Natta 2372 (1990)

In the Matter of the Compensation of
MARIE C. WALSH, Claimant
WCB Case No. 88-21956
ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Bennett's order that: (1) admitted into evidence, over the insurer's objections, the reports of claimant's treating psychiatrist who did not submit to cross-examination; and (2) affirmed a Determination Order award of permanent total disability for her neck condition. The insurer seeks exclusion of the admitted reports. On review, the issues are evidence and extent of unscheduled permanent disability, including permanent total disability. We exclude the disputed reports, but affirm the Referee's decision that claimant was permanently and totally disabled.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, as set forth in the "Findings" and "Findings of Ultimate Fact" portions of the order, with the following supplementation.

On June 22, 1988, a Determination Order issued awarding claimant permanent total disability. The insurer requested a hearing, which convened on March 16, 1989 before Referee Leahy. The insurer objected to the introduction of all exhibits authored by Dr. Petroske, arguing that Petroske refused to submit to cross-examination. Referee Leahy overruled the objection and admitted the reports into the record. On his own motion, Referee Leahy refused to proceed with the hearing in order to allow claimant opportunity to obtain additional psychiatric reports.

At the subsequent hearing, on August 9, 1989, Referee Bennett overruled a subsequent objection to the admission of all exhibits authored by Dr. Petroske, i.e., Exhibits 9, 15, 18, 19, 22-28, 30, 35, 44, 48, 57, 60, 65, and 67-69.

Dr. Petroske refused to submit to cross-examination and no "good cause" has been shown why the reports should be admitted.

CONCLUSIONS OF LAW AND OPINION

Admissibility of Documents

The Referee, without explanation, admitted all of the reports from claimant's psychiatrist, Dr. Petroske, identified as Exhibits 9, 15, 18, 19, 22-

28, 30, 35, 44, 48, 57, 60, 65, and 67-69. The insurer argues that the exhibits should be excluded, contending that Dr. Petroske refused to submit to cross-examination, pursuant to OAR 438-07-005(3), and that no "good cause" has been shown why the reports should be admitted. We agree.

OAR 438-07-005(3) provides:

> "The insurer may subpeona the claimant's attending physician or consulting physician(s) or vocational expert for cross-examination. . . . The reports of any medical or vocational expert who has refused to make herself or himself available for cross-examination shall be excluded from the record unless good cause is shown why such evidence should be received. . ."

Here, the record establishes that Dr. Petroske was suspended from the practice of psychiatric medicine and has withdrawn from practice. The insurer attempted to contact Dr. Petroske both through claimant's counsel and personally for purposes of cross-examination. The insurer contacted Dr. Petroske's office and was informed of the suspension. Petroske's office refused to provide the insurer with Dr. Petroske's address or location for purposes of serving a subpeona to have him testify at hearing. (Tr. 3). Claimant's counsel did not dispute the representations made by the insurer regarding Dr. Petroske's unavailability, nor did claimant attempt to make any showing of "good cause" why such evidence should be received.

Based on the representations of the parties in their briefs before the Board and on their representations to the Referee at hearing, we find that Dr. Petroske refused to make himself available for cross-examination. OAR 438-07-005(3); see, e.g., William V. Bellamy, 42 Van Natta 651 (1990).

Accordingly, because Dr. Petroske has refused to consent to cross-examination, we disagree with the Referee's evidentiary ruling and exclude all exhibits authored by Dr. Petroske. Therefore, Exhibits 9, 15, 18, 19, 22-28, 30, 35, 44, 48, 57, 60, 65, and 67-69 have not been considered on review.

Permanent Total Disability

We adopt the Referee's Conclusions of Law and Opinion, as set forth in the "Opinion" portion of the order, which found claimant permanently and totally disabled, with the following comment.

After excluding the reports authored by Dr. Petroske, we find and conclude, based on the reports of Dr. Colbach, Dr. Borroughs, Dr. Carr, Dr. Dixon, as well the reports of vocational counselor Godt, that claimant is permanently and totally disabled.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the permanent total disability issue is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 25, 1989 is affirmed. For services on Board review concerning the issue of permanent total disability, claimant's attorney is awarded a reasonable assessed fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
JOYCE V. WALTER, Claimant
WCB Case No. 88-21227
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Davis' order which granted permanent total disability, whereas a Determination Order awarded no additional permanent disability beyond prior awards totalling 50 percent (160 degrees) unscheduled permanent disability for neck and shoulder conditions, and 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of claimant's left arm. On review, the sole issue is permanent total disability. We affirm.

FINDINGS OF FACT

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

Claimant is at a high risk of medical relapse should she attempt either full-time or part-time work. Medical and vocational experts were unable to suggest any part-time job that claimant could regularly perform.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusion of Law and Opinion" with the following comment and supplementation.

Claimant must prove by a preponderance of the evidence that she is permanently totally disabled. Harris v. SAIF, 292 Or 683, 695 (1982). There are two types of permanent total disability: (1) that arising entirely from physical incapacity; and (2) that arising under the "odd-lot" doctrine, resulting from less than total physical incapacity plus nonmedical factors, which together may result in permanent total disability. Welch v. Bannister Pipeline, 70 Or App 699,701 (1984); Shaw v. SAIF, 78 Or App 588 (1986).

In addition, claimant has the burden to establish that she has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983). However, even if a work search would be futile, such a claimant must establish that she, but for the compensable injury, would have been willing to seek regular gainful employment. SAIF v. Stephen, 303 Or 41 (1989).

The Referee concluded that claimant's permanent total disability derives solely from medical causes. We do not agree that claimant's disability arises entirely from her physical incapacity and we observe that the Referee's analysis includes factors normally considered under the "odd-lot" doctrine. Instead, we find that claimant's permanent total disability derives from a combination of medical and nonmedical factors which render her unable to perform work at a gainful and suitable occupation. See Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

Here, claimant sustained serious compensable injuries to her head, neck, and shoulder area in October 1983. Thereafter, she required multiple surgeries, including: laminectomy, foraminotomy, cervical fusion, and carpal tunnel release. Following the surgeries, claimant has severe pain upon minimal exertion and movement and this has become progressively worse.

At the time of hearing, claimant was 53 years old, had a 12th grade education and no other formal training. Claimant's prior work experiences include running her own dry cleaning business, cashier, dispatcher for a telephone repair operation, and general clerical work. She was a spot cleaner at a dry cleaners at the time of injury.

Following her injury, claimant sought rehabilitation services and it was determined that she had transferable skills in customer services, sales, and clerical work. This was based in part on claimant's love of the public and her "people" skills. However, after claimant's numerous surgeries, her employer said there were no positions available that fit her physical limitations. Therefore, claimant's vocational counselor referred her for "brush-up" classes in typing and word processing to place claimant in clerical/secretarial positions. However, claimant had to drop out of the retraining program because of increasing pain. Claimant's vocational services status was frequently on hold due to her medical condition. The record is replete with evidence of claimant's cooperative and motivated attitude, despite her pain.

During 1987 claimant contacted 50 to 75 potential employers and she was finally hired by an insurance agent in July 1987. Claimant performed the duties of a part-time secretary (three full days per week) at the rate of $5 per hour with wage subsidy. Numerous modifications were made at the job site and in claimant's work station to accommodate her disability. After about three months on the job, claimant's employer gave her a good performance rating. Additionally, she was observed to have regular attendance and a positive attitude. However, by January 1988 claimant's pain began hampering her performance and she started missing work. The employer observed the pain behavior and saw claimant in tears due to pain. Claimant's attending physician took her off work in late February 1988.

Claimant can stand for about one hour if she is moving. Additionally, she cannot sit without pain and light housekeeping of any kind exacerbates her pain. A brief attempt to work for her daughter resulted in claimant experiencing pain in her hands, arms, neck, and shoulders. Claimant's social life is also extremely restricted due to pain. She is awakened at night because of pain and gets only 3-4 hours of sleep. Claimant takes physical therapy, as well as injection therapy, and does stretching, breathing, and walking exercises--all of which provide minimal, if any, relief.

Claimant's physician, Dr. Kemple, opines that claimant is at a high risk of relapse should she attempt most available full-time job positions. At the most, claimant might be able to perform limited part-time work on a "trial and error" basis. However, Dr. Kemple seemed to base this speculation on claimant's sincere desire to work, rather than on her physical capacity to perform a specific part-time job.

The only expert vocational testimony is from claimant's rehabilitation counselor who, like Dr. Kemple, completely rules out full-time employment. The vocational specialist was unable to suggest any part-time job that claimant could perform for more than a few months because of her frequent flare-ups of severe pain.

In sum, claimant is incapable of regularly performing work at a gainful and suitable occupation in the general labor market within the constraints of her severe physical limitations, incapacitating chronic pain, age, and lack of readily transferable skills. In addition, claimant has made reasonable efforts to reenter the work force and, based on expert opinion, any further attempts would be medically contraindicated and futile.

The SAIF Corporation's sole argument is that claimant could perform part-time work, such as a process server, and she is therefore not permanently and totally disabled. Thus, SAIF contends that the Referee erred because he did not consider part-time work "gainful and suitable" employment. Pournelle v. SAIF, 70 Or App 56 (1984); Hill v. SAIF, 25 Or App 697 (1976). This is an accurate reference to the law on part-time work as it pertains to permanent total disability; however, there is a qualifying requirement that claimant be able to perform the part-time work on a "regular" basis.

In Georgia-Pacific Corp. v. Perry, 92 Or App 56 (1988), the vocational expert was mistaken in concluding claimant must be able to return to full-time work for the employment to be considered gainful and suitable. The Court of Appeals held that where a claimant is able to do regular part-time work, he is not permanently and totally disabled. Perry, supra, at 58. Apparently, "regular" part-time work requires some degree of permanency. For example, in Pournelle v. SAIF the ability to work on a permanent part-time basis was sufficient to avoid a finding of permanent total disability. 70 Or App 56 (1984), citing Hill v. SAIF, 25 Or App 697, 701 (1976). Unlike the claimant here, the claimant in Hill, supra, was not found permanently totally disabled because at the time of hearing he held a regular part-time job as a barber and was experiencing no difficulties which would abbreviate his employment. In contrast, the claimant in Pournelle was found permanently totally disabled because he had made sincere efforts to return to part-time work. Even with the special accommodations of his employer, the increasing pain prevented claimant from performing regular part-time work. Pournelle, supra, at 61.

Like the worker in Pournelle, despite extensive physical accommodations, the claimant here has been unsuccessful in her attempts to complete vocational retraining and to perform part-time work. Furthermore, the suggestion that claimant could continue "trying-out" certain jobs to see if she could possibly do something for more than a few months is speculation. Job availability cannot be based on speculation. See Blaine M. Jones, 42 Van Natta 869 (1990). Contrary to SAIF's assertions, the vocational consultant actually dismissed the process server position because it was not a realistic or viable employment option for claimant.

The purpose of permanent total disability is to maintain claimants who are totally precluded from supporting themselves. See Georgia-Pacific Corp., supra. This record sustains the Referee's determination that claimant cannot regularly support herself in either full-time or part-time employment. Claimant has proven that she is unable to perform any work at a gainful and suitable occupation.

ORDER

The Referee's order dated May 31, 1989 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $2,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
RALPH S. BURKETT, Claimant
Own Motion No. 88-0429M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Michael T. Garone, Claimant Attorney
Saif Legal Department, Defense Attorney

The Board issued an Own Motion Order on September 22, 1988, which reopened claimant's claim for the payment of temporary total disability benefits. By Notice of Closure dated July 24, 1990, as corrected August 2, 1990,

the SAIF Corporation closed the claim, finding claimant medically stationary on July 25, 1990. SAIF terminated temporary total disability benefits as of July 9, 1990. Claimant requests Board review of SAIF's claim closure, contending he is entitled to claim evaluation and closure pursuant to ORS 656.268, not ORS 656.278. Alternatively, he argues that he is not yet medically stationary.

The Board reopened claimant's claim on September 22, 1988, and directed SAIF to close the claim pursuant to OAR 438-12-055, which governs the closure of claims reopened under the Board's own motion authority pursuant to ORS 656.278. Notwithstanding that order, upon further consideration, we conclude that this claim should be closed pursuant to ORS 656.268.

Prior to claimant's recent worsening, his claim was last closed by Determination Order dated February 9, 1988. Claimant's claim was reopened September 22, 1988, within the one-year period for appealing from the Determination Order. See former ORS 656.268(6). Therefore, this claim must be closed under ORS 656.268 rather than ORS 656.278. Carter v. SAIF, 52 Or App 1027 (1981); Coombs v. SAIF, 39 Or App 293 (1979); Rosemary J. Harrell, 42 Van Natta 639 (1990). Therefore, we set aside the Notice of Closure and remand claimant's claim to SAIF for further processing to closure pursuant to ORS 656.268. Claimant's attorney is awarded 25 percent of any additional temporary and/or permanent disability compensation which results from this order, not to exceed $400, as a reasonable attorney fee.

IT IS SO ORDERED.

October 17, 1990 Cite as 42 Van Natta 2377 (1990)

In the Matter of the Compensation of
ROBERT C. KILLION, Claimant
WCB Case No. 89-04208
ORDER ON RECONSIDERATION
Patrick Lavis, Claimant Attorney
Nelson, et al., Defense Attorneys

The insurer requests reconsideration of the Board's Order on Review dated September 28, 1990. Specifically, the insurer asks that the Board award claimant 33 percent (44.55 degrees) scheduled permanent disability for loss of the left foot, whereas the Board had awarded claimant 33 percent (49.5 degrees) for loss of use or function of his left leg.

Inasmuch as our findings concern the loss of use or function of claimant's left foot/ankle, we find that claimant is entitled to a scheduled permanent disability award for loss of his left foot/ankle and not his left leg. ORS 656.214(2)(d) and former OAR 436-35-190. Accordingly, we correct those portions of our Order on Review that refer to a loss of use or function of claimant's left leg. We find that claimant's loss of use or function is limited to those portions of his left leg below his knee; therefore, claimant is entitled to a scheduled permanent disability award for loss of use or function of his left foot/ankle equal to 33 percent (44.55 degrees).

On reconsideration, as supplemented and corrected herein, we adhere to and republish our September 28, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEAN E. NEALY, Claimant
WCB Case No. C0-00116
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Merrill Schneider, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

On September 17, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $4,500 by Sedgwick James of Oregon, Inc., claimant agrees to release her right to future workers' compensation benefits, except medical services, for her compensable injury. We set aside the proposed disposition.

We shall not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

The Board requires that a claim disposition agreement be in a separate document from a disputed claim settlement (DCS). OAR 438-09-020(2)(b). Any claim disposition agreement which does not comply with this rule must be returned to the drafter. OAR 438-09-020(3). Here, the parties submitted a DCS to the Referee in WCB Case No. 90-05873 to resolve issues arising from the employer's denials of various claims, including one for medical services. Additionally, a copy of that DCS was submitted to the Board as "Exhibit A" to this claim disposition agreement and incorporated therein by reference (Page 2, ll. 1-3). The agreement also provides: "The claimant further understands that pursuant to the terms of a Disputed Claim Settlement ..., that he [sic] April 29, 1988 industrial injury no longer materially contributes to her wrist and forearm symptoms or her need for treatment" (Page 2, ll. 16-20).

By incorporating terms of the DCS into the claim disposition agreement, the agreement exceeds the bounds of OAR 438-09-020(2)(b). Moreover, the provision quoted above could reasonably be interpreted to limit claimant's right to medical services for her compensable injury. Any limitation of that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). See Kenneth D. McDonald, 42 Van Natta 2307 (1990); Sharon Watkins-Aubert, 42 Van Natta 2093 (1990). Accordingly, we find that the proposed disposition is unreasonable as a matter of law and set it aside. See ORS 656.236(2); Louis R. Anaya, supra.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MARCHETA CONRADI-WEST, Claimant
WCB Case No. 89-06954
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Mulder's order which found she was not entitled to temporary disability benefits on the basis that she had removed herself from the work force. The insurer cross-requests review of that portion of the order which awarded claimant's counsel a $1,800 assessed attorney fee. On review, the issues are temporary disability benefits and attorney fees.

FINDINGS OF FACT

Claimant sustained a compensable injury to her low back in May 1981. As a result of this injury, claimant underwent surgery in July 1984. Her claim was first closed by an August 1985 Determination Order which awarded 20 percent unscheduled permanent disability as well as 5 percent scheduled permanent disability for the left leg.

Thereafter, claimant was placed in an authorized training program. She was removed from this program in September 1987 for medical reasons. Her claim was again closed by a January 1988 Determination Order which increased her unscheduled permanent disability award to 40 percent. The Determination Order further awarded claimant 5 percent scheduled permanent disability for the right leg. Claimant appealed this Determination Order contending that she was permanently and totally disabled.

In a May 1988 Opinion and Order, an earlier Referee found that claimant was not permanently and totally disabled. The Referee, however, increased claimant's unscheduled permanent disability award to 55 percent as well as increasing her scheduled permanent disability award for the left leg to 25 percent. He affirmed the Determination Order award of 5 percent scheduled permanent disability for the right leg.

In June 1988, claimant experienced increased symptoms and was referred to Dr. Berkeley, neurosurgeon. At that time, an MRI scan revealed a mild broad-based disc bulge at L4-5 and a moderate broad-based disc bulge at L3-4. On November 16, 1988, Dr. Berkeley requested authorization to perform surgery.

On December 28, 1988, claimant's counsel wrote to the insurer requesting all medical-vocational claims processing documentation together with a summary and/or breakdown of payments made pursuant to the January 1988 Determination Order and May 1988 Opinion and Order. Counsel also noted that a request for surgery had been made and inquired into the status of that request. On February 13, 1989, claimant's counsel wrote the insurer once again noting that there had been no response to his December 28, 1988 request for information. He enclosed a copy of the prior letter and requested a response. He again inquired as to the status of the surgery request.

On April 11, 1989, clamant filed a hearing request, raising as issues the insurer's failure to process her surgery claim and to provide medical reports in a timely fashion. The insurer authorized Dr. Berkeley's request by letter dated May 22, 1989. On June 23, 1989, the insurer's counsel wrote to claimant's counsel asking for copies of any information or reports regarding claimant's scheduled surgery. The insurer's counsel enclosed duplicate copies of all medical reports and other discoverable documents produced since the prior hearing.

Claimant has not worked since her withdrawal from the authorized training program in September 1987. In the winter of 1988, she registered for classes at a community college, but failed to attend any of the classes.

At the time of hearing, claimant had undergone the surgery proposed by Dr. Berkeley.

FINDINGS OF ULTIMATE FACT

Claimant was not in the work force at the time of her June 1988 aggravation.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

The Referee concluded that claimant was not entitled to temporary disability benefits on the basis that she had withdrawn from the work force. We agree.

To receive temporary disability benefits upon a worsening of her industrial injury, claimant must be in the work force at the time of the worsening. See Cutright v. Weyerhaeuser, 299 Or 290 (1985). A claimant is deemed in the work force if she is engaged in regular gainful employment or, although not employed, is willing to work and is making reasonable efforts to obtain employment. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Here, claimant has not been employed since September 1987. In the winter of 1988, she did have some contact with a vocational provider and registered for classes at a community college, but did not attend the classes. There is no persuasive evidence in the record that indicates that claimant was working or seeking work at the time of the June 1988 aggravation. In fact, the weight of the evidence indicates that she had removed herself from the work force as early as September 1987. Under these circumstances, we conclude that claimant was not in the work force at the time of the June 1988 aggravation. Accordingly, she is not entitled to temporary disability benefits.

Attorney Fees

The Referee awarded claimant's counsel an assessed attorney fee of $1,800, for overcoming a "de facto" denial of surgery as well as a penalty-related attorney fee for a late authorization of surgery and a penalty-related attorney fee for a discovery violation. We modify.

Claimant is not entitled to an assessed attorney fee for overcoming a "de facto" denial of surgery. Although the insurer's authorization of surgery was delayed, it was ultimately authorized in May 1988 and subsequently performed prior to the hearing. In light of the insurer's authorization, the surgery was not denied, but rather accepted, therefore, claimant is not entitled to an assessed attorney fee on this basis.

As noted above, the insurer's authorization of claimant's surgery was untimely. Dr. Berkeley requested authorization in November 1988, however, it was not authorized until May 1989. The insurer offers no explanation for this delay. We conclude that the insurer's delay in authorizing the proposed surgery was unreasonable, therefore claimant's counsel is entitled to a penalty-related attorney fee for the insurer's unreasonable action.

Finally, the Referee awarded a penalty-related attorney fee for failure to provide discovery in a timely manner. There was no hearing request pending in

December 1988 and February 1989, when claimant's counsel requested documents from the insurer. Therefore, the insurer's duty to provide discovery is controlled by the Director's rules. See Lawrence A. Durette, 42 Van Natta 413 (1990). The Director's rule, OAR 436-10-030(10), does not provide for a specified time in which to provide discovery. We have interpreted the rule as requiring that documents be produced in a reasonable time given the circumstances surrounding the request. Id. at 414.

Here, claimant's counsel requested all vocational/medical documents pertaining to claimant in December 1988, and again in February 1989. The documents were not provided until June 1989. The insurer offers no explanation for this delay and we find it to be unreasonable. Despite our finding that the insurer's conduct was unreasonable, there is no evidence to suggest that the conduct constituted an unreasonable resistance to the payment of compensation. We therefore are unable to award a penalty-related attorney fee in this instance. See Ellis v. McCall Insulation, 308 Or 74 (1989). In reaching this conclusion, we note that claimant did not establish entitlement to temporary disability benefits or any other compensation at the hearing. We further note that the insurer's untimely production did not affect the issues litigated at hearing.

In light of our conclusions above, claimant is entitled to an assessed attorney fee only on the basis of the insurer's untimely authorization of surgery and the Referee's award of $1,800 will be modified accordingly.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing concerning the untimely authorization of surgery issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated August 9, 1989 is modified in part and affirmed in part. That portion which awarded claimant's counsel an $1,800 assessed attorney fee is modified. Claimant's counsel is awarded an assessed attorney fee of $500, payable by the insurer, concerning the untimely authorization of surgery. The remainder of the order is affirmed.

October 18, 1990 Cite as 42 Van Natta 2381 (1990)

In the Matter of the Compensation of
PAULA J. COLLAR, Claimant
WCB Case No. 88-16202
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Merrily McCabe (Saif), Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Daron's order that: (1) found her claim was not prematurely closed by Determination Order; (2) upheld the SAIF Corporation's denial of claimant's current treatment for musculoskeletal symptoms, headaches, and a cervical condition; (3) upheld SAIF's denial of claimant's aggravation claim for the same conditions; and (4) in the alternative, affirmed a Determination Order that did not award permanent partial disability. In its brief, SAIF repeats its request made at hearing for authority to offset overpayments against any future award of permanent partial disability.

The issues on review are compensability, premature closure, aggravation, extent of permanent disability, if any, and offset.

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

The Board has the authority to authorize offsets where the parties have had an opportunity to litigate the merits of the overpayment issue and the record is sufficiently developed to address the issue. Forney v. Western States Plywood, 66 Or App 155, 160, aff'd 297 Or 628 (1984); Berliner v. Weyerhaeuser Co., 92 Or App 264 (1988). This authorization extends only to future awards of permanent disability. See Sullivan v. Banister Pipelines, 91 Or App 493 (1988); Harold D. Bates, 38 Van Natta 992 (1986). We, therefore, authorize SAIF to offset temporary disability compensation paid after January 14, 1988 (the date through which such compensation was awarded by the March 22, 1988 Determination Order) against future permanent disability compensation awarded.

ORDER

The Referee's order dated August 15, 1989 is affirmed, as supplemented. SAIF is authorized to offset overpaid temporary disability compensation against any permanent disability compensation awarded in the future.

In the Matter of the Compensation of
SUSAN L. FERGUSON, Claimant
WCB Case No. 89-08492
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Leahy's order that affirmed a Determination Order that awarded no scheduled permanent disability for a bilateral wrist and forearm condition. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

In May 1985, claimant underwent bilateral carpal tunnel repair. No claim was filed for the surgery.

In April 1987, claimant received treatment from Dr. Laubengayer, M.D., for hand and wrist pain. She underwent a release of the right trigger thumb and the riggering of the ring and long fingers. She was released to return to work in late May 1987. No claim was made for this surgery.

In June 1987, claimant filed a claim for a bilateral hand strain which occurred while pulling veneer off a dry belt. This claim was ultimately accepted.

In June 1988, Dr. Laubengayer noted claimant's condition as chronic inflammatory problems, bilateral tendinitis with bilateral thoracic outlet syndrome.

In August 1988, claimant treated with Dr. McKellar, M.D., for a work-related back strain. Later that same month, claimant's car was rear ended which

resulted in right hip pain. The compensability of the back and hip conditions are not at issue.

By January 1989, claimant's compensable bilateral wrist and forearm condition had resolved with no pain in her wrist, no numbness or tingling in her fingers, normal range of motion and no tenderness. An April 17, 1989 Determination Order closed claimant's claim, awarding no permanent disability. Claimant requested a hearing.

Claimant continued to receive treatment for her August 1988 back injury. In February 1989, she treated with Dr. Klump, M.D. That same month, claimant returned to her regular work.

In late April 1989, claimant again injured her back after slipping and falling. (Ex. 17). This time, she treated with Dr. Campagna, neurosurgeon, for her ongoing back condition, which was worsened by her April 1989 fall. (Ex. 17).

Claimant was evaluated by Dr. Raaf, neurosurgeon, in June 1989. She complained of pain in both shoulders, shoulder blades and low back pain, all stemming from the August 1988 work-related back injury. Dr. Raaf noted adequate range of motion in her shoulders, elbows and wrists, no crepitation in either shoulder, no occipital tenderness on either side, and that touch and pain sensation through the body was normal. (Ex. 18). Raaf concluded that the bilateral hand and wrist condition had resolved and was no longer a problem. Id.

Claimant last treated with Dr. Laubengayer regarding her hand and wrist problems in January 1989. Her medical treatment since February 1989 was for back and neck pain associated with her August 1988 back injury. (Ex. 15).

Claimant suffers no permanent impairment resulting from her compensable 1987 bilateral wrist and forearm condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant did not suffer permanent impairment resulting from her compensable 1987 bilateral wrist and forearm condition. We agree.

Claimant's condition became medically stationary on January 30, 1989. Her claim was closed by Determination Order dated April 17, 1989. Therefore, the "standards" adopted effective January 1, 1989 through September 30, 1990, former OAR 436-35-001, et seq., apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

Scheduled disability is rated on the permanent loss of use or function of a body part due to an injury connected with the job. Former OAR 436-35-010(2).

Claimant essentially concedes that there is no medical evidence to establish a measurable loss of range of motion or loss of sensation. Her only contention is that she is entitled to a permanent disability award based on a chronic condition which limits repetitive use. In making this contention, claimant relies upon her own testimony to establish that she is limited in the repetitive use of her wrists.

Former OAR 436-35-010(7) provides that "[c]chronic conditions limiting repetitive use of a scheduled body part shall be rated at 5% of the affected body part." Therefore, claimant must establish that she suffers from a chronic

condition, and that that condition limits the repetitive use of a scheduled body part. Claimant has failed to so establish.

The medical evidence establishes that claimant's compensable bilateral wrist/forearm condition has resolved. (Exs. 14, 18). The treatment claimant was receiving from February 1989 through the date of hearing was for her August 1988 work-related back injury. Further, while we acknowledge that claimant had a chronic condition, chronic inflammation, that condition has, by a preponderance of the medical evidence, resolved. Consequently, we cannot award disability for a chronic condition which has resolved.

Accordingly, because claimant does not suffer ratable loss of range of motion, loss of sensation, or from a chronic condition limiting repetitive use, we find that claimant has failed to establish permanent loss of use or function due to her 1987 compensable condition.

ORDER

The Referee's order dated October 18, 1989 is affirmed.

In the Matter of the Compensation of
ARVA M. PERKINS, Claimant
WCB Case No. 89-05009
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Peterson's order which: (1) declined to grant permanent total disability; and (2) affirmed a Determination Order awarding 72 percent (230.4 degrees) unscheduled permanent disability for a low back injury. Claimant also moves the Board to reopen the evidentiary record to admit a post-hearing report from Dr. Zimmerman, her treating physician. On review, the issues are remand, extent of permanent disability, including permanent total disability, and offset. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of that portion of the third paragraph on page three which deals with the expert vocational evidence. We make the following additional findings. Claimant is unable to perform her usual and customary job as a rag cutter. Claimant has no transferable skills from performing this unskilled job. Claimant has low manual dexterity skills.

On numerous occasions, the at-injury employer stated that it could not modify claimant's at-injury job to enable her to perform it. Three days prior to hearing, it offered to modify claimant's job. The job offer stated that claimant's doctor had approved of the job. The job was not within claimant's residual physical capacity and was approved by an independent medical examiner, not by claimant's attending physician.

FINDINGS OF ULTIMATE FACT

The additional medical report from Dr. Zimmerman is cumulative insofar as it pertains to the relevant issues in this case. The record has not been improperly, incompletely, or otherwise insufficiently developed.

Claimant is permanently incapacitated from performing gainful and suitable employment due to a combination of medical and nonmedical factors. Claimant is willing to work; although a work search would be futile, claimant has made reasonable efforts to find work.

CONCLUSIONS OF LAW AND OPINION

Remand

We interpret claimant's motion to reopen the evidentiary record to admit new evidence as a motion for remand. The Board may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

In this case, we find that the evidence which claimant seeks to introduce into the record upon remand is cumulative as to the severity of and recommended treatment for claimant's back condition. We are not persuaded that the record concerning the extent of disability issue has been improperly, incompletely or otherwise insufficiently developed. Consequently, the request for remand is denied.

Propriety of Dismissal

The Referee affirmed the Determination Order and dismissed claimant's hearing request. There was no basis for dismissing claimant's hearing request, nor was there any request by the parties to do so. A hearing was held on the matter and we review on the merits.

Permanent Total Disability

The Referee found that claimant is employable and, therefore, concluded that she is not permanently and totally disabled. We disagree.

In order to establish permanent total disability, claimant must prove that she is completely physically disabled and therefore unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Permanent total disability may be established through evidence of complete physical incapacity, or by establishing that the physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd-lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984), rev den 298 Or 470 (1985).

Claimant has marked degenerative disc disease, an L5-S1 herniation, and lateral recess stenosis. A total lumbar laminectomy is the only treatment for this latter condition, and claimant is not a good candidate for surgery.

All the treating, examining, and consulting physicians, with the exception of Western Medical Consultants, have opined that claimant is only capable of performing limited sedentary work. Western Medical Consultants performed an independent medical examination on claimant on December 29, 1988. The Consultants noted only that claimant had slight degenerative disc disease of the lumbosacral spine, and ignored evidence of severe recess spinal stenosis. We find their opinion that claimant could return to her at-injury job to be based on an incomplete and inaccurate medical history, to be contrary to the preponderance of the medical evidence, and to be inconsistent witht the group's own physical capacities evaluation. Therefore, we give it little weight. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

On the other hand, we find the medical reports of treating physicians Gritzka and Zimmerman, Drs. Tilson, Watson, and Olscheid, and the Orthopaedic

Consultants to be well-reasoned and based on complete information. Dr. Gritzka, claimant's prior treating orthopedic surgeon, has indicated that claimant can left only up to 10 pounds, that she should avoid all bending and stooping, that she cannot sit for prolonged periods without being able to sit or stand at will, and that she cannot stand or walk for prolonged periods.

All these physicians agree that claimant has a moderately severe physical impairment that precludes all but restricted sedentary work activity. We find their reports to be consistent with the medical findings and the diagnostic studies and, therefore, we find their opinions to be persuasive. Somers v. SAIF, 77 Or App 259, 262 (1986).

Claimant is severely disabled as a consequence of her compensable injury, and cannot return to the work she had done for the 20 years prior to her injury. Nevertheless, despite these limitations, claimant is not precluded from performing all work activity. Accordingly, we conclude that claimant is not completely physically disabled and not totally precluded from employment on medical grounds alone. We must, therefore, determine whether claimant is permanently and totally disabled under the "odd-lot" doctrine.

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, work experiences, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Clark v. Boise Cascade Co., 72 Or App 397 (1985); Welch v. Bannister Pipeline, supra. Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although she need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206(3); SAIF v. Stephen, 308 Or 41 (1989); SAIF v. Orr, 101 Or App 612 (1990). Additionally, in evaluating permanent total disability, we consider preexisting disabilities and their impact on performing work at a gainful and suitable occupation. See ORS 656.206(1).

In addition to her severe physical limitations as a result of her compensable low back condition, claimant is further restricted by preexisting physical and psychological disabilities, as well as intellectual, social and vocational factors. Claimant has preexisting degenerative disc disease of the lower spine which was aggravated by her injury. She has a significant speech impediment that makes it difficult for people to understand her. This hinders her communication and makes her hesitant to talk with others. Claimant has low manual dexterity skills and a marginal intellect. She is uneducated, has no math skills and less than a fourth grade reading ability. Claimant's preexisting schizoid personality disorder limits her ability to cope with society and deal with new experiences. She becomes easily upset around others. She has led a sheltered, structured life; she does not drive and lives with her family.

Claimant worked for one year as a rag cutter at Goodwill Industries, and then worked for 20 years for the insured at the same unskilled, light-level job. At hearing, Mr. McNaught, SAIF's vocational expert, testified that claimant has no transferable skills from this work experience. Although he speculated that there were jobs that claimant could perform, he never identified specific jobs that claimant could do. Dr. Male, claimant's vocational expert, testified that getting a job depends on one's residual physical capacity and the ability to sell oneself. Considering claimant's physical, emotional, speech, and intellectual limitations, Male explained why claimant could not secure a job in a competitive market. We are more persuaded by the more complete and well-reasoned opinion of Male.

Claimant testified that she is willing to seek work, but is unsure what she could do. A work search would be futile for this claimant; nevertheless, she has attempted to secure other employment. The at-injury employer repeatedly stated that it could not modify claimant's at-injury job for her. Yet three days prior to hearing, the insured offered claimant this same job, now stating that the job could be modified and that her doctor had approved of the job. The offered job exceeds claimant's residual physical capabilities as delineated by both her treating physician and the physical capacities evaluation performed by the Western Medical Consultants. Further, this job was approved not by claimant's treating physician, but by one of the independent medical examiners who overlooked claimant's severe lateral recess stenosis. Under these circumstances, the job offer is not persuasive evidence that claimant can be gainfully employed in the regular labor market.

In sum, claimant's impairment attributable to the compensable injury, in combination with her preexisting disabling conditions, both physical and mental, prevent her from returning to her regular employment. Her age, lack of basic reading and math skills, lack of transferable skills and severely limited physical and psychological capabilities, prevent her from finding suitable and gainful employment. Considering claimant's physical limitations and lack of transferable skills, we find that additional efforts to seek employment would be futile.

Consequently, we conclude that claimant is permanently and totally disabled as a result of her compensable injury and, therefore, is entitled to an award of permanent total disability.

A permanent total disability award is effective as of the date the evidence establishes the disability status. See Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988); Morris v. Denny's, 50 Or App 533, modified 53 Or App 863 (1981). Claimant became medically stationary on December 29, 1988. Therefore, we conclude that the award of compensation for permanent total disability shall commence as of December 29, 1988. The SAIF Corporation is authorized to offset any permanent partial disability compensation paid after December 29, 1988 as a prepayment of claimant's permanent total disability compensation. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983).

ORDER

The Referee's order dated July 6, 1989 is reversed. Claimant's request for hearing is reinstated. In lieu of the Determination Order award of 72 percent (230.4 degrees) unscheduled permanent disability, claimant is granted permanent total disability effective December 29, 1988. The SAIF Corporation is authorized to offset permanent partial disability compensation, if any, paid subsequent to that date against claimant's permanent total disability award. Claimant's attorney is awarded a fee equal to 25 percent of the increased disability compensation created by this order, payable by SAIF directly to claimant's attorney, not to exceed $6,000.

October 18, 1990 Cite as 42 Van Natta 2387 (1990)

In the Matter of the Compensation of
SAMMY L. TURNER, Claimant
WCB Case No. 89-09215
ORDER ON REVIEW
Roger J. Leo, Claimant Attorney
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of that portion of Referee Shebley's order that awarded claimant an assessed attorney fee for services

rendered as a result of SAIF's failure to timely execute and return a stipulation to claimant. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

At hearing, the Referee found that the sole issue was the amount of the assessed fee due claimant's counsel for services related to a stipulation. The Referee concluded that claimant was entitled to the $750 attorney fee previously agreed upon between SAIF and claimant. The Referee also found that, because claimant was required to proceed to hearing on SAIF's delay in executing the stipulation, he was entitled to an additional $300 assessed fee. We disagree.

Before commencement of the hearing, SAIF agreed to rescind its denial of claimant's low back injury claim. SAIF also agreed to pay claimant a $750 attorney fee for his efforts in obtaining a rescission of the denial. Accordingly, the only issue at hearing was claimant's entitlement to an additional assessed fee for services rendered after his counsel had successfully obtained SAIF's agreement to accept the claim.

Attorney fees are not "compensation" within the meaning of ORS 656.382(2). Therefore, a delay in payment of attorney fees is not equivalent to a resistance to payment of compensation. Furthermore, no other authority has been cited in support of the additional fee awarded by the Referee. We conclude that claimant is not entitled to an assessed attorney fee beyond the $750 agreed upon between the parties.

ORDER

The Referee's order dated September 5, 1989 is modified. In lieu of the $1,050 total assessed fee awarded to claimant, an assessed fee of $750, payable by the SAIF Corporation, is awarded.

In the Matter of the Compensation of
JEANNIE L. WEAKLEY, Claimant
WCB Case No. 89-07224
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of those portions of Referee Livesley's order which: (1) found the claim was not prematurely closed; (2) awarded claimant 5 percent (16 degrees) unscheduled permanent disability for her low back, in addition to the 2 percent (6.4 degrees) unscheduled permanent disability awarded by Determination Order; and (3) declined to award claimant temporary total disability for the period March 3, 1989 through April 24, 1989. On review the issues are premature closure, extent of permanent disability and entitlement to temporary total disability benefits. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured her low back in April 1988 while working at her regular job as a skoog operator for the self-insured employer. She began gaining weight shortly after the injury.

Claimant was treated at the Pacific Institute of Rehabilitation beginning in September 1988. The rehabilitation program was interrupted in November 1988 as a result of a non-work related surgery. Claimant returned to the program on January 9, 1989. Claimant was discharged from the program on February 24, 1989. At that time the director of the program, Dr. Daskalos, recommended a weight reduction program and stated that claimant was medically stationary.

Dr. Freeman, a neurosurgeon, examined claimant on March 3, 1989. He agreed that claimant was medically stationary; however, he opined that claimant should see Dr. Nicholas, claimant's general practitioner, for weight loss. Dr. Nicholas prescribed a weight loss program for claimant on March 28, 1989. Claimant began the weight loss program on March 27, 1989. By June 3, 1989 she had lost 13 pounds

On June 5, 1989, Dr. Nicholas released claimant to part time regular work with increasing hours to full time work within four weeks. On July 6, 1989, Dr. Nicholas stated that claimant was not yet medically stationary because of her need to lose weight to prevent a possible disc herniation.

A Determination Order dated May 15, 1989 found claimant medically stationary on March 3, 1989. It awarded temporary total disability benefits through that date. The employer paid temporary total disability benefits through May 2, 1989.

ULTIMATE FINDING OF FACT

At the time claimant was found medically stationary, and the Determination Order issued there was a reasonable expectation that her condition would improve through further treatment in the form of a weight loss program.

CONCLUSIONS OF LAW AND OPINION

The critical issue in this case is whether claimant was medically stationary on March 3, 1989 as found by the Determination Order and the Referee. This issue turns on whether the weight loss program was curative or palliative treatment for the compensable injury. If it was curative treatment, then there was a reasonable expectation that claimant's compensable condition would improve through that treatment. If it was palliative treatment, then there was no reasonable expectation that claimant's compensable condition would improve through that treatment. We conclude that the weight loss program was curative treatment and that there was a reasonable expectation that claimant's compensable condition would improve through that treatment.

We base this conclusion on the opinion of Dr. Nicholas, claimant's family doctor, that claimant needed the weight loss program to avoid the possibility of a herniated disc. His opinion is reinforced by the opinions of Drs. Daskalos and Freeman. We recognize that both doctors stated that claimant was medically stationary; however, both also opined that claimant needed a weight loss program. The opinions that claimant needed a weight loss program together with Dr. Nicholas' opinion that the weight loss program would reduce the risk of a herniated disc and alleviate claimant's pain are sufficient to convince us that it is more likely than not that the weight loss program was curative. Accordingly, we conclude that claimant was not medically stationary on March 3, 1989

or May 15, 1989, when the Determination Order issued. Therefore, we conclude that the claim was prematurely closed.

In light of our finding that the claim was prematurely closed, the issue of extent of disability is not ripe. Furthermore, the issue which the parties frame on review as entitlement to temporary total disability is resolved by our decision on the premature closure issue. The insurer actually paid temporary total disability for the relevant period. The issue at hearing was whether it was entitled to offset the temporary total disability paid between the medically stationary date and the date claimant returned to work, which is before the issuance of the Determination Order. Because we have concluded that the Determination Order prematurely closed the claim, claimant was substantively entitled to that temporary total disability and the insurer has no valid claim for an offset.

ORDER

The Referee's order dated August 9, 1989 is affirmed in part and reversed in part. The May 15, 1989 Determination Order is set aside as premature. The claim is remanded to the insurer for further processing. Those portions of the Referee's order that: (1) increased claimant's permanent disability; (2) granted claimant's counsel 25 percent of the increased compensation awarded by the Referee's order; (3) held that claimant was not entitled to temporary disability for the period March 3, 1989 through April 24, 1989; and (4) authorized an offset of alleged overpaid temporary disability, are reversed. The remainder of the Referee's order is affirmed. Claimant's counsel is allowed a reasonable attorney fee of 25 percent of the increased compensation created by this order, not to exceed #3,800.

October 18, 1990 Cite as 42 Van Natta 2390 (1990)

In the Matter of the Compensation of
PATTI L. WILSON, Claimant
WCB Case No. 89-08089
ORDER ON RECONSIDERATION
Merrill Schneider, Claimant Attorney
Roy Miller (Saif), Defense Attorney

Claimant requests reconsideration of our September 28, 1990 order which affirmed the Referee's award of attorney fees out of compensation rather than awarding an assessed fee. Claimant argues that she is entitled to an assessed fee because the SAIF Corporation withdrew its aggravation denial at hearing.

Under ORS 656.386(1), fees are only allowed if the claimant prevails in a hearing before a Referee. It is not enough that claimant simply prevail. She must finally prevail before the Referee. Claimant does not finally prevail unless the Referee takes some action which resolves the claim for compensation. Greenslitt v. City of Lake Oswego, 305 Or 530, 534 (1988).

Here, SAIF rescinded its denial of claimant's aggravation claim at hearing and on the record. However, the sole issue decided by the Referee at hearing was "whether claimant's attorney fees are payable out of compensation or in addition to it." On this record, then, claimant did not finally prevail in overcoming SAIF's denial of compensability and, therefore, no assessed attorney fee can be awarded under ORS 656.386(1). Carla J. Schrock, 42 Van Natta 2324 (1990); Duane L. Jones, 42 Van Natta 875 (1990).

Accordingly, our September 28, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 28, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARLOS A. AGUILAR-RAMOS, Claimant
WCB Case No. 89-03913
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee McCullough's order that awarded 6 percent (19.2 degrees) unscheduled permanent disability for a low back injury, whereas a Determination Order awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We vacate and remand.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See former ORS 656.283(7). Specifically, the Referee applied the version of OAR 436-35-001 et seq, in effect from January 1, 1989 through September 30, 1989, the rules in effect at the time of the February 21, 1989 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well.

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

Age

The appropriate value for claimant's age of 28 years is 0. Former OAR 436-35-290(3).

Formal Education

The appropriate value for claimant's high school education is 0. Former OAR 436-35-300(3)(a).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT) published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant ten years prior to the date of the hearing is used to determine a value for skills. Claimant's highest SVP during the ten years prior to the hearing was 8 as a professional soccer player. Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Training

Former OAR 436-35-300(5) provides that no training value is allowed for workers who have competence in some specific vocational pursuit. "Specific vocational pursuit" means employment other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has obtained training that provides him competence in a specific vocational pursuit, that as a professional soccer player. Accordingly, no value is allowed under the standards. Former OAR 436-35-300(5).

Claimant contends that, because his back injury precludes him from playing soccer, he has no competence in a specific vocational pursuit and that, therefore, the appropriate value for skills is +1. Former OAR 436-35-300(5). Claimant misreads the rule. The rule allows no value for training whether or not he has the present ability to play soccer because he obtained training that provides him competence in that pursuit. No value is allowed.

Impairment

The Referee found that claimant had no loss of motion in his lower back but, based on claimant's credible testimony that he suffers chronic low back pain which limits the repetitive use of his back. The Referee awarded a 5 percent impairment value. We agree. Former OAR 436-35-320(4).

Claimant argues that the Referee erred in discounting a report that documented a loss of motion. We disagree. Dr. Gorman, the treating chiropractor who filed that report, failed to indicate to what extent that loss of motion was attributable to claimant's compensable injury versus other causes, most notably claimant's unrelated foot surgery that subsequently caused biomechanical stress on his lumbosacral joint. Moreover, before the surgery, Dr. Butdorf, a physician who treated claimant in late 1988, reported that claimant had full range of motion.

Because claimant has permanent injury-related impairment he is entitled to a permanent disability rating under the standards. See former OAR 436-35-320 and Hattie L. Goodrich, 42 Van Natta 1752 (1990).

An adaptability value for a claimant who is unable to return to his or her regular work, but who has returned to modified work, is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the strength requirements of the claimant's regular work with that of his or her modified work.

In determining claimant's adaptability value, the Referee relied on strength requirements not in the record, but those found in the Dictionary of Occupational Titles. We are not at liberty to rely on such information. Sharon A. Ipox, 42 Van Natta 1568 (1990). Because there is nothing in the record to determine claimant's physical capacity, we conclude that the record has been "improperly, incompletely or otherwise insufficiently developed," and remand for the taking of further evidence from which claimant's adaptability can be determined. Former ORS 656.295(5); Hattie L. Goodrich, 42 Van Natta 1752 (1990). Specifically, evidence should be obtained regarding the strength requirements, i.e., lifting per categories at former OAR 436-35-310(4), of claimant's usual and customary work and modified work. Thereafter, the Referee shall issue a final appealable order concerning the extent of claimant's permanent disability.

ORDER

The Referee's order dated June 21, 1989, which awarded claimant 6 percent (19.2 degrees) unscheduled permanent partial disability, is vacated and the matter is remanded to Referee McCullough for further proceedings consistent with this order.

October 19, 1990 Cite as 42 Van Natta 2393 (1990)

In the Matter of the Compensation of
MARY A. SUMMERS, Claimant
WCB Case No. 90-0522S
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant has requested review of Referee McCullough's approval of a Disputed Claim Settlement between claimant and the insurer. Among other arguments, claimant contends that the agreement is unconscionable and likely entered into based on misrepresentation, duress, and/or mistake. Since no hearing has been convened and no evidence admitted, claimant seeks remand for the development of a record concerning her contentions. We grant the request to remand.

Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction or other necessary action. ORS 656.295(5).

Here, no record exists upon which to determine the circumstances surrounding the execution of the agreement. Thus, the record is insufficiently developed to resolve the issues raised by claimant's request for review. Consequently, we conclude that remand is appropriate. See John A. Tallant, 39 Van Natta 344 (1987).

Accordingly, this matter is remanded to Referee McCullough with instructions to convene a hearing. At that hearing, evidence shall be taken concerning all of the issues raised by the parties herein. After closing the record and considering the evidence in light of the parties' respective arguments, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TINA M. TRANA, Claimant
WCB Case No. 89-05374
ORDER ON REVIEW (REMANDING)
Leeroy O. Ehlers, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Tenenbaum's order that affirmed a Determination Order award of 14 percent (44.8 degrees) unscheduled permanent disability for an upper back condition. On review, the issue is extent of disability. We vacate and remand.

FINDINGS OF FACT

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

Claimant suffers a 5 percent permanent partial impairment, due to her chronic upper back condition, which limits its repetitive use.

CONCLUSIONS OF LAW AND OPINION

Impairment

Claimant seeks a 14 percent impairment rating for spinal ankylosis, citing former OAR 436-35-350(3) [from those standards effective January 1, 1989 through September 30, 1990]. She relies on the conclusion of Dr. Turnbull, treating chiropractor, that "ankylosis (loss or locked motion), x-ray changes, and motor deficit attach an approximate 30% spinal impairment (not disability) to her condition." (Ex. 27). Turnbull stated that he understands spinal impairment with ankylosis to mean "locked or lost motion of a normal segment or structure." (Ex. 36).

The Referee declined to rate claimant's spinal ankylosis, because she concluded first that claimant suffers no permanent impairment due to ankylosis, based on Turnbull's observation that claimant suffers no loss of motion "from a global aspect." (Ex. 36-1). Second, the Referee decided that ankylosis is defined by former OAR 436-35-350(3) as spinal fusion resulting from surgery. We agree with the Referee's result, but for different reasons.

The rule describes ankylosis of the spine parenthetically as "spinal fusion." Therefore, we find that the rule is neither limited to instances of lost "global" range of motion, nor to fusion due to surgery. We conclude that the standards' ratings for ankylosis are limited to cases where two or more vertebrae are fused, as the rule unambiguously provides. See former OAR 436-35-350(3). Because claimant offers no evidence that she suffers from injury-related fused vertebrae, we find that she is not entitled to an impairment rating for this condition under the standards.

The Referee found claimant entitled to the following values for her lost range of motion: +1 for loss of cervical extension; 0.5 each for loss of right and left rotation; and +1 each for loss of right and left cervical flexion, for a total of +4. We disagree. Turnbull observed that claimant's range of motion may be normal one day and 50 percent, or less, the next. In this context, he concluded, "from a global aspect there is no loss of motion."

(Ex. 36-1). Therefore, we are not persuaded that the episodic losses he reported represent permanent impairment. Because the standards rate only permanent partial disability (See former OAR 436-35-270), we conclude that claimant has not carried her burden with regard to any range of motion deficits which she suffers.

Turnbull reported, and claimant's testimony corroborates, that she suffers from persistent overuse, myofascial pain, and chronic soreness especially with heavy use." (Ex. 36-1). On this basis, and noting that claimant's first post-injury job change was necessary to alleviate her symptoms, we find that she is entitled to a 5 percent impairment rating for her chronic condition which limits repetitive use of her injured upper back. Former OAR 436-35-010(7).

Claimant suffers a total of 5 percent permanent partial impairment, due to her compensable upper back condition.

Adaptability

In this case, the parties stipulated that claimant returned to modified work. However, they dispute the adaptability value assigned by the Referee.

Our review must be based on the record developed before the Referee. Former ORS 656.295(3), (5). In order to determine the proper adaptability value under the standards, former OAR 436-35-310(3) requires that we utilize the physical capacity necessary to perform claimant's usual and customary work and the physical capacity necessary to perform the modified job. The evidence necessary to make these determinations is not in the record before us. Specifically, the record contains inadequate information to determine the lifting requirements of the employments.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the the Referee for further evidence taking, correction, or other necessary action. See former ORS 656.295(5). Considering the circumstances of this case, we conclude that remand is an appropriate action.

Accordingly, this matter is remanded to the Referee with instructions to take evidence on the physical capacities necessary to perform claimant's usual and customary work and that required to perform her modified job -- both findings to be based on the categories set forth in former OAR 436-35-310(4). The Referee shall then determine the appropriate adaptability value under former OAR 436-35-310(3) and issue a final appealable order rating claimant's disability under the standards.

ORDER

The Referee's order dated July 10, 1989 is vacated and the matter is remanded to Referee Tenenbaum for further proceedings consistent with this order.

In the Matter of the Compensation of
PETER G. VOORHIES, Claimant
WCB Case No. 89-09531
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Davis' order which: (1) increased his unscheduled permanent disability award for a low back and hip injury from 20 percent (64 degrees), as awarded by Determination Order, to 36 percent (115.2 degrees); and (2) increased his scheduled permanent disability award for a knee injury from 30 percent (45 degrees), as awarded by Determination Order, to 42 percent (63 degrees). On review, the issue is extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Unscheduled Disability

The Board adopts the Referee's "Conclusions of Law and Opinion" with respect to the issue of unscheduled permanent disability, with the following comment.

Claimant argues that his hip disability should be rated as a scheduled body part because the acetabular cuff has not been replaced, although it was broken. See former OAR 436-35-230(4)(b). We do not agree and find that the Referee correctly rated the hip as an unscheduled body part. See former OAR 436-35-130(1); ORS 656.214(2)(c), (d), (e); John Cameron, 34 Van Natta 211 (1982).

Scheduled Disability

The evidence shows that claimant's left knee has 15 degrees flexion contraction. In the case of the knee, this represents a loss of extension to the neutral position. He is entitled to a rating of 4 percent. Former OAR 436-35-220(2). The evidence also shows that the left knee has retained flexion to 100 degrees, for a rating of 18 percent. Former OAR 436-35-220(1). Thus, adding each rating, the total impairment due to loss of range of motion of claimant's left knee is 22 percent. Former OAR 436-35-220(4). We agree with the Referee's other findings of 5 percent impairment for weakness and atrophy, and 10 percent impairment for loss of use or function due to disabling pain. Combining the findings of the knee, the total impairment under the "standards" is 33.3, rounded to the nearest whole number, 34. Former OAR 436-35-220(4).

The Referee found that claimant had demonstrated by clear and convincing evidence that claimant was entitled to a greater award for loss of his left leg than that derived from the standards. We agree that claimant is entitled to a rating of 42 percent scheduled permanent disability for the left leg and adopt the Referee's reasoning in that regard.

ORDER

The Referee's order dated September 25, 1989 is affirmed.

In the Matter of the Compensation of
ELIZABETH LEMMONS, Claimant
WCB Case No. 87-07490
ORDER ON REVIEW
Flaxel, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of that portion of Referee Howell's order that set aside its partial denial of claimant's psychological condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as supplemented below.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's psychological condition was compensable. The Referee found that claimant's compensable facial injury of September 6, 1986, was a material contributing cause of claimant's conversion reaction condition. We disagree.

In order to establish the compensability of a psychiatric condition following an industrial injury, claimant must prove by a preponderance of the evidence that the work-related injury was a material contributing cause of the condition, or, if the claimant's mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen, Inc. v. Page, 73 Or App 136, 139 (1985). Although the compensable injury need not be the sole cause or the most significant cause it must be material. Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987).

On September 6, 1986, claimant was struck by a patient on the right side of her face. Claimant sought treatment the next day. It was diagnosed as a contusion. This condition was accepted.

Prior to this compensable injury, claimant had been involved in a motor vehicle accident. This injury resulted in a severe neck injury, which required claimant to wear a neck brace for an extended period and ultimately resulted in a cervical fusion at C4-6. Sometime after the compensable 1986 injury, claimant fell out of a chair reinjuring her neck. Consequently, the insurer accepted the facial contusion, but denied both a new neck injury and aggravation of the compensable 1986 injury. The Referee upheld this denial, and the parties have not requested review on this aspect of the Referee's order.

Additionally, claimant has an extensive history of migraine headaches which predate the compensable 1986 injury as well as the noncompensable 1985 neck injury. The etiology of these headaches has not been firmly established by the medical evidence. It appears there are many other complicating factors involved. Claimant has suffered from these headaches, both prior to and after the compensable 1986 injury.

Considering the extent of claimant's medical history and complaints, we conclude the nature and causative factors of claimant's psychological condition is a complex medical issue, for which we rely on authoritative medical opinions in order to resolve. Uris v. Compensation Dept., 247 Or 420 (1967). The medical opinion is unanimous that claimant has a psychological condition described as "conversion reaction." More specifically, claimant has paralysis of the

lower limbs with no discernible physical disorder present. This condition first presented itself on January 29, 1988, shortly after claimant had received a Determination Order which had awarded her 20 percent unscheduled permanent partial disability. Although the medical record reveals claimant has been subject to varying degrees of depression, there is no evidence that the conversion reaction was preexisting.

Claimant was initially seen by Dr. Wadley, a psychiatrist, when she was hospitalized for the paralysis. It was his opinion that claimant's conversion reaction represented an accumulation of a number of stressors. He found these stressors to be multiple and complex in nature. Dr. Wadley ultimately concluded that, "since I cannot determine that a stress not related to the injury of 1986 was a sole contributing factor to her conversion disorder, in my opinion, the work-related physical injury including its sequelae would seem to be a material cause for the psychiatric condition for which she was hospitalized."

We do not rely on Dr. Wadley's opinion due to the inaccurate medical history upon which his conclusion is based. Dr. Wadley places significance on the headaches suffered by claimant. Specifically, he stated that claimant's chronic headaches were a "major contributing cause" of her stress and the resulting conversion reaction. Although, he noted other stressors as well.

However, Dr. Wadley mistakenly assumed that claimant's headaches began as a result of the compensable 1986 injury. In actuality, claimant's medical history demonstrates that her headaches were of a long standing origin, which preexisted the 1986 compensable injury. Moreover, the record does not establish that the headaches either resulted from, or were related to, the compensable 1986 injury. Accordingly, we do not find a causal link between the compensable 1986 injury, the subsequent headaches, and the resulting conversion reaction condition.

Wadley also attributed claimant's conversion reaction to other "claim-related" stressors. We are not persuaded that these stresses are materially related to the 1986 compensable face injury. Following the compensable injury, claimant was treated only once for her facial condition. Subsequent to this treatment, there is an absence of medical evidence referring to the 1986 compensable facial condition. Rather, the focus of claimant's medical complaints have primarily concerned the migraine headaches, which we have previously found unrelated to the compensable injury.

We are similarly unpersuaded that claimant's stress from "financial pressures" was attributable to her compensable injury. To begin, the source of this problem is not clear. In addition to the closure of her claim, we find that there are far more plausible reasons. In particular, claimant's financial pressures can be attributed to setbacks related to the rental property enterprise she was involved in with her husband, her husband's continual unemployment, and the death of a close friend. This friend was also a business associate involved with rental property.

Based on the foregoing reasoning, we decline to rely on Wadley's opinion in finding a causal relationship between the compensable 1986 injury and the conversion reaction.

It was Dr. Turco's opinion that the compensable 1986 injury was not a material contribution to claimant's conversion reaction. He found an element of conscious malingering, noting claimant's "theatrical tendencies." The Referee, as factfinder, agreed with Dr. Turco's finding regarding malingering and theatrical tendencies.

Dr. Turco found that many of claimant's actions, such as her attitude toward work, are volitional in nature. Inasmuch as Turco questioned claimant's motivation his opinion supports a finding that claimant's malady is attributable to malingering and not on account of the conversion reaction.

Upon our de novo review of the record, we likewise agree with Dr. Turco's assessment that claimant is malingering, and that her actions are volitional. It is also evident from the record that claimant is manipulative and given to dramatic exaggeration with questionable reporting of her medical and social history.

In light of claimant's extensive family history of being abused and neglected as a child, her abandonment of her own children, the marital strains and stresses including domestic violence, her long history of poly-drug abuse, the off-the-job physical injuries and ailments, the death of a close friend, as well as the compensable injury; we are unable to find that claimant's 1986 compensable face injury is a material contributing cause of her current psychological condition. Consequently, we hold that the psychological condition is not compensable.

ORDER

The Referee's order dated November 7, 1988 is reversed in part, and affirmed in part. The insurer's denial, dated May 5, 1988, is reinstated and upheld. The $1,750 assessed fee awarded by the Referee's order is reversed. The remainder of the Referee's order is affirmed.

October 22, 1990 Cite as 42 Van Natta 2399 (1990)

In the Matter of the Compensation of
CHARLES E. NEGUS, Claimant
WCB Case No. 89-07622
ORDER ON REVIEW
Flaxel, et al., Claimant Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Leahy's order which set aside its denial of claimant's claim for a right knee injury. On review, the issue is course and scope of employment. We affirm.

FINDINGS OF FACT

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

While playing charades at an employer-sponsored Christmas party, claimant sustained a knee injury. Pertinent facts include:

(1) The Christmas party was a traditional event initiated and sponsored by the employer and held at corporate headquarters.

(2) All costs were paid by the employer, including food, prizes, etc.

(3) Invitations were formal, as well as by office memoranda, and through discussion at staff meetings.

(4) Some of the formal invitations were hand delivered by members of the Board of Directors.

(5) Some employees believed they would receive bonuses at the party, as had been the practice in previous years.

(6) The Board of Directors scheduled and planned the event with the help of the paid director.

(7) A Board meeting was held immediately before the planned festivities.

(8) The program of the party was highly structured and there were stated purposes for the party that were of benefit to the corporation.

(9) The employer's stated purpose for the party was to get Board members and employees to mix; to thank underpaid employees for their hard work; and to build employee morale.

(10) The "Employee of the Year" was announced at the party.

(11) Claimant and other employees were "encouraged" to attend the party to the point that they felt an obligation to go.

(12) The employees felt compelled to participate in the "games" since teams were pre-arranged by management to encourage "mixing."

(13) The work activities of the corporation go on 24 hours a day, and, even though it was not claimant's regular work-time, it was the practice of the employer to obtain temporary replacements for those who were working to permit their attendance at the party.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions" with the following comments.

Compensable Injury - Recreational and Social Activity Exclusion

Pursuant to former ORS 656.005(7)(a)(B):

> "A 'compensable injury' is an accidental injury, ... arising out of and in the course of employment .... However, 'compensable injury' does not include: ... (B) Injury incurred while engaging in or performing, or as a result of engaging in or performing, any recreational or social activities solely for the worker's personal pleasure." (Emphasis added).

In 1987, the Legislature enacted a limitation for injuries sustained by a worker who engages in any recreational or social activity solely for the worker's personal pleasure. Or Laws 1987, ch 713, sec. 3 (codified at ORS 656.005(7)(a)(B)). This "enactment[] reflect[s] a legislative intent to define and limit the phrase 'arising out of and in the course of employment' through statutory amendment[]." See David D. Zimmerman, 40 Van Natta 862, 865 (1988) rev'd on other grounds, 97 Or App 512 (1989).

Senator Hill made the following comment in the committee discussions regarding inserting the word "solely" into the textual language of House Bill 2271:

> "On page 2 there's a first proposed amendment on line 15. You would insert the word 'solely' between the words 'activities' and 'for.'"
>
> "'The injury' -- it would read, 'The injury incurred while engaging in or performing, or as a result of engaging in or performing any recreational activities solely for the worker's personal pleasure.' This is the definition of a compensable injury. It will provide an exclusion for an injury incurred while engaging in certain activities rather than strictly in the course of or in the scope of employment."

> "My feeling on offering this amendment is to indicate that we're not talking about something that the worker may be engaged in which is actually a part or within the scope of employment. For instance, a working lunch in which the worker is eating and may find pleasure in the experience of eating salmon or something and may choke on a salmon bone and therefore incurs a compensable injury."
>
> "What we're trying to get at are those recreational or social activities that are not part of the work -- that are performed solely for the worker's personal pleasure. And that would clarify that." (Transcript, HB 2271, Senate Committee on Labor, June 8, 1987).

These clarifying comments by Senator Hill, if anything, indicate that certain recreational or social activities could have a close work nexus and as such are not performed solely for the worker's personal pleasure. This category of "social" activity (undertaken, at least in part, for reasons other than just the worker's personal pleasure) would not be automatically excluded from the "compensable injury" definition.

Similarly, the plain-meaning of the phrase "solely for the worker's personal pleasure" is difficult to misinterpret. If claimant can persuade the trier of fact that he engaged in the disputed activity in part for work-related reasons, the recreational or social activity is not automatically excluded from the definition of compensable injury under former ORS 656.005(7)(a)(B).

Here, there is considerable evidence that the office Christmas party that claimant attended was not purely a "social" occasion, but it also had a significant work nexus. For example, the event was sponsored and fully funded by the employer. In addition, management orchestrated the entire occasion and attendance was not perceived as "voluntary." Based on this record, we conclude that claimant's injury was not incurred while he was engaging in activities "solely" for his personal pleasure. Accordingly, this particular Christmas party does not fit into the 1987 statutory exclusion to the definition of "compensable injury." We note parenthetically that Senate Bill 1197, enacted by the 1990 Special Session, has amended ORS 656.005(7)(a)(B) by changing the word "solely" to "primarily" for the worker's personal pleasure. However, the amended version is not applicable here.

Unitary Work Connection Test

Even if the "activity" is not excluded by subsection (7)(a)(B) of former ORS 656.005, claimant's injury must still be sufficiently work-related, and could be found noncompensable under the unitary work-connection test. See Rogers v. SAIF, 289 Or 633 (1980); Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575 rev den 300 Or 249 (1985). The "arising out of and in the course of employment" language involves the application of a unitary work-connection approach to each set of facts whereby the ultimate inquiry is whether the relationship between the disputed activity and the employment is sufficient to find the injury compensable. Ismeal M. Barajas, 42 Van Natta 479, 480 (1990), citing Rogers, supra, at 642-43.

The Court of Appeals has identified seven factors to consider in evaluating whether an activity at the time of injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises;

(6) whether the activity was directed by or acquiesced in by the employer; and, (7) whether the employee was on a personal mission of his own. Mellis, supra at 574. While all seven factors are considered, no one factor is dispositive. Mellis, supra.

Benefit to the Employer

SAIF argues that the Christmas party provided no direct benefit to the employer. We disagree. The Board of Directors planned the event for the stated organization purposes of encouraging the "mixing" of employees with management; as a "thank you" to overworked and underpaid employees; and, to build employee morale. The Board then proceeded to structure the event to achieve these goals by such actions as planning all the activities, distributing annual bonus checks, and announcing the "Employee of the Year." We conclude that the employer had the expectation to benefit the organization, as well as their staff members, and these benefits were not merely incidental. Compare Mt. Hood Community College v. Kim, 103 Or App 39, 41 (1990); Haugen v. SAIF, 37 Or App 601 (1978).

Activity Contemplated by the Parties

There is little doubt that the parties contemplated the Christmas party since it was a traditional event which involved formal invitations and extensive management planning and support.

Ordinary Risk of and Incidental to Employment

Here, the Christmas party was held at corporate headquarters and employees were subtly encouraged to attend. Although attendance was not mandatory, some employees felt obligated to go. Also, a number of activities at the party were clearly incidental to employment, such as giving employee awards and bonuses.

Payment for the Activity

Although the party was not scheduled during claimant's regular worktime, it was the practice of the employer to find replacements for those employees whose shifts conflicted with the party. Staff members who did not attend the party were required to work.

Activity on Premises

The Christmas party was held at corporate headquarters and even though this was not claimant's actual work location, we are not convinced that this diminishes the work-connection. The key concept under this factor is whether the employer exercises some control over the place where the injury is sustained. See Cope v. West American Ins., 309 Or 232, 239 (1990); Sheri v. Hiltner, 42 Van Natta 1039 (1990). We conclude that claimant was injured while engaged in an activity on his employer's premises.

Employer Direction and Acquiescence

This is a significant factor in our evaluation. The employer, through its Board and top executives, directed this "social" activity from the planning stage through its implementation.

Personal Mission

Here, the claimant was not on a personal mission of his own. He was at a "social" function sponsored and funded by his employer. He felt obligated to attend and compelled to participate in the activity that caused his injury because he was assigned to a pre-arranged team of collegues and his failure to participate would have been problematic for the management organizers.

A key case under the work-connection prong of our analysis is Colvin v. Industrial Indemnity, 83 Or App 73 (1986), rev'd on other grounds, 301 Or 743 (1986). In Colvin a picnic sponsored by a law firm had a sufficiently close work-connection such that the injury suffered by a paralegal at the picnic arose out of and in the course of employment. In Colvin, attendance at the picnic was also voluntary; however, the law firm provided encouragement to participate by requiring staff to work if they did not attend and by paying those who did attend. The employer in Colvin also financed the event in its entirety and the picnic was regarded by some as an employment benefit. Colvin, supra, at 78. The Court of Appeals summarily rejected the argument that because the injury occurred after normal business hours (5:00 p.m.) that the work-connection had ended. Id.

Although no one Mellis factor is dispositive, our conclusions concerning each factor, when taken as a whole, persuade us that there is a significant work-connection between the Christmas party and claimant's employment. Consequently, the injury that occurred while engaging in the activities of the party, arose out of and in the course of claimant's employment. Accordingly, we affirm the Referee.

ORDER

The Referee's order dated July 13, 1989 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $650, to be paid by the SAIF Corporation.

October 23, 1990 Cite as 42 Van Natta 2403 (1990)

In the Matter of the Compensation of
DANIEL FARMER, Claimant
WCB Case No. 89-07472
ORDER ON REVIEW (REMANDING)
Emmons, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Perry.

Claimant, pro se, requests review of Referee's Daron's order that dismissed his request for hearing for failure to appear at the hearing. On review, the issue is jurisdiction. We remand.

Claimant requested a hearing on April 19, 1989. The hearing convened on July 21, 1989. Claimant did not appear at the hearing; however, claimant's counsel did appear. The Referee found that claimant had abandoned his request for hearing and he granted the employer's motion to dismiss claimant's request for hearing. The Referee noted that his dismissal was based only upon claimant's failure to appear.

On July 25, 1989, the Referee issued an order dismissing claimant's request for hearing. In a letter received by the Board on August 17, 1989, claimant, pro se, wrote the Referee requesting reconsideration of the dismissal

order. Claimant's letter informed the Referee that he had been notified of the date of hearing by his attorney, but that he had misplaced the notification and was unaware that his hearing had convened until his attorney reached him at work. Claimant advised the Referee that, although he left work as soon as possible, his counsel had left the Hearings Division before he arrived. Claimant also emphasized that he had not abandoned his request for hearing.

The Referee reviewed claimant's request and issued an Order on Motion for Reconsideration on August 22, 1989. The Referee found that claimant's excuse did not establish good cause for his failure to appear.

Subsequent to the Referee's order, the Court of Appeals held that former OAR 438-06-071 does not provide authority for dismissal for failure of a claimant to appear at hearing if claimant's attorney appears on his behalf. Williams v. SAIF, 99 Or App 367 (1989). On review, the Supreme Court reversed and remanded. Williams, 310 Or 320 (1990). The Court concluded that the Referee and the Board had relied on former OAR 438-06-085, rather than former OAR 438-06-071, in dismissing claimant's hearing request. The Court affirmatively noted that it expressed no opinion regarding the Court of Appeals' interpretation of former OAR 438-06-071. Consequently, the Court of Appeals' discussion of former OAR 438-06-071 was dicta.

Nevertheless, we are persuaded that the Court of Appeals' dicta in Williams v. SAIF, supra, regarding the application of former OAR 438-06-071 is correct and we continue to apply that interpretation to cases involving the rule. See Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990). Accordingly, we find that the Referee was without authority to dismiss. The case will therefore be remanded to the Referee for a hearing.

Our next inquiry is whether claimant has waived his right to testify in the hearing before the Referee by failing to establish sufficient grounds which would have justified a postponement. Mark S. Lesowske, 41 Van Natta 2154 (1989). Claimant's request for reconsideration is to be treated as a motion for postponement. Mark R. Luthy, 41 Van Natta 2132 (1989).

Here, the Referee concluded, in effect, that claimant had not established grounds to justify a postponement and rescheduling of the hearing. We agree. We conclude that claimant's misplacement of the notification of the date of hearing and his failure to communicate with his attorney do not constitute extraordinary circumstances beyond his control which would justify postponement. OAR 438-06-081. The motion to postpone was properly denied. Claimant has therefore waived his appearance and his right to testify in his own behalf.

Accordingly, the case will be remanded to the Referee to hold a hearing and decide the case on the merits. In holding the new hearing, the Referee will be required to determine what exhibits may be received into evidence and/or relied upon, but no exhibit shall be received which was not submitted in connection with the prior hearing nor shall any witness, including claimant, be permitted to testify who was not available to and planning on testifying at the prior hearing or under subpoena to testify at that hearing. See Mario Miranda, 42 Van Natta 405 (1990).

ORDER

The Referee's order dated July 25, 1989, as reconsidered by the August 22, 1989 order, is vacated. This case is remanded to Referee Daron for further proceedings consistent with this order.

In the Matter of the Compensation of
TONY GOMEZ, Claimant
WCB Case No. 89-06266
ORDER ON REVIEW
Doblie, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of those portions of Referee Thye's order which: (1) set aside its denial of claimant's claim for a low back injury; and (2) assessed a penalty and attorney fee for an alleged unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant has worked for the employer as a mechanic for 14 years. In June 1986, and again in May 1988, he underwent laminectomies at the L4-5 level for non-work related low back pain and left radiculopathy. In November 1988, Dr. Wilson, neurologist, found claimant to be stationary with mild permanent impairment. Claimant was advised to protect his back. He returned to modified work where he no longer lifted over 30 pounds, crawled under buses, or made road calls to repair disabled buses. He continued to take Motrin for residual back pain.

Approximately the first of February 1989, a snow storm occurred, disabling many buses on the road and requiring claimant to make a road call to repair the brake system on a bus. In order to make the repair, claimant crawled under the bus and lay on his back to repair a broken valve. To repair the broken valve, claimant had to apply force with a wrench. In the process of the repair, he felt a sharp pain in his back and right leg. Claimant finished his shift that day, but the pain progressed and he declined to work over the weekend.

On February 7, 1989, claimant called Kaiser for an appointment. On February 8, 1989, he reported the incident to his supervisor. On February 9, 1989, claimant's attorney sent the employer's attorney a "notice of potential claim" and advised that a claim might be filed after claimant saw his physician. A "dummy" 801 form was prepared sometime in March 1989, indicating that the employer first knew of the injury on March 14, 1989.

On February 21, 1989, claimant was examined at Kaiser. At that time, a CT scan revealed a right L3-4 defect. Claimant was released from work from February 22, 1989 through March 15, 1989.

On May 15, 1989, the employer denied claimant's claim.

ULTIMATE FINDINGS OF FACT

Claimant sustained a compensable injury on or about February 1, 1989.

The employer had notice of claimant's claim on March 14, 1989. The employer did not deny claimant's claim within 60 days of notice of the claim.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Penalties and Attorney Fees

The Referee assessed a penalty and related attorney fee on the basis that the employer's denial was unreasonable and untimely. We modify.

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 action must be gauged based upon the information available to the carrier at the time of its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123 (1985).

At the time that the employer issued its denial, it had Dr. Brown's opinion which indicated that the February 1989 incident did not materially contribute to claimant's low back condition, but rather was a continuation of his previous back injuries. In light of Dr. Brown's opinion, we do not find that the insurer's denial was unreasonable. Therefore, we decline to assess a penalty or attorney fee on this basis.

Although we have not found the denial to be unreasonable, we agree with the Referee that it was untimely. The employer was originally notified of the incident on February 8, 1989. However, the following day, claimant's counsel indicated that a claim "might" be filed following an examination by a physician. On March 14, 1989, the employer received an 827 form indicating a possible work relationship. The March 14, 1989 date was also used on the "dummy" 801 form as the date the employer knew of the claim.

We conclude that the employer had notice of the claim as of March 14, 1989. It did not deny the claim until May 15, 1989, approximately 62 days after notice of the claim. The employer gives no explanation for the two day delay and therefore we find it unreasonable. Inasmuch as the delay was minimal, we find that a penalty of 10 percent is appropriate in this situation. As we have reduced the penalty awarded by the Referee, the related attorney fee will be modified accordingly.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel services at hearing concerning the penalty issue is $200, payable by the self-insured employer. We further find that a reasonable assessed fee for claimant's counsel's services on review concerning the compensability issue is $1,000, payable by the employer. In reaching these conclusions, we have particularly considered the time devoted to the case, the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated September 14, 1989, is modified in part and affirmed in part. That portion which assessed a 25 percent penalty of benefits payable to May 15, 1989 and awarded an assessed attorney fee of $500, is modified. Claimant is awarded a penalty of 10 percent of benefits payable to May 15, 1989 and his attorney is awarded an assessed fee of $200, payable by the self-insured employer, for an untimely denial. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
HENRY M. GRANADO, Claimant
WCB Case No. CO-00128
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Welch, Bruun et al., Claimant Attorneys
David L. Jorling, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

On September 21, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of payments of $10,000 upon Board approval of the agreement, $15,000 in the year 1995, $25,000 in the year 2000, and $40,000 in the year 2005 by the City of Portland, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

We shall not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Here, claimant agrees to release any and all rights to future workers' compensation benefits, except medical benefits "provided for and related to" his accepted conditions, i.e., concussion, skull fracture, dislocated left shoulder and left neurosensory hearing loss. Claimant further agrees to release "[a]ny and all claims for any condition that may be claimed in the future to be related to this claim or the four accepted conditions."

The claimant's right to medical services for a compensable injury under ORS 656.245 is expressly excluded from matters which may be disposed under ORS 656.236 and rules promulgated thereunder. See OAR 436-60-145(1), 438-09-001(1). The language quoted above purports to limit medical benefits to the four accepted conditions. However, claimant is entitled to reasonable and necessary medical treatment, even for conditions not previously accepted by the carrier, insofar as the need for treatment is compensably related to the industrial injury. See ORS 656.245(1); Jordan v. SAIF, 86 Or App 29, 32 (1987); Taylor v. SAIF, 75 Or App 583, 586 (1985); Lorna G. Baker, 41 Van Natta 1844, 1847 (1989). Thus, by restricting medical benefits to previously accepted conditions, the proposed disposition amounts to a partial limitation on claimant's right to medical services under ORS 656.245.

Any limitation on claimant's statutory right to medical services exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). Kenneth D. McDonald, 42 Van Natta 2307 (1990); Sharon Watkins-Aubert, 42 Van Natta 2093 (1990). Accordingly, we find that the proposed disposition is unreasonable as a matter of law and set it aside. See ORS 656.236(2).

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD C. KELLY, Claimant
WCB Case No. 89-06852
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of Referee Tenenbaum's order that increased claimant's unscheduled permanent disability award for a low back injury from 21 percent (67.2 degrees), as awarded by Determination Order, to 49 percent (156.8 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability award from 21 percent to 49 percent. We modify.

Claimant's compensable low back condition became medically stationary on November 1, 1988. His claim was closed by Determination Order on March 23, 1989. Therefore, the "standards" adopted effective January 1, 1989, former OAR 436-35-001, et seq., apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent partial disability.

The employer does not dispute the values assigned to the age and education factors assigned by the Referee, as follows: age (0), formal education (1), skills (4), and training (1). Therefore, we do not address the age and education factors.

The employer does dispute the values assigned to the adaptability and impairment factors. We turn to those factors.

Adaptability

After finding that claimant had not returned to work and had not been offered employment, the Referee assigned an adaptability value under former OAR 436-35-310(4). We agree.

The employer contends that claimant was offered work, and that claimant's adaptability should be based on an application of former OAR 436-35-310(3). Claimant, on the other hand, contends that no bona fide offer was actually made, thereby requiring the application of former OAR 436-35-310(4).

After our review of the record, we find that claimant's adaptability should be based on an application of former OAR 436-35-310(4).

It is uncontested that claimant has not returned to work. The crucial issue here is whether or not the employer made a work offer to claimant. After our de novo review of the record, we conclude that a bona fide offer was not made.

Claimant's at-injury work was of a temporary, seasonal nature. He had, at no time, been employed on a permanent, full-time basis with the employer. The

employer worked with a vocational counselor in early 1989 and was prepared to modify claimant's job when seasonal packing work became available.

The record does not establish that an actual offer was made to claimant to return to work. At best, the record establishes that the employer was willing to modify a job and claimant's work scheduled when work became available. (Ex. 61). Under the circumstances, then, we find that no bona fide offer of work was made.

Because claimant has not returned to work and because he has not been offered work, we conclude that claimant's adaptability value must be based on an application of former OAR 436-35-310(4).

Here claimant testified that he is capable of doing light work. (Tr. 10). This evidence is not contradicted. Therefore, we find that claimant is capable of performing light duty work, for an adaptability value of 4. Former OAR 436-35-310(4)(c).

Impairment

The Referee concluded that claimant was entitled to a lost range of motion value of 4 percent, an unoperated disc derangement value of 4 percent, a chronic condition limiting repetitive use value of 5 percent, and miscellaneous impairments not considered by the administrative rules totalling 13 percent, for a total permanent impairment value of 26 percent. We modify.

Claimant does suffer some permanent loss of range of motion resulting from his compensable injury. However, that loss of range of motion, based on the objective medical evidence, is not as high as that calculated by the Referee.

The employer contends that because of the multiple inconsistencies in Dr. Phillips' report, the range of motion findings found in that report should be disregarded. We agree.

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). We find persuasive reasons not to defer to claimant's treating chiropractor, Dr. Phillips.

After reviewing Phillips' only report that includes range of motion findings, we do not find Phillips' opinion to be persuasive. (Ex. 62). Phillips reported in June 1989 that claimant's loss of range of motion findings totalled approximately 13 percent. Phillips also reported "normal lateral flexion" at 20 degrees. We note, however, that former OAR 436-35-360(8) sets the standard that "normal" means 30 degrees, not 20 degrees. Phillips then concluded that, as of June 12, 1989, claimant "has lost 25-50% of normal motion of the low back." (Ex. 62-5). Despite this conclusion, Phillips finally concluded that claimant "is still improving slowly with exercises and light activities, therefore, I would rate his permanent impairment at 10-20% or mildly impaired." Id.

Because of the contradictory findings in Phillips' report, we do not find her opinion to be persuasive. Weiland, supra. Consequently, we do not rely on Phillips' report in determining loss of range of motion.

The remaining medical evidence establishes that claimant's condition became medically stationary on November 1, 1988. The only reliable and objective medical report listing range of motion findings near or at the time of claim

closure is the October 4, 1988 Orthopaedic Consultants' report. (Ex. 49). We rely on that opinion as it was well-reasoned and based on accurate information. Somers v. SAIF, 77 Or App 259, 262 (1986); see Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

The relevant ratable range of motion findings in the Consultants' report include: 85 degrees retained thoracolumbar flexion (for a value of .5) and 20 degrees retained thoracolumbar extension (for a value of 1). The total loss of thoracolumbar range of motion, therefore, is 1.5 percent.

Claimant also contends entitlement to a value of 4 percent for a L4-5 disc derangement. Any unoperated rupture bulge or other disc derangement is entitled to a value of 4 percent. Former OAR 436-35-350(2). There is no requirement under former OAR 436-35-350(2) that there be clinically related symptoms. Therefore, given the fact that claimant does suffer from an unoperated disc bulge at L4-5, we find that claimant is entitled to an impairment value for his intervertebral disc lesion of 4 percent.

Claimant also contends entitlement to a value of 5 percent under former OAR 436-35-320(4) for a chronic condition limiting repetitive use of an unscheduled body part. The employer contends that claimant has failed to establish that his chronic condition is one which limits repetitive use. We agree with the employer.

Phillips reported that claimant suffers from chronic lumbar strain/sprain. This much is conceded by the employer. The issue, however, is whether claimant has established that that chronic condition limits repetitive use. This he has failed to do.

Dr. Brett, referring physician, the Consultants and Phillips noted the chronic condition, but none of the physicians reported that the condition limited repetitive use. In fact, Phillips reported that claimant was "waiting to go back to work during the cherry season." (Ex. 62-4).

Therefore, because claimant is not working, and there is no evidence establishing limitations on repetitive use, we find that claimant has failed to prove that his chronic condition limits, in any way, repetitive use of an unscheduled body part. Consequently, we do not assess a value for claimant's chronic condition.

Claimant's total permanent impairment resulting from his compensable injury is represented by the loss of thoracolumbar range of motion value (1.5) combined with the disc derangement value (4). Those values are combined for a total impairment value of 5.44. Former OAR 436-35-360(11).

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 6, the sum is 6. When that value is multiplied by claimant's adaptability value 4, the product is 24. When that value is added to claimant's impairment value 5.44, the result is 29.44 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 30 percent.

ORDER

The Referee's order dated June 17, 1989 is modified. In lieu of the Referee's increased award, and in addition to the Determination Order award, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability, for a total of 30 percent (96 degrees) unscheduled permanent disability.

In the Matter of the Compensation of
MELVIN G. MONDAY, Claimant
WCB Case Nos. 86-05959 & 86-13498
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Seymour's order that upheld the insurer's denials of all current medical treatment for a neck and back condition. In its respondent's brief, the insurer requests that the Board seek sanctions against claimant's treating chiropractor as provided under ORS 656.990(1). On review the issues are whether the denials were procedurally proper, and whether the Board has jurisdiction to sanction providers under ORS 656.990(1). We deny the insurer's sanction request and affirm.

FINDINGS OF FACT

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

The insurer accepted claimant's claims for a 1983 neck and mid-back injury and a 1985 low back injury. Claimant has degenerative disc disease in the cervical and lumbar spine that preexisted these compensable injuries. He had sustained a number of neck, mid-back and low back injuries prior to the 1983 and 1985 injuries.

Claimant received chiropractic treatment for his injuries from Dr. Llewellyn. The Form 827 Dr. Llewellyn submitted for the 1983 injury listed as the diagnoses acute cervicothoracic sprain, cervical and upper thoracic scoliosis, and mild cervical spondylosis. The Form 801 filed by claimant was for a neck and back strain. The Form 827 Dr. Llewellyn submitted for the 1985 injury listed as the diagnoses lumbosacral sprain, intervertebral disc syndrome and degeneration, lumbar spondylosis and scoliosis. The Form 801 filed by claimant was for "slipped disc in low back." The record contains no written acceptance of either injury claim, or any other documentation regarding the scope of the insurer's acceptance.

On October 8, 1986, and again on January 6, 1987, the insurer issued denials, under the 1983 and 1985 injury claims, of all current medical and chiropractic treatments on the grounds that the current treatment was for an underlying, noncompensable degenerative condition that preexisted claimant's compensable injuries. The denials also informed claimant that the insurer was "closing your claim, as the preponderance of medical evidence indicates that you are medically stationary."

On February 12, 1987, the insurer's attorney wrote a letter to claimant's attorney which included additional information regarding claimant's aggravation rights, his entitlement to temporary and permanent disability, and his right to request reclassification of his injury as disabling within one year of the date of injury. The additional information did not include a statement regarding claimant's right to request a determination order from the Evaluation Division within one year of the date of the insurer's closure. The insurer never issued a separate notice of closure containing the latter information.

FINDINGS OF ULTIMATE FACT

The insurer's medical services denials were issued prior to closure of claimant's claims.

The insurer's letters, dated October 8, 1986 and January 8, 1987, denied all current medical treatment related to claimant's underlying degenerative disc condition.

The insurer's acceptance of the 1983 and 1985 claims did not include claimant's underlying degenerative disc disease, which is a separate condition from the strains and slipped disc listed on the 801 Forms submitted for those injuries.

The 1983 and 1985 injuries did not worsen claimant's underlying degenerative disc disease.

Claimant's 1983 and 1985 injuries have resolved without permanent impairment. Claimant's current need for treatment is entirely attributable to his degenerative disc disease.

CONCLUSIONS AND OPINION

Procedural Propriety of Denials

An insurer may not issue a preclosure denial of all current treatment for an accepted condition on the grounds that the accepted condition has resolved. See Webb v. SAIF, 83 Or App 386 (1987); Roller v. Weyerhaeuser Company, 67 Or App 583 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983).

The Referee concluded that the denials were not invalid preclosure denials, reasoning that the prohibition against preclosure denials did not apply to the claims at issue here because claimant had retired and no temporary disability compensation was due. The Referee further concluded that claimant was not substantively entitled to ongoing chiropractic treatment for his accepted neck and back injuries.

On review, claimant argues that the prohibition against preclosure denials applies, notwithstanding the fact claimant was not entitled to temporary disability compensation. Claimant further argues that the denials in question were not valid notices of closure under ORS 656.268(3), so that the denials of treatment were invalid preclosure denials. The insurer contends that the Referee's analysis was correct and further argues that the preclosure denial prohibition does not apply because its denials were for treatment of a separate, noncompensable degenerative disease that it never accepted.

Our first inquiry is whether the insurer had effectively closed claimant's claims when it issued its denials. The insurer's denial letters of October 8, 1986 and January 6, 1987 did not provide various items of information required in a notice of closure. See former ORS 656.268(3). Specifically, the denials did not inform claimant of his entitlement to temporary and permanent disability, his aggravation rights, or his right to request a determination order from the Evaluation Division within one year of the date of the insurer's closure. The February 12, 1987 letter from the insurer's attorney provided the requisite information regarding temporary and permanent disability and aggravation rights, and it informed claimant of his right to have his claim reclassified as disabling within one year of the date of injury. However, it did not inform claimant of his right to request a determination order within one year of the date of the insurer's closure. Consequently, we conclude that these letters did not operate as notices of closure under former ORS 656.268(3).

Therefore, the denials at issue here were improper preclosure denials if they denied current treatment of a previously accepted condition on the grounds that condition had resolved. If the denials were of treatment for a separate,

unaccepted condition, they were procedurally proper. See Roller, supra at 730; Aquillon v. CNA Insurance, 60 Or App 231, 235 (1982). Cf. Destael v. Nicolai Co., 80 Or App 596 (1986).

The denials were of current chiropractic treatment for claimant's degenerative disc disease; therefore, we must first determine whether the insurer's acceptance included this condition. The Form 827 submitted for the 1983 injury listed two separate diagnoses--cervicothoracic strain and degenerative changes in the cervical spine. The Form 827 submitted for the 1985 injury listed the separate diagnoses of lumbosacral strain and degenerative changes in the lumbar spine. However, the 801 Forms filed by claimant for the 1983 and 1985 injuries were for neck/back strain and a slipped low back disc, respectively. The insurer did not accept the injuries by checking the 801 Forms, and there is no formal acceptance in the record. Nor is there any other evidence that the insurer's acceptance included claimant's degenerative condition. We are, therefore, not persuaded that the insurer's acceptance included that condition.

Moreover, we are persuaded by the medical evidence that the underlying degenerative condition is separable from the strains and slipped disc listed on the 801 Forms. The medical evidence conclusively establishes that claimant's degenerative condition preexisted his compensable injuries. Every physician who examined claimant following the 1983 injury, including Dr. Llewellyn, diagnosed two separate conditions--a neck and low back strain, and a separate degenerative condition. Likewise, Dr. Llewellyn and every other physician that examined claimant following the 1985 injury diagnosed two separate conditions--a low back strain and a separate degenerative condition.

We are further persuaded by the medical record that claimant's compensable injuries did not worsen his underlying degenerative condition, and that his current need for treatment is entirely attributable to that condition. In reaching this conclusion, we defer to the opinions of Dr. Simpson, chiropractor, and Dr. Howell, osteopath, who performed independent medical examinations in June 1986 and February 1987, respectively. They opined that claimant's compensable injuries had resulted in strains only and had not worsened claimant's underlying degenerative condition. They further opined that the accepted strains had resolved, and that claimant's remaining need for treatment is due to his degenerative condition.

Dr. Llewellyn and consulting chiropractors Bamforth and Butler took a contrary position. They opined that claimant's injuries had both weakened the soft tissue making reinjury more likely, and worsened claimant's preexisting degenerative condition. However, they did not discuss the relative impact of claimant's prior neck and back injuries or otherwise provide a well-reasoned explanation for their opinion. In contrast, Drs. Simpson and Howell relied on a comparison of cervical x-rays taken in 1979, 1983 and 1984, and lumbar x-rays taken in 1978, 1980, 1985 and 1986. These x-rays showed no significant worsening of the degenerative disc disease following the injury.

In summary, the examining physician have, without exception, diagnosed claimant's degenerative disease as a separate condition from the accepted strains and slipped disc. Drs. Simpson and Howell have persuasively opined that the compensable injuries did not worsen claimant's degenerative condition, and that the accepted strain conditions have resolved and the current need for treatment is entirely attributable to the underlying degenerative condition. These findings persuade us that the denials at issue were of treatment for a separate, noncompensable condition that the insurer never accepted. As such, the denials were not improper preclosure denials of current treatment for an accepted condition. See Roller, supra; See Aquillon v. CNA, supra. Accordingly, the Referee correctly upheld the denials, and we affirm his ruling.

In light of our conclusion that the insurer's denials were not of treatment for an accepted condition, we need not address whether the prohibition against preclosure denials applies to denials of medical services only.

Sanctions Under ORS 656.990(1)

The insurer requests that the Board bring criminal sanctions against claimant's treating chiropractor under ORS 656.990(1). Under that statute "[a]ny person who knowingly makes any false statement or representation to the board or its employes . . . for the purpose of obtaining any benefit or payment under ORS 656.001 to 656.794, either for self or any other person . . . is punishable, upon conviction, by imprisonment for a term of not more than one year or by a fine of not more than $1,000, or by both."

The Board has jurisdiction over matters concerning a claim, that is matters in which a worker's right to receive compensation, or the amount thereof, is directly in issue." ORS 656.283(1) and 656.704(3). Enforcement of criminal sanctions against a provider does not directly concern claimant's entitlement to receive compensation, or the amount thereof. Consequently, the Board does not have jurisdiction over litigation under ORS 656.990(1). Accordingly, the insurer's request is denied.

ORDER

The Referee's order issued April 14, 1987 is affirmed.

October 23, 1990 Cite as 42 Van Natta 2414 (1990)

In the Matter of the Compensation of
STEVEN A. MURPHY, Claimant
WCB Case No. 89-11689
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of Referee Seifert's order that increased claimant's scheduled permanent disability award for the loss of use or function of claimant's left leg (knee) from 15 percent (22.5 degrees) to 40 percent (60 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.

Claimant's condition was found to be medically stationary on May 3, 1989 and his claim was closed by a June 16, 1989 Determination Order awarding him 15 percent scheduled permanent disability.

Claimant does not suffer left knee instability due to his compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's scheduled permanent disability award by 25 percent, awarding an additional 5 percent for a chronic condition limiting repetitive use and 20 percent for left knee instability. The insurer contests

only that portion of the award regarding left knee instability. Therefore, we address only that particular issue.

We note that both chronic conditions limiting repetitive use and instability are rated under the standards. Therefore, we first look to the standards to determine whether claimant has established ratable instability under former OAR 436-35-230(3).

Under former OAR 436-35-230(3), knee joint instability is rated based on joint opening, as measured by millimeters. The record is devoid of any medical or lay evidence which would allow us to rate claimant's alleged instability based on joint opening.

Claimant testified that he was conscious of knee instability when climbing stairs. (Tr. 11). However, we find that the statement alone, without some objective measurement, does not allow for a rating under the standards.

Furthermore, contrary to claimant's testimony, claimant's knee surgeon, Dr. Davis, reported in his closing May 1989 report, that claimant had "no instability of the knee." (Ex. 5). Because Dr. Davis operated on claimant's knee, and continued to treat and evaluate claimant's knee condition for several months, we find his opinion persuasive. Somers v. SAIF, 77 Or App 259, 262 (1986).

Under the circumstances, we find that claimant has no ratable instability under the standards. Therefore, we do not award claimant a value for knee instability under former OAR 436-35-230(3).

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 302 (1987).

The medical evidence establishes that claimant did not have any instability in his left knee in May 1989. While claimant credibly testified at hearing, several months later, that he is "conscious of instability" in his legs while climbing stairs, we are not convinced that this declaration, when considered in light of the contrary medical evidence, is clear and convincing evidence that claimant suffers permanent disability in excess of that amount awarded by an application of the standards. Therefore, we do not award claimant any additional disability outside the standards.

Finally because the insurer has not objected to the Referee's award of 5 percent for a chronic condition limiting repetitive use under former OAR 436-35-010(7), regardless of its characterization, we do not disturb that award. Therefore, we find that claimant is entitled to a total scheduled permanent disability award of 20 percent.

ORDER

The Referee's order dated October 23, 1989 is modified. In lieu of the Referee's increased award, and in addition to the Determination Order award, claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability, for a total of 20 percent (30 degrees) scheduled permanent disability for the loss of use or function of his left leg (knee).

In the Matter of the Compensation of
OLLIE D. WIGGER, Claimant
WCB Case Nos. 88-12473 & 88-09689
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Beers, et al., Defense Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

St. Paul Fire and Marine (St. Paul) requests review of Referee Higashi's order that: (1) set aside its denial of claimant's aggravation claim for his current left knee condition; and (2) upheld EBI Companies' denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

The Board adopts the Referee's findings, except for his ultimate finding.

CONCLUSIONS OF LAW AND OPINION

There were two accepted claims in this matter, the last having been accepted by St. Paul. The Referee analyzed this case under Champion International v. Castilleja, 91 Or App 556 (1988). In that case, the court held that the "last injurious exposure rule" applies to successive injury cases. Pursuant to that rule, the Referee assigned responsibility to St. Paul as the last employment that could have contributed to claimant's disability. Since the Referee's order, the Board has issued its decision in Linda L. Wise, 42 Van Natta 115 (1990). In Wise, we held that the Castilleja decision does not apply where, as here, there are accepted injuries to the same body part followed by an increase in disability during subsequent employment. In this situation, a rebuttable presumption exists that a claimant's last accepted industrial injury contributed independently to the worsened condition and that the insurer at that time is responsible. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). For this reason, a presumption exists that St. Paul is responsible. St. Paul can establish that it is not responsible by showing that the work activities at its insured did not independently contribute to claimant's condition.

The Referee concluded that St. Paul has not shown that claimant's work activities at its insured did not independently contribute to claimant's worsened left knee condition. We agree.

Former treating physician McHolick, orthopedic surgeon, opined that claimant's pathology would have progressed to its current state as a result of daily living activities, regardless of the type of work he performed. He noted that claimant's heavy work with EBI's insured had caused serious degenerative changes before claimant began working for St. Paul's insured.

Claimant's current treating physician, Dr. James, M.D., opined that the pathological worsening of claimant's condition was hastened by his work activity with St. Paul's insured. He reasoned that the repetitive standing and twisting involved in that work put additional stress on claimant's knee. He also relied on the fact that x-rays taken in 1988 demonstrated a pathological worsening, and the fact the accepted 1987 injury with St. Paul and the current exacerbation involved not just increased symptoms but increased effusion as well.

We do not find Dr. McHolick's opinion more persuasive than that of Dr. James. Both doctors have special training in knee injuries, familiarity with

claimant's condition both before and after the work activity with St. Paul's insured and an accurate understanding of the nature of that work activity. Dr. James' opinion is equally well-reasoned and consistent with the record. Further, the fact claimant's 1981 injury with EBI resulted in significant degenerative changes does not rule out the possibility of a subsequent independent contribution from the employment with St. Paul's insured.

For these reasons, Dr. McHolick's opinion does not persuade us that claimant's employment with St. Paul's insured did not independently contribute to a pathological worsening of his condition. Therefore, St. Paul has not carried its burden and is responsible. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated February 27, 1989, as supplemented March 10, 1989, is affirmed.

October 24, 1990 Cite as 42 Van Natta 2417 (1990)

In the Matter of the Compensation of
RAYMOND M. HAMMER JR., Claimant
WCB Case No. 88-18627
ORDER ON REVIEW
Ormsbee & Corrigall, Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of that portion of Referee Livesley's order that increased claimant's unscheduled permanent disability award for a neck and back injury from 20 percent (64 degrees), as awarded by Determination Order, to 37 percent (118.4 degrees). In his respondent's brief, claimant contends entitlement to disability in excess of that calculated under the standards. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant returned to modified work. His at-work injury required the physical capacity to perform heavy work. His modified job required the physical capacity to perform light work.

Claimant suffers from ratable loss of cervical and lumbar range of motion and a chronic condition which limits repetitive bending, crawling and sitting.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability from 20 percent to 37 percent. We modify.

Because claimant's claim was closed by Determination Order on July 19, 1989, the "standards" effective January 1, 1989 through September 30, 1990 apply to a rating of claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's unscheduled permanent disability.

The parties do not dispute those values assigned to age (0) and education (3). Therefore, we do not address these categories. The parties do dispute, however, the values assigned to adaptability and impairment. We turn to those issues.

Adaptability

The Referee assigned an adaptability value of 6. In reaching this determination, the Referee added a pain value to the adaptability value under former OAR 436-35-310. The employer contends that the pain value is incorporated into the adaptability value, and that no additional value for pain may be added to the adaptability value. We agree with the employer.

Former OAR 436-35-320 provides that pain is considered in the standards to the extent that it results in measurable impairment. The rule further provides that, "[t]o the extent that pain results in disability greater than that evidenced by the measurable impairment, . . . this loss of earning capacity is considered and rated under OAR 436-35-310 and is included in the adaptability factor." (Emphasis added.)

The parties do not dispute the fact that claimant's pain has resulted in disability greater than that evidenced by the measurable impairment. Any pain in excess of measurable impairment is automatically made a part of the adaptability value under former OAR 436-35-310. Therefore, the adaptability value encompasses a value for pain.

Here, claimant's work-at-injury required the physical capacity to perform heavy work. His modified work required the physical capacity to perform light work. Accordingly, under former OAR 436-35-310(3), the appropriate adaptability value is 2.5.

Impairment

The parties do not dispute the Referee's findings regarding loss of range of motion (7 percent for loss of range of cervical range of motion and 7 percent for loss of lumbar range of motion). The Referee, however, awarded claimant an additional 5 percent disability for a chronic condition limiting repetitive use or function under former OAR 436-35-320(4). The employer contends that claimant failed to establish entitlement to the additional 5 percent for a chronic condition limiting repetitive use. We disagree.

Former OAR 436-35-320(4) provides that "[c]hronic conditions limiting repetitive use of an unscheduled body part shall be rated at 5% impairment of that part."

Claimant credibly testified that he had difficulty with repetitive bending, crawling and sitting. Furthermore, his treating physician reported in December 1988 that he was restricted from performing repetitive bending, crawling, reaching, pushing and pulling. Consequently, we find that claimant does suffer from a chronic condition which limits repetitive use.

Therefore, we agree with the Referee and award claimant 5 percent for a chronic condition limiting repetitive use under former OAR 436-35-320(4).

Claimant's total impairment, therefore, is his loss of cervical range of motion value (7), combined with his loss of lumbar range of motion value (7), combined with his chronic condition value (5). After combining these figures, claimant's total impairment is 17.83.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 3, the sum is 3. When that value is multiplied by claimant's adaptability value 2.5, the product is 7.5. When that value is added to claimant's impairment value 17.83, the result is 25.33 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 26 percent.

Disability Outside the Standards

The Referee did not find claimant entitled to disability in excess of that awarded under the standards. Claimant contends that he has established by clear and convincing evidence entitlement to a greater award than that awarded under the standards. We disagree.

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 302 (1987).

Here, claimant contends that because he can no longer return to the lumber industry, he is entitled to a greater award than calculated under the standards. We find this contention insufficient to establish by clear and convincing evidence claimant's entitlement to an award in excess of that awarded under an application of the standards.

ORDER

The Referee's order dated September 19, 1989 is modified. In lieu of the Referee's increased award, and in addition to the Determination Order award, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, for a total of 26 percent (83.2 degrees) unscheduled permanent disability.

October 25, 1990 Cite as 42 Van Natta 2419 (1990)

In the Matter of the Compensation of
KENNETH R. BARKER, Claimant
WCB Case Nos. 89-03350 & 88-14541
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
David O. Horne, Defense Attorney
Arthur Stevens (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Menashe's order that set aside its denial of claimant's bilateral carpal tunnel syndrome claim. On review, SAIF contends that this matter should be remanded to the Referee for a determination as to whether a federal remedy is available to claimant for his claim. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

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

On review, SAIF cites Miville v. SAIF, 76 Or App 603 (1985), and contends that claimant must prove that he sought benefits under the Longshore and Harbor Worker's Compensation Act (LHWCA) and received a final order disallowing compensation before it, as an Oregon employer's insured, can be held responsible for claimant's condition.

We do not agree that this case is controlled by Miville. That case involved a subsequent out-of-state incident that contributed independently to claimant's condition. Had both events occurred in Oregon, responsibility would have shifted to the second employer under the last injurious exposure rule. However, because a finding of liability under Oregon law would not have operated against the out-of-state employer, the court held that the Oregon employer would remain liable if the claimant had claimed, but had not been awarded, compensation with the out-of-state employer. Id.

This case, on the other hand, does not involve a subsequent incident that contributed independently to claimant's condition. The Referee found, and we agree, that the subsequent employment merely increased claimant's symptoms and did not materially contribute to his carpal tunnel syndrome condition. A symptomatic worsening, by itself, is not enough to shift responsibility from the original employer. Hensel Phelps Construction Co. v. Mirich, 81 Or App 290 (1986). Therefore, claimant was not required to file a claim under the LHWCA before seeking benefits in Oregon. Harry W. Clark, 38 Van Natta 1371 (1986).

SAIF also contends that this matter should be remanded to the Referee for a determination whether a federal remedy is available to claimant for his claim. If claimant's condition is compensable under the LHWCA, he would be, by definition, not a "subject worker" for whom compensation is available under Oregon law. ORS 656.027(4). See Thomas A. Wuellett, 42 Van Natta 1927 (1990). Consequently, at that point, SAIF's responsibility would terminate. Wuellett, supra.

Claimant has established the compensability of his condition under Oregon law. To avoid responsibility, it is up to SAIF to establish that the LHWCA provides compensation for claimant's condition. It has not done so and has offered no reason why evidence bearing on that issue could not have been obtained and submitted at hearing.

Under such circumstances, we do not consider the record to be insufficiently, incompletely or inadequately developed. ORS 656.295(5). Accordingly, the request for remand is denied.

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

ORDER

The Referee's order dated June 15, 1989 is affirmed. For services on Board review, claimant's attorney is awarded $600, to be paid by the SAIF Corporation.

October 25, 1990 Cite as 42 Van Natta 2421 (1990)

In the Matter of the Compensation of
DWANE M. BURCH, Claimant
Own Motion No. 89-0760M
OWN MOTION ORDER
Coughlin, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his April 28, 1978, industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the claimant's condition. However, it opposes reopening of his claim for payment of temporary total disability benefits, contending that any request for time loss in February 1987 should have been handled in the last own motion request. (Own Motion No. 86-0585M). Further, that claimant had over two years, during which time he was represented by counsel, to ask the Board to allow him time loss benefits during his hospitalization, and that he failed to respond to the Board's January 1989 letter and failed to ask for reconsideration of the March 1989 dismissal. Claimant contends that the dismissal of March 19889 was for a request for own motion filed December 5, 1986, and had nothing to do with any situation that occurred after December 5, 1986.

We may exercise our own motion authority and reopen claimant's claim for additional temporary total disability compensation if he has sustained a worsening of his compensable injury requiring either inpatient or outpatient surgery, or other treatment requiring hospitalization. ORS 656.278(1)(a). We conclude that claimant has sustained such a worsening. However, because of changes to ORS 656.278 effective January 1, 1988, and because the own motion claim was not filed until April 28, 1989, we are only authorized to award temporary disability compensation to commence from the time claimant was hospitalized.

Also, because claimant is self-employed and the hospitalization occurred in 1987, he is required to submit to SAIF evidence that the worsening caused him to lose earning capacity in his construction business. Therefore, claimant is ordered to furnish SAIF with copies of his 1986, 1987 and 1988 federal and state income tax returns, and any other information he wishes to submit to prove a loss of earnings, so they may have a basis on which to determine the amount of temporary disability compensation due. Upon SAIF's receipt of the ordered documents, claimant's claim is reopened and his temporary disability is to be paid from February 12, 1987, the date he was hospitalized. SAIF shall continue paying temporary disability benefits until authorized to reduce or terminate such benefits pursuant to OAR 438-12-035. 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.

In the Matter of the Compensation of
MARY CHADWICK, Claimant
WCB Case Nos. 88-15962 & 88-12858
ORDER ON REVIEW
Brown & Tarlow, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Nichols' order that: (1) set aside its denial of claimant's "new injury" claim for her current low back condition; and (2) upheld Liberty Northwest Insurance Corporation's aggravation claim for the same condition. In its brief, SAIF contends that the Referee's penalty for an unreasonable denial was excessive. On review, the issues are responsibility and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Board adopts the Referee's "Opinion and Conclusions" on the issue of responsibility.

Penalties

SAIF argues that the Referee's penalty of 25 percent of all temporary total disability due prior to the issuance of the .307 order is excessive. SAIF contends that it should only be penalized on the compensation withheld due to its own actions, i.e., between the time it denied compensability on August 12, 1988 and the time it amended its denial to one of responsibility only on October 21, 1988. SAIF argues that it did nothing to cause the delay between October 21, 1988 and the time the .307 order issued on December 14, 1988. We agree.

We conclude that SAIF should not be assessed a penalty for the administrative delay that ensued after it amended its denial to responsibility only, on October 21, 1988. We therefore modify the Referee's assessed penalty.

ORDER

The Referee's order dated March 9, 1989 is affirmed in part and modified in part. That portion of the Referee's order that assessed a 25 percent penalty of the time loss due claimant prior to the issuance of the .307 order is modified. The SAIF Corporation is directed to pay claimant a penalty of 25 percent of the time loss due prior to October 21, 1988. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CATHERINE L. ELDRED, Claimant
WCB Case No. 89-08297
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The self-insured employer requests review of those portions of Referee Myers' order that: (1) set aside its partial denial of claimant's cervical condition as procedurally improper; and (2) assessed a penalty and related attorney fee for an unreasonable denial. Claimant cross-requests review of that portion of the Referee's order that found, on the merits, that her degenerative disc disease was not related to her compensable injury. On review, the issues are propriety of the employer's denial, compensability and penalties and attorney fees.

The Board affirms and adopts those portions of the Referee's order that set aside the employer's partial denial of claimant's cervical condition and assessed a penalty and attorney fee for an unreasonable denial. We note that, because we have affirmed the Referee's conclusion that the denial was invalid, we do not reach the merits of claimant's claim.

Attorney fees

Claimant has requested an attorney fee for her counsel's services on review. Claimant did not submit a respondent's brief; however, a cross-reply brief was submitted by claimant on the merits of her claim. Because we have affirmed the Referee on procedural grounds only, claimant is not entitled to a fee for her cross-reply brief on the merits of this case. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated September 15, 1989 is affirmed.

In the Matter of the Compensation of
ATHER FRAZIER, Claimant
WCB Case No. 89-0573M
OWN MOTION ORDER
Popick & Merkel, Claimant Attorneys
Roberts, et al., Defense Attorneys

The insurer has submitted to the Board claimant's claim for an alleged worsening of his October 1979 compensable left knee injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for claimant's January 12, 1990 surgery. However, contending that claimant has withdrawn from the work force, the insurer opposes payment of temporary disability benefits.

We may exercise our "Own Motion" authority to reopen a claim for additional 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. ORS 656.278(1)(a). In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

After review of the record, we conclude that claimant's compensable condition has worsened requiring surgery. Notwithstanding such a finding, to receive temporary disability benefits for such a worsening, claimant must be in the work force at the time of the worsening, or if not in the work force, willing to work and making reasonable efforts to obtain employment (unless such efforts would be futile because of the work-related injury). Wausau Ins. Companies v. Morris, 103 Or App 270 (1990).

Here, claimant has not worked since July 1985. His compensable condition was most recently evaluated at an April 1989 hearing before a Referee on appeal from an August 1988 Determination Order. At that time, claimant sought an award of permanent total disability. Following a hearing, the Referee found that, although claimant was significantly disabled by his compensable left knee condition, he was not permanently incapacitated. The Referee further held that claimant was not willing to seek regular gainful employment or make reasonable efforts to obtain such employment. Such a holding was based on vocational assistance efforts which were unsuccessful primarily because of claimant's "unrealistic expectation" for a $12 per hour job and a refusal to consider school training. This date, we have affirmed and adopted the Referee's order.

Such a prior finding does not irrevocably commit claimant to retirement for purposes of workers' compensation benefits. Wausau Ins. Companies v. Morris, supra. If he is willing to seek work at the time of the worsening, he is considered to be a member of the work force at that time. Id.

Here, claimant does not contend that he was willing to seek work at the time of the worsening of his compensable condition. Moreover, he has not submitted any evidence to suggest that his attitude toward work has changed since the April 1989 hearing. Instead, he asserts that he was "medically unable to work or look for work at the time of the worsening." We interpret such a statement as an assertion that, prior to the worsening of his condition, it would have been futile for claimant to make reasonable efforts to obtain employment because of his compensable condition.

The record does not support such a contention. To begin, there is no indication that the circumstances present at the time of the April 1989 hearing had changed by the time claimant's compensable condition subsequently worsened. Thus, we find no persuasive reason to depart from the Referee's prior determination, which we have adopted in our Order on Review, that claimant's compensable condition did not make it futile for him to make reasonable efforts to obtain employment.

Furthermore, in support of his assertion that he was medically unable to look for work prior to his worsening, claimant relies upon a medical opinion authored by Dr. Blackwell, his treating surgeon. Yet, Blackwell based his conclusion that claimant was permanently and totally disabled on the severity of claimant's back condition, as well as his knee condition. The Referee's April 1989 order, which we have adopted, concluded that claimant's back condition is unrelated to his compensable knee condition and was not a disability that preexisted the compensable injury.

Therefore, because back condition is unrelated to claimant's compensable knee condition and since the back condition was not a preexisting disability at the time of the compensable knee injury, it cannot be considered in determining whether it was futile for claimant to make reasonable efforts to obtain employment at the time of the worsening of his compensable condition. Arndt v. National Appliance Co., 74 Or App 20 (1985). Finally, when asked to solely consider the compensable left knee condition, Blackwell concluded that

claimant was capable of employment, provided that he avoid heavy work such as his prior construction laborer duties.

In conclusion, based on the aforementioned reasoning, we are not persuaded that, at the time of the worsening of his compensable knee condition, claimant had made reasonable efforts to obtain employment or that those efforts would have been futile as a result of his compensable condition. Consequently, we hold that, at the time of the worsening of his compensable condition, claimant had withdrawn from the work force. Accordingly, the request for own motion relief is denied.

IT IS SO ORDERED.

October 25, 1990 Cite as 42 Van Natta 2425 (1990)

In the Matter of the Compensation of
RAY GRAVES, Claimant
WCB Case No. 87-00109
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brittingham, Nichols and Crider.

Claimant requests review of that portion of Referee Leahy's order which declined to grant permanent total disability. The self-insured employer cross-requests review of those portions of the order which: (1) affirmed a Determination Order award of 35 percent (112 degrees) unscheduled permanent disability for a low back injury; and (2) did not find that claimant was medically stationary on July 17, 1984, whereas the Determination Order found claimant to be medically stationary on November 3, 1986. The employer further requests that, in the event claimant is found to be medically stationary at an earlier date, all temporary total disability benefits paid beyond that date be declared an overpayment for which the insurer is entitled to an offset against any future permanent disability benefits. On review, the issues are extent of permanent disability, including permanent total disability, medically stationary date, and offset. We reverse.

FINDINGS OF FACT

On January 4, 1984, claimant sustained a low back strain superimposed on preexisting spondylolisthesis and spinal stenosis at L3-4. The employer accepted the claim for lower back pain due to a defective truck seat. Myelogram and CT scan suggested the presence of a herniated disc at L4-5, in addition to preexisting spinal anomalies and, therefore, claimant underwent exploratory surgery on August 29, 1984. At surgery, no evidence of disc herniation was found. Nevertheless, Dr. Golden performed extensive decompression laminectomies from L-3 to L-5 as treatment for claimant's spinal stenosis and spondylolisthesis.

Claimant's pain continued and Dr. Golden recommended further surgery. On July 8, 1985, the employer issued a partial denial of compensability and medical services for claimant's underlying spinal stenosis and degenerative changes of the spine. Referee Garaventa upheld that denial as did the Board and the Court of Appeals.

Claimant was found to be medically stationary on November 3, 1986. The claim was closed by a Determination Order issued December 22, 1986 awarding 35 percent unscheduled permanent disability.

FINDINGS OF ULTIMATE FACT

Claimant's compensable injury did not worsen his preexisting stenosis or spondylolisthesis.

Claimant's current impairment is a result of his preexisting stenosis and degenerative condition, and the effects of surgery to treat those conditions.

Claimant has sustained no permanent loss of earning capacity as a result of his compensable injury.

Claimant became medically stationary from his compensable strain on October 10, 1984.

CONCLUSIONS OF LAW AND OPINION

Propriety of Dismissal

The Referee affirmed the Determination Order and dismissed claimant's hearing request. There was no basis for dismissing claimant's hearing request, nor was there any request by the parties to do so. A hearing was held on the matter and we review on the merits.

Extent of Disability

Permanent Total Disability

In order to establish permanent total disability, claimant must prove that he is completely physically disabled and therefore unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Although we consider preexisting disabilities and their impact on performing work at a gainful and suitable occupation, preexisting disabilities are considered only as the condition exists at the time of the claimant's compensable injury, or to the extent that the claimant's compensable injury worsened the preexisting condition. Searles v. Johnston Cement, 101 Or App 589 (1990); Fowler v. SAIF, 82 Or App 604 (1986).

Here, claimant contends that he is permanently and totally disabled due to his chronic pain syndrome resulting from his underlying spinal stenosis and spondylolisthesis, and the scarring which occurred as a consequence of the surgery. Thus, to prevail on his argument, claimant must prove that his underlying spinal conditions were disabling at the time of the compensable injury, or that the scarring (worsening) resulted from surgery for a compensable condition.

The record does not establish and claimant has never asserted that his underlying spinal conditions were disabling at the time he sustained the soft tissue injury to his low back. To the contrary, claimant testified that he had no back or leg problems prior to the injury. Any post-claim worsening of these conditions not caused by his compensable back injury cannot be considered in determining whether claimant is permanently and totally disabled. Fowler, supra. Accordingly, in our permanent and total disability analysis, we must determine to what, if any, extent claimant's chronic pain syndrome results from the worsening of his underlying spinal conditions as a consequence of his compensable injury.

Claimant challenges the Referee's failure to consider the effects of claimant's surgery in rating the extent of his disability. Specifically, claimant asserts that the scarring caused by his surgery contributes to his chronic pain syndrome. Dr. Golden, claimant's treating neurosurgeon, and

Dr. Rosenbaum, examining neurologist, both agree that claimant's chronic pain problem is due in part to the sequela of the decompression laminectomies. We accept their conclusions as to the etiology of claimant's chronic pain syndrome.

Nevertheless, claimant's argument fails to recognize that the issue is not whether the scarring is a result of his back surgery, but whether it is the consequence of surgery for a compensable condition. This Board and the Court of Appeals have previously held that claimant's spinal stenosis and degenerative changes of the spine are not compensable. Graves v. Weyerhaeuser Co., 86 Or App 752 (1987). That is the law of this case and, on review, we base our analysis on that finding. If surgery to treat an underlying noncompensable condition discovered during an otherwise compensable diagnostic procedure is not compensable, it follows that any sequela from the surgery to treat the noncompensable conditions are also not compensable. See Brooks v. D & R Timber, 55 Or App 688 (1982). Therefore, we find that claimant has not established that his disabling chronic pain syndrome was caused by his compensable low back injury. Consequently, there is no basis for an award of permanent and total disability.

Extent of Permanent Unscheduled Disability

The Referee found that claimant's preexisting noncompensable stenosis and degenerative condition are the cause of claimant's current impairment. Nevertheless, he affirmed the Determination Order awarding claimant 35 percent permanent unscheduled disability. We reverse.

To be entitled to an award of unscheduled permanent partial disability, claimant must prove "permanent loss of earning capacity due to the compensable injury." ORS 656.214(5). [Emphasis supplied.] As we have previously found, the worsening of claimant's underlying spinal conditions and his resultant chronic pain syndrome are not a consequence of his compensable injury.

Claimant's compensable injury was a strain of the low back. Thus, the only impairment which may be considered in determining the extent of claimant's unscheduled permanent partial disability is that arising from his musculoligamentous strain. There is none. The effects of that injury had resolved prior to claim closure. Claimant has sustained no permanent loss of earning capacity as a result of his compensable injury. Accordingly, we find that there was no basis for any award of permanent partial disability to claimant. Consequently, we reverse the Determination Order award of 35 percent unscheduled disability, and reduce claimant's award to zero.

Medically Stationary Date

A claim may be closed if claimant's compensable condition is medically stationary, that is, no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). Here, the Determination Order found that claimant's condition was medically stationary on November 3, 1986.

At the hearing, the employer cross-appealed for an earlier medically stationary date. However, the Referee did not address this issue in his Opinion and Order. On Board review, the employer renews its cross-appeal. Specifically, the employer requests that the medically stationary date be revised to July 17, 1984, and that all temporary total disability benefits paid beyond that date be declared an overpayment for which the employer is entitled to an offset against any future permanent disability benefits. The employer has the burden of establishing that 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).

The employer relies on Dr. Rosenbaum's report dated August 4, 1986, in which he specifically discussed claimant's compensable low back strain and explained that the pain of a lumbosacral strain would be expected to improve within approximately six months. Therefore, he posited, it was medically probable that in relation to his strain, claimant would have been medically stationary by July 17, 1984.

We agree that claimant's compensable injury resolved and was medically stationary earlier than found by the Evaluation Section. However, we note that diagnostic testing performed in April and May 1984 suggested that claimant might have a herniated disc at L4-5 as a result of his compensable injury. Furthermore, claimant underwent exploratory diagnostic surgery on August 29, 1984 in an effort to determine if the suspected disc was the source of his back pain. Thus, we find that as of that date, further medical improvement was expected. At surgery, no herniated disc was found. Nevertheless, the surgeon proceeded to treat claimant's noncompensable underlying spinal stenosis and spondylolisthesis with decompression laminectomies.

Dr. Rosenbaum testified at hearing that it takes six weeks to completely heal and recover from the type of surgery proposed to diagnose and treat claimant's suspected disc problem. His testimony was unrebutted. Based on Dr. Rosenbaum's opinion, we are persuaded that, had the surgeon only performed the diagnostic surgery authorized by the employer, no further improvement in claimant's compensable condition reasonably would have been expected through treatment or the passage of time by October 10, 1984. Consequently, we conclude that claimant's compensable condition was medically stationary October 10, 1984.

Offset

The employer seeks an offset for the overpayment of temporary total disability beyond the medically stationary date against any future awards of permanent disability. The claim was closed by Determination Order on December 22, 1986, with an award of temporary total disability from January 20, 1984, through November 3, 1986, when claimant was found to be medically stationary. The Referee affirmed the medically stationary date in the Determination Order. This Board has now determined that claimant became medically stationary October 10, 1984.

The filing of a request for review or court appeal by an employer/insurer does not stay the payment of compensation to claimant. ORS 656.313(1). Further, an employer is prohibited from recovering, by offset against a later award of permanent disability, benefits that are or should have been paid pending a request for review pursuant to a Referee's award that is later determined to be excessive. ORS 656.313(2). Sullivan v. Banister Pipeline American, 91 Or App 493 (1988).

Here, however, the overpayment was not made pending review, pursuant to a Referee's award. Rather, the employer paid benefits prior to and/or pursuant to the December 1986 Determination Order, before the Referee's order of October 21, 1987 and before the request for Board review. Therefore, the employer is entitled to an offset for overpaid temporary disability compensation between October 11, 1984 and November 3, 1986. Id.

ORDER

The Referee's order dated October 21, 1987 is reversed in part and affirmed in part. Claimant's request for hearing is reinstated. The Determination Order dated December 22, 1986 is modified to reflect a medically stationary date of October 10, 1984. The employer is authorized to offset temporary disability paid

between October 11, 1984 through November 3, 1986 against claimant's future permanent disability awards, if any. The Determination Order award of 35 percent (112 degrees) unscheduled permanent disability is reversed to zero. The remainder of the order is affirmed.

Board Member Crider, dissenting.

I agree with the majority's finding that claimant's current disability is caused by a combination of spinal stenosis and the residuals of surgery performed in 1984. If the 1984 surgery was performed due to claimant's compensable back injury, then its residuals are compensable; and, inasmuch as those compensable residuals are a material cause of his current back condition, claimant is entitled to permanent disability compensation for that current condition. If, on the other hand, the 1984 surgery was not performed for a compensable condition, then its residuals are also not compensable and his current condition is not compensable. The majority concludes that the 1984 surgery was performed for a noncompensable condition and, consequently, awards claimant no permanent disability and, also, authorizes an offset of overpaid temporary disability based on a medically stationary date arrived at without regard to the time required to recover from the surgery. The record offers no support at all for the conclusion that the surgery is not compensable. Therefore, I dissent.

The self-insured employer concedes and the record establishes that the 1984 surgery was authorized and paid for by the employer for this injury. That being the case, it would appear obvious that the employer is responsible for the residuals of the surgery. Williams v. Gates, McDonald & Co., 300 Or 278 (1985).

The self-insured employer asserts, however, that the surgery was authorized as a diagnostic procedure to determine whether or not there was a herniated disc for which the employer might be responsible. Then, the argument goes, although Dr. Golden, claimant's surgeon, found no herniated disc, he proceeded to decompress nerve roots which he found to be compressed due to stenosis and spondylolisthesis. Since the stenosis was denied following the surgery and found noncompensable notwithstanding the initial acceptance of claimant's "back pain," the employer contends that the surgery for which it paid is not its responsibility.

The majority has accepted this argument, finding that claimant underwent exploratory surgery to determine whether claimant had a disc herniation at L4-5 although there is no basis for the finding in the record. Dr. Golden was not authorized to do exploratory surgery to determine whether there was a herniated disc at L4-5. At the outset, stenosis, reverse spondylolisthesis and facet changes were noted and no evidence of disc herniation appeared. The problems appeared severe at L3-4. Dr. Golden interpreted a myelogram to indicate some bulging at L4-5. On June 11, 1984, after examining oblique films, Dr. Golden concluded that claimant's problems stemmed from stenosis at L3-4 with a questionable herniation. Dr. Schroeder, a consultant, advised that while there was probably a mild disc lesion at L5-S1, claimant's problems were primarily due to degenerative spondylolisthesis at L3-4. A subsequent CT scan lead Dr. Michels to confirm stenosis at L3-4 and not a herniation. Armed with this knowledge, the employer authorized decompressive surgery. Pursuant to that authorization, Dr. Golden admitted claimant on August 28, 1984, according to a report dictated that day, "for a decompression lumbar laminectomy to relieve spinal canal stenosis." The diagnostic impression was of lumbar spondylosis with spinal canal stenosis at L3-4. Surgery was performed the following day. Decompression was performed at L3-L5 to relieve compression at all levels.

In short, although the contemporaneous reports do note that no disc herniation was found, there is no indication whatever that claimant was admitted

for exploratory surgery related to a disc herniation, much less a disc herniation at L4-5. Dr. Golden did exactly what he planned to do. He did not go beyond the authorized surgical procedure. The fallacy of the majority's finding that Dr. Golden was only to do an exploratory surgery is underlined by Dr. Rosenbaum's testimony that the manner in which Dr. Golden performed the surgery, as described in his operative report, indicates that he went into surgery knowing that he was planning to do a full decompression for stenosis and not merely an exploration to determine whether or not there was a herniated disc at L4-5. (Tr. 49-50).

Having authorized and paid for decompression surgery for the compensable injury, the self-insured employer is responsible for its residuals. That responsibility does not evaporate because the self-insured employer denied stenosis when, a year later, claimant sought authorization for further surgery.

Claimant is severely disabled due to the residuals of the surgery combined with the stenosis. The two conditions, according to Dr. Rosenbaum, are inseparable. The entire condition must be considered. Weyerhaeuser Company v. Rees, 85 Or App 325 (1987). It would appear that, in light of his current condition, he is permanently and totally disabled.

In addition to denying claimant permanent disability compensation for a condition caused in part by surgery authorized and paid for by the self-insured employer, the majority also reduces claimant's temporary disability award by finding that he was medically stationary on October 11, 1984, a date based on Dr. Rosenbaum's post hoc estimation that claimant's strain injury had resolved by that time since most strain injuries resolve within six months. There is no evidence whatever that claimant had recovered from either the strain or the compensable surgery at that time, however. Consequently, I believe that we must find that the self-insured employer has failed to prove that claimant was stationary before November 3, 1986, as indicated by the Determination Order.

For these reasons, I cannot join my colleagues.

In the Matter of the Compensation of
ELIZABETH A. HALLBURTON, Claimant
WCB Case No. 89-10381
ORDER ON REVIEW
Roger J. Leo, Claimant Attorney
Paul G. Mackey, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Leahy's order that: (1) upheld the self-insured employer's denial of her occupational disease claim for mental stress; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm in part, and reverse in part.

FINDINGS OF FACT

Claimant has been employed as a Corrections Officer with the Multnomah County Sheriff's Office since December 1986. Her primary job duty was the supervision of inmates. Claimant was initially assigned to the Multnomah County Detention Center (MCDC) from April 1987 to November 1988. In November 1988

claimant was transferred to the Multnomah County Inverness Jail (MCIJ) performing similar duties until released from work by her physician for mental stress.

Claimant's job as a Corrections Officer was consistently stressful. At both facilities, claimant's job involved supervising a growing inmate population in overcrowded facilities. Eventually, at MCDC the overcrowding of inmates exceeded the facilities' capacity. The number of inmates for which claimant was personnally responsible grew over a period of time from a desired level of 30 to 40 inmates. Although these working conditions were stressful, claimant was able to cope in part due to the existence of good management and set procedures.

However, upon her transfer to a new facility, MCIJ, in November 1988, she encountered problems which although similar to those she experienced at MCDC, were intensified. Again, the facility experienced overcrowding. The overcrowding, in turn, caused confinement problems and excessive noise levels. Again, claimant was faced with supervising an increasing inmate population. Claimant's work load increased from a desired level of 40 inmates to 50 inmates, and by March of 1989, 60 inmates per Corrections Officer was being projected.

Although the MCIJ facility was designed and built for a inmate population requiring minimum supervision, in fact, many of the inmates housed at this facility were considered difficult to manage. Such prisoners required constant supervision. As a result, claimant was concerned for her personal safety. At the same time, claimant no longer had the necessary support structures for dealing with these problems. Management was splintered in that contradictory instructions were given by management. Nor did the MCIJ facility have set procedures for subordinate Officers to follow. Working in the MCIJ facility was generally considered more stressful by the Corrections Officers who worked there as compared to the MCDC facility.

As a consequence of these working conditions, claimant experienced heart palpitations when required to respond to a "body alarm" from a fellow employee requiring assistance. The rising inmate population caused claimant to experience feeling of inadequacy as she was no longer able to effectively do her job. She had a loss of appetite, and experienced sleeplessness. She had feelings of anxiety, fear, hopelessness and frustration.

On March 1, 1989, claimant sought treatment from Dr. Rega, an internal medicine specialist, for her above related symptoms. He diagnosed "major depression reaction" and prescribed anti-depressant medication and referred her to psychological counseling. On March 15, 1989, Dr. Rega, took her off work due to her psychological condition.

Claimant filed a claim for stress on March 21, 1989 with a occupational disease date of March 16, 1989.

In March 1989 claimant began attending mental health counseling sessions with Dr. Johnstone, a psychologist. Dr. Johnstone diagnosed "post-traumatic stress syndrome." Claimant has had three sessions with Dr. Johnstone.

Claimant's mental stress claim was denied by the employer on May 22, 1989.

As of the date of hearing, claimant had not returned to work.

Claimant is a credible witness, her testimony was supported by other lay witnesses.

Claimant had no preexisting psychological condition.

Off-work stressors included her relationship between immediate family members, notably an ill mother, a brother involved in drug abuse, and an adult daughter's involvement with drugs. Claimant has had some relationship difficulties with her boy friend. Finally, there is evidence of financial problems, including a past discharge in bankruptcy.

ULTIMATE FINDINGS OF FACT

Claimant's psychological condition arose out of and in the course of her employment as a Corrections Officer for the employer. The psychological condition required medical treatment, and resulted in disability.

Claimant's psychological condition was alternatively diagnosed as major depressive reaction, post-traumatic stress disorder, and adjustment disorder with mixed emotional features. Those conditions are generally recognized in the psychological community.

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

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

The employer's denial was supported by a legitimate doubt as to its legal liability for claimant's mental stress claim.

CONCLUSIONS OF LAW AND OPINION

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

This claim is for an occupational disease. Claimant's last exposure to potentially causal employment conditions occurred after January 1, 1988. As of March 15, 1989, claimant's psychological condition required medical services, and resulted in disability. We therefore apply ORS 656.802 as amended effective January 1, 1988, and before its amendment on July 1, 1990. Accordingly, claimant must establish that the employment materially contributed to the claimed psychological condition. Ellen L. Crawford, 41 Van Natta 1362 (1989); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Claimant was initially treated for her psychological condition by Dr. Rega. He noted that claimant experienced symptoms of fatigue, severe sleep disturbance, palpitations, weight gain, mild tremors, emotional distress, tearfulness, and feelings of hopelessness and frustration. His diagnosis was "major depressive reaction." Dr. Rega attributed this illness to a combination of work and off-work stressors.

Dr. Rega in his assessment relied on a complete medical history. He was aware of claimant's off work-stressors which included: (1) problems with the relationship with her boy friend; (2) problems with her daughter; (3) problems with her parent's illness; (4) a brother with a drug and alcohol problems; and (5) personal financial problems. It was his assessment that these off-work stressors did contribute to claimant's psychological condition.

With regard to work, he was familiar with claimant's job and the employment conditions. He was knowledgable about the fact that claimant was required to work in an environment dealing with a high volume work load. In particular,

he mentioned the extreme stress encountered by claimant in working with "worsening difficulties dealing with the inmate jail population." He opined that work significantly contributed to the precipitation of her depressive symptoms. (Exs. 26, 27).

Dr. Rega treated claimant's condition with an anti-depressant medication, and referred her to counseling. Claimant received mental health counseling from Dr. Johnstone, a resident psychologist under Dr. Zeedyk, a supervising psychologist, in order to deal with depression, anxiety, diminished responsiveness, difficulty concentrating, and stress. Dr. Johnstone reported similar symptoms as those noted by Dr. Rega, that of depression, extremely stressed, eating and sleep disturbances, tearfulness and anxiety. In addition, Dr. Johnstone reported that claimant also experienced headaches and stomach aches from the time she reported to work until she went to sleep at night.

Dr. Johnstone also was aware of claimant's stressful work conditions entailing an increasingly heavy work load while assigned to the MCIJ facility. Her diagnosis of claimant's condition was "post traumatic stress disorder." Dr. Johnstone opined a "strong causal connection between her symptoms and the working conditions at the jail." (Exs. 24, 28).

On April 21, 1989, claimant underwent an independent medical examination (IME) by Dr. Parvaresh, a psychiatrist. Dr. Parvaresh's findings are generally consistent with those of Dr. Rega and Dr. Johnstone. He had available a complete medical history and description of her working conditions. He noted the clinical findings of anxiety, depression, and problems with stress. In essence he concurred that claimant had suffered a psychological condition, although he felt that at the time of the IME claimant was medically stationary. He diagnosed her condition as "adjustment disorder of adulthood with mixed emotional features, currently in remission." With respect to causation he indicated claimant had been exposed to multiple stressors one being her working conditions. (Exs. 19, 25).

Accordingly, we find that the medical record supports, and the lay testimony corroborates, that claimant suffered a psychological condition arising in March 1989. Although the diagnoses differ, we note the symptoms have been consistently described by the three the medical experts who have seen her. Thus, we conclude claimant's psychological condition, regardless of the label, is a condition generally recognized in the psychological community. We also find that claimant's psychological condition arose out of her employment. The working conditions experienced at the MCIJ facility have been described as stress producing consistently by the lay witnesses and as well as the medical providers. These work conditions existed in a real and objective sense. We find support in Dr. Rega, Dr. Johnstone, and Dr. Parvaresh's opinions that these stressful working conditions were a material contributing cause of claimant's psychological condition.

The employer argues, and the Referee ultimately held, that the phrase "generally inherent in every working situation" means present in the claimant's particular job or occupation. This interpretation has been recently considered and rejected. In Kathleen M. Payne, 42 Van Natta 1900 (1990), we held that the phrase "generally inherent in every working situation" is meant to mean usually present in all jobs or occupations.

Based on our review of the record, we find that the stressful working conditions to which claimant was exposed as a Corrections Officer supervising an inmate population that was both increasing in numbers by sheer volume and increasing in the dangerousness of those prisoners is not generally inherent in every working situation.

Claimant has established by clear and convincing evidence that the psychological condition which caused her to leave work on March 15, 1989 arose out and in the course of her employment. Claimant's mental stress is compensable as an occupational disease.

Penalty and Attorney Fee

Based upon the factual information available at the time, and the uncertainty as to the meaning of former ORS 656.802(2)(b), we find that the employer had a legitimate doubt as to its legal liability for claimant's mental stress claim. We therefore conclude that the employer did not issue an unreasonable denial. See Norgard v. Rawlings, 30 Or App 999 (1977).

ORDER

The Referee's order dated October 30, 1989 is affirmed in part, and reversed in part. That portion of the order which upheld the employer's denial is reversed. The denial is set aside and the mental stress claim is remanded to the employer for acceptance and processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $4,950, payable by the employer.

October 25, 1990 Cite as 42 Van Natta 2434 (1990)

In the Matter of the Compensation of
ELIZABETH A. LEMMONS, Claimant
WCB Case No. 88-21857
ORDER ON REVIEW
Benton Flaxel, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of that portion of Referee Mongrain's order which: (1) found that her claim had not been prematurely closed; and (2) affirmed the Determination Order which had awarded no permanent disability in addition to the 20 percent (64 degrees) unscheduled permanent disability that claimant had previously received. On review, the issues are premature claim closure and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant's conversion reaction condition, and its disabling consequences, are not attributable to claimant's compensable claim.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's claim had not been prematurely closed and that claimant was not entitled to additional permanent disability. We agree with the Referee on both issues and adopt his opinion as our own.

Additionally, we note that the issues of premature claim closure and extent of permanent disability turn on claimant's conversion reaction condition. The Board has found this condition to be not compensable. Elizabeth Lemmons, 42

Van Natta 2397 (1990). Claimant, therefore, is not entitled to additional compensation for the conversion reaction condition or its sequela. Because the employer declined to file a cross-request to reduce the compensation awarded to claimant, we will not disturb the order of the Referee.

ORDER

The Referee's order dated November 15, 1989 is affirmed.

October 25, 1990 Cite as 42 Van Natta 2435 (1990)

In the Matter of the Compensation of
DANIEL MOHOFF, Claimant
WCB Case No. 88-14778
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of those portions of Referee Schultz's order which: (1) assessed a penalty and related attorney fee for an alleged unreasonable delay in payment of temporary disability benefits; and (2) awarded claimant's counsel an assessed attorney fee for prevailing against a "de facto" denial. In his respondent's brief, claimant cross-requests review of those portions of the order which affirmed a Determination Order that awarded no unscheduled permanent partial disability for a low back injury. On review, the issues are penalties and attorney fees and extent of permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

The insurer calculated claimant's time loss rate in error by using a 26-week average instead of his hourly wage as provided in the 801 form. This resulted in claimant experiencing a delay of compensation until the correct adjustment was made. As a result of the delay, $15.72 had been improperly withheld from claimant. The insurer did not offer any justification for the error.

Claimant received a total of 30 percent unscheduled permanent partial disability for a prior low back injury.

Claimant was involved in a motor vehicle accident in April 1988. He subsequently experienced neck and shoulder pain.

Claimant's mid-upper back condition is not related to the September 3, 1987 compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's mid-upper condition was a compensable consequence of the accepted low back claim. We disagree. With respect to the low back injury, the Referee found that as a factual matter claimant experienced no impairment. On procedural grounds, the Referee noted that ORS 656.222 requires consideration of prior awards of permanent partial disability. From a

prior award, claimant had received 30 percent unscheduled permanent partial disability for his low back. The Referee found insufficient evidence to award additional permanent partial disability. We agree.

Jurisdiction

The insurer argued that the Referee did not have jurisdiction to review the compensability issue as it had not previously been given notice of the mid-upper back claim. We disagree.

The insurer received notice of cervical, thoracic and lumbar strains in September 1987. (Exs. 2, 3A-2, 4). The insurer did not deny claimant's mid-upper back condition until at hearing on March 14, 1989. Hence, the insurer had ample time to investigate the mid-upper back condition, and consequently, can not claim prejudice in proceeding to hearing. Under the circumstances, the Referee had authority to consider the compensability of the mid-upper back condition which had been orally denied at hearing.

Claimant's claim had been closed by an August 12, 1988 Determination Order which awarded no permanent disability. Claimant was medically stationary on July 19, 1988. (Ex. 16). Claimant's hearing was held on March 14, 1989. Claimant's condition was still stationary at the time of hearing. Consequently, the Referee also had jurisdiction to rate the extent of unscheduled permanent disability. See Raymond E. Pardee, 41 Van Natta 548 (1989).

Compensability

Before proceeding to rate the extent of permanent disability, we must address the threshold issue of whether claimant's mid-upper back condition is related to the September 3, 1987 compensable injury.

The burden of proof is on claimant to show that the September 3, 1987 low back injury is a material contributing cause of the mid-upper back condition. Hutchenson v. Weyerhaeuser, 288 Or 51, 56 (1979); James v. Kemper Ins. Co., 81 Or App 80, 81 (1986). The causal connection between the September 1987 low back injury and the mid-upper back condition is a complex medical question that requires expert medical evidence. While claimant's testimony is probative, the resolution of this issue primarily turns on medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or 1105, 109 (1985).

In our de novo review of the medical evidence, we find that claimant's mid-upper back condition is not related to the September 3, 1987 incident.

In April 1988 claimant was involved in a motor vehicle accident. (Ex. 15, Tr. 49). The car in which claimant was a passenger was rear ended. Claimant experienced neck and left shoulder pain following the accident.

Dr. Hagen, chiropractor, reported on September 9, 1987 that claimant experienced upper back soreness. (Ex. 4). He did not indicate that these symptoms were related to the September 3, 1987 incident. Consequently, we do not find his opinion persuasive.

Dr. Bozarth, chiropractor, first examined claimant approximately a year and a half after the September 1987 incident. She acknowledged that claimant had experienced back pain prior to the September 3, 1987 incident. Bozarth linked claimant's mid-upper back pain to the September 3, 1987 incident. However, her opinion did not provide analysis as to the causal connection between the September 1987 incident and the mid-upper back pain. Nor does Dr. Bozarth

indicate knowledge of claimant's April 1988 motor vehicle accident and resulting neck and left shoulder pain.

In evaluating medical opinions, we give weight to those that are well reasoned and based on complete information. Dr. Bozarth's opinion does not indicate any knowledge of claimant's motor vehicle accident. Inasmuch as we find that Dr. Bozarth's opinion regarding causation is based on an inaccurate medical history, we decline to rely on her opinion. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

The record contains no persuasive evidence showing a material causal relationship between claimant's September 1987 incident and the mid-upper back condition. Under the circumstances, we conclude that claimant has not met his burden of proving that the September 3, 1987 incident was a material contributing cause of the mid-upper back condition. Hutchenson v. Weyerhaeuser, supra. Therefore, we do not include this condition in the rating of claimant's unscheduled permanent partial disability.

Extent of Unscheduled Permanent Disability

The Referee found that claimant had not experienced low back permanent impairment caused by the September 3, 1987 compensable injury. We agree.

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1). Former OAR 436-35-280(1) provides, "...There shall be no unscheduled disability if the injury did not result in impairment."

The opinions of Drs. Hagen, Parsons and Bozarth do not prove that claimant experienced permanent impairment.

Dr. Hagen first treated claimant for lumbosacral injuries suffered in 1981. Hagen did not offer an opinion on permanent impairment derived from the September 3, 1987 accident. (Ex. 4). Consequently, we do not find his opinion persuasive.

Dr. Parsons, neurologist, also treated claimant for back pain prior to the September 1987 injury. (Ex. 5). He released claimant to regular duty on December 8, 1987. Parsons concluded that claimant's impairment was undetermined. Parsons did not indicate what body part was impaired, or whether the impairment was related to the September 1987 injury. Accordingly, we do not find his opinion persuasive.

Only Dr. Bozarth opined that claimant experienced permanent impairment. (Ex. 18). However, her opinion did not explain why claimant's back symptoms rose to the level of permanent impairment. Bozarth's range of motion findings were related to claimant's cervical range of motion. (Ex. 18-2). We have already determined that claimant's cervical condition is not compensable. Under the circumstances, we do not find Dr. Bozarth's opinion persuasive.

Under these circumstances, claimant has failed to meet his burden of showing that he experienced compensable low back impairment related to the September 3, 1987 incident. We conclude that claimant was not entitled to an award of unscheduled permanent partial disability.

Assessed Attorney Fee for Prevailing on "De facto" Denial

The Referee awarded claimant an assessed attorney fee for prevailing on a "de facto" denial. We disagree. ORS 656.386(1) provides for an assessed fee where claimant finally prevails in a hearing before a Referee. Inasmuch as we have concluded that claimant's compensable low back injury did not materially contribute to claimant's mid-upper back condition, we find no basis for awarding an assessed attorney fee to claimant for prevailing on a denied claim.

Assessed penalty related attorney fee

The Referee in his "Conclusions and Opinions" portion of his order also indicated that claimant was entitled to an assessed penalty-related attorney fee for an alleged unreasonable denial. We disagree.

A written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge, is a claim. ORS 656.005(6). On September 14, 1987, the insurer received an 827 First Medical Report form which gave notice of claimant's mid-upper back condition. We find the 827 was sufficient notice of a claim.

The insurer had 60 days in which to accept or deny the mid-upper back condition. ORS 656.262(6). The insurer neither accepted nor denied the condition, until the time of hearing on March 14, 1989. At that time the insurer orally denied responsibility for the mid-upper back condition. This was more than 60 days after the insurer first had notice of the claim. Accordingly, we further find that the insurer unreasonably delayed accepting or denying claimant's mid-upper back claim.

However, despite the fact that the insurer's conduct was unreasonable, we find no "amounts then due" on which to base a penalty for failing to timely accept or deny claimant's upper back condition. We have found that this condition was not related to the compensable low back injury. Accordingly, there is no basis for a penalty. See ORS 656.262(10).

However, a penalty related attorney fee can be awarded in absence of a penalty if an insurer's action constituted an unreasonable resistance to the payment of compensation. See ORS 656.262(10); ORS 656.382(1); Ellis v. McCall Insulation, 308 Or 74 (1989). In this case, we have concluded claimant's mid-upper back claim is not compensable. Consequently, the delay in accepting or denying the claim was not an unreasonable resistance to the payment of compensation. See Lloyd L. Cripe, 41 Van Natta 1774 (1989). Claimant is not entitled to an assessed attorney fee.

Penalties and Attorney Fees for Unreasonable Delay of Temporary Disability.

We adopt the Referee's reasoning associated with this issue.

Inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for successfully defending the Referee's award on review. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated April 12, 1989, as amended April 26, 1989, is reversed in part and affirmed in part. That portion which awarded claimant's counsel a $2,150 attorney fee for prevailing on the "de facto" denial issue is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
WOODIE R. STRIPLIN, Claimant
WCB Case No. 89-04290
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Michael Johnson's order that upheld the insurer's denial of his medical services claim for his current low back condition. On review, the issue is medical services. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that a prior Board order (Woodie R. Striplin, 40 Van Natta 1301 (1988), aff'd Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989)) stated that claimant's current need for chiropractic services was related solely to his preexisting degenerative condition. Because claimant's condition had not changed since the earlier hearing, the Referee concluded that the Board's order precluded him from finding that the need for medical services was due to the compensable 1984 injury. We disagree.

Claimant argues that Referee Johnson was not bound by the order because the Board only affirmed the prior Referee on procedural grounds. In the first paragraph of the order, the Board stated that, because the denial was procedurally improper, "we do not reach the merits of the claim." Claimant contends that, because the Board's finding of fact that the treatment was not related to the injury was not essential to the final judgment, the decision on that determinative fact should not be conclusive in a later action. See North Clackamas School Dist. v. White, 305 Or 468 (1988).

We agree with claimant's argument that the Board's prior order was not based upon the merits of the case. Because the order was predicated upon procedural grounds, we do not find that claimant is bound by the language in the order which found that his need for medical services was not due to his compensable injury. Accordingly, we address claimant's medical services claim on the merits.

The Referee found that the only medical opinion that supported claimant's need for chiropractic treatment was provided by Dr. Llewellyn, the treating chiropractor. The Referee concluded that Dr. Llewellyn's opinion was not persuasive. We agree.

From June 1985 up until the time of hearing, Dr. Llewellyn has continued to maintain that claimant's treatment is related to the compensable injury and is reasonable and necessary. Dr. Llewellyn has also opined that claimant continues to improve and that he responds well to treatment.

In May 1985, Dr. Peterson, chiropractor, examined claimant and diagnosed a lumbar strain and moderate degenerative disc disease at L5-S1. Dr. Peterson opined that claimant was medically stationary and he concluded that frequent chiropractic care would not hasten his recovery. In April 1986, Dr. Peterson reported that the chiropractic treatment provided to claimant by Dr. Llewellyn was excessive.

In May 1986, the Independent Chiropractic Consultants also diagnosed lumbar strain and moderate degenerative disc disease. The Consultants found no impairment due to claimant's 1984 injury and they concluded that further care or treatment was not necessary.

In August 1987, Dr. Peterson reported that he found no change in claimant's disc space from earlier films. Dr. Peterson concluded that the injury of 1984 and aggravation of 1985 had not worsened claimant's condition. Dr. Peterson found no permanent impairment from claimant's industrial injury.

In September 1987, Dr. Peterson reported that chiropractic care should have been discontinued. Dr. Peterson opined that claimant's present condition was due to degenerative joint disease attributable to poor muscle tone and aging. In November 1987, the Independent Chiropractic Consultants concurred with Dr. Peterson's reports.

In March 1988, Dr. Raaf, M.D., reviewed claimant's past medical records and opined that his condition was due to arthritis and degenerative disc disease which preexisted the 1984 industrial injury. Dr. Raaf reported that claimant's injury and exacerbations temporarily increased his symptoms but did not increase the pathology due to the arthritis and disc disease. Dr. Raaf also opined that continued chiropractic care was not reasonable or necessary.

In March 1988, the Orthopaedic Consultants diagnosed preexisting lumbosacral strain and preexisting minimal to mild degenerative joint disease of the lower back. The Consultants opined that claimant's low back condition was probably stable, although it could continue to bother him in the future. The Consultants reported that claimant apparently obtained some relief from his present palliative therapy.

We conclude that the weight of the medical evidence shows that claimant's current condition is not related to his compensable 1984 injury. Accordingly, we find claimant's chiropractic treatments are not compensable.

ORDER

The Referee's order dated August 8, 1989 is affirmed.

In the Matter of the Compensation of
BENJAMIN B. BRACKIN, Claimant
WCB Case No. 89-00837
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Mongrain's order that upheld the insurer's denial of claimant's low back injury claim on the basis that the claim was barred because of untimely filing. On review, the issues are timeliness of the claim and compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

ULTIMATE FINDINGS OF FACT

The employer had knowledge of claimant's injury and its relationship to his work activities on the date that it occurred.

The June 1986 lifting incident was a material contributing cause of claimant's low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's low back injury claim was barred by claimant's failure to give the employer written notice within 30 days of the accident and that his untimeliness was not excused under ORS 656.265. We disagree.

ORS 656.265(1) requires that notice of an accident resulting in an injury be given to the employer within 30 days. ORS 656.265(4)(a) provides that failure to give such notice bars a claim unless "[t]he employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice[.]" The knowledge of the injury "must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury" and "should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate." Argonaut Ins. Co. v. Mock, 95 Or App 1, 5 (1989).

Here, claimant told his boss about the lifting incident at work and asked for the "papers" to fill out a claim. The knowledge of a person in a supervisory capacity can be imputed to the employer. Colvin v. Industrial Indemnity, 301 Or 743 (1986). While claimant did not fill out those papers or immediately seek medical treatment, he did notify the employer of a possible work related injury. Given those facts, we conclude that a reasonable employer would believe that workers' compensation liability was a possibility.

We conclude that claimant has proved that his employer had sufficient knowledge of the injury to excuse his untimely notice Because we conclude that the employer had the requisite knowledge, we need not address the question of prejudice. Argonaut Ins. Co. v. Mock, supra.

The Referee also found that, if claimant's claim was not barred because of untimely filing, his claim was compensable. We hold that his claim is not barred and adopt the conclusions and reasons regarding compensability as set forth in the Referee's order.

Claimant's counsel is entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review for ultimately prevailing on the issue of compensability. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $2,000 is a reasonable assessed fee for claimant's counsel's efforts. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue presented, and the value of the interest involved.

ORDER

The Referee's order dated August 17, 1989, as reconsidered October 16, 1989, is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded a $2,000 assessed attorney fee, payable by the insurer.

In the Matter of the Compensation of
MIKE RICE, Claimant
WCB Case No. 89-04305
ORDER ON REVIEW (REMANDING)
David Fowler (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Tenenbaum's order which dismissed his hearing request because claimant failed to appear at hearing. Claimant seeks to have the dismissal set aside, and an order remanding the case to the Hearings Division for a hearing by telephone. On review, the issue is dismissal. We remand.

FINDINGS OF FACT

Claimant requested a hearing on a denial of an aggravation of his low back injury. The hearing was set for June 2, 1989.

Claimant failed to appear for the hearing, asserting that he could not afford to travel to Oregon from Nevada, and requested a hearing by telephone. Claimant was represented at hearing by his attorney.

CONCLUSIONS OF LAW AND OPINION

The Referee entered a dismissal order and a subsequent order denying reconsideration, reasoning that claimant failed to appear at the June 2, 1989 hearing, and that claimant's personal appearance was necessary in order to properly and fully evaluate the testimony. We reverse and remand.

The Referee relied on former OAR 438-06-071 which authorizes a Referee to dismiss a request for hearing for "failure of a party, or the parties' representative to appear at the time and place scheduled for a hearing." Claimant personally failed to appear. However, claimant did appear by counsel. In Williams v. SAIF, 99 Or App 367 (1989), the Court of Appeals held that former OAR 438-06-071 does not provide authority for dismissal for failure of a claimant to appear at hearing if claimant's attorney appears on his behalf. On review, the Supreme Court reversed and remanded. 310 Or 320 (September 20, 1990). The Court concluded that the Referee and the Board had relied on former OAR 438-06-085, rather than former OAR 438-06-071, in dismissing claimant's hearing request. The Court affirmatively noted that it expressed no opinion regarding the Court of Appeals' interpretation of former OAR 438-06-071. Consequently, the Court of Appeals' discussion of former OAR 438-06-071 was dicta.

Nevertheless, we are persuaded that the Court of Appeals' dicta in Williams v. SAIF, supra, regarding the application of former OAR 438-06-071 is correct and we continue to apply that interpretation to cases involving the rule. Jose Arisqueta-Martinez, 42 Van Natta 2072 (September 27, 1990). Accordingly, we find the Referee was without authority to dismiss.

Claimant requested reconsideration of the Referee's dismissal, contending that he could not afford to travel from Nevada to Oregon for the hearing, and requesting that his testimony be taken by telephone. Former OAR 438-07-022, in effect at the time of hearing, provides that a lay witness must testify by personal appearance unless unable to attend the hearing due to extraordinary circumstances beyond the offering party's control and either; 1) all parties and the referee agree or 2) the referee finds that the witness' testimony should be taken by other than personal appearance. Under that rule, a

determination must first be made as to whether a witness is unable to attend the hearing due to extraordinary circumstances beyond the control of the party offering the testimony. Such a finding has not been made.

We remand this matter to the Referee for a hearing and a determination of whether claimant demonstrated extraordinary circumstances and either of the other requisites which would allow taking testimony by telephone. At hearing the referee shall determine what other evidence may be received. However, absent a showing of grounds sufficient for postponement of the original hearing, no exhibits shall be received which were not submitted in connection with the prior hearing, nor shall any witness, including claimant, be permitted to testify who was not available to and planning on testifying at the prior hearing or under subpoena to testify at that hearing.

ORDER

The Referee's Order of Dismissal dated June 12, 1989, as reconsidered on August 4, 1989, is vacated and the case is remanded to the Referee for further proceedings consistent with this order.

October 26, 1990 Cite as 42 Van Natta 2443 (1990)

In the Matter of the Compensation of
BRENDA M. WINSHIP, Claimant
WCB Case No. 88-11672
ORDER ON REVIEW
Minturn, et al., Claimant Attorneys
Lane Powell, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Nichols' order that: (1) set aside its July 1, 1988 partial denial of claimant's current "neuropathic-myopathic process of the cervical region and upper extremities" condition; (2) set aside its August 22, 1988 partial denial of claimant's current "thoracic outlet syndrome" condition; and (3) assessed penalties and related attorney fees for an alleged unreasonable July 1, 1988 partial denial. Claimant in her brief, cross-requests review of that portion of the Referee's order which declined to assess penalties and related attorney fees for an alleged unreasonable August 22, 1988 partial denial. On review, the issues are compensability and penalties and attorney fees. We affirm in part, and reverse in part.

FINDINGS OF FACT

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

On September 30, 1987, claimant filed a claim. The 801 claim form listed July 24, 1987 as the date of injury/onset of disease. The nature of the injury/disease indicated "strain," and the location referred to "hands, shoulders, arms, and neck," both right and left. Additionally, in the comments section of the 801, claimant stated:

> "Pain started 2 months ago, have lost about 2 or 3 days of work from this pain in hands, arms, shoulders and neck. It starts out slow and by friday after 30 to 40 hours of sewing they (body parts) feel strained. I can not pick up or hold very much weight at all. I feel it's progressing as each day I pull this material around."

The claim was deferred on the face of the 801.

Claimant has not been able to work due to her pain symptoms since October 1987.

On November 2, 1987, the insurer issued a "Notice of Claim Acceptance" formally accepting "cervical (neck) injury."

On July 1, 1988, the insurer issued a partial denial. The partial denial accepted "cervical strain" and denied claimant's "neuropathic-myopathic process of the cervical region and upper extremities."

On August 22, 1988, the insurer issued a second partial denial. This partial denial accepted "cervical strain injuries" and denied claimant's "thoracic outlet syndrome."

Claimant was a credible witness.

ULTIMATE FINDINGS OF FACT

We reject the Referee's "Ultimate Findings of Fact" and make our own.

The compensable 1987 cervical claim was the major contributing cause of claimant's current condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that Georgia Pacific v. Piwowar, 305 Or 494 (1988) precluded the insurer from attempting to deny claimant's "neuropathic and myopathic process of the cervical and upper extremities" as the underlying disease of claimant's accepted cervical claim. Thus, she concluded that the July 1, 1988 partial denial was an impermissible back up denial. The Referee also found that the August 22, 1988 partial denial of claimant's thoracic outlet syndrome was procedurally proper. Proceeding to the merits, she analyzed claimant's thoracic outlet syndrome condition as an occupational disease, and found claimant's condition compensable.

We agree that claimant's condition, whether diagnosed as a neuropathic and myopathic process or, in the alternative, as a thoracic outlet syndrome is compensable. Therefore, because we find that claimant's current condition to be compensable, we do not consider the procedural validity of the July 1, 1988 or August 22, 1988 partial denials.

We proceed to the merits. As an initial matter, we must first consider whether to analyze claimant's claim as an occupational disease or as an accidental injury. We note that the insurer in its notice of acceptance, accepted the claim as a cervical injury. However, we are not required to consider claimant's accepted claim as an "injury" where the facts indicate its proper classification is as an occupational disease. See ORS 656.804.

The two prong test for distinguishing between an industrial injury and occupational disease requires a determination whether the claimed medical condition was unexpected or expected, and whether the onset was sudden or gradual. Valtinson v. SAIF, 56 Or App 184 (1982); O'Neal v. Sisters of Providence, 22 Or App, 16 (1975); Patrick Horstman, 42 Van Natta 1288 (1990).

Here, claimant was employed as a seamstress operating a power machine sewing tents and sleeping bags. The job required extensive repetitive movements involving her hands, wrists, arms, shoulders, and cervical area. Claimant credibly testified that her work as a seamstress caused her pain symptoms, and that these symptoms developed over a long period of time. Typically, at the end of her thirty to forty hour work week, her symptoms would be severe. Finally, in October 1987, claimant was no longer able to work due to the continually worsening symptoms.

Thus, we conclude that claimant's condition is not the result of a "sudden onset" of symptoms. We note the absence of any reported trauma occurring over a "discrete period of time," and further that initial reporting of the claim strongly suggests an occupational disease. Claimant's credible testimony is supported by the medical record in establishing that claimant's condition was gradual and progressive. Consequently, claimant's July 24, 1987 cervical "claim" does not satisfy the "sudden in onset" requirement. Accordingly, her claim should be analyzed as an occupational disease rather than an accidental injury.

Inasmuch as claimant's last exposure to work activity that could have contributed to her condition occurred prior to the January 1, 1988 legislative enactment, prior law applies. Therefore, in order to establish that the current condition is compensable, claimant must prove by a preponderance of the evidence that her work activities, when compared to her nonwork exposure, were the major contributing cause of the onset or worsening of her current condition. See former ORS 656.802(1)(a); Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985).

The medical record indicates that claimant's current condition has not been definitively diagnosed by either her treating physicians or by independent medical examiners. Initially, a diagnosis of bilateral carpal tunnel syndrome was entertained. This was followed by other potential diagnoses including, but not limited to, cervical radiculopathy and neuropathic and myopathic process, and thoracic outlet syndrome.

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). It is not a necessary predicate to compensability that the medical experts know the exact mechanism of the disease. Robinson v. SAIF, 78 Or App 581 (1986); Candace M. Griffin, 42 Van Natta 624 (1990). Without a specific diagnosis, it is difficult to be certain that claimant's work is the major contributing cause of her disability. Certainty, however, is not the degree of proof required; preponderance of the evidence is. International Paper Company v. Tollesfson, 86 Or App 706 (1987). In any event, the causation issue, as opposed to the question of diagnosis, must be resolved. Stewart E. Myers, 41 Van Natta 1985 (1989). Further, this issue is of sufficient medical complexity as to require expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

In this regard, claimant's treating physician, Dr. Eckman opines that her work activities were related to her condition. In contrast, Dr. Porter, an independent medical examiner, concluded that claimant's condition is best described as a pain symptom complex with unknown etiology. In weighing the conflicting medical opinions, we note that Dr. Eckman's position is supported by

the opinions of Dr. Anderson and Dr. Goldsmith. Therefore, we find, as did the Referee, that the opinion of Dr. Eckman to be better reasoned and more persuasive. Inasmuch as Dr. Eckman attributed claimant's current condition to her work activities and not to any nonwork cause, we find that the major contributing cause of her condition is her work activity. The claim is, therefore, compensable. See Candace M. Griffin, supra.

Penalties and related attorney fees

The Referee on procedural grounds determined the issuance of the July 1, 1988 denial to be unreasonable, and assessed an attorney fee. Additionally, on appeal claimant argues penalties and related attorney fees are warranted for an alleged unreasonable August 22, 1988 partial denial. We disagree.

In light of the fact that at the time the insurer issued the denials there was considerable uncertainty among the medical experts in the diagnosis of claimant's condition, we do not find the conduct of the insurer to be unreasonable.

Claimant also contends the August 22, 1988 partial denial was unreasonable because the insurer failed to accept or deny the claim within the required 60 days. See former ORS 656.262(6). With regard to timeliness, a tentative and speculative diagnosis of thoracic outlet syndrome was first made by Dr. Anderson in November 1987, but discounted a month later by Dr. Wiest. Contemporaneous with these diagnoses were others, as medical opinion was deeply divided concerning the causation of claimant's condition. Finally, in July 1988 another diagnosis was made of thoracic outlet syndrome by Dr. Eckman. This diagnosis was rendered with conviction, as by this time additional testing and medical analysis had been accomplished. Accordingly, we consider Dr. Eckman's July 17, 1988 report to be notice of claim, and find the denial issued timely within 60 days of the insurer's receipt of Dr. Eckman's report. Thus, we find there has been no unreasonable delay in processing claimant's claim for thoracic outlet syndrome.

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

ORDER

The Referee's order dated November 1, 1988, is affirmed in part, and reversed in part. The Referee's assessment of a penalty for an unreasonable July 1, 1988 partial denial is reversed. Claimant's penalty-related assessed attorney fee of $250 is reversed. The remainder of the order is affirmed. For services on Board review regarding compensability, claimant's attorney is awarded an assessed fee of $700, payable by the insurer.

In the Matter of the Compensation of
CLARA P. BRUMLEY, Claimant
WCB Case No. 89-04686
ORDER ON REVIEW
Black, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of Referee Brown's order that set aside its partial denial of claimant's claim for her cervical condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings," with the exception of the findings numbered (9) through (12). We find the following additional facts.

After her May 1987 work-related injury, claimant's neck pain continued to improve. Between October 1987 and March 1988, claimant did not report neck pain.

Following an August 11, 1988 auto accident, claimant's condition was diagnosed as "cervical hyperextension injury," due to the auto accident. In January 1989, Dr. Purtzer diagnosed a "huge anterial lesion at C4-5, consistent with a large herniated cervical disc."

CONCLUSIONS OF LAW AND OPINION

The Referee did not find any of the doctor's opinions to be persuasive. However, he concluded that claimant's credible testimony and the record as a whole established that her compensable injury remained a material contributing factor to her current need for surgery. We disagree.

SAIF argues that, because an intervening injury was involved, the issue is a complex medical question that requires a doctor's opinion to support claimant's theory of compensability. After her industrial injury in May 1987, chart notes indicate that claimant's neck pain was continuing to improve and she had few symptoms in the area, along with full range of motion of the cervical spine. In July and October 1987, Dr. Campagana noted neck pain. From that time until March 1988, none of the records indicate neck pain. In March 1988, a chart note recorded claimant's neck pain. In May 1988, a chart note mentioned claimant's "occasional neck pain."

On August 11, 1988, claimant was involved in an auto accident. Her condition was diagnosed as "cervical hyperextension injury" due to the auto accident. In January 1989, Dr. Purtzer diagnosed "a huge anterial lesion at C4-5, consistent with a large herniated cervical disc." Dr. Purtzer recommended surgery.

In February 1989, Dr. Purtzer wrote that he could not date the onset of the lesion. He believed that there was a possibility that the disc ruptured with her industrial injury, but he also opined that it may have been related to her auto accident.

In March 1989, Dr. Dunn reported that claimant's neck symptoms had been present since the time of her original injury and the disc had evolved on a very slow basis. However, Dr. Dunn wrote that he was not aware of any specific

instance that had occurred since claimant's original injury that could have contributed to her condition.

In April 1989, Dr. Purtzer reported that he had reviewed claimant's records and still believed that there was a distinct possibility that claimant's current condition was related to her industrial injury. Dr. Purtzer wrote that the condition was slowly progressive and could not be proved with certainty.

In June 1989, Dr. Purtzer checked the "yes" box in response to a question that asked: "If you assume that claimant complained of a May 1987 neck injury and has suffered continuous neck symptoms since that time, is it your medical opinion that her present need for medical services and disability is probably related to the May 1987 injury?"

In July 1989, Dr. Kho wrote that the most probable explanation of the herniated disc was cervical spondylosis, and, as mentioned by Dr. Dunn, slow evolvement of the condition was most likely aggravated by her 1988 auto accident. He agreed that claimant's condition was, in all medical probability, degenerative in nature, and would probably even have occurred in the absence of the industrial injury.

In July 1989, Dr. Woolpert wrote that claimant's neck symptoms had resolved (after her work accident) and her next cervical complaints of significance were not until about 10 months after the auto accident. Dr. Woolpert opined that, in order to cause a ruptured disc, he would have expected sufficient trauma to cause symptoms of tightness, spasm, and restricted range of motion, none of which were present in this case. Dr. Woolpert opined that it was probably unlikely that claimant's current problems were related to her 1987 injury.

We agree with the Referee's conclusion that none of the medical opinions are persuasive. We are also unable to find that the medical opinions, whether considered individually or as a whole, are sufficient to prove that claimant's original injury remains a material contributing cause to her current need for treatment.

Finally, although the Referee found claimant to be a credible witness, we conclude that this matter involves a complex medical question, due to the intervening auto accident in which claimant sustained a second cervical injury. See Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Under the circumstances, claimant's testimony alone is not sufficient to persuade us of the necessary causal connection between her current condition and her compensable 1987 neck injury. See James A. Ross, 41 Van Natta 250 (1989). We conclude that claimant has not proven by a preponderance of the evidence that her 1987 work-related injury is a material contributing cause of her existing disability or need for medical treatment.

ORDER

The Referee's order dated September 22, 1989 is reversed. The SAIF Corporation's February 28, 1989 denial is reinstated and upheld. The Referee's award of an assessed fee of $2,000 is reversed.

In the Matter of the Compensation of
ROBERT E. CAIN, Claimant
Own Motion No. 90-0041M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for additional medical benefits related to his January 27, 1964, injury. Claimant's aggravation rights have expired. Claimant is requesting reimbursement to his family for medical insurance premiums paid because of difficulties encountered in reopening his 1964 claim.

In cases involving pre-1966 injury claims, as here, we may exercise our "own motion" authority to reopen a claim for payment of further medical benefits. ORS 656.278(1)(b). After review of the record, we conclude that claimant's request for reimbursement of the payments made for "group" medical insurance coverage in the amount of between $8,000 and $9,000 is not a claim for "medical services". The Board can only authorize reimbursement of "medical services", i.e., medication, prosthesis, surgery, etc. The premiums paid for a group insurance policy to provide medical coverage of surgery and additional medical benefits were not "medical services". Therefore, claimant's request for reimbursement is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILMA F. MACAITIS, (Deceased), Claimant
WCB Case Nos. 88-08605 & 87-06841
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The Personal Representative of the deceased claimant's estate requests review of Referee Emerson's order that: (1) dismissed claimant's request for hearing; and (2) upheld the SAIF Corporation's denial of a burial allowance. On review, the issue is standing.

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

We agree with the Referee that there is no "person," under ORS 656.218(3), who may pursue claimant's previous request for hearing. Therefore, the Referee correctly dismissed that request.

As to the subsequent request for hearing and on the merits, we note that here there is no "unpaid award," so that the lesser of the unpaid award (zero) and the burial expenses is zero. See ORS 656.218(5). Therefore, the Referee correctly upheld SAIF's denial of a burial allowance.

ORDER

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

In the Matter of the Compensation of
AUDREY RUDD, Claimant
WCB Case No. 89-07280
ORDER OF ABATEMENT
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

The Board has received the self-insured employer's October 15, 1990 "Motion for Clarification" of our Order on Review dated October 9, 1990.

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 10 days from the date of this order. Thereafter the Board shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM A. BURT, Claimant
WCB Nos. 87-14262, 87-19512, 88-00583, 88-00587, 88-04786, 88-18591 & 89-02307
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Schwabe, et al., Defense Attorneys
David Smith (Saif), Defense Attorney
Meyers & Radler, Defense Attorneys
Davis & Bostwick, Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Acker, Underwood, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

United Employers Insurance Company (United), on behalf of Thriftee Thriftway, requests review of that portion of Referee Shebley's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld the denials of claimant's new injury claim for the same condition issued by CNA Insurance Companies on behalf of Kelly Services Inc., by Anderson Forge, a self-insured employer, by the Travelers Companies on behalf of A.C. & S., by Safeway Stores, a self-insured employer, by the SAIF Corporation on behalf of Performance Industries, by the SAIF Corporation as a processing agent for Adams Landscape Service (Adams), a noncomplying employer, and by the SAIF Corporation on behalf of Princeton Property Management (Princeton). On review, the issues are compensability, responsibility and the propriety of United's denial. We reverse.

FINDINGS OF FACT

Claimant worked for Thriftee Thriftway from September 1980 through November 1985. He sustained a compensable lumbosacral strain in 1981. The claim was accepted by United as insurer of Thriftee. Claimant was treated conservatively.

Claimant worked for approximately a month and one-half at Anderson Forge from December 1985 through January 1986.

Claimant worked for A.C.& S., Inc. in October 1986.

Claimant worked for Kelly Services, Inc. from October 1986 through December 1986.

Claimant worked for Safeway Stores as a freight handler from December 1986 through February 1987.

Claimant worked for Performance Insulation for three weeks in March 1987.

Claimant worked for Princeton Property Management performing landscaping work on July 12, 1987 and July 29, 1987. After performing his last task for Princeton on July 29, he proceeded to work for Jeff Adams.

Claimant worked for Jeff Adams performing landscaping work between April 20, 1987 and July 29, 1987.

Claimant was seen by Dr. Banker, claimant's treating chiropractor, on May 16, 1987.

Claimant underwent a diskectomy on June 10, 1988 for a left herniated disc at L5-S1.

On September 4, 1987, United responded to claimant's July 31, 1987 aggravation claim by denying further temporary disability benefits on the ground that the five year aggravation period had expired.

On December 2, 1987, United denied responsibility for claimant's back condition.

Claimant's subsequent employers have also denied compensability of, and/or responsibility for, his worsened back condition.

FINDINGS OF ULTIMATE FACT

Claimant's work activity at Thriftee Thriftway was a material contributing cause of his worsened back condition.

Claimant's work exposure at Adams last independently contributed to a worsening of his back condition.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

The Referee held that in order for claimant to prevail against any employer subsequent to Thriftee Thriftway, the record must establish that claimant's more recent work activities materially contributed to a worsening of his underlying back condition. The Referee concluded that claimant was not credible and, therefore, that the medical evidence was insufficient to show that any of claimant's work activities since his 1981 compensable injury materially contributed to the worsening of his condition. Consequently, he held United responsible. On review, United agrees with the Referee that the controlling law is stated in Hensel Phelps Const. v. Mirich, 81 Or App 294 (1986). However, United contends that the medical evidence is reliable notwithstanding claimant's questionable credibility and that it establishes that landscaping work with subsequent employers independently contributed to claimant's degenerative disc condition. United argues that, if it is impossible to determine which landscaping work actually caused the worsening, the last employer for whom he performed landscaping work is responsible. We agree and reverse.

This case involves an accepted compensable injury with United's insured followed by an increase in disability during employment with later employers/insurers. In such a case, United as the employer/insurer which accepted the

claim, remains responsible if the increase in disability is simply a continuation of his prior problems. If, however, a later employment independently contributed to a pathological worsening of the accepted condition, then responsibility shifts. Crowe v. Jeld-Wen, 77 Or App 81 (1985); Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795 (1985); see Hensel Phelps Const. v. Mirich, supra. The last carrier is responsible for claimant's disability and medical treatment if the injury or the work activities at the time it is on the risk independently contributed, even slightly, to a worsening of claimant's underlying condition. Hensel Phelps Const. v. Mirich, Id. (emphasis supplied).

Finding that claimant lacked credibility, the Referee held United responsible. The relationship between claimant's work activity and his 1987 disc problems presents a complex medical question. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1986). Therefore, we rely on medical evidence, based on reliable history, in determining whether claimant's work activity after he left Thriftway independently contributed to a pathological worsening of his back condition.

On review SAIF, on behalf of Adams, argues that the parties have stipulated that claimant's last employment was at Princeton. The evidence establishes that claimant's last employment of the type that contributed to the worsening of his condition was with Adams Landscape Service. During July 1987, claimant lived in an apartment complex managed by SAIF's insured, Princeton. On several occasions he performed landscaping work at the complex for Princeton. Claimant's apartment manager testified by deposition that on July 29, 1987, claimant stopped at the apartment complex to remove a tree; this was the last time claimant worked for Princeton. She further testified that claimant then continued on to complete landscaping work for Adams Landscape Service. This testimony persuades us that claimant's last employment exposure was with Adams. There is no contrary testimony in the record. We are not bound by the stipulation to the contrary. SAIF v. Casteel, 301 Or 151 (1986); Norris and Norris, 302 Or 123, 126 n. 3 (1986); See Brenda Hinkle, 40 Van Natta 1660 (1988). Consequently, based on the unrebutted testimony, we find that claimant's last employment was with Adams.

We further find that claimant's work with Adams independently contributed to a worsening of his degenerative disc condition.

Claimant's treating physician, Dr. Banker, stated on March 25, 1988 that claimant's post-Thriftway work activities independently contributed to his degenerative disc process. Dr. Banker clarified his opinion on December 15, 1988, reporting that claimant experienced an exacerbation of his low back condition during the time he worked as a commercial landscaper from some time in early May 1987 until mid to late July 1987. He opined that the cumulative affect of the bending and lifting claimant performed as as landscaper at least hastened his disc herniation.

On review SAIF, on behalf of Adams, argues that Dr. Banker had an incomplete history because claimant is an unreliable historian and Banker's opinion is based on the false assumption that claimant's work as a commercial landscaper required much lifting and bending. However, even though he did not specifically name claimant's employers, Banker was aware of the type of work claimant performed when claimant worked for Adams and for Princeton, indicating that it was "heavy work." Thus, Dr. Banker had an accurate history of heavy work. His opinion is persuasive evidence that claimant's employment exposure with Adams independently contributed to a pathological worsening of his back condition.

Dr. Banker's opinion is supported by that of Dr. Snodgrass, neurologist. Dr. Snodgrass reported on November 4, 1987 that the wear and tear from claimant's job activities subsequent to his employment with Thriftee contributed to his disc herniation. At this point Dr. Snodgrass was unaware of claimant's specific employment with Adams but felt that claimant's final worsening occurred while doing landscaping in June 1987.

United's attorney then sent Dr. Snodgrass a letter describing claimant's work activities after his employment with Thriftee. This included claimant's job with Princeton, but not with Adams. After receipt of this information, Dr. Snodgrass opined on November 19, 1987 that claimant's work activities after his job at Thriftee independently contributed to a worsening of his degenerative disc process. Although he was unaware of claimant's specific employment activity with Adams, the thrust of his opinion suggests that if Dr. Snodgrass felt that claimant's employment at Princeton contributed to a pathological worsening of his condition, it follows that similar activities carried out by claimant for Adams over a longer period of time would likewise be a contributing factor. Therefore, we find Dr. Snodgrass' opinion to be supportive of a conclusion that claimant's work with Adams contributed to a pathological worsening of his condition.

SAIF argues further that because claimant did not experience any particular incident with Adams causing a worsening of his condition, there is insufficient evidence to prove that his condition worsened after his employment with Thriftee.

Under Oregon law, the fact that no single incident precipitated claimant's worsened back condition does not have any bearing on whether a subsequent employer is liable in a responsibility case. Hensel Phelps Const. v. Mirich, supra. Persuasive evidence reflecting a worsening of claimant's condition attributable to routine work activity is all that is required to shift responsibility to the later employers. Id.

In sum, the opinions of Drs. Banker and Snodgrass persuade us that claimant's work at Adams independently contributed to a pathological worsening of his back condition. Therefore, Adams is responsible for claimant's need for surgery. Accordingly, the Referee's order is reversed.

Preclosure/Back-up Denial

On review SAIF, on behalf of Adams, argues that at the time of United's denials claimant's 1981 claim against Thriftee had not been closed and United's denials were, therefore, improper preclosure denials. Roller v. Weyerhaeuser, 67 Or App 583 (1984); Safstrom v. Reidel International, Inc., 65 Or App 728 (1983). We disagree.

Claimant filed his aggravation claim on July 31, 1987. United responded to the aggravation claim on September 4, 1987. That response was a letter advising claimant of his rights and referring the temporary disability compensation portion of the claim to the jurisdiction of the Workers' Compensation Board's Own Motion Division. This is reflected in claimant's attorney's request of the Board to review the matter under its Own Motion jurisdiction. Therefore, United's September 4, 1987 correspondence does not constitute a denial of compensability.

On December 2, 1987, United properly issued a denial of responsibility, expressly stating that this was not a denial of compensability.

SAIF's denials did not violate the case law cited by SAIF. Roller and Safstrom, supra, involved disability claims where the employer initially accepted compensability for a claim and then later attempted to deny compensability prior to closing the accepted claim. No injury related to subsequent employment was at issue. Whether or not closure was required for the 1981 injury prior to a denial of compensability does not affect United's right to raise the responsibility question. Compare Stephanie L. Vollendroff, 42 Van Natta 945 (1990), with Mason L. Asbury, 38 Van Natta 961 (1986). Therefore, United's denial was properly issued.

Adams argues further that because more than sixty days had passed from the issuance of United's denial of reopening for time loss until United issued its denial of responsibility, United issued an impermissible back-up denial. Bauman v. SAIF, 295 Or 788 (1983). We disagree.

In Bauman, the carrier attempted to deny a previously accepted condition. United's issuance of the denial of temporary disability compensation was not an acceptance of the low back condition. Consequently its later clarification of the denial as a denial of responsibility only was procedurally legitimate under Bauman.

ORDER

The Referee's order dated April 24, 1989 is reversed in part and affirmed in part. United Employers Insurance Company's denial is reinstated and upheld. The SAIF Corporation's denial as processing agent for the noncomplying employer, Adams Landscape Service, is set aside, and the claim is remanded to SAIF for processing according to law. The remainder of the order is affirmed.

October 30, 1990 Cite as 42 Van Natta 2454 (1990)

In the Matter of the Compensation of
RICHARD A. COLCLASURE, Claimant
WCB Case No. 88-15666
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Rankin, et al., Defense Attorneys

Reviewed by Board Members Myers, Gerner and Crider.

The self-insured employer requests review of Referee Leahy's order which found claimant eligible for vocational assistance and which awarded claimant an attorney fee. On review, the issues are whether the Referee was correct in reversing the Director's order finding that claimant is not eligible for vocational assistance and attorney fees.

BACKGROUND

Claimant has a compensable claim for a back injury which occurred in August 1982. The claim was initially closed by Determination Order of September 6, 1984 with an award for 10 percent unscheduled disability. Claimant returned to regular work with the modification that he not pull out bleachers. Occasionally, claimant helped other custodians pull out bleachers because he likes to do the best job he can. Claimant experienced intermittent back problems, but continued to work until March 9, 1987 when Dr. Paltrow, a psychiatrist, took him off work. Claimant's treating physician, Dr. Waller stated in both February 1987 and again in August 1987 that claimant was physically capable of doing his work.

On December 15, 1987, claimant entered into a stipulation and disputed claim settlement. In that document, claimant and the employer agreed that claimant's psychological condition was not a compensable consequence of his accepted injury. The parties further agreed that claimant's compensable condition had aggravated, thus entitling him to an additional 10 percent unscheduled disability. The parties agreed that claimant would be referred for "whatever vocational assistance to which he is administratively entitled." Finally, the parties agreed that claimant would resign his position as a custodian with the employer. The stipulation states: "Claimant hereby acknowledges that his low back condition in conjunction with his psychological stress condition has rendered him physically incapable of performing any type of employment at Beaverton School District."

Claimant applied for vocational assistance. A vocational assistance provider evaluated claimant for eligibility and concluded on March 22, 1988 that claimant was not eligible for vocational assistance. The basis for this decision was that claimant left work for reasons unrelated to his compensable injury. Claimant requested that the Director review the eligibility decision. On August 31, 1988, the Director issued an order concluding that claimant was not eligible for vocational assistance. The Director made no evidentiary record. The Director's order contains the following ultimate findings of fact:

> "[Claimant] returned to work for his employer after an on-the-job back injury, and worked for over three years at his usual job as a custodian, permanently modified to eliminate the requirement that he pull down the bleachers in the gymnasium, the only job activity reported to have caused him difficulty. He left this job in February 1987, not because of physical difficulties in performing his job duties, but because of psychological stress, which has been denied by the employer as disabling or compensable under the workers' compensation laws. While the intent of the parties to the December 15, 1987 Stipulation and Order may have been to recognize a 'dry' aggravation of [claimant's] back injury, in the absence of a reopening of [claimant's] back injury claim and evidence that he stopped working because of a worsening of his back condition, there is no causal link between the injury and the need for vocational assistance. What the parties intended in this regard, therefore, has no bearing on the issue of vocational assistance."

The Director applied these facts to OAR 436-120-040 and OAR 436-120-45 and concluded that claimant was not eligible for vocational assistance.

Claimant requested review by a Referee pursuant to ORS 656.283(1).

The Referee held an evidentiary hearing and concluded that claimant left his custodian job on medical advice that continued work would cause the need for low back surgery in the future. Consequently, he reversed the Director's order and found claimant eligible for vocational assistance.

CONCLUSIONS OF LAW AND OPINION

Claimant alleges that the Director's order was characterized by an abuse of discretion or clearly unwarranted exercise of discretion. To this end, claimant testified at hearing that he left work on medical advice because that

type of work would cause additional surgery in the future. Claimant then argues that because the Director's order contains findings contrary to the claimant's testimony at hearing, therefore, the Director's order was characterized by an abuse of discretion or an unwarranted exercise of discretion. We disagree.

ORS 656.283(1) provides:

> "Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim." See also OAR 436-120-210.

ORS 656.283(2) provides that, as to the decision of the Director regarding vocational assistance;

> "[T]he decision of the director may be modified only if it:
>
> (a) Violates a statue or rule;
>
> (b) Exceeds the statutory authority of the agency;
>
> (c) Was made upon unlawful procedure; or
>
> (d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

A finding of one of the circumstances listed at ORS 656.283(2)(a) through (d) is mandatory before a Director's order regarding vocational assistance may be changed by a Referee. Here, the Referee made no findings on any of the four bases for modifying the Director's order.

Claimant alleges that the Director abused his discretion by failing to find certain facts asserted by claimant and by failing to properly apply OAR 436-120-040 to those asserted facts.[1]

Thus, in this case, it is clear that in order to modify the Director's order, it must be found that he abused his discretion. What is not clear is how a Referee is to review for abuse of discretion.

Courts have applied various definitions of the term "abuse of discretion." One definition commonly cited with approval is; "A discretion exercised to an end or purpose not justified by, and clearly against, reason and evidence." Bouvier's Law Dictionary. See e.g. Casciato v. OLCC, 181 Or 707 (1947); Port of Umatilla v. Richmond, 212 Or 596 (1958); Farwest Landscaping v. Modern Merchandising, 207 Or 653, 664 (1979). While this definition is often applied to the review of the judicial discretion given a court, it applies equally to orders of administrative agencies, such as the order of the Director in this case. See Casciato v. OLCC, supra, 181 Or at 716, 717. We apply that definition here.

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[1] On review claimant asserts that, for the same reason, the director violated the rule. The dissent argues that where the question is whether the Director violated a rule, we cannot uphold the Director's application of law simply because it is not unreasonable. We do not reach that question, because, in this case, a decision on whether the Director abused his discretion in his findings of fact will also determine whether he violated the rule. If the Director correctly found the facts, his application of the rule is correct.

From the language of ORS 656.283(2) it is apparent that the legislature intended that orders of the Director regarding vocational assistance be subject to very limited review. Nevertheless, such orders are subject to review. The Director does not have free and totally unrestricted discretion in matters of vocational assistance.

The fundamental question presented by this case is: if abuse of discretion includes discretion which is unjustified by reason and evidence, how does the referee determine if the Director's exercise of discretion was or was not justified by the evidence? The Director's administrative review does not involve a "hearing" in the usual sense. See OAR 436-120-210(2) through (6). There is no "record" of the Director's administrative review. There is, therefore, nothing for a referee to review to determine if, at least in the case of fact finding, the Director has abused his discretion.

ORS 656.283(2), when read in conjunction with existing procedures of the Director for the conduct of administrative review of vocational assistance matters, permits only one reasonable conclusion. The referee must review the record made before him or her to determine if the Director abused his discretion. While it may seem incongruous to review the Director's order for abuse of discretion based upon a record made after the order issued, there can be no doubt regarding the legislature's power to adopt such a process.[2] Furthermore, given the absence of a "record" prior to hearing, it is the only way in which the Director's fact finding can be reviewed for abuse of discretion. To do otherwise would be to permit the Director free and unrestricted discretion in finding facts which, because it would be impossible to do so, would not be subject to review. Such a result is not consistent with ORS 656.283(2), which requires some limited review.

In short, the Referee "makes a record." The Referee then determines if the Director's order involved an abuse of discretion, had it been based upon the hearing record. The referee does not determine how the evidence preponderates or even if there is substantial evidence to support the director's order. The referee may only modify the Director's order pursuant to ORS 656.283(2)(d) if the hearing record "as a whole" indicates that the Director acted (found fact, reached conclusions or applied the law) ". . . to an end or purpose not justified by, and clearly against reason and evidence."

Here, claimant alleges that the Director's ultimate finding that claimant was required to leave work for reasons unrelated to the compensable injury constitutes an abuse of discretion. Thus, we must determine whether in making this ultimate finding of fact, the Director acted to an end or purpose not justified and clearly against reason and evidence. Because the evidentiary record supports the finding, we conclude that the Director did not abuse his discretion in making that finding.

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[2] Although distinct, a procedure existing during the days of the State Industrial Accident Commission (S.I.A.C.) was analogous. The Commission, upon a sufficient showing, had the "discretion" to permit claim filing after the usually permissible period. Where the Commission refused to exercise its discretion and extend the filing period, its action was subject to review by a Circuit Court. There, a jury was permitted to "review", based upon evidence presented in court. Reviewing that procedure, the Supreme Court noted that, while such a process was unusual, it was permissible. The Court found that the Commission's discretion was not "free and unhampered" but subject to review. In order to conduct such a review, the Court found it necessary to conduct a hearing, since the Commission did not do so, and to create a "record", since there was none of the proceeding before the Commission. Tice v. State Ind. Acc. Comm., 183 Or 593 (1948).

It can reasonably be concluded from the evidentiary record made at hearing that claimant left work because of a non-compensable psychological condition. The parties' agreement that the noncompensable psychological condition in conjunction with claimant's compensable low back condition precluded him from jobs with the employer does not compel a conclusion that claimant's low back condition, alone, precluded him from his regular work. Furthermore, claimant's testimony at hearing could reasonably have been rejected in favor of evidence suggesting contrary facts.

Under OAR 436-120-040(7) and OAR 436-120-045(3) a claimant who leaves work for reasons unrelated to his injury is ineligible for vocational assistance. Consequently, we conclude that the Director did not abuse his discretion in finding that claimant was not eligible for vocational assistance. Absent a finding of such abuse, neither we nor the Referee has authority to modify the Director's order. ORS 656.283(2).

ORDER

The Referee's order dated January 18, 1989 is reversed. That portion of the Referee's order which found claimant eligible for vocational assistance is reversed. The Director's order is reinstated in its entirety. That portion which awarded claimant's attorney a $750 approved attorney fee out of compensation is reversed.

Board Member Crider, dissenting.

The majority holds that we may affirm the Referee's order modifying the Director's order in this vocational services matter only if we find that the Director abused his discretion by making findings of fact which are "not justified by, and clearly against, reason and evidence" in the hearing record. The majority reverses the Referee's order because "it could reasonably be concluded" that the claimant left work for a reason other than the compensable injury and, therefore, is not entitled to services under the applicable administrative rule. Because I believe that the statute contemplates that the Referee is the primary factfinder and must make independent findings of fact on issues directly bearing on entitlement to vocational services, I dissent.

I note, preliminarily, that the majority articulates a legal rule which I believe must be implemented by the following procedure: The referee conducts a full evidentiary hearing on all matters related to claimant's eligibility for vocational services. The referee then examines any findings of fact that the Director has chosen to make.[1] If the referee finds that the Director's findings of fact are not justified by, and are clearly contrary to the evidence, then the referee may find that the director has abused his discretion in factfinding. Then, I take it, and only then, the referee would make independent findings of fact and resolve the dispute in reliance thereon.

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[1] Nothing in either the statute or the administrative rules requires the Director to make any findings of fact at all. See ORS 656.283(2); OAR 436-120-210.

The majority declares that:

> "The referee does not determine how the evidence preponderates or even if there is substantial evidence to support the director's order. The referee may only modify the director's order . . . if the hearing record 'as a whole' indicates that the director acted (found fact, reached conclusions or applied the law)'. . . to an end or purpose not justified by, and clearly against reason and evidence.'"

There are two faults in this formulation. First, it suggests that we review decisions of the Director in vocational rehabilitation matters only for abuse of discretion--whereas the statute requires us to modify an order if it violates a statute or rule, exceeds statutory authority, was made pursuant to unlawful procedure, or was an abuse of discretion. I submit that, in applying the former three standards, we are not permitted to defer to "reasonable" or "justifiable" conduct by the Director. Rather, where the question is one of violation of statute or rule, we must decide the question of law; we cannot uphold the Director's application of law simply because it is not unreasonable. Just as an appellate court, reviewing a trial judge's decision, does not apply the clearly erroneous standard to review of questions of law, we cannot apply the standard for review of exercises of discretion to questions of violation of law, of extent of authority, or improper procedure.

My second, and corollary, objection is to the majority's assumption that the abuse of discretion test applies to essentially deprive the hearing process of its factfinding purpose.

The Board's approach makes a sham of the evidentiary hearing conducted in this forum. The parties are invited to come, to tell their stories and to make their cases to the referee. Yet the referee, no matter how compelling the evidence, may not make findings of fact which contradict those reached by the Director without hearing provided that there is a reasonable basis in the hearing record for the Director's finding. This approach is inconsistent with prior agency interpretations of the statute, it offends fundamental notions of due process, and it is without support in the language of the statute itself.

The Board has clearly held that the referee must independently find the basic facts in cases involving vocational services. Richard O. Fischer, 36 Van Natta 822 (1984). The Director's decision must be modified if, given the facts found after hearing, the Director's decision is in conflict with the statute or his own rules. Thus, in Charles E. Barney, 41 Van Natta 1057, 1058 (1989), we held that:

> "Under former ORS 656.283(2), the standard for review is limited. However, the statute does not preclude examination and scrutiny of the underlying facts upon which the Director's decision is based by the Referee, and by the Board. See generally, Daniel T. Cobbin, 41 Van Natta 326 (1989). Accordingly, we proceed to review, as a factual matter, the basis of the Director's decision..."

41 Van Natta at 1058. The Director's decision in Barney was predicated on findings that: (1) claimant suffered no permanent physical limitations due to the compensable injury; and (2) he was able to return to work for the employer at injury and would have been employed for that employer but for a termination for reasons unrelated to the injury. The Director concluded, based on finding (1),

that claimant was ineligible under former OAR 436-120-040, which provides that only worker's likely to sustain permanent disability due to a compensable injury may be eligible for vocational services. He further concluded, based on finding (2), that claimant was ineligible under former OAR 436-120-090, which provided that a worker is ineligible if his lack of suitable employment is no longer due to the compensable injury. The referee found that claimant was permanently impaired in light of a Determination Order which awarded claimant 5 percent unscheduled permanent disability. He also found, based on a hearing record replete with conflicting evidence, that claimant was not able to return to his prior work. In affirming the referee's order, modifying the Director's order and ordering the insurer to provide vocational services, we held that, given the facts as found by the referee, the Director's decision was contrary to law.

The majority errs here because it fails to make the independent findings based on the hearing record which are required by Barney.

The role of the referee, and the Board on de novo review, in hearing on a matter concerning a claim under ORS 656.283 is twofold. First, the referee must find the facts based on the record before him. In so doing, the referee must independently weigh the evidence before him. Second, the referee (and the Board) must apply the law to the facts. See Armstrong v. Asten Hill Company, 90 Or App 200 (1988).[2]

A workers' compensation referee's unique responsibility is to conduct an evidentiary hearing and to find facts based on his own observation of the witnesses as well as on the substance of their testimony and the documentary record. See Miller v. Granite Construction Co., 28 Or App 473 (1977). The referee does not lose this pivotal position even when the issue has been initially determined by the Director or his subordinates. To afford any presumption of correctness to the Director's decision in such cases "would undercut the referee's and the Board's de novo fact finding function." SAIF v. Baer, 61 Or App 335 (1983).

In cases involving vocational services, to be sure, a party must first seek relief from the Director of the Department of Insurance and Finance and the Director's order may be modified only if one of four circumstances obtains: The order violates a statute or rule, exceeds the Director's statutory authority, was made upon unlawful procedure, or was characterized by abuse of discretion. ORS 656.283(1).

Nevertheless, nothing in ORS 656.283(2) suggests that the referee should not make findings of fact de novo in vocational services cases. Certainly nothing in the statute supports the majority's declaration that the referee is tied to any findings of fact made by the Director provided that they are supported by "any evidence". The statute simply prescribes the circumstances in which the referee may modify the Director's decision. The legislative history establishes that the purpose of the special provision was not to eliminate evidentiary hearings but to make certain that referees do not substitute their

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2 In my view, a hearings referee must make findings of fact on the record before him. Only after those findings are made, does the referee address the legal question as to whether those findings together with the applicable law require modification of the order for one of the reasons stated in ORS 656.283. Under the majority's approach, the cart comes before the horse. The referee first, without making findings on the central facts governing eligibility for vocational services, decides whether the Director has abused his discretion in finding facts. Then, as I take it, if he has not abused his factfinding discretion, the referee again addresses whether modification is required assuming the Director's findings are correct.

judgment--with regard to matters involving the exercise of statutorily granted discretion--for that of the Director.[3]

In view of this obligation that we not substitute our judgment for that of the Director, it is clear that the referee's duty to independently weigh the evidence and make basic findings of fact does not authorize him to grant or deny vocational services according to his own predilection. If the referee's findings of basic fact compel the conclusion that the Director violated the statute or the rules in granting or denying benefits, the referee must modify the Director's decision. If, however, the Director's decision is grounded in an exercise of discretion granted by statute or rule, then the decision should not be disturbed. See Lincoln County School District v. Mayer, 39 Or App 99 (1979); Fairview Hospital v. Stanton, 28 Or App 643 (1977); Jones v. Employment Division, 30 Or App 103 (1977).[4]

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[3] That portion of ORS 656.283(2) limiting the power of referees to modify a Director's order was first enacted as applied to questions of eligibility as opposed to participation in vocational rehabilitation in 1979. At that time, Senator Kulongoski objected to the language proposed by the Workers' Compensation Department for the reason that it would deprive the worker of a hearing on vocational issues. The Department's spokesperson assured him that the bill simply codified an existing Department rule under which evidentiary hearings did take place. The proposal was not intended to eliminate the right to hearing but simply to assure that "the referee or the board cannot substitute their judgment for the judgment of the agency that made the initial decision, unless the agency does not follow its rules and regulations down the line." Testimony of Cliff Allison before the Senate Committee on Labor, Consumer and Business Affairs, Minutes of April 12, 1979. Although Senator Kulongoski agreed but nonetheless urged that the worker ought to be permitted to question the agency's judgment in placing him in a particular type of program at hearing. According to the minutes, the Senator

> "moved that an amendment be drafted on the question of participation to allow a claimant to appeal the decision of the participation in a particular program of Vocational Rehabilitation to allow them to appeal that decision and have the referee substitute their opinion for the director."

Minutes, Senate Committee on Labor, Consumer and Business Affairs, April 12, 1979 (emphasis added). The motion failed. Nevertheless, the discussion does suggest that ORS 656.283(2) was designed to insulate the Director's judgment while preserving the integrity of the evidentiary hearing.

[4] The majority's analogy to circuit court review of SIAC's discretionary decisions to permit filing of a claim after the expiration of the filing period is appropriate. I submit, however, that the role of the jury in such cases was not to determine whether the Commission's findings of fact were an abuse of discretion but whether, given the facts as the jury found them, the Commission's ultimate decision to allow or not to allow late filing was a justifiable exercise of its discretion. Indeed, the Supreme Court, in Tice v. SAIF, 183 Or 593 (1948) specifically held that the trial judge did not err in declining to instruct the jury that it was the claimant's burden to prove that, "the finding of fact (of the Commission) are contrary to the admitted or clearly proven facts." Id., at 615. The court left the jury's factfinding power unfettered precisely because, as here, there was no right to hearing before the Commission.

This understanding of the statutory scheme is informed by constitutional considerations. In Carr v. SAIF, 65 Or App 110 (1983), the court of appeals held, relying on Fuentes v. Shevin, 407 U.S. 67 (1972), that when the state acts to deny an individual workers' compensation benefits, that deprivation must be accompanied by due process protections even though benefits are actually paid by an insurer rather than the state. Therefore, the court held that a worker is entitled to some process before the Director approves suspension of benefits under ORS 656.325(1) as well as the post-suspension hearing to which a worker is entitled under ORS 656.283. In this case also, claimant has a property interest in vocational services. The worker is afforded notice and an opportunity to be heard informally, prior to the Director's decision. The Director, however, conducts no evidentiary hearing. The hearing before the Referee, under ORS 656.283, is what provides the evidentiary hearing to which the Constitution of the United States entitles the worker. If, as the majority holds, that evidentiary hearing is so hollow that it does not permit the Referee to act as de novo factfinder, then claimant is denied due process. For this reason, in addition to the purely statutory reasons stated above, I conclude that the Referee is the primary finder of fact where there is a dispute over vocational services.

The court of appeals has given weight to the protection of due process rights in interpreting the ambiguous statute governing hearings before the Employment Relations Board (ERB) on a state employer's appeal from a disciplinary action. Fairview Hospital and Training Center v. Stanton, supra. The nature of the hearing before ERB was not specified by state. However, the court held that

> "ERB is, under the statute and constitution, the primary factfinder, that is, the tribunal before which all parties have an opportunity to present and rebut evidence relevant to a disciplinary action against a public employe, the tribunal that resolves any conflicts in the evidence, and the tribunal which draws inferences from the evidence."

Fairview Hospital v. Stanton, supra, 28 Or App at 649. See analogously, Lincoln County School District v. Mayer, supra (Employment Relations Board is primary factfinder in employee discipline cases). Similarly, here, if there is any ambiguity with respect to the referee's role in a vocational services dispute, constitutional concerns should lead us to conclude that the referee, and the Board on review, must itself resolve conflicts in the evidence and must independently draw inferences from the evidence.

Before we can decide whether the denial of vocational services was in violation of a rule or was an abuse of discretion as alleged by claimant, we must determine, on de novo review on the hearing record, whether in fact claimant left work for reasons related to the compensable injury. The majority has failed to take that initial step.

In the Matter of the Compensation of
SARAH C. COMBS, Claimant
WCB Case No. 89-06815
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Michael Whitty (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Garaventa's order that affirmed a Determination Order award of 18 percent (57.6 degrees) unscheduled permanent disability for a chronic nonallergic rhinitis with nasal and sinus polyps condition. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

In paragraph 2, page 1 the Referee found that claimant developed an allergy to airborne chemicals and strong odors. Instead, we find that claimant suffers from chronic nonallergic rhinitis with nasal and sinus polyps, caused by long term exposure to inhalant chemical irritants. (Ex. 27).

Claimant is capable of performing medium work.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 30 percent loss of earning capacity as a result of her occupational disease of chronic nonallergic rhinitis with nasal and sinus polyps.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that, because claimant's condition is not encompassed by any definition in the standards, the test of her disability is loss of earning capacity without regard to the standards. We disagree.

Former ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to former ORS 656.726(3)(f)(A). The standards in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010 and former OAR 436-35-003.

Because claimant's claim was closed by a March 28, 1989 Determination order, the standards adopted effective January 1, 1989, apply to the rating of claimant's permanent partial disability.

The Referee applied former OAR 436-35-430(8), which provides: "When exposure to physical or chemical agents has resulted in the development of an allergic response, impairment of the endocrine system shall be rated as follows: . . ." Claimant argues that, if the standards are applied, this section does not apply to her condition because her condition is not an allergic response and does not involve the endocrine system.

There is no rule which exactly fits this situation. We are reluctant to apply a rule by analogy that does not precisely apply by its terms. See Ralph A. Neeley, 42 Van Natta 1638 (1990). In this case, we are persuaded that if we were to calculate an award based on impairment pursuant to former OAR 436-35-385, which incorporates former OAR 436-35-430(8) by reference, we would

nonetheless be persuaded that claimant's loss exceeds that indicated by the standards.

We first calculate claimant's disability assuming claimant has impairment recognized by the standards. Claimant sustained nasal and sinus polyps and chronic rhinitis as a result of exposure to airborne chemical irritants in her work. This condition constitutes a respiratory system impairment, the subject of former ORS 436-35-385. The note at the end of this section states: "For workers who have developed an allergic respiratory response to physical or chemical agents refer to OAR 436-35-430(8)," the section applied by the Referee. Although we decline to find that claimant has an allergic reaction, the conditions covered by these sections are the most closely analogous to claimant's respiratory response.

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

The underlying facts to which the standards are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the standards. Former ORS 656.283(7) and 656.295(5).

Age

Claimant has not returned to or been offered her usual and customary work. The appropriate value for claimant's age of 46 years is 1. Former OAR 436-35-290.

Formal Education

The appropriate value for claimant's 10 years of formal education is 1. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by claimant during the ten years prior to the date of hearing is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 7 (DOT # 840.381-010). Therefore, the appropriate value for skills is 1. Id.

Training

Claimant has documented training. Therefore, the appropriate value for training is 0. Former OAR 436-35-300(5). Claimant's total education value is 2, the formal education value plus the skills value plus the training value. Former OAR 436-35-300(6).

Adaptability

An adaptability value for claimant, who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] and who has not returned to modified work, is determined by her residual physical capacity, without regard to her physical capacity prior to her occupational disease. Former OAR 436-35-310(4). The Referee found that claimant was able to perform medium work prior to her occupational disease and is now able to perform only sedentary to light work. We agree that claimant was able to do medium work before contracting the compensable disease. We find no evidence, however, that claimant's occupational disease has changed her ability to perform medium work. Her limitations due to the disease result from exposure to airborne irritants and not to lifting. Thus, claimant's physical capacity falls within the medium category. The appropriate adaptability value is 1. Id.

Impairment

When a reaction to exposure to physical or chemical agents prevents some work related activities, the impairment value is 5-10 percent. Former OAR 436-35-430(8)(b). The value is 10-15 percent when the reaction prevents most work-related activities. Former OAR 436-35-430(8)(c). In this case, claimant is prevented from some, but not most, work-related activities. Thus, her impairment rating is 10 percent assuming claimant has impairment recognized by the standards.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the standards, we proceed to that calculation. When claimant's age value 1 is added to her education value 2 the sum is 3. When that value is multiplied by claimant's adaptability value 1 the product is 3. When that value is added to claimant's impairment value 10 the result is 13 percent unscheduled permanent partial disability under the standards. Former OAR 436-35-280(7).

Clear and Convincing Evidence

Claimant contends that she has sustained a greater loss of earning capacity than that provided for under the standards. See former ORS 656.283(7). We agree. Claimant's symptoms recur with exposure to paint fumes even while wearing a mask, and with exposure to nearly all chemicals, including household cleaning agents. Dr. Hodgson, otolaryngologist, who performed an independent medical examination, recommended that claimant be retrained for an occupation that would enable her to avoid chemical irritants or perfumes. Dr. Eschelman, M.D., claimant's treating physician, restricted claimant to employment where she will not be exposed to any significant amount of airborne chemicals. He has expressly excluded jobs such as painting supervisor, painter, cabinet finisher, paper hanger and beautician, jobs that claimant has either performed or to which she could transfer her skills. These residual functional capacity restrictions were not considered under our Standards analysis.

Furthermore, in addition to these uncontradicted medical restrictions, the vocational evidence indicates that claimant has no transferable skills that she can use within her limitations. As a result, she would be confined to entry level work. This has two effects. She will be limited to about 61 percent of the labor market, and her former wage-earning capacity will be considerably diminished. Although the Board has held that a labor market limitation is insufficient in itself to establish loss of earning capacity, here, where claimant is in addition unable to perform her relatively well-paid skilled work, we find

that claimant has established, by clear and convincing evidence, that she has experienced a 30 percent loss of earning capacity.

ORDER

The Referee's order dated August 11, 1989 is modified. In addition to claimant's Determination Order award of 18 percent (57.6 degrees) unscheduled permanent disability, claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability, giving her a total award to date of 30 percent (96 degrees) unscheduled permanent disability for her nonallergic rhinitis and nasal polyp condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, not to exceed $3,800.

October 30, 1990 Cite as 42 Van Natta 2466 (1990)

In the Matter of the Compensation of
CARL V. DUMLER, Claimant
WCB Case Nos. 83-05840 & 84-06784
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Rankin, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Argonaut Insurance requests review of Referee Michael Johnson's order that: (1) set aside its denial of claimant's aggravation claim for his current low back condition and need for surgery, dated July 23, 1983; (2) upheld EBI Companies' denial of claimant's aggravation claim for the same condition; (3) awarded an attorney fee upon closure of the remanded claim by the Evaluation Section, equal to 10 percent of the increased compensation awarded by the Evaluation Section, if any, to a maximum of $500; (4) assessed penalties and attorney fees for an alleged unreasonable denial; and (5) declined to rate extent of permanent disability. On review, the issues are compensability, responsibility, penalties, attorney fees, and authority to rate extent of disability. We affirm in part, and reverse in part.

FINDINGS OF FACT

In general, we adopt the Referee's "Findings of Facts." However, we do not adopt the Referee's finding that the Argonaut claim had not been closed by the Evaluation Section. We further supplement the Referee's findings below.

Argonaut issued a partial denial of claimant's medical services claim for low back surgery, dated June 15, 1983. The basis of the denial was that Argonaut was not in receipt of allegedly essential medical records. This denial was tentative pending receipt of the needed documents. On July 23, 1983, Argonaut issued a partial denial of claimant's current low back condition. This denial also confirmed that claimant's surgery request was denied due to the still missing medical reports.

The compensable November 1982 injury with Argonaut's insured was initially closed by Determination Order dated December 12, 1983. The Order did not taken into account claimant's current low back condition and surgery.

The issue of compensability and responsibility for claimant's suicide attempt and underlying psychological condition was preserved, and not litigated, at hearing.

ULTIMATE FINDINGS OF FACT

We adopt the Referee's "findings of ultimate fact" as supplemented below.

The November 1982 compensable injury with Argonaut's insured independently contributed to claimant's low back condition and current need for treatment.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded as a matter of law that Argonaut's denial was procedurally improper as a back up denial, relying on Georgia Pacific v. Piwowar, 305 Or 594 (1988), and Bauman v. SAIF, 295 Or 788 (1983). However, inasmuch as we find claimant's condition to be compensable, we need not consider the procedural validity of Argonaut's denial.

From a substantive perspective, the Referee found that the compensable November 1982 injury was a material contributing cause of claimant's current low back condition. We agree.

When compensability and responsibility are both at issue, as here, the threshold issue is compensability. Elizabeth Coomer, 41 Van Natta 2300 (1989). Claimant has the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to his disability or need for medical treatment. Harris v. Albertson's Inc., 65 Or App 254 (1983).

The medical record establishes that claimant's current low back condition and need for surgery resulted from the May 1981 and November 1982 compensable injuries. As a result of the May 1981 injury, claimant experienced continuing low back pain up to the date of the November 1982 injury. Subsequent to the November 1982 injury, claimant's symptoms were sufficiently acute as to require low back surgery. Claimant's treating physicians have opined a causal relationship between the need for surgery and both injuries. Therefore, we conclude that claimant has established a material contribution from each injury.

Responsibility

Because we find claimant's current condition compensable we proceed to the responsibility issue. The Referee concluded that the responsible insurer was Argonaut. We agree.

Where there are two accepted injuries to the same body part, there is a rebuttable presumption that the insurer on risk at the time of the last accepted injury remains responsible. That insurer may rebut the presumption by establishing that the prior accepted injury last independently contributed to claimant's worsened condition. Industrial Indemnity v. Kearns, 70 Or App 583 (1984); Champion International v. Castilleja, 91 Or App 556 (1988); Linda L. Wise, 42 Van Natta 115 (1989).

We do not find that Argonaut as the last employer has overcome the presumption of responsibility. Claimant's treating physician and surgeon, Dr. Bernson persuasively opined that the second injury was "equally culpable" in contributing to claimant's need for surgery. Dr. Bernson explained that the November 1982 injury precipitated acute low back symptoms resulting in the subsequent surgery. Indeed, Dr. Bernson's, "tree-cutting" analogy strongly suggests a pathological worsening, by analogizing a second whack of the axe killing the tree, to the second injury causing the herniation of the L5-S1 disc requiring surgery. We also note that prior to the November 1982 injury claimant was able to work full time at a physically demanding job even though experiencing

low back pain. However, after the November 1982 injury claimant was no longer able to work due to severe low back symptoms brought on by the November 1982 injury. Accordingly, we find that Argonaut has not rebutted the presumption of liability.

Penalties and attorney fees for an alleged unreasonable partial denial.

We adopt the Referee's "Conclusions of Law" with regard to this issue.

Extent of permanent disability

Because the Referee had set aside Argonaut's denial and remanded the claim to Argonaut for processing, he concluded he did not have jurisdiction to rate extent of permanent disability. We agree.

The November 1982 compensable injury had been accepted as a low back strain by Argonaut. Argonaut subsequently denied claimant's current low back condition by denial letter in July 1983. Claimant became medically stationary on October 10, 1983, and the November 1982 claim was closed by Determination Order on December 12, 1983. The order specifically noted that the condition denied by the July 1983 denial letter was not considered by the Evaluation Section.

Thus, we find that claimant's low back claim has never been fully processed in accordance with law, and further, has not been closed by the Evaluation section. Inasmuch as we affirm the Referee's decision to set aside Argonaut's July 1983 denial letter, and remand the claim to Argonaut for processing in accordance with law, we decline to rate claimant's permanent disability.

Prospective attorney fee on closure by Evaluations

Furthermore, because we have affirmed remanding the aggravation claim for processing and declined to rate extent of disability, we find no authority for awarding claimant's counsel an approved attorney fee under OAR 438-15-040. Claimant is, however, entitled to an assessed fee for prevailing against a denied claim. ORS 656.386(1). We note that the Referee, in fact, awarded such an attorney fee.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services on review concerning the compensability issue is $525, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 31, 1989 is affirmed in part, and reversed in part. That portion of the Referee's order assessing an attorney fee based upon 10 percent of a future award by the Evaluation Section if any, up to a maximum of $500, is reversed. The remainder of the order is affirmed. For services on Board review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $525, payable by Argonaut.

In the Matter of the Compensation of
ARLENE C. ENGEN, Claimant
WCB Case No. 87-08595
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of that portion of Referee Jacobson's order that set aside its denial insofar as it pertained to claimant's medical services claim for back surgery. In addition, the insurer seeks remand for admission of post-hearing evidence. Claimant cross-requests review of that portion of the Referee's order which declined to address claimant's aggravation claim. On review, the issues are remand, compensability of medical services, and aggravation. We reverse.

FINDINGS OF FACT

In October 1985, after working for the employer for about three months, claimant was first treated for hand and wrist pain, allegedly caused by operating machinery at work. Her condition was diagnosed as probable tendonitis. Nerve conduction testing was normal and claimant was treated conservatively with anti-inflammatories and physical therapy. On November 18, 1985, claimant's claim for bilateral hand and wrist tendonitis was accepted. Claimant was released to return to work in February 1986. She returned to work in April of 1986 and was declared medically stationary on May 7, 1986. In a May 28, 1987 Determination Order, claimant was awarded 10 percent scheduled permanent disability for each of her forearms (wrists).

For two years, claimant continued to experience hand, arm, and elbow symptoms and numerous medical experts diagnosed her condition as tendonitis, overuse syndrome, and carpal tunnel syndrome. Initially claimant's symptoms remained stationary and then completely resolved and then shifted from the right side to the left. Objective testing, including nerve conduction, was normal until August 1986 when "borderline" median nerve slowing was reported. Claimant had right carpal tunnel release in September 1986, and left carpal tunnel surgery in December 1986.

In the months immediately following surgery, claimant's symptoms disappeared. In May 1987, claimant was thrown from her horse. She suffered a broken nose and wore a neck brace for a week. Thereafter, claimant complained of neck pain. Claimant failed to reveal to her doctors that she had a serious accident with her horse that caused injury to the neck region. By October 1987, claimant's symptoms had slowly worsened to the point that she allegedly was unable to do any activity with her hands. Claimant changed her treating physician of record six times during this period and all treating and examining physicians reported no objective basis for claimant's ongoing complaints.

Claimant was first seen by Dr. Smith in late October of 1987. Based on x-ray results that showed minimal cervical pathology, Dr. Smith concluded that claimant's upper extremity symptoms were caused by cervical spondylosis with possible nerve root compression. On December 1, 1987, the insurer denied claimant's request to make Dr. Smith her seventh treating physician, and would not authorize cervical spine surgery. Several weeks later, Dr. Smith performed a cervical discectomy and interbody fusion of C5-6. Claimant reported that her hands and wrists improved following the surgery.

Two doctors (Ziven and Davies) examined claimant on behalf of the insurer and they both strongly disagree with Dr. Smith's diagnosis and treatment.

ULTIMATE FINDINGS OF FACT

Claimant's degenerative cervical condition is not related to her working conditions.

CONCLUSIONS OF LAW AND OPINION

Remand

The insurer requests remand, alleging that the hearing record is incompletely or otherwise insufficiently developed according to statute. ORS 656.295(5). Specifically, the insurer contends that the record is insufficiently developed because claimant returned to work after the hearing and is now complaining of the same symptoms she had before the disputed surgery. We disagree that this constitutes an insufficiently developed record.

Remand is generally appropriate only upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A "compelling reason" for admission of post-hearing evidence exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser, 301 Or 641 (1986). Evidence which is not in existence at the time of hearing is "unavailable" but may still be "obtainable." Compton, supra, at 648.

Here, both sides have had ample opportunity to obtain and present evidence relative to the issue of whether the requested surgical procedure was related to the accepted condition and a reasonable and necessary medical treatment. The record is sufficiently developed and the post-hearing circumstances regarding claimant's current complaints are not relevant. Evidence is not newly discovered merely because it was promulgated after the hearing. We accordingly deny the insurer's request for remand, and proceed with our review.

Compensability of Back Surgery

The insurer must pay for the cervical discectomy and interbody fusion so long as claimant proves, by a preponderance of the evidence, that the procedure is related to the accepted condition and that either the nature of the injury or the process of recovery required the surgery. ORS 656.245(1).

The Referee concluded that claimant established her cervical discectomy and interbody fusion of C5-6 were directly related to her compensable wrist and hand condition and were reasonable and necessary procedures for the treatment of this condition. We reverse.

The Referee supported her decision primarily on the testimony of the surgeon, Dr. Smith. She concluded that Dr. Smith was claimant's "treating physician" and, as such, his opinions should be given special deference. The Referee also found Dr. Smith's testimony was based on a more thorough knowledge of claimant's condition and more extensive medical tests. We disagree.

Unlike the Referee, we find persuasive reasons not to accord special deference to the opinions of Dr. Smith. See Allie v. SAIF, 79 Or App 284 (1986); Weiland v. SAIF, 64 Or App 810 (1983). Dr. Smith acknowledged that he did not have a complete history of claimant's condition either when he first examined claimant, or at the time of surgery, or at the time of his deposition. In addition, the information Dr. Smith relied on came primarily from claimant who was found not credible. We defer to the Referee's credibility finding which was based on demeanor and the fact that claimant gave contradictory testimony,

and failed to disclose relevant medical information to her doctors. See Coastal Farm Supply v. Hultberg, 76 Or App 259, 263 (1986).

Based on an x-ray finding that revealed minimal cervical pathology, Dr. Smith concluded that claimant's wrist and hand symptoms were caused by cervical spondylosis with possible nerve root compression. However, no medical source, including Dr. Smith, related this degenerative cervical spondylosis to claimant's working conditions. Furthermore, claimant did not mention to Dr. Smith that she had been hit in the head and thrown from her horse several months before the disputed surgery, and that after this accident she wore a neck brace for a week.

All medical specialists who treated or examined claimant between August 1985 and the hearing date, reported findings and diagnoses inconsistent with and contrary to the medical opinion(s) of Dr. Smith. For example, Dr. Zivin testified that there was no connection between claimant's cervical condition and her compensable carpal tunnel condition. According to Dr. Zivin, there was no evidence of nerve root impingement or pathology. He supported this opinion by noting the lack of clinical verification of pain, numbness, weakness or reflex changes that trace the nerve root distribution of C5-6. Dr. Zivin agreed with the numerous medical specialists who had examined and treated claimant before October 1987: claimant has tendonitis of the wrists with fluctuating areas of pain and tenderness.

On this record, we find ample support for the conclusion that claimant is not a credible witness. Accordingly, we find Dr. Smith's opinions are based on both an inaccurate and incomplete history and as such are not entitled to greater weight. See Somers v. SAIF, 77 Or App 259 (1986). In the face of persuasive contrary medical evidence, Dr. Smith's opinion is therefore insufficient to establish that claimant's degenerative cervical condition and the spinal surgery are materially related to the accepted claim. Accordingly, we reverse the Referee and hold that the cervical discectomy and interbody spinal fusion are not compensable medical treatments.

Aggravation

The Referee concluded that, while the insurer's denial letter also denied any aggravation or reopening of the claim, since claimant only appealed the denial of medical benefits, "aggravation" was not an issue at hearing. We disagree.

Claimant requested a hearing concerning the insurer's denial. That denial pertained to a "request for aggravation, reopening of [claimant's] claim and surgery authorization." At hearing, the parties identified one of the issues to be resolved as "the insurer's denial." Inasmuch as the insurer denied claimant's aggravation claim and since that denial was disputed at the hearing, we conclude that the "aggravation" claim was properly before the Referee.

However, because we conclude that claimant's degenerative cervical condition is not materially related to the compensable injury, it follows that the aggravation denial should likewise be upheld.

ORDER

The Referee's order dated April 8, 1988 is reversed. The insurer's denial dated December 1, 1986 is reinstated and upheld. The Referee's assessed attorney fee award of $2,600 is reversed.

In the Matter of the Compensation of
FRANK GIESBRECHT, Claimant
WCB Case No. 88-15923
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols

Claimant requests review of Referee Brown's order that found that claimant is no longer permanently and totally disabled. On review, the issues are the constitutionality of ORS 656.206 and permanent total disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Constitutionality of ORS 656.206

On review, claimant argues that ORS 656.206 is unconstitutional under Article 1 20 of the Oregon Constitution and under the 14th Amendment of the U.S. Constitution because it denies equal protection to claimant. Claimant asserts that this is because claimant is not entitled to increased permanent disability if his condition worsens after his aggravation rights have expired, while under ORS 656.206, the carrier has the right to a reduction of the benefit at any time.

When legislation treats individuals differently from others based on certain immutable characteristics, a court will strictly scrutinize the legislation in question. However, where legislation does not treat individuals differently from others based on immutable characteristics, to withstand review under the 14th Amendment the legislation must rationally further a legitimate state interest. See U.S. Department of Agriculture v. Moreno, 413 U.S. 528 (1973). The Oregon courts apply the same standard in determining whether legislation violates Article 1 20 of the Oregon Constitution. Wisherd v. Paul Koch Volkswagen, Inc., 28 Or App 513 (1977).

Here, ORS 656.206 does not treat workers differently based on immutable characteristics. Therefore, in order to be constitutional, ORS 656.206 must rationally further a legitimate state interest. We find that it is rationally related to the purpose of delivering the maximum possible benefits from limited resources. Therefore, ORS 656.206 is constitutional.

Permanent Total Disability

The Board affirms and adopts the order of the Referee on this issue.

ORDER

The Referee's order dated January 18, 1989 is affirmed.

In the Matter of the Compensation of
KENNETH W. MALLOY, Claimant
WCB Case No. 89-08680
ORDER ON REVIEW
Barnes, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of Referee Galton's order which set aside its denial of claimant's claim for a head injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer on or about August 24, 1988 as an outside traffic director in front of an airport terminal. He worked 10 hours per day, four days per week. Claimant was paid for 8 hours and 40 minutes of work per day. He was not paid for two 40 minute rest and meal breaks each day.

The employer maintained a non-management employee lunch room which was located in the airport's long-term parking lot. Regular employees and supervisors routinely took breaks and ate meals in the airport terminal cafeteria which was located on the second floor of the terminal. Only employees of companies at the airport were allowed to use the terminal cafeteria.

On December 15, 1988, claimant was not scheduled to work, but was called in to work. Claimant worked the first 3 to 3.5 hours of his shift, then took a forty minute break in the employer's lunchroom. He did not eat, but did smoke cigarettes during this break. Thereafter, claimant returned to his work.

Claimant worked the next 2 to 2.5 hours and then took his second forty minute break. He spent the majority of this break in the terminal lunchroom eating. After eating, he walked down a flight of stairs to the main terminal level and went into a gift shop to buy lifesavers and get matches. As claimant was leaving the gift shop, the gift shop manager rolled the steel door down, unintentionally striking claimant on the forehead. Claimant experienced neck and forehead pain and reported the incident to his supervisor. He ultimately left work that day prior to the end of his shift.

In March 1989, the employer denied claimant's claim on the basis that it did not arise out of nor was it in the course and scope of his employment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's injury arose out of and was in the course of his employment. We disagree.

In Rogers v. SAIF, 289 Or 633 (1980), the Supreme Court adopted a unitary "work-connection" approach which poses the following question: "Is the relationship between the injury and the employment sufficient that the injury should be compensable?" Id. at 642. See also Phil A. Livesley Co. v. Russ, 296 Or 25 (1983).

Seven factors have been identified to determine whether an injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the risk was an ordinary risk of, and incidental to, the employment; (4) whether

the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). All of the factors may be considered; no one factor is dispositive. Id.

Claimant's trip to the gift shop was a personal mission to obtain matches and lifesavers. Although he testified that the matches were to warm his hands and the lifesavers were to keep his throat moist, we find this too tenuous a connection to support a conclusion that this activity was for the benefit of the employer. Further, although it may have been contemplated that claimant would use the terminal cafeteria during the course of his work, it was not contemplated that he would patronize the gift shop as a part of his job duties.

Claimant's injury did not occur on the employer's premise and was not an ordinary, risk of, or incidental to his employment as a traffic director. As noted above, the employer may have acquiesced to claimant's use of the terminal lunchroom, but it neither directed nor acquiesced in his use of the terminal gift shop. Finally, we conclude that claimant did not establish that he was paid during the time in which the injury occurred. Although Mr. Pruett, claimant's former supervisor, testified to the contrary, he also testified that he was unfamiliar with payroll procedures. Further, the union agreement and the testimony of Bill Hung, the employer's manager, indicated that claimant was not paid during his lunch break.

Under these circumstances, we conclude that claimant has not established that his injury arose out of or was in the course and scope of his employment. Accordingly, his claim is not compensable.

ORDER

The Referee's order dated October 30, 1989 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's award of $2,618 as an assessed attorney fee to claimant's counsel is reversed.

October 30, 1990 Cite as 42 Van Natta 2474 (1990)

In the Matter of the Compensation of
MIKE S. MAMETIEFF, Claimant
And, in the Matter of the Complying Status of
DEAN A. ROSTAD, dba ROSTAD TIMBER FALLERS, Employer
WCB Case Nos. 88-16434, 88-16435, 88-16436, 88-17141, 88-17142 & 89-04492
ORDER ON REVIEW
Ron Bohy, Claimant Attorney
David Hittle, Attorney
Gracey & Davidson, Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Dean Rostad, an alleged noncomplying employer, requests review of those portions of Referee Irving's order that: (1) found him to be a subject employer on the date of claimant's injury; and (2) declined to set aside the SAIF Corporation's acceptance, on Rostad's behalf, of claimant's injury claim for a forehead laceration, dizziness and headaches. On review, the issues are subjectivity and compensability.

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

A person may contest a proposed order declaring that person to be a noncomplying employer by filing, within 20 days of receipt thereof, a written request for a hearing. ORS 656.740(1). If a request for a hearing is not filed within 20 days of receipt, the order and/or penalty as proposed shall be a final order and shall not be subject to review by any agency or any court. ORS 656.740(3).

In this case, the proposed order finding Rostad to be a noncomplying employer was dated July 14, 1988. His request for hearing was postmarked August 11, 1988. The Referee apparently recognized the issue whether Rostad had timely appealed, but did not reach it because the question of timeliness had not been raised. We do not agree with the Referee's suggestion that the requirement to file a request within 20 days can be waived. As provided above, the requirement is a matter of jurisdiction and, therefore, cannot be waived.

Nonetheless, there is nothing in the record as to when Rostad received the proposed order. Therefore, there is no evidence that Rostad's request was not filed within the 20 day period. Consequently, we turn to the merits of Rostad's hearing request. After conducting our review, we agree with the Referee's findings and conclusions that Rostad was a subject employer on the date of claimant's injury.

Subsequent to the Referee's order, the Board issued Kristi L. Chase, 42 Van Natta 1247 (1990). Under Chase, Rostad can only defeat the compensability of claimant's claim upon a showing of misrepresentation, fraud or other illegal activity, because he failed to request a hearing from SAIF's September 12, 1988 acceptance of claimant's claim within 60 days from August 2, 1988, the date SAIF received notice of the claim. Because Rostad has made no such showing, claimant's claim is compensable. See also John A. Tallant, 42 Van Natta 939 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $500. In reaching this conclusion, we have particularly considered the complexity of the issues, the time devoted to the case (as represented by claimant's respondent's brief), and the value of the interest involved.

ORDER

The Referee's order dated April 20, 1989 is affirmed. For services on review, claimant's attorney is awarded a $500 assessed fee, payable by the SAIF Corporation on behalf of the noncomplying employer.

October 30, 1990 Cite as 42 Van Natta 2475 (1990)

In the Matter of the Compensation of
RICHARD L. MILLS, Claimant
WCB Case Nos. 89-14611 & 89-12037
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Woodrow W. Pollock, Jr., Defense Attorney
Sharon Schooley (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Irving's order that upheld denials of compensability issued by the SAIF Corporation on behalf of Molalla Transport

Systems, Inc. and Commercial Driving Service on the ground that claimant was not an Oregon subject worker. On review, the issue is compensability (subjectivity). We affirm.

FINDINGS OF FACT

We adopt those portions of the Referee's order headed "Stipulated Facts," "Findings of Fact" and "Findings of Ultimate Fact" with the following qualifications. In lieu of the Referee's finding that trucks were dispatched from the Vancouver office after July 1986, we find that after July 1986 trucks were dispatched by Fred Magenheimer, Rocky Compton, and Art Funkhouiser. All were based in Vancouver, Washington. However, Magenheimer and Funkhouiser worked from time to time at Molalla Car & Truck, where the trucks were repaired, and at other locations as necessary. These men were contacted by drivers, from time to time, at locations other than the Vancouver office to receive dispatch orders.

We make the following additional findings:

After each haul, a truck is inspected. Trucks are inspected at the Vancouver yard or, if the attention of a mechanic is required or if the next load will be picked up closer to Molalla than to Vancouver, at Molalla Car & Truck.

When claimant first contacted Mr. Magenheimer regarding employment in November 1986, he was hired immediately. He was instructed to pick up a truck at Molalla Car & Truck and get a load of Christmas trees in Estacada for transport to California. There was no discussion at that time of the anticipated duration of claimant's employment; he was hired for an indefinite term. There was no discussion of the nature of the loads or the location of the shippers or the destinations to which claimant might subsequently be dispatched.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Opinion and Conclusions. There is no basis in the record for claimant's contention that claimant was hired only to haul Christmas trees from Oregon.

ORDER

The Referee's order dated October 25, 1989 is affirmed.

October 30, 1990 Cite as 42 Van Natta 2476 (1990)

In the Matter of the Compensation of
BENJAMIN G. PARKER, Claimant
WCB Case No. 85-10591
ORDER ON REVIEW
Dean Heiling, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Howell's order which: (1) did not assess a penalty for late payment of medical services; (2) assessed a penalty in the amount of 15 percent of all temporary disability due from April 17, 1984 through January 17, 1986; and (3) did not assess a penalty for the self-insured employer's failure to pay a previously ordered penalty. On review, the issue is penalties. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant contends that the Referee erred in not assessing penalties on two issues and not assessing a greater penalty on the third issue. We disagree.

Medical Services and Penalties

The Referee, in his order on remand, did not address whether penalties were due for the late payment of medical services. The Referee had decided that issue in his first order and had found that the issue of penalties for late payment of medical services was barred by res judicata. Claimant contends that since that order was remanded by the Court of Appeals, Parker v. D. R. Johnson Lumber Co., 93 Or App 675 (1988), the Referee erred in not assessing penalties on that issue. We disagree.

In the Referee's first order, he found that the issues of penalties for late payment of medical services and late payment of temporary disability were both barred by res judicata. The Board affirmed. Claimant appealed to the Court of Appeals and asserted the Referee's failure to assess penalties on both of these issues in a single assignment of error. In its decision, the Court of Appeals concluded that:

> "Claimant is entitled to penalties and attorney fees for late payment of temporary total disability benefits now due. Because of our disposition of the petition for review, we do not reach claimant's remaining assignments.
>
> "Reversed and remanded to the referee for a determination of benefits, penalties and attorney fees." Parker v. D. R. Johnson Lumber Co., supra, 93 Or App at 676. (emphasis added).

We read the remand to address only the determination of what temporary disability benefits were due and to assess a penalty thereon. Therefore, we believe the issue of late payment of medical services is outside the scope of the court's remand order. The Referee was correct in not addressing this issue. Claimant is thus not entitled to a penalty for the late payment of medical services for the reasons stated in the Referee's original order.

Temporary Disability and Penalties

We adopt the Referee's "Conclusion" on this issue as our own.

Late Penalties and Penalties

Claimant contends that the Referee should have assessed a penalty for the nonpayment of previously ordered penalties. The employer contends that claimant did not raise this issue in the original proceeding and, therefore, cannot raise it for the first time now on review. We agree with the employer.

When an issue is not raised at hearing and the record is closed, that issue will not subsequently be considered. Mavis v. SAIF, 45 Or App 1059 (1980); Richard C. Centeno, 41 Van Natta 619, 620 (1989); Randy D. Johnson, 39 Van Natta 463, 465 (1987). We have reasoned that to address an issue that was not raised at hearing would be fundamentally unfair. See Gunther H. Jacobi, 41 Van Natta 1031 (1989).

In this case, the issues stated at the original hearing were claimant's entitlement to penalties and attorney fees for the employer's late payment of medical services and late payment of temporary disability. (Tr. 5). No other issues were raised or addressed by the parties or the Referee. Since the issue was not raised in the original proceeding, it cannot be raised now after this matter has gone through Board review, to the Court of Appeals and then back to the Referee on remand.

Even if that were not the case, claimant would still not be entitled to an award of a penalty for nonpayment of a penalty. Penalties are not "compensation" within the meaning of ORS 656.382. MacDonald v. Safeway, 87 Or App 86 (1987); Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Bahler v. Mail-Well Envelope Co., 60 Or App 90 (1982). Since penalties are not compensation, there is no basis upon which to award an additional penalty under ORS 656.262(10).

ORDER

The Referee's order dated December 14, 1989 is affirmed.

October 31, 1990 Cite as 42 Van Natta 2478 (1990)

In the Matter of the Compensation of
IVAN J. ADAMS, Claimant
WCB Case No. 87-12162
ORDER ON REVIEW
Malagon & Moore, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of that portion of Referee Miller's order that upheld the insurer's "de facto" partial denial of claimant's low back spondylolysis (vertebral dissolution) and spondylolisthesis (slipped vertebral disc). On review, the issues are improper denial and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the "FINDINGS" portion of the Referee's order with the following supplementation.

In November 1985 claimant compensably injured his low back and shortly thereafter submitted a claim for a low back strain. A subsequent 827 form diagnosis reported lumbar strain and spondylolisthesis. A second 827 form reported "L5-S1 Spondylolisthesis [sic]."

Claimant became medically stationary on December 18, 1985. The insurer accepted the claim on January 31, 1986, stating that "[w]e are accepting your claim for workers' compensation benefits." Claimant's low back injury claim was closed by Determination Order on April 17, 1986, with no permanent disability award.

Shortly before hearing on December 16, 1987, the insurer advised claimant that it was denying compensability of his spondylolysis and spondylolisthesis on grounds that they preexisted claimant's injury claim and were not worsened by his work activities.

CONCLUSIONS OF LAW AND OPINION

Improper Denial

The Referee found that claimant's spondylolysis and spondylolisthesis were not accepted by the insurer and, accordingly, that the insurer's partial denial was not an improper "back-up" denial. Bauman v. SAIF, 295 Or 788 (1989). We agree.

The 801 form that claimant originally submitted stated that he had sustained a "strain" to his "low back." The claim was deferred. Subsequent medical reports revealed that claimant had congenital spondylolysis and spondylolisthesis, conditions unrelated to his injury. The insurer accepted the claim by Notice of Acceptance dated January 31, 1986, stating that "[w]e are accepting your claim for workers' compensation benefits." The Notice of Acceptance enclosed a copy of the 801 form.

We do not agree with claimant that the insurer's acceptance should be construed to include the acceptance of claimant's congenital conditions. The acceptance, albeit inartfully worded, accepted claimant's low back condition only insofar as the industrial injury caused his low back strain, the injury indicated on claimant's 801 form. Under those circumstances, we find that the insurer's later denial does not deny a previously accepted condition and therefore conclude that the denial is valid. See Johnson v. Spectra Physics, 303 Or 49 (1987).

Compensability

The Referee further found that claimant's spondylolysis and spondylolisthesis were not compensable. We disagree insofar as the Referee found claimant's increased symptoms from those conditions not to be compensable.

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). An injury that does not worsen a preexisting condition, but which precipitates symptoms causing disability or requiring medical services, is compensable as to such symptomatic worsening. There is, however, no liability for the underlying condition per se. Donald L. Call, 39 Van Natta 672 (1987). Under those circumstances, claimant need not prove that the compensable injury caused a pathological worsening of his preexisting condition. See Jameson v. SAIF, 63 Or App 553, 555 (1983). Rather, he need only show that the compensable injury caused his condition to become symptomatic, causing disability or requiring medical services. Grace v. SAIF, 76 Or App 511, 517 (1985).

Here, it is undisputed that claimant's congenital conditions preexisted his injury claim and were not pathologically worsened by the compensable injury. However, Dr. Carter, claimant's treating physician since July 1986, opined that the compensable low back strain materially contributed to the onset of symptoms of claimant's underlying back conditions, including the spondylolysis. Those symptoms, which required treatment and resulted in a period of disability, resolved in December 1985, at which time claimant was released to regular work. We conclude, therefore, that claimant's temporary symptomatic increase of his spondylolysis and spondylolisthesis resulting from the compensable low back injury was compensable until it resolved in December 1985.

Claimant's counsel is entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review for prevailing on the issue of the compensability of claimant's increased symptoms. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(6), and applying them to this case, we find that $1,500 is a reasonable assessed fee for claimant's

counsel's efforts. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue presented, and the value of the interest involved.

ORDER

The Referee's order dated March 9, 1988 is affirmed in part and reversed in part. The insurer's "de facto" denial is upheld insofar as it denied responsibility for claimant's underlying congenital conditions. The insurer's "de facto" denial is set aside insofar as it denied claimant's temporary symptomatic increase of his spondylolysis and spondylolisthesis resulting from the compensable low back injury. The claim for this temporary symptomatic increase is remanded to the insurer for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review, claimant's attorney is awarded a $1,500 assessed fee, to be paid by the insurer.

October 31, 1990 Cite as 42 Van Natta 2480 (1990)

In the Matter of the Compensation of the Beneficiaries of
WARREN E. BECHTOLT, SR. (Deceased), Claimant
WCB Case No. 88-11825
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Mulder's order that upheld the SAIF Corporation's denial of his injury or occupational disease claim for a thromboembolic stroke. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except we find that claimant's stroke occurred on March 31, 1988.

CONCLUSIONS OF LAW AND OPINION

Injury claim

To prevail under an "injury" theory, claimant must establish by a preponderance of the evidence that his work was a material contributing cause of his disability or need for treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Harris v. Albertson's Inc., 65 Or App 254, 257 (1983). Here, SAIF does not dispute that claimant did exert himself more than usual on the day of his stroke. The issue is whether his work exertion was a material contributing factor in causing or precipitating the stroke. This case is sufficiently medically complex that medical causation must be established by medical experts. Somers v. SAIF, 77 Or App 259, 262 (1986). In this case, we do not give special deference to the opinions of examining physicians, because resolution involves expert analysis, rather than expert external observation. See Allie v. SAIF, 79 Or App 284, 287 (1986).

Dr. Feldstein, M.D., offers the only medical opinion supporting a causal relationship between claimant's exertion at work on March 31, 1988 and his stroke. Feldstein stated that it is well known that physical activity increases blood pressure; that claimant's hypertension was likely to be the major cause of his stroke; and concluded that increased blood pressure "probably accelerated the thrombotic process." (Ex. 12-4).

The medical evidence is in agreement that claimant suffered a thromboembolic stroke. Dr. Young, nephrologist specializing in hypertension, opined that the stroke was caused by claimant's preexisting atherosclerosis and that a thromboembolic stroke is not caused by contemporaneous elevated blood pressure. (Tr. 58-9; 76-8). Dr. Reimer, treating neurologist, opined that claimant's stroke resulted from his high cholesterol, preexisting hypertension and weight. (Exs. 5a-1, 7, 11). Young and Reimer concluded that the stroke was unrelated to claimant's work.

We are persuaded by the opinions of Young and Reimer, rather than Feldstein, for two reasons. First, the former doctors are specialists, with expertise relevant to evaluating claimant's condition. Feldstein is not. See Abbott v. SAIF, 45 Or App 657, 661 (1980).

Second, Young and Reimer both distinguished between thromboembolic and hemorrhagic strokes. They agreed that claimant's stroke was thromboembolic and based their conclusions regarding its etiology at least partially on that distinction. Although Feldstein apparently agreed that claimant's stroke resulted from an accelerated thrombotic process, he did not acknowledge the resulting implications regarding causation. We are persuaded by the opinions of Young and Reimer, because we find them to be more qualified and their opinions better reasoned. See Somers, supra.

Occupational disease claim

Alternatively, claimant contends that his stroke was caused by stress at work and, consequently, is compensable as an occupational disease. Claimant's last exposure to potentially causal employment conditions occurred on March 31, 1988, the day of his stroke. We, therefore, apply ORS 656.802 as amended effective January 1, 1988, and before its amendment on July 1, 1990. Ellen Crawford, 41 Van Natta 1362 (1989).

In order to prevail under an occupational disease theory, claimant must prove that his employment materially contributed to his condition. Former ORS 656.802(1); Donna E. Aschbacher, 41 Van Natta 1242 (1989). The medical evidence indicates that two contributing causes of his stroke were his preexisting hypertension and atherosclerosis. Under such circumstances, claimant has not proven that work-related stress was a material cause of his stroke.

ORDER

The Referee's order dated September 29, 1989 is affirmed.

October 31, 1990 Cite as 42 Van Natta 2481 (1990)

In the Matter of the Compensation of
CHARLES P. BODDY, Claimant
WCB Case No. 89-07150
ORDER ON REVIEW (REMANDING)
Gary M. Carlson, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Baker's order which upheld the insurer's denial of claimant's aggravation claim for bilateral carpal tunnel syndrome. On review, the issue is aggravation. We remand.

FINDINGS OF FACT

Claimant worked for the instant employer as a custodian. In July 1987, he filed a claim for bilateral carpal tunnel syndrome which was accepted by the insurer. He underwent carpal tunnel release surgery on both arms in late 1987. Claimant's claim was closed by a July 1988 Determination Order which awarded 5 percent scheduled permanent disability for loss of use or function of the right arm, as well as 5 percent scheduled permanent disability for loss of use of the left arm. Claimant requested a hearing on the Determination Order and his award was increased by Opinion and Order to 15 percent for the right arm and 20 percent for the left arm.

In December 1988, claimant began working at Fairline Marine as a delivery driver and sweeper. Fairline Marine is insured by another carrier under the Longshoremen's and Harbor Workers' Compensation Act. During the course of his duties at Fairline, claimant was required to drive a late model truck with a standard transmission. He was further required to lift boxes weighing 50 pounds in order to deliver the boxes. After performing these duties claimant experienced increased pain symptoms in his wrists and forearms.

In February 1989, Dr. Neuman released claimant from work due to increased forearm and wrist symptoms. Claimant filed an aggravation claim with the insurer. This claim was denied in April 1989 on the basis that his condition was caused by the work at Fairline. Claimant also filed a claim with Fairline Marine under the Longshoremen's and Harbor Workers' Compensation Act.

FINDINGS OF ULTIMATE FACT

Claimant's 1987 compensable injury is a material contributing cause of his current bilateral wrist and forearm condition.

Claimant's work activities at Fairline Marine independently contributed to a pathological worsening of his underlying bilateral wrist and forearm condition.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's denial solely on the basis that claimant's work activities at Fairline Marine independently contributed to his current bilateral wrist and forearm condition. We agree claimant's work activities with Fairline independently contributed to his current condition. However, the record is incomplete with regard to the status of his claim against Fairline Marine. We therefore remand this matter for further development of the record.

Where claimant has a compensable claim in Oregon and thereafter experiences an injury or injurious exposure with an employer in another jurisdiction, the Oregon employer remains responsible for the condition if the Oregon injury remains a material contributing cause of that condition, just as it would where the alleged worsening occurred off the job. Grable v. Weyerhaeuser Co., 291 Or 387 (1981); Miville v. SAIF, 76 Or App 603 (1985). However, if it can be shown that the out-of-jurisdiction employment or injury independently contributed to a worsening of the underlying condition, then to establish a compensable aggravation claim, claimant must show that he filed for benefits in the foreign jurisdiction and that those benefits were finally determined not to be compensable. William B. Simpson, 41 Van Natta 1811 (1989). See also, Olson v. EBI Companies, 78 Or App 261 (1986); Miville, supra; Harry C. Clark, 38 Van Natta 1371 (1986).

Here, Dr. Woolpert opined that claimant's industrial injury was a material contributing cause of claimant's current bilateral wrist and forearm condition. Dr. Woolpert, however, also opined that claimant's work activities at Fairline

Marine independently contributed to a pathological worsening of his current condition. Dr. Neuman concurred with Dr. Woolpert's opinion. There is no medical evidence to the contrary.

We conclude therefore that claimant has established that his compensable injury remains a material contributing cause to his current bilateral wrist and forearm condition. We further conclude that the work activities at Fairline Marine independently contributed to a pathological worsening of his underlying bilateral wrist and forearm condition.

Although the evidence suggests that claimant has filed a claim with Fairline Marine under the Longshoremen's and Harbor Workers' Compensation Act, it is unclear whether a final determination has been achieved. Consequently, as in William B. Simpson, supra, we remand to the Referee for hearing to determine whether claimant has been "awarded" compensation from his Longshoremen's and Harbor Workers' Compensation claim. If so, the worsening is not compensable under the Oregon claim. If the claim has been finally determined not to be compensable under the Longshoremen's Act, the worsening is compensable under the Oregon claim.

ORDER

The Referee's order dated August 4, 1989 is vacated. This matter is remanded to Referee Baker for further proceedings consistent with this order.

October 31, 1990 Cite as 42 Van Natta 2483 (1990)

In the Matter of the Compensation of
BOBBY E. BONNER, Claimant
WCB Case No. 89-08676
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Shelly McIntyre (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Bennett's order that upheld the SAIF Corporation's denial of his current psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact

CONCLUSIONS OF LAW AND OPINION

The date of "injury" for purposes of determining the compensability of an occupational disease is the date upon which the claimant was last exposed to the employment conditions that caused the disease. Johnson v. SAIF, 78 Or App 143, 146-48, rev den 301 Or 240 (1986). Here, claimant's occupational disease claim for his current psychological condition alleges exposure to potentially causal employment conditions occurring after January 1, 1988. We therefore apply ORS 656.802 as amended effective January 1, 1988 (See Oregon Laws 1987, Chapter 713, Section 4) and before its amendment on July 1, 1990 (See Oregon Laws 1990, (Special Session) Chapter 2, (SB 1197 A - Engrossed), section 43). Ellen L. Crawford, 41 Van Natta 1257 (1989).

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

"(2)(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.

" (b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.

" (c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

" (d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

In the present case, claimant's treating psychotherapist, Dr. Fuller, reported that claimant's difficulties with his supervisor were the major contributing cause of his need for psychological help. Claimant had previously stated that the supervisor, Mr. Goff, disapproved of him because of claimant's prior divorce and failure to attend church. Claimant also felt that his suggestions at work were disregarded and that Mr. Goff excluded him from involvement in the budget process and equipment purchases. Claimant contended that, in the past, employees had been able to drop by Mr. Goff's office, but now, appointments were required. Finally, claimant testified that his shift was changed after he accidentally left lights on at work and ran down a generator's batteries.

Claimant asserts that the examples provided above prove that his supervisor was retaliating against him for both his divorce and his filing of grievances. Claimant contends that Mr. Goff's alleged harassment and retaliation against him are the cause of his mental disorder and need for psychological treatment. We disagree.

Claimant is unable to point to specific examples that demonstrate that Mr. Goff retaliated against him because of his divorce, his religious beliefs or his filing of grievances. We are also unable to conclude that claimant was excluded from the budget process or that his opinion was purposely disregarded. Claimant acknowledged that he was able to make an appointment to talk to Mr. Goff, but that he became impatient and decided not to wait for his appointment. Finally, we are not convinced that claimant's shift change demonstrates retaliation by his supervisor. Although claimant testified that his shift was changed because of his grievances and/or prior divorce, he initially reported that the shift change resulted from the incident involving his failure to turn off the lights at work.

We conclude that the employment conditions claimant contends have caused his mental disorder, i.e., exclusion, harassment and retaliation by Mr. Goff, are not employment conditions that exist in a real and objective sense. Although he may have believed that he was being persecuted by his supervisor, we conclude that the conditions perceived by claimant did not exist in an objective sense, as required by ORS 656.802(2)(a).

We conclude that claimant has failed to prove that his current psychological condition is compensable. In addition, because claimant has failed to prove the first element of ORS 656.802, we decline to address the remaining elements of the statute.

ORDER

The Referee's order dated October 16, 1989 is affirmed.

In the Matter of the Compensation of
DAVID L. DANIELS, Claimant
WCB Case No. 88-03489
ORDER ON REVIEW
Gatti & Gatti, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Davis' orders which: (1) upheld the portions of the self-insured employer's denial which denied compensability of right shoulder sprain, cervical sprain with muscle spasm, myositis, radiculopathy, and compensability of chiropractic treatments as not reasonable and necessary treatment for an accepted carpal tunnel syndrome claim; (2) declined to assess a penalty and related attorney fee for an allegedly unreasonable denial; (3) declined to award an attorney fee for claimant's prevailing on the employer's request to terminate temporary disability benefits; and (4) awarded claimant's attorney an assessed fee of $1,400 for prevailing on a portion of the employer's denial. Claimant also contends that the Referee erred in excluding Exhibits 24-28. The employer cross-requests review of that portion of the Referee's order which set aside a portion of its denial. We affirm in part and reverse in part.

ISSUES

Claimant contends that all his shoulder and neck problems are compensable either as sequelae of his accepted carpal tunnel syndrome or as a separate occupational disease. The employer contends that its denial never denied that shoulder and neck problems were sequelae of the accepted carpal tunnel syndrome. Rather, it contends, it denied that certain enumerated conditions (right shoulder strain, cervical sprain with muscle spasm, myositis and radiculopathy) are compensable either as sequelae of the accepted carpal tunnel syndrome or as a separate occupational disease. Consequently, it argues that claimant prevailed on no portion of the denial.

Claimant contends that chiropractic treatments are reasonable and necessary treatments for the compensable carpal tunnel syndrome.

Claimant contends that the employer raised an issue of termination of temporary disability benefits and that he prevailed on that issue. Consequently, he seeks an assessed fee for prevailing on that issue.

Claimant contends he is entitled to a penalty and attorney fee for an allegedly unreasonable denial.

Claimant contends that he is entitled to a greater fee than awarded by the Referee for prevailing on a portion of the denial. As noted, the employer contends that claimant did not actually prevail on any portion of the denial. Consequently, it argues that he is entitled to no assessed fee for prevailing on the denial.

Finally, claimant contends that the Referee erred in excluding proposed Exhibits 24 through 28.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. At hearing, the employer requested that the Referee terminate claimant's temporary disability benefits; the Referee did not do so. The Referee had no authority to terminate temporary disability benefits. The employer's denial

encompasses only certain enumerated conditions. It does not deny shoulder and neck pain as sequelae of the accepted carpal tunnel syndrome.

CONCLUSIONS OF LAW AND OPINION

We adopt those portions of the Referee's conclusions under the headings "Chiropractic treatment" and "Penalties and Fees." We also adopt that portion of the Referee's third paragraph which denies claimant's motion to admit Exhibits 24 through 28 into evidence.

We accept Dr. Karasek's opinion that claimant's shoulder and neck pain is due to referred pain from the accepted carpal tunnel condition. We have found that the employer never intended to deny this referred pain, but only the conditions enumerated in its denial. We base that finding on the language of the denial itself as well as the employer's counsel's statement at the beginning of the hearing that: "there are, in fact, these other conditions, we think the evidence will establish, which are not even causally related to the carpal tunnel problem and claimant's chiropractor is relying on this double crush theory...." We understand from this statement that the employer was merely contending that claimant did not suffer a separate injury or occupational disease to the shoulder and neck and that the accepted claim did not cause the "other conditions" enumerated in the denial. In its brief, the employer concedes that the referred pain is compensable. Because the employer never denied the referred pain and that is what is compensable, we conclude that claimant has not prevailed on the denial. Therefore, claimant's attorney is not entitled to an assessed fee for prevailing on the denial.

Likewise, we conclude that claimant's attorney is not entitled to an assessed fee in connection with the employer's attempt to terminate temporary disability benefits. This issue was originally raised by a letter from claimant's counsel in which he stated:

> "Claimant requests a hearing on the employer's request to suspend claimant's workers' compensation benefits under ORS 656.325(2)."

At hearing, the employer's counsel again raised the issue. He noted that the Department of Insurance and Finance had not terminated temporary disability benefits pursuant to ORS 656.325. He then stated:

> "I think we're within our rights to turn around and say to you, Mr. Referee, you can take a look at this situation. You can authorize us to stop paying time loss...."

Claimant objected to the employer's raising the issue at that point. The Referee took the matter under advisement, but did not address it in his orders.

We conclude that the Referee was without authority to rule on the employer's request to terminate temporary disability benefits. ORS 656.325(2) allows an insurer or self-insured employer to suspend temporary disability benefits for failure to submit to a surgery "with the consent of the director." Former OAR 436-60-105, the rule applicable in this matter, provided the mechanism for obtaining the Director's consent to a suspension. Former OAR 436-60-008, the rule applicable to this matter, provided that if a party is aggrieved by a decision of the Director on any matter concerning a claim, that party may request a hearing with the Hearings Division. Because the statute gives the Director authority to consent to a suspension and the rules provide the mechanism for the

exercise of that authority, we conclude that under former OAR 436-60-008 the parties must go through the mechanisms for suspension in the Director's rules before requesting a hearing which would invoke the Hearing Division's jurisdiction.

Therefore, claimant's request for a hearing on the employer's "request to suspend benefits" was premature and did not vest the Hearing Division with jurisdiction. At that time, the Director had apparently not acted on the employer's request and neither party was aggrieved. On the other hand, the employer did not request a hearing on the Director's alleged refusal to terminate benefits. Rather, the employer, midway through the hearing, simply verbally raised this issue. Claimant, at that point objected. The employer's raising of the issue at hearing over claimant's objection is not sufficient to request a hearing or to invoke the Hearing Division's jurisdiction. Accordingly, this matter was not properly before the Referee. Therefore, claimant is not entitled to an attorney fee under either ORS 656.382(2) or ORS 656.386(1).

ORDER

The Referee's order dated May 11, 1989, as reconsidered October 18, 1989, is affirmed in part and reversed in part. That portion of the Referee's order which set aside a portion of the employer's denial of March 1, 1988 is reversed. The denial is reinstated and upheld in its entirety. That portion of the Referee's order which awarded claimant's attorney a $1,400 assessed fee for prevailing on that denial is reversed. The balance of the Referee's order is affirmed.

October 31, 1990 Cite as 42 Van Natta 2487 (1990)

In the Matter of the Compensation of
DOMINIC R. GORDON, Claimant
WCB Case No. 89-10089
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Black's order that assessed a penalty and related attorney fee for an allegedly unreasonable claim closure pursuant to ORS 656.268(3)(f). On review, the issue is penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found the insurer's issuance of a Notice of Closure unreasonable because claimant was not medically stationary and there was evidence of permanent disability on the date of closure relying on Volk v. SAIF, 73 Or App 643 (1985). On this basis, he assessed a penalty and related attorney fee against the insurer. 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). It is claimant's burden to prove that he was not medically stationary at the time of closure. Post closure changes in claimant's condition are not considered. Scheuning v. J. R. Simplot & Co., 84 Or App 622 (1987).

We agree that the insurer's action in prematurely closing the claim was unreasonable. However, in so deciding we do not consider, as did the Referee, the existence of permanent disability, evidence of which, is not relevant to the determination of premature claim closure. Accordingly, we confine our analysis to consideration of claimant's medically stationary status on the date of closure, March 14, 1989.

We find that the alleged closing report authored by claimant's treating physician, Dr. Glas, dated March 14, 1989, did not indicate that claimant was medically stationary. The report, although noting that claimant had returned to regular work, indicated claimant did not have full control of his hands, that he had "lock down" problems with the fifth digits on each hand, continuing pain at the base of thumb, limited range of motion in his hands, and decreased grip strength.

Thus, we find it was unreasonable for the insurer to assume a medically stationary status based upon the above report. Accordingly, we find the Notice of Closure issued by the insurer to be unreasonable, and subject to a penalty equal to 25 percent of all compensation determined to be then due at the time of hearing, but not less than $1,000. See ORS 656.268(3)(f).

In this regard, we note that the Referee stated that the parties stipulated that the "compensation due to claimant at closure would not exceed $4,000." Therefore, the Referee concluded that a penalty of $1,000 was appropriate. Although we agree $1,000 is the appropriate penalty amount, we do so on slightly different grounds. Determination of the penalty amount is to be determined at the time of hearing, not the time of closure. See ORS 656.268(3)(f). In our de novo review, we note the parties during closing arguments stipulated that the compensation due did not exceed $4,000. (Tr 5-6). In the absence of evidence to the contrary, we will assume the compensation amount stipulated to was at the time of hearing. Inasmuch as the parties have agreed to the amount of penalty based upon the compensation then due, we find a penalty of $1,000 appropriate.

We now turn to the issue of whether or not claimant is entitled to an assessed attorney fee. Entitlement to an attorney fee is statutory. Korter v. EBI Companies, Inc., 46 Or App 43, 52 (1980). We therefore, consider whether claimant would be entitled to an attorney fee under former ORS 656.262(10) and ORS 656.382(1). In Ellis v. McCall Insulation, 308 Or 74, 78 (1989), the Court noted that the basis for an attorney fee is not hinged to "amounts then due." Instead ORS 656.262(10), the Court explained, 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. Ellis, supra; SAIF v. Wilson, 95 Or App 748 (1989); Lloyd L. Cripe, 41 Van Natta 1744 (1989).

As previously discussed, we have found that the Notice of closure was unreasonably issued. At the time of closure, on March 14, 1989, claimant was working full time. The preponderance of the evidence indicates claimant was working a modified job, at his regular wage. Thus, we conclude, that no time loss was due and owing at the time of closure. See Safeway Stores v. Owsley, 91 Or App 475 (1988).

However, subsequent to the Notice of Closure, claimant became unable to work due to the injury. On April 24, 1989, claimant was taken off work by his treating physician, and did not return to modified work at regular wage until July 6, 1989. (Exs 5A, 6, 10, 11). Thus, we conclude that due to the unreasonable claim closure, claimant's temporary disability was unreasonably delayed. Thus, we find that there has been an unreasonable resistance to the payment of

compensation. Claimant is therefore entitled to an assessed attorney fee. Former ORS 656.262(10); 656.382(1). See Earl F. Childers, 40 Van Natta 481 (1988).

Inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for successfully defending the Referee's order concerning these issues.

ORDER

The Referee's order dated September 7, 1989 is affirmed.

October 31, 1990 Cite as 42 Van Natta 2489 (1990)

In the Matter of the Compensation of
JAY A. HAGAN, Claimant
WCB Case No. 88-04831
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of that portion of Referee Galton's order that set aside its denial of claimant's claim for his current low back condition on the grounds claimant had sustained a compensable aggravation. On review, the issue is the procedural propriety of SAIF's denial. We modify.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" portion of the Referee's order with the following supplement.

Claimant, a production line chop saw operator, compensably injured his low back on July 8, 1987, while pulling a pallet stacked with alder boards. He completed his shift but woke up the next morning with low back pain. He sought emergency room care and was diagnosed with mild middle and low back strain. X-rays revealed evidence of some degenerative disc changes in the low back and old compression injuries to the thoracic spine. Claimant returned to work on July 13, 1987, but quit three days later for reasons unrelated to his injury. Claimant has not returned to work.

On September 8, 1987, SAIF accepted claimant's claim for a nondisabling "temporary low back strain." On September 23, 1987, claimant began treating with Dr. Cleary for pain in the middle back, low back and hips. In his report of that date, Dr. Cleary diagnosed recurrent lumbar muscle strain and old compression fractures in the middle back, authorized time loss from work and prescribed physical therapy. The time loss authorized was for the period from September 16, 1987 to November 25, 1987.

On December 2, 1987, claimant underwent an independent medical examination by Dr. Duff, an orthopedist. Despite claimant's complaints of low back pain occasionally radiating into the right thigh and clicking and popping sensations in the right hip, Duff found no objective evidence of physical impairment and declared claimant medically stationary.

Claimant had earlier been examined by Dr. Lisac, upon referral from Dr. Cleary. Dr. Lisac's exam findings were similar to those of Dr. Duff.

In mid-December, 1987, claimant began treating with Dr. Shipp, a chiropractor, for pain and stiffness in the low back and right hip. In a December 14, 1987 report, Shipp diagnosed chronic moderate to severe lumbar strain/sprain and chronic moderate sacroiliac sprain.

It is unclear whether SAIF viewed Dr. Cleary's reports of September, 23, 1987 and December 3, 1987 or Dr. Shipp's report of December 14, 1987 as a claim for reopening; however, on December 18, 1987, SAIF denied the compensability of claimant's then-current low back condition, contending that his condition was unrelated to the accepted low back injury. Claimant's accepted nondisabling claim has never been closed.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's denial, concluding that claimant had proven a compensable aggravation of his accepted injury. He remanded the claim to SAIF for further processing, including payment of temporary disability benefits and referral to the Evaluation Section for issuance of a Determination Order. We instead set aside SAIF's denial on procedural grounds.

Former ORS 656.262(12) provides, inter alia, that a worker has one year from the date of an accepted nondisabling injury to submit a claim that the injury has become disabling. Upon receiving notice or knowledge of that claim, an insurer is required to report it immediately to the Director. Id. The Evaluation Section then determines whether the accepted injury claim is disabling or nondisabling and issues a Determination Order to that effect. ORS 656.268(8). Any party dissatisfied with the Determination Order can request a hearing on the Determination Order on that issue. Former ORS 656.268(6).

Here, claimant's claim for the July 8, 1987, industrial injury was accepted as nondisabling. Within three months of that injury, Dr. Cleary notified SAIF by report dated September 23, 1987, that he was treating claimant in connection with the accepted injury and was authorizing time loss from work (Ex. 5). By letter dated December 3, 1987, Dr. Cleary confirmed that he had authorized over two months of time loss from work (Ex. 9). Based on those reports, we find that SAIF had notice of claimant's claim that his injury had become disabling and that such notice was received within one year of the date of the accepted injury.

However, there is no evidence that SAIF ever submitted that claim to the Director in accordance with ORS 656.262(12). Rather, SAIF denied the claim on the ground claimant's current condition was not causally related to the accepted injury. In so doing, SAIF effectively sought to circumvent the statutory provisions which allow claimant to seek reclassification of his nondisabling injury as disabling. That is impermissible and is analogous to an impermissible preclosure denial. See Safstrom v. Riedel International Inc., 65 Or App 728 (1983). On that procedural ground alone, we set aside SAIF's denial.

We lack jurisdiction to comment on whether the accepted nondisabling injury has, in fact, become disabling, because the Evaluation Section has not yet issued a Determination Order pursuant to ORS 656.268(8). Upon issuance of that Determination Order, any interested party may then vest jurisdiction with the Hearings Division by requesting a hearing on that order pursuant to former ORS 656.268(6).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services n review concerning the denial issue is $700 to be paid by SAIF. In reaching this decision, we have particularly considered the time devoted to the

case (as identified in the statement of services submitted by claimant's attorney).

ORDER

The Referee's order, dated July 19, 1988, is modified in part and affirmed in part. The portion of the Referee's order directing the SAIF Corporation to pay claimant temporary total disability benefits from September 16, 1987 through November 25, 1987 is vacated. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed fee of $700, payable by SAIF, for services rendered on Board review concerning the denial.

October 31, 1990 Cite as 42 Van Natta 2491 (1990)

In the Matter of the Compensation of
DAWNA M. HEATHMAN, Claimant
WCB Case No. 87-10543
ORDER ON REVIEW
Wilbur Smith, Jr., Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

The self-insured employer requests review of Referee Wasley's order that: (1) admitted evidence disclosed to the employer more than seven days after receipt, but submitted to the Referee ten days prior to the scheduled hearing; (2) set aside the employer's denial of claimant's occupational disease claim for right carpal tunnel syndrome; and (3) awarded an assessed fee on the compensability issue. On review, the issues are evidence, compensability and attorney fees. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

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

On September 1, 1987, the employer requested disclosure of certain reports from claimant's treating orthopedic surgeon, Dr. Thiel. Claimant's attorney mailed Dr. Thiel's reports to the Hearings Division on or about November 5, 1987. The reports were received by the Hearings Division on November 9, 1987, ten days prior to the scheduled hearing on November 19, 1987. Defense counsel received copies of Dr. Thiel's reports on November 11, 1987.

At the request of defense counsel, the hearing was reset for November 18, 1987. As a result, the Hearings Division received Dr. Thiel's reports nine days prior to the actual hearing. At hearing, defense counsel objected to the introduction of Dr. Thiel's reports on timeliness grounds. The Referee admitted the reports, but left the record open for cross-examination of Dr. Thiel or submission of rebuttal evidence.

CONCLUSIONS OF LAW AND OPINION

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

On review, the employer contends that claimant did not produce Dr. Thiel's reports until the day of hearing, and that the Referee improperly admitted the reports. It argues that the reports were improperly admitted because they were not timely disclosed or timely filed as exhibits with the Referee. We disagree.

Contrary to the employer's assertion, claimant did not produce Dr. Thiel's reports on the day of hearing. The Hearings Division received the reports on November 9, 1987, and claimant served copies of the reports on the employer on November 11, 1987.

Pursuant to former OAR 438-07-005(3)(b), claimant was required to submit exhibits for admission at hearing "[n]ot less than ten (10) days before the scheduled date of hearing, or within seven (7) days of mailing of a copy of the insurer's exhibit index, whichever occurs later . . . ." Claimant was required to serve copies of the submitted exhibits on all other parties, but was not required to do so within any specific time frame. Id.

Here, claimant filed the reports with the Hearings Division within ten days of the hearing, as originally scheduled for November 19, 1987. Accordingly, the exhibits were timely submitted under former OAR 438-07-005(3)(b).

The employer argues that the reports were, nonetheless, not admissible because they were not filed with the Referee within seven days of receipt. Apparently, the employer is referring to the so-called "seven day rule" that allowed claimants to submit exhibits less than ten days prior to hearing so long as they were submitted within seven days of receipt. See former OAR 438-07-005(3)(b) (effective November 5, 1985 through April 14, 1987 and October 14, 1987 through November 16, 1987); Dorothy L. Packard, 40 Van Natta 823 (1988). That rule was effective at the time claimant submitted Dr. Thiel's reports to the Referee, but not on the date of hearing.

Assuming, without deciding, that the seven day rule applies here because it was in effect on the date claimant submitted Dr. Thiel's reports, the employer's reliance on the rule is misplaced. The rule provides an alternative means of submitting evidence; it does not come into play where, as here, a claimant timely submits exhibits within the ten day deadline.

We turn to the employer's alternative argument that the reports were improperly admitted because they were not timely disclosed. Pursuant to former OAR 438-07-016(3)(WCB Admin. Order 3-1987), claimant was required to disclose claims information then in her possession to the employer within 15 days of a request for disclosure. Failure to timely disclose was "a ground for exclusion of the document from evidence on the motion of an adverse party . . . ." Id. We interpret this language to mean that exclusion of a document not timely disclosed was within the discretion of the Referee.

Here, claimant disclosed Dr. Thiel's reports more than 30 days after the employer's request for disclosure. Therefore, the disclosure was not timely under former OAR 438-07-016(3). Nevertheless, the Referee cured any surprise or prejudice to the employer by leaving the record open for cross-examination of Dr. Thiel or submission of rebuttal evidence. Under the particular circumstances of this case, the Referee's admission of the reports was not an abuse of discretion.

Accordingly, we affirm the Referee's evidentiary ruling.

ORDER

The Referee's order dated December 31, 1987 is affirmed. Claimant's attorney is awarded a $325 assessed fee for services on review concerning the compensability issue.

In the Matter of the Compensation of
PAMELA J. HUDDLESTON, Claimant
WCB Case No. 86-13452
ORDER ON REVIEW
Callahan & Gardner, Claimant Attorneys
Ruth Cinniger (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Menashe's order that: (1) declined to grant claimant's request to submit additional documentary and testimonial evidence; and (2) upheld the SAIF Corporation's denials of her aggravation claim for a back, neck, shoulder and arm condition. On review, the issues are evidence and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Summary of Facts" and make the following additional findings.

The December 1985 stipulation was claimant's last award of compensation. Claimant experienced increased neck, shoulder and arm symptoms in May 1986, as compared to her symptoms at the time of the stipulation.

At the time of the stipulation, claimant was restricted from carrying more than 20 pounds, lifting more than 10-20 pounds from the floor, and performing more than occasional repetitive pushing, pulling and grasping. Claimant did not work during the period September 1985 through March 1987 for reasons unrelated to her physical restrictions.

On September 18, 1986, SAIF denied claimant's aggravation claim on the grounds that she had not experienced a worsening and she had refused to attend an independent medical examination. On October 20, 1986, SAIF issued a second denial of the aggravation claim on the ground that the condition had not worsened.

As part of its closing argument at hearing, SAIF for the first time argued that claimant's increased cervical symptoms were not causally related to her compensable injury. Claimant's attorney moved for reopening of the evidentiary portion of the hearing to offer documentary and testimonial evidence in response to the causation challenge. The Referee allowed claimant to testify further on this issue, but otherwise denied the motion.

FINDINGS OF ULTIMATE FACT

Claimant's condition has not worsened since the last arrangement of compensation in December 1985.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not demonstrated that her cervical condition was causally related to her compensable injury. Accordingly, he upheld SAIF's aggravation denials. On review, claimant contends that the Referee erred in not allowing her to submit additional evidence in response to SAIF's causation defense, and she requests remand for further development of the record on this issue. In the alternative, claimant contends she has established a compensable aggravation on the merits.

To establish an aggravation, claimant must show that her condition has worsened since the last arrangement of compensation and that the worsened condition is materially related to her compensable injury. 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.

Assuming, for the sake of argument, that all of claimant's increased symptoms are causally related to the compensable injury, claimant has not established a worsening of her condition since the last arrangement of compensation in December 1985. As a result, our decision regarding the evidence and causation issues raised on review would not change our ultimate disposition of this case. Accordingly, we confine our discussion to the worsening analysis.

There is evidence that claimant's back, neck, shoulder and arm symptoms were greater in May 1986 than at the time of the stipulation. However, claimant has not established that she was less able to work as a result of her symptomatic flare-up.

Here, the last arrangement of compensation is the December 1985 stipulation pursuant to which claimant received an additional 20 percent unscheduled permanent disability. On June 24, 1985, claimant's treating physician, Dr. Smith, an orthopedic surgeon, opined that she was permanently restricted from carrying more than 20 pounds, lifting more than 10-20 pounds from the floor, and performing more than occasional repetitive pushing, pulling and grasping. We accept Dr. Smith's opinion because his assessment was closest in time to the December 1985 stipulation, he was claimant's treating physician, and there is no evidence that claimant's condition changed after his opinion and prior to the December 1985 stipulation. Therefore, we conclude that his report accurately describes claimant's limitations at the time of the stipulation.

At the time claimant reported increased symptoms in 1986, she had not worked since September 1985 for reasons unrelated to her physical limitations. The record, therefore, contains no "release from work" to support her position.

Claimant's treating chiropractor, Dr. Krasowski, opined that claimant's condition had worsened in May 1986. He further opined that she had been unable to perform any type of work without aggravating her condition since May 16, 1986.

Dr. Hoffman, the consulting neurologist, advised claimant on May 30, 1986 to avoid housework and prolonged sitting. On August 28, 1986, Dr. Hoffman restricted claimant to "a light type of activity" involving no heavy or repetitive lifting or repeated extension of the neck.

Finally, Dr. Tobin, orthopedic surgeon, opined that claimant's condition had not objectively worsened since she was examined by the Consultants in August 1984. He based his opinion on his independent medical examination on October 14, 1986.

We are not persuaded by Dr. Krasowski's opinion because he did not explain the basis for the opinion; he only began treating claimant in April 1986; and we cannot ascertain whether he had the opportunity to fully review claimant's prior medical record.

Further, Dr. Hoffman's opinion does not persuade us that claimant was less able to work as a result of her symptomatic flare-up. When claimant returned to Dr. Hoffman on July 7, 1986, Hoffman noted that claimant's symptoms had decreased despite the fact she apparently had not restricted her housekeeping and sitting as he recommended on May 30, 1986. We are, therefore, not persuaded

that claimant was unable to perform housework or sit for prolonged periods of time when Dr. Hoffman examined her on May 30, 1986. Dr. Hoffman's subsequent restriction to "a light type of activity" is not significantly different than Dr. Smith's restriction in December 1985.

Claimant told Dr. Tobin in October 1986 that she was unable to lift anything because of weakness in her left lower arm. However, her subjective limitation is inconsistent with Dr. Tobin's finding of normal upper extremity strength on examination. Claimant testified that, at the time of the alleged aggravation, she had difficulty carrying things and going up stairs. However, it is not clear to what degree these activities were limited.

We conclude this record is not sufficient to carry claimant's burden of proving that she was less able to work as a result of her alleged aggravation. Accordingly, we affirm the Referee's ultimate conclusion that claimant has not established a compensable aggravation.

ORDER

The Referee's order issued November 17, 1987 is affirmed.

October 31, 1990 Cite as 42 Van Natta 2495 (1990)

In the Matter of the Compensation of
WILBUR A. LEWIS, Claimant
WCB Case Nos. 87-16921, 87-15619 & 87-12042
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney
Foss, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Quillinan's order that: (1) denied claimant's motion to continue or postpone the hearing to allow for the deposition of his treating physician; (2) addressed an oral denial of claimant's cervical condition made by Liberty Northwest Insurance Corporation at the hearing and appealed by claimant at the hearing; and (3) upheld Liberty Northwest's denial of that condition. Claimant also seeks remand for the taking of additional evidence. On review, the issues are remand and the Referee's procedural and evidentiary rulings. We deny the motion to remand and affirm.

FINDINGS OF FACT

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

The Board received claimant's hearing request on October 13, 1987. A "Specification of Issues" accompanied his request and listed, inter alia, compensability, medical services, extent of scheduled and unscheduled disability, responsibility, and penalties and attorney fees. Claimant identified Liberty Northwest as the carrier with regard to his request and these issues.

At the hearing, Liberty Northwest explained that it was denying responsibility for claimant's current cervical condition. Claimant appealed Liberty Northwest's denial at hearing. However, contending that he was "not ready" to proceed, claimant sought postponement or continuance in order to depose Dr. Campagna. (Tr. 3).

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant seeks remand for the taking of additional testimony from Dr. Campagna. He argues that his case was incompletely heard, without such testimony regarding the causation of claimant's current cervical condition. Claimant contends that he failed to depose Campagna, due to a "crush" of cases unexpectedly scheduled for hearing.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5). To merit remand, it must be established that the evidence relevant to the issues raised in the remand request was unobtainable with due diligence before the hearing. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Several opinions regarding the etiology of claimant's condition from Dr. Campagna are already present in the record. (Exs. 18, 19, 20, 22, 23, 25, 26 & 27). Campagna's final diagnosis was "post-traumatic aggravation of cervical spondylosis at C5-6 and C6-7 secondary to the motor vehicle accident of February 27, 1987." (Ex. 22). His opinion was unchanged after performing cervical decompression on July 20, 1987. (Ex. 26). Consequently, we do not consider the record -- without another opinion from Dr. Campagna concerning the causation of claimant's current cervical condition -- to be incompletely, improperly, or otherwise insufficiently developed.

Moreover, claimant requested a hearing on November 5, 1987 and approximately a month passed between the Board's Notice of Hearing and the January 27, 1988 hearing. On this basis, we are not persuaded that another opinion from Dr. Campagna was unobtainable by the time of the hearing with the exercise of due diligence. Consequently, we deny claimant's motion for remand.

Application of ORS 656.307

Claimant contends that the Referee was without authority to consider the issue of responsibility for claimant's cervical condition between Liberty Northwest and SAIF. Specifically, he argues that the amendments to ORS 656.307(2), requiring appointment of an arbitrator, apply to this case because the hearing was held on January 27, 1988. We disagree.

First, the case came before the Hearings Division when claimant requested a hearing, not when the hearing was held. Claimant's hearing request was received by the Hearings Division on October 13, 1987, before the amendments took effect on January 1, 1988. Moreover, because no ".307 order" issued, that statute did not govern the hearing, which was correctly assigned to a Referee rather than an arbitrator. See former OAR 436-60-180(13); Timothy R. Schroeder, 41 Van Natta 568 (1989).

Liberty Northwest's denial

The Referee upheld Liberty Northwest's denial of claimant's cervical condition, after finding that claimant's current complaints are due to a motor vehicle accident unrelated to his work with Liberty's insured. We agree and adopt the Referee's conclusion.

Claimant contends that Liberty Northwest's oral denial should be ineffective, citing ORS 656.262(6) and (8). He argues that his subsequent oral

request for a hearing on that issue was a premature request which did not permit the Referee to address the denial. We disagree.

Liberty Northwest conceded at hearing that claimant's first mention of a neck problem resulted from an April 23, 1987 chart note by Dr. Smith. (Tr. 8). Smith's chart note of that date states that "[claimant] has been having increasing pain in the neck and back." (Ex. 17D-2). Smith's chart note dated June 24, 1987, states that "[claimant] has been seen by Dr. Campagna, who has found some spurs in his neck which require resection. This is scheduled for early July." (Id.) The aforementioned notes were sent to Liberty Northwest on July 9, 1987. (Id.)

Notice or knowledge of a claim includes sufficient facts to lead a reasonable employer/insurer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate. See Argonaut Ins. Co. v. Mock, 95 Or App 1 (1989). Because Smith sent chart notes to Liberty Northwest which indicated that claimant was having neck problems, for which surgery was scheduled, and because Liberty Northwest had an accepted left shoulder claim, we conclude that the insurer had notice of its potential liability.

Liberty Northwest did not respond to the claim. It neither accepted nor denied the claim for a cervical condition within 60 days of its notice, as required by ORS 656.262. Such failure to act constitutes a "de facto" denial. Barr v. EBI Companies, 88 Or App 132 (1987). We conclude that Liberty Northwest had effectively denied claimant's claim for his cervical condition by November 1987.

Claimant's hearing request supports this conclusion. The request listed responsibility in the specification of issues. In addition, claimant identified Liberty Northwest as the "carrier." By requesting a hearing raising the issue of responsibility and listing Liberty Northwest as the insurer, claimant requested a hearing from Liberty Northwest's "de facto" denial of his cervical condition. Thus, claimant sought to postpone a hearing to allow further preparation, based on an issue he had already raised. Because claimant failed to show extraordinary circumstances beyond his control, we conclude that the Referee properly declined to grant claimant's motion to continue or postpone the hearing. Former ORS 656.283(4); OAR 438-06-081(3). We further hold that the Referee had authority to consider all issues raised by the parties, including the responsibility issue raised by claimant.

ORDER

The Referee's order dated March 1, 1988 is affirmed.

October 31, 1990 Cite as 42 Van Natta 2497 (1990)

In the Matter of the Compensation of
WALTER MANCHUR, Claimant
WCB Case No. 88-15223
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Brown's order that set aside its partial denial of claimant's current thoracic-lumbar and bilateral arm condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant was involved in a compensable motor vehicle accident on May 30, 1986. This claim was accepted per the 801 by the insurer as a disabling injury on June 13, 1986.

On June 28, 1986, claimant's treating physician, Dr. Versteeg, described claimant's injuries resulting from the motor vehicle accident as "right leg and right arm injuries." He diagnosed "Closed fractures right tibia and fibula. Fractured right wrist."

Claimant became medically stationary from his injuries on July 7, 1987. A Determination Order issued on July 31, 1987, awarding claimant scheduled permanent partial disability for both the right leg and right forearm.

On November 11, 1987, claimant sought treatment from Dr. Crisp, a chiropractor. Claimant's subjective complaints were recorded as "dull pain thru (sic) out body, inability to sit or stand without discomfort for moderate periods, lack of feeling in thigh, pain in arms after carrying heavy object." Dr. Crisp diagnosed "Lumbar-Thoracic neural compression syndrome. Brachial radiculitis to segmental dysfunction of cervical spine with resulting brachial muscle weakness."

On January 14, 1988, Referee Baker signed a stipulated order granting claimant additional scheduled permanent partial disability for the right leg and right forearm.

Claimant underwent surgery for the "removal of Lottes nail, right tibia."

On June 26, 1988, Dr. Crisp made a further diagnosis of "moderate sciatica to the left ankle, as well as bilateral muscle weakness in the arms secondary to neck subluxations."

By report, Dr. Versteeg reaffirmed that claimant's tibial fracture was completely healed and stationary. In this same report Dr. Versteeg indicated he had not treated claimant for his back, and had not referred claimant to anyone else for any back problems.

On August 8, 1988, the insurer issued a partial denial. The partial denial stated that claimant's "non-displaced right wrist fracture, closed fractures of the right tibia and fibula" were accepted parts of the claim. The partial denial also indicated that claimant's current condition diagnosed as "moderate low back pain in the lower thoracic upper lumbar region, as well as severe pain in both arms" was denied. (Ex. 29).

ULTIMATE FINDINGS OF FACT

Claimant's compensable May 30, 1986 injury was not a material contribution to claimant's current thoracic-lumbar and bilateral arm conditions.

CONCLUSIONS OF LAW AND OPINION

From a substantive perspective, the Referee found that claimant failed to prove that the compensable May 1986 injury was materially related to claimant's current thoracic-lumbar and bilateral arm conditions. We agree. However, the Referee also concluded as a matter of law that the partial denial was procedurally improper as a back up denial, relying on Georgia-Pacific v. Piwowar, 305 Or 594 (1988). With this conclusion, we disagree.

We note that the parties have framed their respective arguments in terms of whether or not the insurer's partial denial was an impermissible back up denial under Bauman v. SAIF, 295 Or 788 (1983).

Here, the insurer issued a denial which on its face accepted a right leg and right wrist fracture condition, and denied a thoracic-lumbar and bilateral arm conditions. There is no medical evidence that the denied condition is either the cause or a symptom of any accepted condition. Accordingly, we do not find that the denial is an attempt to deny the entire claim from the outset. Rather, we find that the denial went no further than to attempt to deny a separate aspect of the claim. Therefore, the denial at hand was not a back up denial under Bauman.

We note that the Referee, as did the parties, made much of the fact that the 801 claim form indicated "All" with reference to body parts affected. However, in finding that the denial here is a partial denial it matters not what was originally accepted. The insurer is not foreclosed from denying current conditions unrelated to the previously accepted condition or injury.

To conclude, we do not find the denial as issued by the insurer to be a procedural bar in going forward. We turn to the merits.

In an injury case, a worker must prove by a preponderance of the evidence that the industrial injury was a material contributing cause of his existing disability or need for medical treatment. Harris v. Albertson's Inc., 65 Or App 254 (1983).

Here, the medical evidence indicates that the thoracic-lumbar and bilateral arm conditions are unrelated to the accepted claim. The conditions did not arise until 18 months after the motor vehicle accident. Although Dr. Crisp opined a relationship, she did not treat claimant until 18 months after the initial injury. Thus, her opinion is based on a history provided by claimant.

In contrast, claimant's treating physician, Dr. Versteeg, who treated claimant throughout this period for continuing right leg difficulties, indicated that claimant did not report back problems to him. On this basis, Dr. Versteeg found it unlikely that the back was causally related to the motor vehicle accident.

In consideration of the conflicting medical histories provided by claimant, and the fact Dr. Versteeg treated claimant during the intervening period of time between the initial injury and the subsequent conditions, we find Dr. Versteeg's opinion more persuasive.

Accordingly, we find there is no persuasive medical evidence that the thoracic-lumbar and bilateral arm conditions are related to the accepted injury. Accordingly, we find the insurer's partial denial was procedurally and substantively valid.

ORDER

The Referee's order dated December 29, 1988, is reversed. The insurer's partial denial is reinstated and upheld. The Referee's attorney fee award of $1,500 is reversed.

In the Matter of the Compensation of
ROBERT W. MCDONALD, Claimant
WCB Case No. 88-04585
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of that portion of Referee Livesley's order which set aside its denial of claimant's aggravation claim for a back and neck condition. Alternatively, claimant contends that he is entitled to an increase in unscheduled permanent disability, beyond the 31 percent (99.2 degrees) awarded by Determination Order. On review, the issue is aggravation and alternatively, extent of unscheduled permanent disability. We reverse with regard to the aggravation issue and modify claimant's award of unscheduled permanent disability.

FINDINGS OF FACT

Claimant has worked for the employer for several years. The last ten years he has worked as a forklift operator. In November 1984, he sustained a compensable injury which was diagnosed as a lumbar thoracic-cervical strain. He sought treatment for this injury from Dr. Herbert, chiropractor. In June 1985, he sustained another compensable injury to his low back and right hip. As a result of these injuries, claimant underwent a L4-5 bilateral lumbar laminectomy in November 1985 which was performed by Dr. Smith, neurosurgeon.

Following the surgery, claimant attempted to return to work. He continued to experience some pain and discomfort. In February 1987, claimant fell at work and reinjured his back. Dr. Smith diagnosed a herniated disc at L5-S1 and recommended further surgery. In September 1987, Dr. Smith performed a decompression and neurolysis with the removal of the herniated disc at L5-S1. Claimant responded well to the surgery and his claim was closed by a February 5, 1988 Determination Order which awarded him 15 percent unscheduled permanent disability.

In late February 1988, claimant experienced increased symptoms and his claim was reopened. In June 1988, claimant underwent a lumbar laminotomy of L5-S1 with discectomy and full neurolysis as well as a decompression foraminotomy. Following surgery, claimant underwent a physical therapy program. He completed the program and was returned to full-time work as of December 3, 1988.

On January 9, 1989, Dr. Herbert reported that claimant had experienced a flare-up of his back condition and indicated that he was not medically stationary. Claimant continued to work until January 11, 1989 at which time he went on strike. Claimant's claim was closed by Determination Order on January 26, 1989. The Determination Order increased claimant's unscheduled permanent disability award to 31 percent. The Determination Order found claimant medically stationary as of December 2, 1988. Claimant timely appealed the Determination Order with regard to the extent of permanent disability.

Dr. Herbert released claimant from work as of February 15, 1989. On February 28, 1989, the employer denied claimant's aggravation claim.

Claimant is 46 years of age and has obtained a GED. For the last ten years he has been employed as a forklift operator. As a result of his injury, he is restricted to work in the light to medium category. As a result of his injury, claimant has unoperated disc bulges at L4-5 and L5-S1 and has lost 20

percent of his thoracolumbar extension. Also as a result of his injury, claimant has difficulty doing repeated lifting, bending and twisting which involves movement of his back.

FINDINGS OF ULTIMATE FACT

Claimant's condition has not worsened since the last arrangement of compensation.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established an aggravation. We disagree.

For every aggravation claim of an unscheduled condition, claimant must show increased symptoms or a worsened underlying condition and which results in diminished earning capacity. Edward D. Lucas, 41 Van Natta 2272 (1989). In those cases in which the last award of compensation anticipated future periods of increased symptoms or exacerbation of the physical condition, accompanied by a diminished earning capacity, claimant must also prove that his earning capacity was diminished longer or in greater degree than was anticipated or that resulted in 14 consecutive days of total disability or inpatient hospitalization. Id.

Here, the last arrangement of compensation was the January 26, 1989 Determination Order. Prior to that time, Dr. Herbert reported that claimant was not medically stationary and was experiencing a "flare-up" of his condition. He further indicated that he had a material worsening of his condition as of his January 16, 1989 treatment. Although Dr. Herbert eventually released claimant from work following the Determination Order, we conclude that the release stemmed from claimant's condition prior to January 26, 1989. Inasmuch as claimant's condition was the same prior to January 26, 1989 as it was subsequent to that date, claimant has not established a worsened condition since January 26, 1989, his last arrangement of compensation. Accordingly, he has not proven a compensable aggravation. See ORS 656.273(1).

We note parenthetically that claimant also did not establish that he was less able to work as a result of his "worsened" condition. Claimant provided no persuasive evidence as to how he was less able to work since the Determination Order. Therefore, assuming claimant's symptoms exacerbated following his last arrangement of compensation, we would still find that he did not establish a compensable aggravation. See Smith v. SAIF, 302 Or 396 (1986).

As we have found that claimant did not sustain an aggravation, we proceed to consider the issue of extent of unscheduled permanent disability.

The Determination Order awarded claimant 31 percent unscheduled permanent disability as a result of his back condition. We modify.

In this case, the "standards" adopted effective January 1, 1989 through October 1, 1990, (former OAR 436-35-001 et seq), apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to

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

Age.

The appropriate value for claimant's age of 46 years is +1. Former OAR 436-35-290.

Formal education.

The appropriate value for claimant's GED is 0. Former OAR 436-35-300(3).

Skills.

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of hearing is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of hearing was 3 as a forklift operator (DOT # 921.683-050). Therefore, the appropriate value for skills is +3. Former OAR 436-35-300(4).

Training.

Former OAR 436-35-300(5) provides for a value of +1 for workers who do not have competence in a specific vocational pursuit. The "standards" do not define the term "specific vocational pursuit." We conclude that OAR 436-35-300(5) was intended to differentiate between those who have and those who have not acquired formal or on-the-job training sufficient to perform something other than entry level employment. We therefore interpret " specific vocational pursuit' to mean employment other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

In this case, claimant had 10 years of training as a forklift operator which we conclude provides him with competence in a position other than an entry level position. Claimant is therefore not entitled to a value for training.

Claimant's total education value is +3, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

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

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work required a light to medium

physical capacity. Therefore, the appropriate adaptability value is +2.5. Former OAR 436-35-310(3)(a).

Impairment

In rating claimant's impairment, we rely on the opinion of Dr. Smith. Therefore, claimant is entitled to a value of 2 percent for loss of 20 degrees of thoracolumbar extension. Former OAR 436-35-360(7).

For disability resultant from claimant's surgeries, he is entitled to: 8 percent for unoperated disc bulges at L4-5 and L5-S1, former OAR 436-35-350(2); 9 percent for right and left medial facetectomy at L4-5 and right facetectomy at L5-S1, former OAR 436-35-350(2); and 10 percent for laminectomy with discectomy at L4-5 and L5-S1. These values are added, not combined for a total of 27 percent impairment.

We further conclude that due to his chronic injury condition, claimant has difficulty repeatedly bending, lifting or twisting. Based upon this chronic limited repetitive use of his back, claimant is entitled to an impairment value of 5 percent. Former OAR 436-35-320(4).

Claimant's loss of thoracolumbar extension of 2 percent is combined, not added with the 27 percent impairment due to his prior surgeries for an impairment value of 28.46 percent. Former OAR 436-35-360(11). This figure is then combined, not added, with his 5 percent impairment value for chronic loss of repetitive use of his back for a total impairment value of 32.03 percent. Former OAR 436-35-320(2).

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value +1 is added to his education value +3 the sum is +4. When that value is multiplied by claimant's adaptability value +2.5 the product is +10. When that value is added to claimant's impairment value 32.03 the result is 42.03 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 43 percent.

ORDER

The Referee's order dated June 19, 1989 is reversed in part and modified in part. That portion which set aside the employer's aggravation denial is reversed. The denial is reinstated and upheld. The Referee's award of an assessed attorney fee of $1,750 to claimant's counsel is reversed. In addition to the Determination Order award of unscheduled permanent disability, claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability for a total award of 43 percent (137.6 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
WALTER OLINGER, Claimant
WCB Case No. 88-08610
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Sharon Schooley (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Mills' order that: (1) upheld the SAIF Corporation's "de facto" denial of claimant's aggravation claim for a low back condition; (2) declined to award additional temporary disability benefits; and (3) declined to assess a penalty and attorney fee for SAIF's allegedly unreasonable claims processing. The issues on review are aggravation, interim compensation, penalties and attorney fees. We reverse.

FINDINGS OF FACT

In April 1986, claimant filed an occupational disease claim for a low back condition which apparently began while claimant was working as a truck driver in early February 1985. He had low back pain radiating into the right leg and foot. Low back surgery at L5-S1 in March 1986, relieved those symptoms temporarily. The claim was accepted and later closed by Determination Order on September 29, 1986, with awards of 15 percent unscheduled permanent disability for the low back condition, and 5 percent scheduled permanent disability for the loss of use or function of the right foot (ankle). An MRI scan in November 1986, revealed some degenerative changes at L5-S1 with mild stenosis. By Stipulation and Order dated September 10, 1987, claimant was awarded additional temporary total disability and another 10 percent unscheduled permanent disability.

Meanwhile, claimant left truck driving and trained at his own expense to be an insurance agent. He passed the state insurance exam and, in November 1987, was hired as an independent agent for an insurance firm. He treated regularly with a chiropractor. In February 1988, he sought treatment for increasing low back pain from Dr. Berkeley, a neurosurgeon, who referred him to Dr. Smith, another neurosurgeon, for consultation. Smith diagnosed subligamentous disc protrusion at L5-S1 and recommended surgical re-exploration at L5-S1 with decompression, neurolysis and probable discectomy. Berkeley agreed and requested authorization for surgery by letter dated February 29, 1988. SAIF did not respond to this request.

In mid-March 1988, claimant was referred for evaluation by the Northwest Pain Center (NWPC). At that time, claimant had almost constant pain and burning sensations in the low back radiating into the right leg and foot with numbness and tingling in the toes. He had more frequent sensations of electricity shooting through the right leg. He also had weakness in the right leg and had begun using a cane for support. Doctors at NWPC found clear evidence of S1 nerve root irritation on the right side and concurred with the recommendation for surgery. However, they also reported that claimant was undecided about whether to undergo surgery.

In May 1988, Berkeley again requested authorization for low back surgery. However, claimant elected not to undergo surgery and, instead, enrolled in a pain management program at NWPC. He was admitted on June 22, 1988, and discharged on July 15, 1988, with significant relief of symptoms. He received time loss benefits during his enrollment, although SAIF never accepted or denied the requested surgery. Nor did it accept or deny an aggravation claim.

FINDINGS OF ULTIMATE FACT

Claimant sustained a worsened condition resulting from his compensable low back condition.

SAIF received medical verification of claimant's inability to work.

SAIF unreasonably resisted the payment of compensation.

SAIF unreasonably failed to properly process claimant's aggravation claim.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee found that SAIF had "accepted and properly processed claimant's aggravation claim insofar as it concern[ed] medical services and time loss benefits during the time period that claimant was in [NWPC]." We disagree.

Perfection of Claim

We must first determine whether claimant perfected an aggravation claim. A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation. ORS 656.273(3). Claimant contends that Berkeley's February 29, 1988, letter requesting authorization for further surgery constituted an aggravation claim, notwithstanding the fact claimant remained undecided about whether to undergo the recommended surgery. NWPC's March 28, 1988, report to SAIF states that claimant is "rather ambivalent about a surgical approach and is not sure whether he wants to have the procedure done at this time." (Ex. 14-2). Nevertheless, claimant's ambivalence about having surgery does not negate what otherwise would be a report that would place the insurer on notice of an aggravation claim.

Additionally, we find that claimant's aggravation claim was further perfected by NWPC's March 28, 1988, report. (Ex. 14). The doctors at NWPC reported that claimant has clear signs of S1 nerve root irritation, in contradistinction to the L5 root symptoms he had in the past (Ex. 14-2). Inasmuch as that report evidences a change in claimant's low back condition, it is a claim for aggravation. See Haret v. SAIF, 72 Or App 668, 672 (1985).

Compensability

The payment of compensation alone cannot be considered an acceptance of a claim or an admission of liability. ORS 656.262(9). Therefore, SAIF's voluntary payment of time loss benefits during claimant's participation in the pain center treatment does not evidence an acceptance of claimant's aggravation claim.

To establish a compensable aggravation, claimant must prove a worsened condition resulting from the compensable injury. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986). A "worsened condition" means increased symptoms, or a pathological change, resulting in diminished earning capacity. Perry v. SAIF, 307 Or 654, on remand 99 Or App 52 (1989). Here, the NWPC report of March 28, 1988, shows that claimant's compensable low back condition had pathologically changed so as to involve the S1 nerve root. That pathological exacerbation resulted in claimant's need for pain treatment which, in turn, caused him to be unavailable for work for three weeks.

Additionally, if claimant's condition has worsened he may nonetheless not be entitled to a claim reopening if his last arrangement of compensation anticipated future worsenings, and the particular worsening at issue did not either diminish his earning capacity longer or in greater degree than was anticipated, or result in 14 consecutive days of total disability or inpatient hospitalization. Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); Edward D. Lucas, 41 Van Natta 2272 (1989).

In determining whether a claimant is totally disabled, we do not distinguish between a claimant who is physically unable to work and one who, because of necessary treatment, is unavailable to go to work. See Weyerhaeuser Company v. Surprise, 89 Or App 296, 300 (1988). In this case there is evidence that claimant was disabled for more that 14 days while he was in the pain center program. Claimant's aggravation claim is compensable.

Interim Compensation

The Referee found that there was insufficient evidence that SAIF had knowledge of claimant's inability to work. Consequently, the Referee failed to order payment of time loss benefits beyond what SAIF had voluntarily paid while the claimant was attending the pain center. SAIF had a duty to pay the first installment of interim compensation no later than the 14th day after it received notice or knowledge of medical verification of claimant's inability to work. ORS 656.273(6); Berkey v. Fairview Hospital, 94 Or App 28, 31 (1988); Silsby v. SAIF, 39 Or App 555, 561 (1979). The notification does not establish a substantive right to benefits as of a certain date; rather, it is a procedural mechanism for insuring prompt payments of interim support to claimant pending a substantive determination of compensability. Silsby v. SAIF, supra, 39 Or at 562.

Claimant argues that he is entitled to time loss benefits beginning on March 28, 1988, the date the NWPC issued a report in which they found surgery to be appropriate treatment provided claimant wanted that approach. This report does not authorize time loss; however, it does suggest that he will be capable of returning to work in the insurance industry after the surgery is completed. Moreover, it is undisputed that SAIF was aware of claimant's pain center treatment at NWPC and voluntarily paid time loss benefits during his participation. Therefore, SAIF was aware of claimant's resulting unavailability for work during that period of time. Hence, we find that SAIF received medical verification of claimant's inability to work during his participation in the NWPC program.

Consequently, SAIF was obligated to commence time loss payments and continue paying those benefits until the issuance of its acceptance or denial of the aggravation claim. SAIF properly began payments but improperly terminated them without issuing an acceptance or denial of the aggravation claim. Since the hearing was held on a "de facto" denial basis, interim compensation benefits should have been paid to the date of the hearing.

Penalty and Attorney Fee

Even finding Dr. Berkeley's February 29, 1988 request for authorization for surgery to have been a claim for aggravation, we do not find SAIF's failure to properly process that request to have been unreasonable. Claimant was ambivalent about having the requested medical service and there was no authorization for time loss. The report itself did not indicate a need for other medical services if the surgery was not provided.

However, it is undisputed that SAIF received NWPC's March 28, 1988, report of S1 nerve root irritation. (Ex. 14). Because that report constituted an aggravation claim, SAIF had 60 days from the date of receipt in which to accept

or deny the claim. See ORS 656.262(6). However, SAIF never issued an acceptance or denial of the claim and has offered no reasonable explanation for its failure to do so. Therefore, its conduct was unreasonable. SAIF was also unreasonable in its failure to pay interim compensation beyond the end of claimant's pain center stay.

Because of its unreasonable action, SAIF shall be assessed a penalty equal to 25 percent of all amounts of interim compensation due but not paid through August 8, 1988, the date of hearing. See ORS 656.262(10); Roy W. Smee, 40 Van Natta 1254, 1256-57 (1988). We further conclude that SAIF's failure to issue an acceptance or denial was an unreasonable resistance to the payment of compensation, so that claimant is entitled to a penalty-related attorney fee, payable by SAIF. See ORS 656.382 (1). After considering the factors set forth in OAR 438-15-010 (4), we find that $400 is a reasonable penalty-related fee. In reaching this conclusion, we have particularly considered the time devoted to the penalty issue.

Assessed Fee For Services on Review

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's services at hearing and on review concerning the aggravation denial is $2,250. In reaching this conclusion, we have particularly considered the time devoted to the aggravation issue and the value of the interest involved.

ORDER

The Referee's order dated September 12, 1988, is reversed. The SAIF Corporation's "de facto" denial of claimant's aggravation claim is set aside and the claim is remanded to SAIF for further processing. SAIF shall pay claimant additional temporary disability compensation, commencing June 22, 1988, less amounts paid during claimant's pain center treatment, and continuing until such compensation can be lawfully terminated. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, payable directly to claimant's attorney, not to exceed $3,800. SAIF is assessed a penalty equal to 25 percent of all amounts of interim compensation due under this order through August 8, 1988, the date of hearing. Claimant's attorney is awarded a penalty-related assessed fee of $400, to be paid by SAIF. For services rendered at hearing and on Board review concerning the aggravation denial, claimant's attorney is awarded an assessed fee of $2,250, to be paid by SAIF.

October 31, 1990 Cite as 42 Van Natta 2507 (1990)

In the Matter of the Compensation of
HERMAN H. PLAETH, Claimant
WCB Case No. 89-08782
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Howell and Speer.

The insurer requests review of that portion of Referee Leahy's order that awarded 39 percent (124.8 degrees) unscheduled permanent disability for a right shoulder injury, whereas a Determination Order awarded 18 percent (57.6 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled disability. We modify.

FINDINGS OF FACT

Claimant compensably injured his right shoulder on March 8, 1988, while working as a carpet cleaner. At the time he was injured, claimant also operated a tailor shop. Before his injury, claimant's dry cleaning work involved moving heavy furniture. After his injury, claimant was unable to frequently lift an eight pound iron.

As a result of his injury, claimant underwent arthroscopic surgery on his shoulder in June 1988. Claimant was found to be medically stationary on February 15, 1989. His claim was closed by an April 20, 1989 Determination Order that awarded 18 percent unscheduled disability for his right shoulder, 5 percent scheduled disability for his right arm and temporary total disability.

Claimant was 62 years old at the time of hearing. He received eight years of formal education in Germany and had four years of training as a tailor. During the ten years preceding the date his permanent disability was evaluated, claimant's highest SVP has been 8, for the occupation of tailor.

As a result of the compensable injury, claimant underwent an anterior acromioplasty and resection of the ligaments. In his right shoulder, claimant has loss of range of motion including lost external rotation (from 90 degrees to 70 degrees); lost internal rotation (from 40 degrees to 25 degrees); loss of abduction (from 150 degrees to 110 degrees). As a result of his injury, claimant also has lost strength in his shoulder and has difficulty doing repeated lifting or reaching which involves movement of his right shoulder.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied the version of OAR 436-35-001 et seq, which was in force between January 1, 1989 and October 1, 1990, and in effect at the time of the April 20, 1989 Determination Order. These are the rules which we apply as well.

Unscheduled permanent disability

The Referee found that claimant was entitled to an award of 39 percent unscheduled permanent disability for his right shoulder injury. We modify.

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

Age

The appropriate value for claimant's age of 62 years is 1. Former OAR 436-35-290.

Formal education

The Referee found that there was no evidence as to whether or not claimant had a high school diploma, however, he concluded that because claimant

had four years of training as a tailor, he was not entitled to a value for education. We disagree.

At hearing, claimant testified that the eighth grade education he received in Germany was not equivalent to a high school education or diploma in the United States. We conclude that, because the employer has not shown evidence to the contrary, claimant is entitled to a value for education.

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

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of hearing is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of hearing was 8 as a tailor (DOT # 785.261-014). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Training

Former OAR 436-35-300(5) states:

> "Training:
>
> "(a) For workers who do not have competence in some specific vocational pursuit, a value of plus one shall be allowed.
>
> "(b) For workers who do have competence in some specific vocational pursuit, no value shall be allowed."

The "standards" do not define the term "specific vocational pursuit". We conclude that OAR 436-35-300(5) was intended to differentiate between those who have and those who have not acquired formal or on-the-job training sufficient to perform something other than entry level employment. We therefore interpret "specific vocational pursuit" to mean employment other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

In this case, claimant had four years of training as a tailor, which we conclude provides him with competence in a position other than an entry level position. Claimant is therefore not entitled to a value for training.

Adaptability where claimant has returned to modified work

The Referee concluded that claimant had not returned to his regular work of carpet cleaning (the job at injury), and could no longer frequently lift an eight-pound iron at his current job. The Referee found that claimant was entitled to an adaptability value of 8.

The insurer contends that the Referee should not have applied former OAR 438-35-310(4)(d), because that section applies only to a worker who is not working. We agree. In the present case, claimant had returned to modified work as a tailor, which was one of the jobs he was performing at the time of injury.

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

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

Impairment

The Referee awarded claimant an impairment value of 5 percent for loss of strength in his shoulder as provided by former OAR 436-35-330(19). We agree. The Referee concluded that claimant credibly testified that he could no longer frequently lift an eight pound iron at work. On June 27, 1988, claimant's physical therapist noted that claimant's shoulder strength was limited. Finally, Dr. German, claimant's treating physician, suggested very light duty work with no heavy lifting or overhead work. We therefore conclude that the Referee properly awarded an impairment value under former OAR 436-35-330(19) of 5 percent for claimant's loss of shoulder strength, due to the compensable injury.

As a result of his compensable shoulder injury, claimant underwent arthroscopic surgery. For an anterior acromioplasty and resection of the ligaments, claimant is entitled to an impairment value of 5 percent. Former OAR 436-35-330(14).

As a result of his injury, claimant sustained lost range of motion of his right shoulder. For lost external rotation, from 90 degrees to 70 degrees, claimant is entitled to an impairment value of 2 percent. Former OAR 436-35-330(11). For lost internal rotation, from 40 degrees to 25 degrees, claimant is entitled to an impairment value of 1.5 percent. Former OAR 436-35-330(9). For loss of abduction, from 150 degrees to 110 degrees, claimant is entitled to an impairment value of 2 percent. Former OAR 436-35-330(5). Claimant's impairment values of 5 percent for loss of shoulder strength, 5 percent for resection and 5.5 percent for lost range of motion are combined for a value of 14.7.

In the present case, due to his chronic injury condition, claimant has difficulty repeatedly lifting or reaching. Based upon this chronic limitation on repetitive use of his right shoulder, claimant is entitled to an impairment value of 5 percent. Former OAR 436-35-320(4). The 5 percent impairment value for limited repetitive use of claimant's right shoulder is combined with (not added to) his loss of shoulder strength, resection and lost range of motion value of 14.7 for a total impairment value of 19.0. Former OAR 436-35-320(2).

Computation of unscheduled disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 2, the sum is 3. When that value is multiplied by claimant's adaptability value, 2.5, the product is 7.5. When that value is added to claimant's impairment value, 19.0, the result is 26.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage.

Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 27 percent.

ORDER

The Referee's order dated September 6, 1989 is modified in part and affirmed in part. In lieu of the Referee's award and in addition to the Determination Order award of 18 percent (57.6 degrees) unscheduled permanent disability, claimant is awarded 9 percent (28.8 degrees), for a total award to date of 27 percent (86.4 degrees) unscheduled permanent disability for his right shoulder injury. Claimant's attorney fee is adjusted accordingly. The remainder of the Referee's order is affirmed.

October 31, 1990 Cite as 42 Van Natta 2511 (1990)

In the Matter of the Compensation of
JESSE M. REYNOLDS, Claimant
WCB Case No. 86-04186
ORDER ON REVIEW (REMANDING)
Coons & Cole, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Gruber's order which dismissed his request for hearing with prejudice. In his brief, claimant attempts to introduce additional facts for the Board's consideration. We treat this as a motion to remand. On review the issues are: (1) whether claimant has established extraordinary circumstances which would justify a postponement; and (2) remand. We vacate the Referee's order and remand.

FINDINGS OF FACT

This case was set for hearing on August 15, 1989. On August 5, 1989, claimant's then attorney, wrote the Hearings Division requesting permission to withdraw as claimant's attorney and requesting a postponement so that claimant could obtain another attorney. On August 10, 1989, the Referee wrote to the attorney, with a copy to claimant, granting the motion to withdraw and denying the motion for a postponement. The letter stated:

> "This matter will, therefore, remain scheduled for hearing on August 15, 1989. If claimant desires to obtain new legal counsel, he should do so immediately and that counsel can request postponement, if necessary. If claimant appears at hearing unrepresented by counsel, the referee will have an opportunity to question claimant regarding whether he desires to be represented by counsel, and if so, why a new attorney has not been retained. It will also give the referee an opportunity to set a specific time schedule for a new hearing, if the August 15, 1989 hearing is postponed."

Sometime before the scheduled hearing, claimant contacted his present attorney to obtain representation. The attorney understood claimant to state that the hearing had been postponed; therefore, he advised claimant that neither claimant nor the attorney needed to appear at the scheduled hearing.

Neither claimant nor the attorney appeared at hearing. The Referee dismissed claimant's request for hearing pursuant to former OAR 438-06-071(2) reasoning that claimant had failed to establish extraordinary circumstances which would justify a postponement.

Claimant's attorney requested reconsideration reciting in his motion that claimant had contacted him just before the hearing, that he had understood that the matter was postponed and that he had advised claimant that he did not need to appear. The Referee abated his order. On reconsideration, he adhered to his original order, reasoning that claimant had failed to establish "good cause" for his failure to appear.

Claimant requested review. In his brief on review claimant's attorney recites several "facts" which allegedly support the conclusion that claimant had "good cause" for his failure to appear. The insurer has moved to strike those portions of claimant's brief which recite "facts" not in the record.

CONCLUSIONS OF LAW AND OPINION

MOTION TO REMAND/MOTION TO STRIKE

We decline to remand for the taking of the additional evidence which would support the "facts" recited in claimant's brief. Claimant has made no showing that those facts were unobtainable at the time he requested reconsideration from the Referee. For the same reason, we grant the insurer's motion to strike. We may not consider facts not in the record.

EXTRAORDINARY CIRCUMSTANCES

Former OAR 438-06-071(2) provides:

> "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."

Accepting the representations contained in claimant's attorney's letter moving for reconsideration, we conclude that there were extraordinary circumstances for claimant's failure to appear which would have justified a postponement or continuance. Claimant apparently understood that the hearing had been postponed; at the very least, he communicated that understanding to his new attorney and the attorney, in fact, advised claimant that he need not appear at hearing. Perhaps there was a miscommunication between claimant and the new attorney; nonetheless, the attorney's advice based on his understanding was that claimant need not appear at hearing. The attorney's advice not to appear, under these circumstances, constitutes extraordinary circumstances which would justify a postponement.

The matter will be remanded to the Hearings Division to schedule a hearing on the merits.

ORDER

The Referee's order dated August 21, 1989, as reconsidered by order of November 3, 1989, is vacated. The case is remanded to Referee Gruber for proceedings consistent with this order.

In the Matter of the Compensation of
JOHN J. RICE, Claimant
WCB Case Nos. 89-17221, 89-14510, 89-17220 & 89-16961
ORDER ON REVIEW
John C. O'Brien, Jr., Claimant Attorney
Daniel J. DeNorch (Saif), Defense Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Connecticut Indemnity requests review of Arbitrator Harri's order that: (1) set aside its denial of claimant's "new injury" claim for his current low back condition; and (2) upheld the SAIF Corporation's responsibility denial for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Arbitrator's findings of fact.

CONCLUSION OF LAW AND OPINION

As a preliminary matter, we note that four exhibits were never formally received into evidence. From the conduct of the Arbitrator, it is apparent that he implicitly admitted the exhibits with Connecticut Indemnity's closing argument. We overlook the technical deficiency and consider all evidence in the record. P.D. Hildebrandt, 40 Van Natta 2057 (1988).

Connecticut Indemnity contends that SAIF should be estopped from denying responsibility for claimant's "new injury" claim, because SAIF's denial had been issued prior to the closing of an earlier accepted claim.

The Board answered that argument in Jimmy C. Lay, 37 Van Natta 583 (1985). In Lay, the claimant had an accepted injury claim with the first insurer. Before closure of that claim, he returned to work while a second insurer was on the risk and reinjured the same body part. He filed claims against both insurers. Both claims were denied on responsibility grounds. The second insurer argued that, because the first injury claim remained in open status, the first insurer's denial was procedurally improper in that it circumvented the claimant's right to proper claim closure. See Roller v. Weyerhauser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983). The Board rejected that argument, reasoning that "it is the better policy to allow an insurer to issue a preclosing denial of continued responsibility for an accepted condition where it appears that injuries or conditions attributal to a subsequent employment aggravate or exacerbate the condition such as to make a shift of insurer responsibility appropriate." See also Karl G. Rohde, 41 Van Natta 1837 (1989).

As in Lay, SAIF's responsibility denial was not procedurally improper. While SAIF has not submitted the claim for closure, there is no evidence that its denial intended to deprive claimant benefits or circumvent his right to proper claim closure. SAIF requested, and has received, designation of a paying agent pursuant to ORS 656.307 to ensure that claimant receives benefits while this matter is being resolved. Moreover, the Arbitrator specifically found that SAIF remains responsible for processing its own claim to closure. The effect of SAIF's denial was for claimant's current condition, not for his condition and impairment prior to the date of the denial.

On the issue of responsibility, we review the Arbitrator's order solely on questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989).

Where there is an accepted compensable injury followed by an increase in disability during employment with a later insurer, responsibility is fixed with the insurer that accepted the claim. In order to shift responsibility to Connecticut Indemnity, SAIF must prove affirmatively that the later employment independently contributed to a pathological worsening of the condition. Linda L. Wise, 42 Van Natta 115 (1990).

The Arbitrator found that the persuasive medical evidence established that claimant's work activities after April 1, 1989 contributed independently to his underlying low back condition. He therefore concluded that Connecticut Indemnity is responsible for claimant's low back condition after that date.

The Arbitrator's conclusion is consistent with the applicable law. See Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986); Linda L. Wise, supra. Accordingly, we adopt the conclusions and reasons regarding the issue of responsibility as set forth in the Arbitrator's order.

ORDER

The Arbitrator's order dated April 17, 1990 is affirmed.

October 31, 1990 Cite as 42 Van Natta 2514 (1990)

In the Matter of the Compensation
DENISE A. ROBINSON, Claimant
WCB Case No. 89-08765
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Shelley K. McIntyre (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Schultz order that: (1) declined to dismiss claimant's request for hearing; and (2) assessed a penalty and associated attorney fee for SAIF's alleged improper claims processing. On review, the issues are jurisdiction and penalties and attorney fees. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that SAIF could not argue that claimant's request for hearing was actually an aggravation claim, as the claim had never been properly closed. The Referee concluded that he had jurisdiction to hear the case. We disagree.

Claimant was injured on September 30, 1983. She initially lost no time from work due to her injuries. In a September 24, 1984 Stipulation and Order, SAIF agreed to accept claimant's claim as a nondisabling injury.

At the time of claimant's injury, former ORS 656.268(3) provided that claims for nondisabling injuries could be closed either through a Notice of Closure or by Determination Order. In any event, closure of a claim was required, whether disabling or nondisabling. See Webb v. SAIF, 83 Or App 386, 390 (1987). As the Referee noted, SAIF did not close this claim with a Notice of Closure, and a Determination Order was not issued.

Claimant contends that, as her claim continues in open status, her aggravation rights have never run. If claimant's injury had been misclassified from the outset and had, in fact, always been disabling, then we would agree with her contention. See Davison v. SAIF, 80 Or App 541, modified on recon, 82 Or App 546 (1986). However, we have concluded that claimant's injury was not disabling at the outset.

SAIF's failure to close a nondisabling claim has no effect on claimant's aggravation rights. If the claim that a nondisabling injury has become disabling is made more than one year after the date of injury, the claim is to be treated as an aggravation claim pursuant to ORS 656.273. Former ORS 656.262(11). If the injury was nondisabling and no determination has been made, a claim for aggravation has to be filed within five years after the date of injury, not the date of closure. Former ORS 656.273 (4)(b).

In Richard M. Egli, 41 Van Natta 149 (1989), we held that we would not apply former ORS 656.262(10) [former ORS 656.262(11) in this case] where a claimant is not advised of his or her right to challenge the initial classification of a claim as nondisabling. Egli does not apply in this case.

SAIF initially accepted this claim as nondisabling. Claimant has not shown that she was not notified of her right to challenge the classification of her claim. Claimant did not seek reclassification of her injury from nondisabling to disabling within one year of her injury. See former ORS 656.262(11) (renumbered ORS 656.262(12)). Accordingly, claimant's claim must be treated as an aggravation claim under ORS 656.273, because it is made on the basis that her previously nondisabling injury has become disabling more than one year after the date of injury. See Smith v. Ridgepine, Inc., 88 Or App 147, 149 (1987); Darold W. Miller, 42 Van Natta 2296 (1990).

Because we have found that the present claim is one for aggravation, we must determine whether claimant filed her claim within five years of the date of her September 23, 1983 injury. Claimant's condition became symptomatic in 1985. Although she received occasional chiropractic care for her continuing condition, claimant did not miss time from work due to her injury and no time loss was authorized.

Claimant's condition became disabling in January 1989. In April 1989, SAIF received Dr. Schmidt's report which indicated that claimant had to quit work in 1989 due to back pain. In May 1989, SAIF received Dr. Christensen's report that claimant had time loss due to her 1983 work-related injury. Dr. Christensen reported that claimant was not medically stationary and he recommended chiropractic treatment. We conclude that Dr. Christensen's report put SAIF on notice that treatment for more than continuing conditions was indicated. See Krajacic v. Blazing Orchards, 84 Or App 127 (1987). Accordingly, we find that Dr. Christensen's report constituted a claim for additional medical services.

Although Dr. Christensen's April 27, 1989 letter, received by SAIF on May 2, 1989, was clearly an aggravation claim, this was the first notice of the claim that SAIF received. Consequently, as this notice was not filed within five years of claimant's injury, the aggravation claim is barred. See ORS

656.273(4)(b). Claimant's rights to compensation other than medical services under ORS 656.245 are within the Board's own motion authority. ORS 656.278. The Referee was, therefore, without jurisdiction to hear claimant's case.

Penalties and attorney fees

Because we have found that the Referee did not have jurisdiction over this matter, the associated issue of penalties and attorney fees for SAIF's alleged improper claims processing is also within the Board's own motion authority.

ORDER

The Referee's order dated September 14, 1989 is reversed. Claimant's May 4, 1989 request for hearing is dismissed.

October 31, 1990 Cite as 42 Van Natta 2516 (1990)

In the Matter of the Compensation of
CALVIN L. ROUNSAVILLE, Claimant
WCB Case Nos. 88-08410 & 88-00919
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
David C. Force, Associate Attorney
Karen Werner, Associate Attorney
Beers, et al., Defense Attorneys
Pamela Schultz, Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Lumbermen's Underwriting Alliance (LUA) requests review of those portions of Referee Myers' order which: (1) set aside its denial of claimant's "new injury" claim for his current low back condition; (2) upheld EBI Companies' denial of claimant's aggravation claim for the same condition; (3) rejected LUA's res judicata argument that an October 1987 Stipulation agreement between EBI and claimant estopped EBI from denying responsibility for claimant's current condition; and (4) declined to authorize an offset of temporary total disability payments from April 7, 1988 through April 22, 1989 against future permanent disability payments as a penalty for claimant's interference in the independent medical examination process. On review, the issues are res judicata, responsibility, and offset.

We affirm and adopt the order of the Referee.

The Director may suspend compensation pursuant to procedures established by rule to implement ORS 656.325(1) where a claimant fails to cooperate with efforts to obtain a medical examination. Neither the Board nor its Referees, however, have authority to authorize an offset where compensation has not been suspended.

ORDER

The Referee's order dated August 21, 1989 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $750, payable by Lumbermen's Underwriting Alliance.

In the Matter of the Compensation of
JAY A. SCHECK, Claimant
WCB Case No. 89-07699
ORDER ON REVIEW (REMANDING)
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant, pro se, requests review of Referee Tenenbaum's order which dismissed his request for hearing on the basis that he failed to appear at the hearing. On review, we interpret claimant to contend that the dismissal order should be vacated, with the matter being remanded to the Hearings Division for a hearing on the merits. We remand.

FINDINGS OF FACT

On April 27, 1989, the parties were notified that this case was scheduled for hearing on July 26, 1989 at 11:00 a.m. Claimant, prior to the hearing, missed several Independent Medical Examinations (IME) arranged by the insurer. The insurer moved to have the hearing deferred until claimant complied with the requests to attend an IME. The motion was granted and the hearing was reset on July 26, 1989 for a hearing on August 14, 1989.

On the appointed date, claimant's attorney appeared, but claimant did not. Claimant's attorney had not recently heard from claimant and had no knowledge why claimant did not appear at the hearing. By order dated August 14, 1989, the Referee dismissed claimant's request for hearing for failure to appear.

Following the dismissal, claimant moved the Referee for a reconsideration of her order of dismissal. Claimant did receive the hearing notice, but did not read the notice for himself. He had been released from jail three days prior to the hearing. Claimant believed that the hearing was on August 17, 1989 based upon a representation of a friend with whom he was living.

The Referee reconsidered her order of dismissal on September 21, 1989 and reinstated it on the basis that claimant had not shown "good cause" for his failure to appear. Claimant has failed to show extraordinary circumstances that would justify a postponement under former OAR 438-06-081.

CONCLUSIONS OF LAW AND OPINION

The Referee relied on former OAR 438-06-071 which authorized the Referee to dismiss a request for a hearing for "failure of a party, or the parties' representative to appear at the time and place scheduled for a hearing." Claimant personally failed to appear. However, claimant did appear by counsel. We have recently stated that the dicta regarding the application of former OAR 438-06-071 in Williams v. SAIF, 99 Or App 367 (1989), reversed and remanded 310 Or 320 (1990) is the correct interpretation of the rule and we continue to follow that interpretation. See Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990). It follows that former OAR 438-06-071 does not provide authority for dismissal for failure of a claimant to appear at hearing if claimant's attorney does appear at hearing. Accordingly, the Referee was without authority to dismiss.

We therefore proceed to consider if claimant has by his failure to appear waived his right to appear and testify on his own behalf. To determine this, we need to determine if claimant's failure to appear would be sufficient to justify a postponement under former OAR 438-06-081. In order to gain a postponement former under OAR 438-06-081, claimant must show that extraordinary circumstances

existed to prevent his presence at the hearing. In this case, claimant has failed to do so. Just as the Referee found that claimant had failed to show "good cause" for failing to appear, we also find a lack of extraordinary circumstances.

Claimant had been in jail, but was released three days prior to the hearing. Claimant had received the notice of hearing, but had failed to read it. Claimant instead relied upon a friend's representation that the hearing was scheduled for August 17 rather than August 14. None of these facts sets out good cause for failure to appear at the hearing or extraordinary circumstances that justify a postponement. Therefore, claimant has waived his right to appear at hearing and have his testimony considered. Denette D. Dale, 41 Van Natta 2179 (1989).

We remand this matter to the Referee for a hearing on the merits. At hearing, no exhibits shall be received which were not submitted in connection with the prior hearing, nor shall any witness, including claimant, be permitted to testify who was not available to and planning on testifying at the prior hearing or under subpoena to testify at that hearing. Mario Miranda, 42 Van Natta 405 (1990).

ORDER

The Referee's order dated August 22, 1989, as reconsidered on September 21, 1989, is vacated. This case is remanded to Referee Tenenbaum for further proceedings consistent with this order.

October 31, 1990 Cite as 42 Van Natta 2518 (1990)

In the Matter of the Compensation of
VICKI A. TAYLOR (Wald), Claimant
WCB Case Nos. 88-07602, 88-06779 & 88-02563
ORDER ON REVIEW
Max Rae, Claimant Attorney
Saif Legal Department, Defense Attorney
Acker, et al., Defense Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

St. Paul Fire & Marine Insurance Company (St. Paul) requests review of those portions of Referee Michael Johnson's order which: (1) set aside its denial of claimant's "new injury" claim for her current low back condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. Claimant cross-requests review of that portion of the order which awarded claimant an assessed attorney fee of $2,300. On review, the issues are compensability, responsibility, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. Claimant filed a "new injury" claim with St. Paul's insured on November 20, 1987. After St. Paul denied that claim on a compensability basis, claimant filed an aggravation claim with SAIF on February 19, 1988. SAIF conceded compensability but denied responsibility on an aggravation basis. SAIF requested the issuance of a .307 order. No .307 order issued because St. Paul denied compensability.

FINDINGS OF ULTIMATE FACT

Claimant's low back condition was unexpected from the activity performed.

Claimant's low back condition was sudden in onset.

Claimant's injury on July 2, 1987 while St. Paul's insured was on the risk independently contributed to a worsening of claimant's underlying condition.

No .307 order issued prior to hearing because St. Paul denied compensability. Claimant's entitlement to compensation was at risk at hearing and on Board review.

CONCLUSIONS OF LAW AND OPINION

Compensability and Responsibility

We affirm and adopt the Referee's conclusion and opinion that the event of July 2, 1987, qualifies as a discrete injurious event. We further affirm and adopt the Referee's conclusion and opinion that the injury with St. Paul's insured independently contributed to a worsening of claimant's underlying condition. Therefore, St. Paul is the responsible insurer for claimant's compensable back injury.

Attorney Fees

Claimant argues that the Referee's fee award was made without sufficient factual findings to justify the amount awarded. She further contends that the award was inadequate to compensate her attorney reasonably for his legal services.

Specifically, claimant asserts that a Referee or the Board must, pursuant to Armstrong v. Austen-Hill Co., 90 Or App 200 (1988), provide a detailed explanation as to how it decided on the eight criteria delineated in OAR 438-15-010(6). In Weyerhaeuser Co. v. Fillmore, 98 Or App 567 (1989), the court held that Armstrong does not apply to the awarding of attorney fees. The court indicated that the reviewing forum "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." Id. at 571. Furthermore, the Referee or the Board need only provide an explanation in enough detail to inform the court that all the factors contained in OAR 438-15-010(4) have been considered and that there is a reasonable basis for the award. Diamond Fruit Growers v. Davies, 103 Or App 280 (1990).

Addressing the merits of claimant's contention, we agree that claimant's attorney is entitled to an increased fee. Claimant's counsel provided detailed documentation of his and his assistant's services. On review, we find, as did the Referee, that "[c]laimant's attorney meaningfully participated at hearing, engaged in after-hearing gathering of evidence, and succeeded in proving that the claim was, in fact, compensable." Under the circumstances of this case, and after considering the factors specified in OAR 438-15-010(4), we find that St. Paul should pay claimant's attorney a reasonable fee of $3,500 for his services at hearing.

We further find that a reasonable fee for claimant's counsel's services on review concerning the denial issue is $1,500. We award this amount after considering the factors set forth in OAR 438-15-010(4) and applying them to this

case. We have particularly considered the time devoted to this case (as represented by claimant's respondent's brief), the above average complexity of the denial issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services concerning the award of attorney fees at hearing.

ORDER

The Referee's order dated December 8, 1988 is affirmed in part and modified in part. In lieu of the Referee's award of an assessed fee of $2,300, St. Paul Fire & Marine Insurance Company (St. Paul) shall pay claimant's counsel $3,500 for services at hearing. For services on Board review concerning the denial issue, claimant's attorney is awarded a $1,500 assessed fee, payable by St. Paul. The remainder of the Referee's order is affirmed.

October 31, 1990 Cite as 42 Van Natta 2520 (1990)

In the Matter of the Compensation of
FRANKLYN D. WEAVER, Claimant
WCB Case No. 88-14917
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Gleaves, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Higashi's order which: (1) found that the insurer had not issued an improper "back-up" denial of his preexisting degenerative cervical condition; and (2) upheld the insurer's partial denial of that condition. On review, the issue is improper denial and compensability. We affirm.

FINDINGS OF FACT

Claimant suffered a compensable injury on December 28, 1984. He was treated for strain of the cervical and lumbar spine. Claimant submitted a claim for a "back" strain, which stated that he had injured his back when a prybar slipped.

Claimant had suffered neck injuries prior to his 1984 compensable injury, and also had a preexisting degenerative condition of the cervical spine.

The insurer accepted the claim as disabling in October 1985. In 1988, the insurer issued a partial denial of claimant's degenerative cervical condition.

The compensable injury caused a symptomatic worsening of claimant's degenerative condition.

CONCLUSIONS OF LAW AND OPINION

Improper Denial

Claimant argues that the insurer's denial of his degenerative condition is an improper "back-up" denial. Bauman v. SAIF, 295 Or 788 (1989). We disagree.

The 801 form that claimant originally submitted stated that he hurt his back. Specifically, his claim was for a "back strain." There are medical reports immediately after claimant's injury that indicate he hurt his neck at the same time. The claim was deferred, and on the 801 form the nondisabling injury box was checked. Sometime later, the insurer accepted the "claim" as disabling. Subsequent medical reports revealed that claimant had a preexisting degenerative condition. Additionally, the records revealed that he had had previous injuries to his neck.

The insurer's denial, although inartfully worded, denied claimant's cervical condition only insofar as the December 28, 1984 incident did not cause or aggravate claimant's preexisting cervical condition. Under these circumstances, we conclude that the insurer's denial does not deny a previously accepted cervical condition and therefore is valid. See Johnson v. Spectra Physics, 303 Or 49 (1987). We now turn to the merits.

Compensability

Both parties agree that the insurer's denial encompassed the compensability of claimant's underlying degenerative cervical condition. The Referee concluded that, in order to prevail on the compensability of a preexisting degenerative condition, claimant must show that the compensable injury was the major contributing cause of the onset or worsening of the condition. We disagree.

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). An injury which does not worsen a preexisting condition, but which precipitates symptoms causing disability or requiring medical services, is compensable as to such symptomatic worsening. Claimant need not prove that the compensable injury caused a pathological worsening of his preexisting degenerative cervical condition. 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).

In such a case, where the compensable injury makes a preexisting underlying disease temporarily symptomatic without causing or worsening the disease, the carrier is responsible for payment of benefits resulting from the temporary symptomatic increase. However, there is no liability for the permanent underlying condition per se. Donald L. Call, 39 Van Natta 672 (1987).

Here, though, claimant's compensable injury caused a symptomatic worsening of his preexisting degenerative cervical condition, the results of the injury have long since subsided, and the current cause of claimant's symptoms is solely the preexisting condition. Both the Orthopaedic Consultants and Dr. Spady agree that claimant's current symptoms are related to the progression of his preexisting cervical condition. See Aldrich v. SAIF, 71 Or App 168, 172 (1984).

We are persuaded that the symptomatic worsening of claimant's preexisting cervical condition caused by the industrial injury has resolved and any current treatment is directed toward the preexisting degenerative condition alone. Accordingly, we find that the insurer's denial was appropriate.

ORDER

The Referee's order dated August 21, 1989 is affirmed.

In the Matter of the Compensation of
RONALD L. ZIEMER, Claimant
WCB Case No. 88-16364
ORDER ON REVIEW
Frank J. Susak, Claimant Attorney
Tom Ewing (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Quillinan's order which upheld the SAIF Corporation's denial of low back surgery. SAIF cross-requests review of those portions of the order which: (1) set aside its denial insofar as it denied current medical care; and (2) awarded claimant's attorney an assessed fee of $1,900. On review, the issues are medical services and attorney fees. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

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

There is no evidence of unpaid medical bills existing at the time of SAIF's denial.

CONCLUSIONS OF LAW AND OPINION

Back Surgery

The Referee found that spinal surgery for an L4-5 disc bulge was not reasonable and necessary because claimant's treating physician, Dr. Nash, believed that the surgery would, at best, relieve claimant's pain and improve his quality of life, but probably would not allow claimant to return to productive employment. We agree with Dr. Nash's characterization of the results of surgery, but we find that it is reasonable and necessary treatment.

At all times relevant to this case, an injured worker was entitled to all reasonable and necessary curative or palliative medical care required for a compensable injury. See former 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). Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra

Claimant's treating physician, Dr. Nash, had no doubt that claimant's 1982 compensable injury was the cause of his continuing chronic complaints. Dr. Nash referred claimant to Dr. Thomas who stated that with claimant's long history of back pain and mild changes on MRI, he was a candidate for an L4-5 laminectomy. Dr. Nash agreed with Dr. Thomas and requested surgery reasoning that claimant does have ongoing, intolerable pain and that all other avenues of treatment had been exhausted.

We find the reasoning of Dr. Thomas and Dr. Nash to be persuasive and conclude that surgery for claimant's low back, necessitated by claimant's compensable injury of September 1982, is at the lease palliative and is reasonable and necessary.

Denial of Current Medical Care

The Referee found that, as long as claimant's compensable injury remained a material factor in his need for medical treatment, that treatment could not be denied by SAIF. SAIF argues that the issue of denial of current medical services was not before the Referee. We agree. The issues as framed at hearing did not include current medical treatment. (Tr. 2-3). However, we nevertheless address the issue of the denial of current medical care on review. In this regard, the Board has, on de novo review, set aside denials as prospective if they deny future medical services, even though the issue was not specifically raised on Board review. See Wayne P. Burke, 42 Van Natta 1358 (1990). Because we find that there were no unpaid medical bills at the time of the denial, we conclude that SAIF improperly issued a prospective denial when it denied "current medical care." Evanite Fiber Corp. v. Striplin, 99 Or App 353, 357 (1989).

Attorney Fee For Prevailing Against Denial Of Medical Services

The Referee awarded claimant's attorney an assessed attorney fee of $1,900 for prevailing against the denial of "current medical services." As noted above, the issue of prospective denial was not raised by a party, but the Referee properly set aside the prospective portion of the denial. SAIF argues that $1,900 is an excessive assessed fee, particularly when claimant did not raise or address the issue and no compensation was obtained. We agree and find that $100 is a reasonable assessed fee for prevailing against the prospective denial.

We turn to claimant's attorney fee for services concerning the surgery denial. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the surgery issue is $2,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case and the value of the interest to claimant.

ORDER

The Referee's order dated May 17, 1989, as reconsidered May 26, 1989, is reversed in part, modified in part and affirmed in part. That portion which upheld the SAIF Corporation's denial of low back surgery is reversed. SAIF's August 30, 1988 denial is set aside in toto. That portion which awarded claimant's attorney an assessed attorney fee of $1,900 is modified. In lieu of the Referee's award, claimant is awarded a reasonable assessed fee of $100 for prevailing against a prospective denial. The remainder of the order is affirmed. For services at hearing and on Board review, regarding the denial of surgery, claimant's attorney is awarded a reasonable assessed fee of $2,000.

In the Matter of the Compensation of
THELMA M. BURCH, Claimant
WCB Case Nos. 88-22358 & 88-21535
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
VavRosky, et al., Defense Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Fink's order which: (1) upheld the SAIF Corporation's denial of her aggravation claim for her low back condition; (2) upheld United Pacific Insurance Company's denial of claimant's "new injury" and occupational disease claims for the same condition; and (3) dismissed her request for a hearing from United Pacific's denial because her claim was barred by res judicata. On review, the issues are aggravation, compensability and res judicata. We reinstate claimant's request for a hearing from United Pacific's denial and, on the merits, affirm.

FINDINGS OF FACT

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

Claimant compensably injured her low back in July 1984, while working for SAIF's insured. Her claim was closed by Determination Order on July 14, 1986 awarding her 25 percent (80 degrees) unscheduled permanent disability. A subsequent Stipulation and Order on December 21, 1986 awarded her an additional 10 percent (32 degrees) for a total award of 35 percent (112 degrees) unscheduled permanent disability.

Claimant worked from December 8, 1987 until February 3, 1988 for United Pacific's insured.

Claimant filed an aggravation claim which SAIF denied March 15, 1988. Claimant appealed that denial and a hearing was held on July 12, 1988. On July 20, 1988, claimant was admitted to the hospital for an "aggressive conservative back rest program." (Ex. 59). SAIF's aggravation denial was upheld by Opinion and Order on July 27, 1988, which claimant appealed by request for review to the Board. (Ex. 61).

On October 21, 1988, SAIF denied claimant's second aggravation claim. (Ex. 65). United Pacific denied claimant's "new injury" and occupational disease claim on December 5, 1988. (Ex. 67).

The Board issued its Order on Review on February 14, 1990, affirming and adopting the July 27, 1988 Opinion and Order. Claimant did not appeal the February 14, 1990 Order on Review.

The Referee held that claimant and her husband were not credible.

CONCLUSIONS OF LAW AND OPINION

SAIF's Aggravation Denial

To establish a compensable aggravation under ORS 656.273(1), claimant must prove: (1) her condition has worsened, either in the form of increased symptoms or a worsened underlying condition, rendering her more disabled, either temporarily or permanently, since the last award or arrangement of compensation;

and (2) a causal connection between the worsened condition and the compensable injury. See Smith v. SAIF, 302 Or 396, 399 (1986); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Edward D. Lucas, 41 Van Natta 2272 (1989). Because an unscheduled body part is involved, "more disabled" means increased loss of earning capacity. See Smith v. SAIF, supra.

The last award or arrangement of compensation was made on December 21, 1986 when the Stipulation and Order awarded claimant an additional 10 percent for a total award of 35 percent unscheduled permanent disability. However, as a result of subsequent developments, this is not the date to which we look to determine whether claimant has proven a worsened condition. Rather, claimant must establish her condition has worsened since the July 12, 1988 hearing at which time claimant's condition prior to July 12, 1988 was litigated to final judgment and has been conclusively determined not to have aggravated. Thus, "claim preclusion" bars relitigation of the claim for aggravation against SAIF, to the extent that aggravation is asserted up to July 12, 1988.

We agree with the Referee that there is no persuasive evidence to support a finding that claimant's condition worsened following the July 12, 1988 hearing. We adopt the Referee's reasoning in this regard, and we further note that a medical opinion based upon a noncredible history is not persuasive. Miller v. Granite Construction Co., 28 Or App 473 (1977). Accordingly, claimant has not established that her low back condition worsened after her last arrangement of compensation, and SAIF's denial of claimant's aggravation claim is upheld.

Res Judicata

The Referee concluded that the doctrine of res judicata precludes claimant from asserting a "new injury" or occupational disease claim against United Pacific and its insured. Similarly, United Pacific contends that claimant is precluded from asserting a "new injury" or occupational disease claim on the grounds that a prior Opinion and Order of July 27, 1988, stemming from a hearing to which United Pacific and its insured were not parties, found that claimant's condition had not worsened and claimant's employment with United Pacific's insured could not have independently contributed to a worsening of her underlying condition. We disagree.

The term "res judicata" has been utilized to refer to the preclusive effect on a claim ("claim preclusion") and on an issue ("issue preclusion"). North Clackamas School Dist. v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Claim preclusion bars claims "which were or could have been litigated in the prior proceeding." See Consolidated Freightways v. Poelwijk, 81 Or App 311, 315 (1986). Issue preclusion bars "relitigation of issues actually litigated and determined, if their determination was essential to the prior order." Id.; see Drews v. EBI Companies, 310 Or 134 (1990); State Farm Fire & Casualty v. Reuter, 299 Or 155, 158 (1985).

United Pacific and its insured were not parties to a prior hearing where claimant asserted a "new injury" or occupational disease claim. Therefore, the issue of whether claimant sustained a compensable condition while working for United Pacific's insured was never actually litigated. Issue preclusion cannot, therefore, apply.

At the July 12, 1988 hearing where claimant asserted an aggravation claim against SAIF, the evidence disclosed that claimant had worked for a period of time with United Pacific's insured subsequent to her employment with SAIF's insured and claimant had not filed a claim against United Pacific's insured. Therefore, what we have in the present case is a "claim preclusion" issue. For

the res judicata/claim preclusion argument to be successful, it must be established that the claim for "new injury" and/or occupational disease was raised and finally adjudicated in the prior hearing involving the same parties; or that if the claim was not actually raised in the prior hearing, that it could have been raised under the same set of operative facts. Restatement, Second, Judgments, 24(2); see also Carr v. Allied Plating Co., 81 Or App 306, 310 (1986); Taylor v. Baker, 279 Or 139 (1977); Dean v. Exotic Veneers, Inc., 271 Or 188, 192-93 (1975); Bryan Thompson, 42 Van Natta 1532 (1990).

Here, United Pacific was not a party at the July 12, 1988 hearing and the operative facts necessary here for a determination against United Pacific are not the same facts as were necessary in the July 12, 1988 hearing against SAIF's insured. Accordingly, claimant was not precluded from asserting a "new injury" or occupational disease claim at the February 23, 1989 hearing.

However, we find on the merits that there is no evidence to support a finding that claimant's employment with United Pacific's insured is causally related to her current back condition. We adopt the Referee's discussion of this issue.

ORDER

The Referee's order dated March 16, 1989 is affirmed in part and reversed in part. That portion dismissing claimant's request for hearing against United Pacific on the basis that her claim is barred by res judicata is reversed. Claimant's request for hearing is reinstated. The remainder of the Referee's order is affirmed.

November 2, 1990 Cite as 42 Van Natta 2526 (1990)

In the Matter of the Compensation of
JIMMIE L. WILSON, Claimant
WCB Case No. 89-05579
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Stafford Hazelett, Defense Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Gruber's order which affirmed a Determination Order award of 14 percent (44.8 degrees) unscheduled permanent disability for an inguinal hernia. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the exception of the first and sixth paragraphs on page 3 of the Order, and with the following supplementation.

Claimant has a nerve entrapment syndrome in the lumbosacral plexus region. (Exs. 12, 14, 15, 18, 20, 22, 23, 29, 33, 37, 42, 44, 51).

Claimant has a loss of strength due to injury to his lumbosacral plexus. (Exs. 17, 29, 41, 46; Tr. 14-21).

Claimant has formal or on-the-job training as a welder sufficient to perform beyond the entry level.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusion and Reasoning" except as modified below.

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See former ORS 656.283(7). Specifically, the Referee applied the version of OAR 436-35-001 et seq, in effect at the time of the January 25, 1989 Determination Order. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. These are the rules which we apply as well.

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

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." Former ORS 656.283(7) and 656.295(5). We modify some of the Referee's findings and proceed with a de novo review of claimant's unscheduled permanent disability.

Age

The appropriate value for claimant's age of 35 years is 0. Former OAR 436-35-290(3).

Formal education

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

Skills

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

Training

Former OAR 436-35-300(5) states:

"Training: (a) For workers who do not have competence in some specific vocational pursuit, a value of plus one shall be allowed.

(b) For workers who do have competence in some specific vocational pursuit, no value shall be allowed."

The "standards" do not define the term "specific vocational pursuit." Because we conclude that former OAR 436-35-300(5) was intended to differentiate between those who have and those who have not acquired formal or on-the-job training sufficient to perform something other than entry-level employment, we interpret "specific vocational pursuit" to mean employment other than an entry-level position. See Larry L. McDougal, 42 Van Natta 1544 (1990).

The Referee concluded that claimant has no training in a particular vocational pursuit which is within his physical capabilities and he therefore assigned a training value of +1. We disagree with the Referee's "physical capabilities" qualification of former OAR 436-35-300(5)(a). The administrative rule contains no such qualification. Here, claimant had training as a welder sufficient to perform something other than an entry-level job and accordingly he has competence in some specific vocational pursuit. Claimant's training rating is therefore 0. Former OAR 436-35-300(5)(b).

Adaptability

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

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

Impairment

Anatomic Loss

The Referee concluded that, pursuant to former OAR 436-35-430(7), claimant is not entitled to an award of 5 percent unscheduled permanent disability for total removal of his left testicle. He reasoned that the loss of a gonad is rated only if it results in an absence or abnormally high level of hormones. Since there was no evidence of hormonal changes, claimant was not entitled to a rating. We agree with the Referee's interpretation of this rule.

The standards require that the anatomic loss or alternation of a gonad "result[] in an absence, or abnormally high level, of gonadal hormones...." Former OAR 436-35-430(7). Here, claimant made no showing as to his level of gonadal hormones. He argues that the Referee read the standard incorrectly and that obviously the removal of a testicle results in zero hormonal production from that testicle. It is claimant's contention that only when there is an

alteration of the gonad, without anatomic loss, that hormonal levels would have to be measured.

Claimant's interpretation of the rule is inconsistent with the purpose of the unscheduled disability category which is to rate claimant's lost earning capacity. Former ORS 656.214(5). The loss or alteration of a gonad is listed in the unscheduled disabilities and as such would have to effect earning capacity in some manner. Former OAR 436-35-320(1). The mere removal of the gonad, without a corresponding impact on claimant's earning capacity, as measured by the absence or abnormally high levels of hormones, is not ratable. Claimant produced no evidence of the impairment level, if any, resulting from the removal of his left testicle and accordingly, the Referee was correct not to give a rating.

Next, claimant requests that the Board avoid the fact that he did not have hormonal testing by applying former ORS 656.295(5) and go outside the standards to find clear and convincing evidence that the removal of his left testicle is a permanent disability greater than that indicated by the standards. In the absence of a showing of impairment resulting in lost earning capacity, this is not the proper application of the statute. On the date of hearing, ORS 656.214(5) provided that unscheduled permanent partial disability "shall be the permanent loss of earning capacity due to the compensable injury." Claimant has provided no other evidence (e.g., signs or symptoms of impairment) from which the Board can conclude that claimant has lost earning capacity as a result of the removal of his testicle. Furthermore, we review the record as a whole when determining whether there is clear and convincing evidence of greater or lesser permanent disability than indicated by application of the standards. Leland M. Pollock, 42 Van Natta 925 (1990). No single factor or piece of evidence relevant to earning capacity is controlling.

Range of Motion and Pain

At the hearing and on review claimant argues that, pursuant to former OAR 436-35-360(6)(7), he is entitled to 5 percent unscheduled permanent disability for decreased flexion and extension of the lumbar spine. In addition, under former OAR 436-35-320(1), he argues that his pain should be considered to the extent it results in measurable impairment. The Referee rejected these arguments and we concur with the Referee for the following reasons.

There is insufficient medical documentation that claimant's industrial injury resulted in decreased flexion and extension of the lumbar spine. About 18 months prior to hearing, neurologist, Dr. Gancher, reported a slight decrease in claimant's range of motion of the lumbar spine. The doctor did not comment on the relationship of these findings to the industrial injury. None of the other medical reports mention restriction in flexion or extension of the lumbar spine. Claimant's testimony at hearing that his condition was unchanged from the time of Dr. Gancher's examination is not sufficiently persuasive to make a finding that claimant has permanent impairment due to a decrease in spinal range of motion. In addition, there is no proof of the causal link between this medical observation and claimant's compensable hernia injury.

The file is replete with medical documentation of claimant's residual pain due to his compensable injury. Furthermore, there is no evidence of functional overlay. However, under the January 1989 "standards" there is no separate rating given for pain. Pursuant to former OAR 436-35-320(1):

> "....To the extent that pain results in disability greater than that evidenced by the measurable impairment, including the disability due to expected periodic exacerbations of the worker's condition, this loss of earning capacity is considered and rated under 436-35-310 and is included in the adaptability factor."

We therefore decline to give a separate value for pain.

Injury to Abdomen

Claimant sustained an injury to the abdomen wall and under the "standards" he would be entitled to a 5 percent impairment rating if there is resulting structural weakness of the abdominal wall. The Referee assigned no impairment value here and we concur. Under former OAR 436-35-375, claimant should receive an impairment rating only if he is restricted to lifting 10 or fewer pounds. Claimant's lifting restrictions from the various medical experts range from 10 to 25 pounds, so an award under this rule is inappropriate.

Chronic Condition Limiting Repetitive Use

The only rating for impairment in the unscheduled area given by the Referee is 5 percent for a chronic condition limiting repetitive use of the torso. Former OAR 436-35-320. We agree with this rating, however, we also find additional impairment as outlined below.

Injury to Lumbosacral Plexus

Pursuant to former OAR 436-35-350(4), claimant is entitled to an award of unscheduled permanent disability of up to 30 percent if he has documented injury to the lumbosacral plexus with resultant loss of strength. Although the Referee made a finding regarding "some type of inguinal nerve entrapment as the source of claimant's continuing pain," he did not give an impairment rating under this rule. We disagree with the Referee's finding and assign an impairment value of 20 percent for injury to the lumbosacral plexus.

The preponderance of persuasive medical documentation supports a finding of significant nerve entrapment of either the ilioinguinal and/or genitofemoral nerves which are major branches of the lumbosacral plexus. However, the maximum value of 30 percent is not given because there is not complete loss of use or function of the lumbosacral plexus generally or the affected branch in particular. See former OAR 436-35-320(3).

There is unanimous agreement that claimant has a nerve entrapment syndrome in the lumbosacral plexus region. In September 1987, Dr. Narus, an orthopedist, diagnosed claimant's condition as chronic left ilioinguinal/genitalfemoral neuralgia and he anticipated surgery would be required to relieve pressure on the ilioinguinal nerve. A January 1988 consultation with neurologist, Dr. Gancher, at the Oregon Health Sciences University also resulted in a diagnosis of ilioinguinal neuropathy secondary to hernia and possibly emergency surgery for hernia repair. Dr. Gancher recommended conservative treatment of nerve block injections to be followed by neurolysis of the ilioinguinal nerve, if the nerve blocks failed.

A second consultation at Oregon Health Sciences University, with urology surgeon, Dr. Fuchs, confirmed the diagnosis of some kind of entrapment of the ilioinguinal nerve. Vascular surgeon, Dr. Hobbs, described claimant's condition as a difficult nerve entrapment syndrome; however, he did not recommend surgery because of the lack of sustained improvement following nerve block.

In the Matter of the Compensation of
EDDIE BORREGO, Claimant
And, in the Matter of the Complying Status of
MORRIS SALTER, Employer
WCB Case Nos. 88-18220 & 88-18219
ORDER OF ABATEMENT
Garrett, et al., Attorneys
David Ray Fowler (Saif), Defense Attorney

The noncomplying employer requests reconsideration of our October 5, 1990 order that vacated a Referee's order that upheld the employer's denial of claimant's back injury claim. In order to allow sufficient time to consider the motion, we withdraw our October 5, 1990 order for reconsideration. The remaining parties are requested to submit their responses to the employer's motion within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CATHERINE A. ROUSE, Claimant
WCB Case No. 89-10779
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of Referee Tenenbaum's order that set aside its denial of claimant's aggravation claim. On review, the sole issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, as set forth in the "Findings" portion of the order, except the last two paragraphs of the "Findings."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had established a compensable aggravation. We disagree.

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from the compensable condition. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening of a scheduled body part, claimant must show that she is more disabled; i.e. has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988).

Claimant's last arrangement of compensation was the December 1987 Stipulation which awarded claimant 15 percent permanent disability for her left arm and 30 percent permanent disability for her right arm. At the time of stipulation, claimant was experiencing loss of mobility in her fingers which was associated with typing, household chores and driving. (Ex. 38).

The first issue is whether claimant suffered an exacerbation of her condition. We find that she did. The medical record establishes that claimant left work because of her increased arm, hand and wrist symptoms, the very same symptoms she experienced with her 1987 compensable condition.

The more important issue is whether claimant sustained an increased loss of use or function of her arms since the December 1987 stipulation. We find that she has not proven an increased loss of use or function.

As we have found, claimant's loss of use or function was created by repetitive use of her hands, wrists and arms. At the time of the stipulation, claimant was restricted from performing such work.

At the time of her worsening, in February 1989, claimant had been performing work which included repetitive use of her arms, the very type of work which caused claimant's initial loss of use or function of her arms and which she was specifically restricted from performing.

We conclude that claimant's current symptoms were caused by repetitive use of claimant's arms; i.e. typing. Further, her current condition, not unlike like her initial compensable condition and her mid-1988 period of increased symptoms, was caused by performing work which included repetitive use of her arms.

As claimant's current condition was caused by performing work which she was permanently restricted from performing at the time of the last arrangement of compensation, we conclude that claimant has not sustained increased loss of use or function of her arms, since her last arrangement of compensation.

Consequently, we conclude that claimant has not demonstrated a compensable aggravation based on his current bilateral arm condition.

ORDER

The Referee's order dated October 11, 1989 is reversed. The self-insured employer's aggravation denial is reinstated and upheld. The $1,125 assessed attorney fee, awarded to claimant's counsel, is reversed.

November 6, 1990 Cite as 42 Van Natta 2534 (1990)

In the Matter of the Compensation of
JOE FERNANDEZ, JR., Claimant
And, in the Matter of the Complying Status of
M & M REFORESTATION LIMITED,
Michael B. Cooke, Individually, and Marlene T. Cooke, Individually, Employer
WCB Case Nos. 89-06549, 89-06550 & 89-07418
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney
Gracey & Davidson, Attorneys

Reviewed by Board Members Howell and Speer.

The alleged noncomplying employer, M & M Reforestation, requests review of those portions of Referee Garaventa's order that: (1) found that claimant was a subject worker; and (2) affirmed the Director's Proposed and Final Order finding it to be a noncomplying employer. On review, the issues are jurisdiction, subjectivity and compensability. We affirm.

FACTS

We adopt the Referee's "Basic Facts" and "Ultimate Facts," with the following supplementation.

The SAIF Corporation accepted claimant's claim on March 8, 1989. (Ex 7-1). The alleged noncomplying employer requested a hearing regarding both SAIF's acceptance and the Director's proposed order, No. 13854-A, finding the employer to be noncomplying. (Ex 7-3).

A hearing was held and evidence taken regarding the employer/employee relationship. The alleged employer raised compensability as an issue. (1 Tr. 9). The Referee concluded that compensability ceased being an issue on the second day of hearing. At that time, the alleged employer "conceded" that the claim is compensable, if claimant is determined to be a subject employee. (2 Tr. 3). We conclude that the employer neither intended to, nor did in fact, concede compensability, because only subject workers may suffer injuries which are compensable under Workers' Compensation Law. ORS 656.005(26) and 656.027.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The alleged employer raised the compensability issue at hearing and in its brief to the Board. Consequently, our jurisdiction is evoked on review. ORS 656.740(4)(c).

Subjectivity

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

The alleged employer ratified Steve Fernandez' apparent authority to act in its stead for hiring purposes, when Mike Cooke, owner and manager, admitted that he was glad to have claimant's help. (1 Tr. 36). Cooke delegated further authority to Fernandez, when he directed him to show claimant "what to do." (2 Tr. 28). For these reasons, as well as those discussed by the Referee, we are persuaded that an employment relationship existed between the alleged employer and claimant. We conclude that claimant is a "subject worker." ORS 656.005(26).

Compensability

The employer conceded that claimant's claim is compensable if claimant is a subject worker. Therefore, inasmuch as we have determined that claimant is a subject worker, we also find that his claim is compensable.

Claimant is statutorily entitled to a reasonable assessed fee for his counsel's services on Board review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $700, to be paid by SAIF on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief) and the complexity of the issues.

ORDER

The Referee's order dated September 25, 1989 is affirmed. Additionally, the SAIF Corporation's acceptance of claimant's injury claim is upheld and the case is remanded to SAIF for further processing consistent with this order. Claimant's attorney is awarded a reasonable assessed fee for his services on review of $700, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

In the Matter of the Compensation of
LORNA G. GARRISON, Claimant
WCB Case No. 89-09652
ORDER ON REVIEW
John E. Uffelman, Claimant Attorney
Acker, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Schultz's order which awarded claimant 15 percent (48 degrees) unscheduled permanent disability for a bilateral shoulder, neck and upper back condition, whereas a Determination Order had not awarded any unscheduled permanent disability. Claimant cross-requests review contending she is entitled to additional unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

As a result of her compensable injury, claimant has bilateral rotation of 75 degrees in her cervical region.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had sustained unscheduled permanent disability equal to 15 percent. We modify.

In the present case, the parties do not dispute the 5 percent value assigned for age and education. Therefore, we adopt the above-mentioned value when we calculate claimant's permanent disability under the standards and discuss only the values for adaptability and impairment.

Adaptability

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

Claimant is unable to return to his usual and customary work and has not returned to, or been offered, regular or modified work since he became medically stationary (when permanent disability is rated). Claimant's physical capacity falls between the light-medium category as defined in former OAR 436-35-310(4). Thus, the appropriate adaptability value is 2.5 which is the average of the values for light and medium work. Former OAR 436-35-310(4)(b) & (c).

Impairment

Claimant contends that she is entitled to more than 5 percent impairment for limited repetitive use of both shoulders as well as lost range of motion in the cervical region. We agree.

The Referee found that claimant has sustained a loss of repetitive use of both shoulders. We agree and adopt his conclusions and reasonings in this regard. However, the Referee only gave this loss a 5 percent impairment value. Since claimant has sustained a loss of repetitive use of both shoulders, she is

entitled to an impairment value of 5 percent for each shoulder for a total impairment value of 10 percent for loss of repetitive use of her shoulders. See former OAR 436-35-320(4); Larry S. McDougal, 42 Van Natta 1544, 1547 (1990).

Claimant is also entitled to an impairment value for bilateral loss of rotation of the cervical area. Dr. Neitling reported that claimant's cervical rotation was 75 degrees. Therefore, claimant is entitled to a .5 impairment value for loss of right cervical rotation as well as a .5 impairment value for loss of left cervical rotation. Former OAR 436-35-360(5).

Claimant's loss of cervical rotation of 1 percent is combined, not added, with the 10 percent impairment for bilateral chronic loss of repetitive use in her shoulders for a total impairment value of 11 percent. Former 436-35-320(2).

We note parenthetically that we have previously rejected the insurer's argument that no unscheduled permanent disability may be awarded if the only impairment value is due to loss of repetitive use of a body part. McDougal, supra at 1547-48.

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. Claimant's age and education value is +5. When that value is multiplied by claimant's adaptability value 2.5, the product is 12.5. When that value is added to claimant's impairment value of 11 percent the result is 23.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 24 percent.

Finally, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the insurer's request for a reduction of unscheduled permanent disability is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated September 12, 1989, is modified. In addition to the 15 percent (48 degrees) unscheduled permanent disability awarded by the Referee, claimant is award 9 percent (28.8 degrees) for a total of 24 percent (76.8 degrees) unscheduled permanent disability. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. For services on review concerning the insurer's request for a reduction of unscheduled permanent disability, claimant's counsel is awarded an assessed attorney fee of $750, payable by the insurer.

In the Matter of the Compensation of
TOMAS A. PUERTA, Claimant
And, in the Matter of the Complying Status of
RALPH H. BUNNEY, Alleged Noncomplying Employer
WCB Case Nos. 88-01127, 87-14583 & 87-14582
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Roy Miller (Saif), Defense Attorney
Meyers & Radler, Attorneys

Reviewed by Board Members Howell and Perry.

Claimant requests review of Referee St. Martin's order which: (1) found that he was not a subject worker of Ralph H. Bunney (Bunney), the alleged noncomplying employer; (2) found that claimant was not a subject worker of the City of Astoria; and (3) declined to adjust claimant's temporary total disability rate. On review, the issues are subjectivity, responsibility, and rate of temporary disability. We reverse in part and affirm in part.

FINDINGS OF FACT

Bunney offered claimant the opportunity to make some money by cutting shake bolts in an area where Bunney had contracted with the City of Astoria to clear downed cedar.

At the time claimant was injured, he was directed by Bunney to cut cedar logs in a particular watershed and to begin with a particular log. Claimant was also expected to be present on each Wednesday, when the logs were flown out of the area by helicopter. If he failed to appear, Bunney would have reduced his pay. Both parties believed their relationship could be terminated without liability. Bunney terminated claimant's brother under the same arrangement as had existed between claimant and Bunney.

Claimant was to be paid $115 per cord of wood. He was capable of cutting one-half cord of wood per day. Bunney paid claimant for the partial cord he had cut prior to his injury.

Claimant filed a claim against the City of Astoria which was denied on August 7, 1987. One hundred and eighty days passed, but claimant did not request a hearing on that denial. The City of Astoria was subsequently joined in the proceedings when Bunney requested a hearing on claimant's status as a subject worker.

CONCLUSIONS OF LAW AND OPINION

Subjectivity

Bunney, the alleged noncomplying employer, argues that claimant was not a worker at the time he was cutting shake bolts. We disagree. A worker is one who is subject to the control of an employer and who furnishes services for remuneration. Dykes v. SAIF, 47 Or App 187 (1980).

Here, claimant was cutting the downed cedar in an area where he was instructed to cut by Bunney. Further, claimant was instructed that he must be present on Wednesdays to indicate where he had cut wood so that a helicopter could fly it out. Additionally, even though claimant only worked for a few hours before he was injured, he did cut a partial cord of wood and was paid for his work. We conclude that claimant was a worker as defined by statute. ORS 656.005(27). In addition, all workers are subject workers except those specifically excluded by statute. ORS 656.027(1). None of the parties argue, nor do

we find, that claimant is subject to any of the exceptions set forth in ORS 656.027. Accordingly, because claimant was a subject worker, we conclude that Bunney was a subject employer. ORS 656.023.

Responsibility of the City of Astoria

At hearing, the SAIF Corporation, on behalf of the City of Astoria, argued that claimant had failed to timely request a hearing from its denial. Claimant argues that the City waived its timeliness defense because SAIF did not raise the issue until after the hearing had commenced. We disagree.

The provisions for timely request for hearing are statutory and not subject to exception, as is the case with notice of injury. See ORS 656.265(5). The time limits for requesting a hearing cannot be waived. ORS 656.319; see Duane Fresh, 42 Van Natta 864 (1990). Moreover, it is our duty to raise a want of jurisdiction on our own motion. See Southwest Forest Industries v. Anders, 299 Or 205 (1985) and Davis v. Aetna Casualty Co., 102 Or App 132 (1990). Therefore, even if SAIF had not raised this issue earlier, (cf. Cary O. Miller, 42 Van Natta 618 (1990)), we would nevertheless address the issue now.

In this regard, SAIF mailed its denial on behalf of the City of Astoria on August 7, 1987. Claimant received the denial, but did not ever request a hearing from that denial. Thus, his claim is not enforceable, a hearing on the claim may not be allowed, and we do not have jurisdiction to address that issue. ORS 656.319.

On appeal, Bunney abandoned its argument that even if claimant was a subject worker, the City of Astoria, not Bunney, would be responsible under ORS 656.029.

Rate of Temporary Disability

Claimant argues that he was paid time loss at an incorrect rate. In determining the rate of temporary disability for workers who have been employed for less that 4 weeks, the intent at time of hire, as confirmed by the employer and worker, is used. OAR 436-60-020(7)(a).

Claimant was to be paid $115 per cord of wood cut. Bunney testified that if claimant cut a half a cord of wood a day, that would be very good progress. He based that estimate on the amount that he could cut himself and he had been doing that type of word for several years. (Tr. 1, 68-69.)

SAIF based claimant's temporary disability payment on the rate of one-half cord per day. Claimant argues that he could have cut more. We are persuaded that Bunney's estimate is accurate, given the fact that he had been doing that sort of work for several years and considering that claimant had not worked long enough to demonstrate that he could cut more. Accordingly, we agree with the Referee that claimant had not met his burden of proving that his rate of temporary disability was incorrectly calculated.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $2,800, to be paid by SAIF on behalf of Bunney, the noncomplying employer. In reaching this conclusion, we have particularly considered the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 3, 1989 is reversed in part and affirmed in part. That portion which found that claimant was not a subject worker is reversed. The Proposed and Final Order of Noncompliance is reinstated and upheld. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a $2,800 assessed fee payable by SAIF on behalf of Bunney, the noncomplying employer.

November 6, 1990 Cite as 42 Van Natta 2540 (1990)

In the Matter of the Compensation of
SHARON SCHETTLER, Claimant
WCB Case No. 89-04388
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Peterson's order that: (1) set aside its denial of claimant's occupational disease claim for a stress disorder; and (2) assessed penalties and associated attorney fees for an unreasonable denial. The issues on review are compensability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Between September 1988 and January 1989, claimant, a 47-year-old accounting supervisor, was subjected to stressful employment conditions during a company reorganization. In November and December of 1988, claimant became nervous, developed stomach problems and insomnia. She sought medical treatment for these symptoms. Stomach medication and tranquilizers were prescribed.

On January 6, 1989, claimant was fired, allegedly for her involvement in attempting to unionize. Claimant experienced "anxiety," "nervousness" and "tension" which she somatized, causing stomach upset and occasional headaches. On February 28, 1989, SAIF denied claimant's occupational disease claim for stress disorder.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's denial, concluding that claimant has a stress disorder which is compensable as an occupational disease. We disagree.

For an occupational disease claim, the date of "injury" is the date upon which claimant was last exposed to employment conditions which allegedly caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant's last exposure to the work-related stress which she alleges caused her mental disorder was January 6, 1989. Accordingly, the occupational disease law, which became effective January 1, 1988, is applicable. See Johnson, supra, at 146-48; Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Pursuant to former ORS 656.802(1)(b) and (2), to establish an occupational disease, claimant must establish that: (1) she has a mental or emotional disorder which is generally recognized in the medical or psychological community; (2) she required medical services or was disabled; (3) the mental disorder was due to employment conditions which were real and objective; (4) such employment conditions are not generally inherent in every working environment; and (5)

the evidence is clear and convincing that the mental disorder arose out of and in the course of employment.

We conclude that claimant has not shown by a preponderance of the evidence that she has a mental or emotional "disorder" which is generally recognized in the medical or psychological community.

Dr. Fisher, claimant's family physician, diagnosed claimant as having an anxiety state with hyperacidity. (Ex. 15). Throughout Dr. Fisher's deposition he variously described claimant as having a simple type of stress, requiring temporary treatment (Ex. 13-11); and "anxiety tension state, manifested by hyperacidity." (Ex. 13-16). In addition, Dr. Fisher would not characterize his diagnosis as an "authentic diagnosis of a medical or psychiatric condition," instead, he said claimant's diagnosis of anxiety with hyperacidity was a "clinical diagnosis" based on claimant's subjective complaints. (Ex. 13-15).

Psychiatrist, Dr. Parvaresh, opined that claimant has no appreciable degree of psychiatric impairment. He described claimant as experiencing "nervousness" and "tension" which she somatizes, causing stomach upset and occasional headaches.

We find Dr. Fisher's testimony to be equivocal. Furthermore, Dr. Fisher is not a psychiatrist and he acknowledges that he based his psychological diagnosis of "anxiety state" on claimant's subjective complaints. On the other hand, Dr. Parvaresh is a psychiatric expert and he found no evidence of a mental or emotional impairment.

This record does not establish that claimant has a "mental or emotional disorder which is generally recognized in the medical or psychological community." ORS 656.802(2)(c) (emphasis added). Claimant has only proven that she experienced anxiety, nervousness, and stress due to her working conditions which in turn were somatized, causing hyperacidity of the stomach. "Stress," in and of itself, is not a condition which is generally recognized as a "mental disorder." See Ronald V. Dickson, 42 Van Natta 1102, 1108-09 (1990).

Even if we were to look to outside sources to decide if claimant's diagnosis is a medically or psychologically recognized mental disorder, we know of no source, from which we could take official notice, that would classify claimant's "anxiety and gastritis," "tension," and "nervousness" as a "mental disorder."

Because the absence of a recognized mental or emotional disorder is determinative, we do not address the remaining elements for establishing a stress-related occupational disease.

Penalty and Related Attorney Fees for Unreasonable Denial

Claimant did not meet her burden of proof that SAIF's February 1989 denial of a stress-induced occupational disease was unreasonable. Based on the available medical evidence, there was a legitimate doubt as to the compensability of the claim. Accordingly, we reverse the Referee's assessment of penalties and attorney fees.

ORDER

The Referee's order dated August 4, 1989 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's 25 percent penalty and attorney fee awards of $500 and $2,500 are reversed.

In the Matter of the Compensation of
JEAN H. HUMPHREY, Claimant
WCB Case No. 89-05330
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee McWilliams' order that reduced claimant's unscheduled permanent disability award for a low back condition from 27 percent (86.4 degrees), as awarded by a Determination Order, to 14 percent (44.8 degrees). The issue on review is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Conclusions of Law and Opinion with the following comments.

The Referee and Board apply the "standards" de novo based on the hearing record. Former ORS 656.283(7) and ORS 656.295(5). The Evaluation Division may have applied the "standards" entirely correctly based on the evidence before it and claimant could still prove a greater permanent disability under the standards based on evidence presented at hearing. Claimant has made no showing of a greater permanent disability under the standards.

In addition, we observe that claimant is not entitled to a +1 for training. We recently concluded that the term "specific vocational pursuit" in former OAR 436-35-300(5) "was intended to differentiate between those who have and those who have not acquired formal or on-the-job training sufficient to perform something other than entry level employment." Larry L. McDougal, 42 Van Natta 1544, 1546 (1990). Here, claimant has competence as a waitress with a SVP of 3, which is more than entry level. Therefore, pursuant to former OAR 436-35-300(5)(b), claimant is entitled to no value for training. However, SAIF did not request a reduction of the 14 percent unscheduled permanent disability award and we, therefore, affirm the Referee.

ORDER

The Referee's order dated August 10, 1989 is affirmed.

In the Matter of the Compensation of
CHERYL S. VAN HEE, Claimant
WCB Case No. 89-06835
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Bennett's order that: (1) upheld the SAIF Corporation's "de facto" denial of claimant's medical services claim for massage therapy; and (2) declined to assess penalties and attorney fees for an alleged unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions with the following supplementation.

Compensability

Claimant first argues that SAIF's "de facto" denial of her claim for massage therapy was an impermissible "back-up" denial under Bauman v. SAIF, 295 Or 788 (1983). We disagree.

Bauman involved the denial of the compensability of a condition of an already accepted claim. Here, SAIF has not denied the compensability of claimant's condition, but rather the compensability of the requested medical services. Accordingly, Bauman does not apply. An insurer can, at any time, deny, in whole or in part, a claim for medical services on the ground that they are noncompensable. North Clackamas School District v. White, 305 Or 48, recon 305 Or 468 (1988).

Claimant next argues that the requested massage therapy is compensable. Massage therapy is only compensable when it is carried out under the "direct control and supervision of the attending physician." Former OAR 436-10-050(2); Verna B. Herb, 37 Van Natta 1247 (1985). Claimant argues that her licensed massage therapist is her "attending physician" and, therefore, he can provide treatment directly without supervision from a physician. We disagree.

Former OAR 436-10-050(1) provides that only physicians licensed by the Board of Medical Examiners, the Board of Dental Examiners, the Board of Chiropractic Examiners, the Board of Naturopathic Examiners, and Nurse Practitioners licensed by the Board of Nursing may be designated as "attending physicians." Accordingly, a person only licensed as a massage therapist can not be an attending physician. Verna B. Herb, supra. We conclude that claimant has not shown that the claimed massage treatment was performed under the direct control of her attending physician.

Penalties and Attorney Fees

Claimant contends that the Referee erred in failing to assess penalties and attorney fees, because SAIF's denial was unreasonable. We disagree.

ORS 656.262(10) provides that an insurer who unreasonably delays acceptance or denial of a claim shall be liable for an additional amount up to

25 percent of the amounts then due plus any attorney fees. Here, there are no amounts due. Therefore, there is nothing on which to base a penalty. Ellis v. McCall Insulation, 308 Or 74 (1989).

With regard to attorney fees, ORS 656.382 provides that attorney fees are to be assessed based on unreasonable resistance to the payment of compensation. Because the claimed services were not compensable, the delay in accepting or denying did not delay any compensation. Therefore, there was no unreasonable resistance to the payment of compensation. No attorney fee may be assessed. Lloyd L. Cripe, 41 Van Natta 1774 (1990).

ORDER

The Referee's order dated September 11, 1989 is affirmed.

November 8, 1990 Cite as 42 Van Natta 2544 (1990)

In the Matter of the Compensation of
CALVIN E. DAVISON, Claimant
WCB Case No. 89-12909
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Brazeau's order that affirmed a Determination Order award of 17 percent (54.4 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt paragraphs one through seven and paragraph nine of the Referee's "Conclusions and Opinions", regarding claimant's age, education and impairment values. We supplement with the following.

The Referee found, and we find, that claimant is not working as a result of his injury and that no employment was offered. Therefore, claimant's adaptability value is based on former OAR 436-35-310(4). The Referee further found, and we find, that claimant was capable of lifting 30 pounds, thereby placing claimant's physical capacity in the light-medium range. See former OAR 436-35-310(4)(b) & (c). For workers with the physical capacity to do more than the requirements of one category, but not the full range of requirements for the next higher category, the value shall be the average of the values for the two categories. Former OAR 436-35-310(4). Therefore, because claimant's physical capacity falls between medium and light, we find that the appropriate adaptability value is 2.5.

In determining claimant's adaptability value, the Referee subtracted the value resulting from claimant's Oregon injury (2.5) from the value resulting from a California injury (4). In so doing, the Referee reached an adaptability value of 1.5. We disagree.

Former OAR 436-35-310(4) provides that:

> "If, as a result of the injury, the worker is not working and no employment has been offered, the value of this factor shall be based on the [claimant's] physical capacity . . . "

The rule does not provide for a reduction in the adaptability factor due to a prior out of state injury. We interpret this to mean that claimant's physical capacity at the time of hearing controls. Therefore, since claimant's physical capacity at the time of hearing was between the light and medium categories, claimant's appropriate adaptability value is the average between those two categories, i.e., 2.5.

Recalculation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 1 is added to his education value 4, the sum is 5. When that value is multiplied by claimant's adaptability value 2.5, the product is 12.5. When that value is added to claimant's impairment value 5, the result is 17.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 18 percent.

ORDER

The Referee's order dated October 23, 1989 is modified. In addition to the Determination Order award, claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability, for a total of 18 percent (57.6 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by the order, not to exceed $3,800.

November 8, 1990 Cite as 42 Van Natta 2545 (1990)

In the Matter of the Compensation of
BARTOLO RODRIGUEZ, Claimant
WCB Case No. C0-00067
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Robert J. Guarrasi, Claimant Attorney
Carol Taaffe (Saif), Defense Attorney

On September 7, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $25,000 by the SAIF Corporation, claimant agreed to release his right to future workers' compensation benefits, except medical services, for his compensable injury. However, by order dated October 12, 1990, the Board withdrew its acknowledgment and refused to approve the agreement because it included a provision that the written Spanish translation of the agreement shall not constitute a part of the text of the agreement and shall not be considered in any dispute as to its meaning. Because claimant cannot read or understand English, the Board reasoned that the Spanish translation must constitute a part of the agreement in order to assure that the terms and conditions contained in the agreement are the same to which claimant had assented.

The parties jointly request reconsideration of the Board's order. They move the Board to strike the aforementioned provision from the agreement

and approve the agreement as modified. The motion is granted on reconsideration.

The Board is persuaded that, in this case, granting the motion to strike resolves its sole objection to the agreement and does not alter the agreement itself in a substantive manner. Furthermore, absent the offensive provision, the terms of the agreement are in accordance with all statutory and administrative prerequisites. Upon removal of the offensive provision, all of those requirements will have been met.

Under these circumstances, it is unnecessary to recommence claimant's 30-day right to disapprove the revised agreement. See ORS 656.236(1)(c). Therefore, the Board shall not require the parties to submit a revised agreement pursuant to the standard acknowledgment procedures. See OAR 438-09-025(1), (2). Striking the aforementioned provision conforms this agreement to the terms and conditions prescribed by the Director on the date of acknowledgment. See ORS 656.236(1); former OAR 436-60-145. Moreover, the Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1).

On reconsideration, as modified herein, the parties' claim disposition agreement is approved, hereby fully and finally resolving this matter. An attorney fee payable to claimant's attorney according to the terms of the agreement is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRISTOPHER GRANT, Beneficiary of
JEANNIE E. SPUNAUGLE (Deceased), Claimant
WCB Case No. 89-05357
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Ken Russell (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant's beneficiary requests review of Referee Quillinan's order that affirmed a Determination Order awarding 14 percent (44.8 degrees) unscheduled permanent disability for a neck, right shoulder and right arm condition. On review the issue is extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings" with the following addition.

Claimant's cervical condition was accepted as compensable.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the Disability Rating Standards are intended to determine the loss of earning capacity of a living claimant. The Referee further found that claimant died before she became medically stationary for reasons unrelated to her compensable injury, so that there are no range of motion findings or other findings of permanent impairment in the record. Accordingly, the Referee concluded the standards were not applicable and that claimant's disability award should be based upon her "actual and proven physical impairment at the

date of death." Concluding that the 14 percent permanent disability awarded by the Determination Order was so based, the Referee affirmed the Determination Order. We affirm the results of the Referee but for different reasons.

A claimant's beneficiaries are entitled to recover an injured worker's benefits. However, the claimant must be entitled to benefits before the claimant's beneficiaries can receive those benefits. ORS 656.218(1).

Claimant argues that all of the standards, including those related to age, education and adaptability, should be considered in rating the decedent's permanent disability. The Referee appears to have based the award on impairment only.

Claimant's age and education values are readily determinable and her death would have no effect on them. The adaptability factor, however, depends on claimant's ability to return to work, and the type of work she would be physically able to perform.

It is undisputed that claimant was never found medically stationary. There has been no medical report in which claimant was released to return to work, nor are there any reports of measurements of her residual physical capacities.

Claimant's treating neurosurgeon indicated claimant likely could return to work. Claimant relies instead on the opinion of Dr. Day, her treating chiropractor, who opined that, had claimant lived, her residual work capacity would have been in the light to sedentary range, with no repetitive use of the arms and a maximum lifting ability of 15 pounds.

We find Dr. Day's opinion of claimant's residual work capacity to be speculative. In light of the speculative medical evidence concerning claimant's adaptability factor, and because evidence of claimant's ability to return to work is likewise speculative, we are not persuaded claimant's adaptability was affected by the injury. Therefore, no value will be given for adaptability. When no value is given for adaptability, which is a multiplier of age and education, the rating of disability becomes one in which the only factor considered is impairment.

The evidence on permanent impairment, other than the evidence of claimant's surgeries, is similarly speculative and unpersuasive. See Rossi v. Zidell Explorations, Inc., 40 Or App 417 (1979). However, since the insurer did not seek a reduction in claimant's disability award, the Referee's order shall be affirmed.

ORDER

The Referee's order dated July 19, 1989 is affirmed.

In the Matter of the Compensation of
LONNIE H. STOUT, Claimant
WCB Case No. 88-19732
ORDER ON REVIEW
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee Quillinan's order which found that claimant was entitled to reimbursement for vocational expenses. On review, the issue is whether the Referee was correct in reversing the Director's order which dismissed claimant's request for reimbursement. We reverse.

BACKGROUND

Claimant has a compensable claim for a low back injury which occurred in December 1985. He became eligible for vocational assistance on December 18, 1986. His claim was closed by a July 17, 1987 Determination Order which awarded 15 percent unscheduled permanent disability and 5 percent scheduled permanent disability for his left leg.

Claimant began working with Kathleen Foreman, rehabilitation consultant, during the summer of 1987. Ms. Foreman indicated that claimant would be entitled to reimbursement for clothes necessary to pursue employment. Claimant was advised to keep receipts of such purchases in order to obtain reimbursement. Thereafter, claimant purchased clothing suitable for his new position.

Following this, claimant located a position as a sales representative for a truck line. He requested reimbursement from the insurer in the amount of $521.68 for clothing that he had purchased. By letter of January 21, 1988, the insurer denied reimbursement on the basis that the purchases had not been preauthorized.

In early March 1988, claimant requested a hearing, concerning the insurer's denial, from the Rehabilitation Review Section ("RRS"). By letter dated May 23, 1988, RRS sent claimant a letter requesting that he submit receipts concerning the $521.68 reimbursement as the receipts submitted prior to that time were not sufficient to support or justify his reimbursement request.

On August 31, 1988, RRS sent claimant a "Letter of Warning" advising that his request for review may be dismissed because he had failed to provide the necessary receipts totalling $521.68. The letter further notified claimant that his request would be dismissed on September 15, 1988 unless itemized, dated receipts totalling $521.68 were provided by that date.

On September 16, 1988, RRS dismissed claimant's review request pursuant to OAR 436-120-210(5) on the basis that he had not provided the requested receipts. Claimant requested review by a Referee pursuant to ORS 656.283(1).

The Referee held an evidentiary hearing and concluded that the dismissal was improper and remanded the claim to the insurer for reimbursement.

CONCLUSIONS OF LAW AND OPINION

The insurer contends that the Referee erred in setting aside the Director's Order of Dismissal and remanding the matter to it for reimbursement. We agree.

ORS 656.283(2) provides that the Director's decision as to vocational assistance matters may be modified only if the decision: (1) violates a statute or rule; (b) exceeds the statutory authority of the agency; (c) was made upon unlawful procedure; or (d) was characterized as an abuse of discretion or clearly unwarranted exercise of discretion.

A finding of one the circumstances listed at ORS 656.283(2)(a) through (d) is mandatory before a Director's order may be changed by a Referee. See Richard A. Colclasure, 42 Van Natta 2454 (1990). Here, the Referee made no findings on any of the four bases for modifying the Director's order.

The Director, through the RRS, dismissed claimant's request pursuant to OAR 436-120-210(5) which allows for dismissal for failure to provide information and participate in administrative review as requested by the RRS. The dismissal was based on the fact that claimant did not provide RRS with itemized and dated receipts, despite being asked to do so.

The evidentiary record contains two letters from RRS to claimant requesting the receipts and warning him that the matter would be dismissed if he failed to comply with the request. The record does not contain evidence that RRS's request was complied with by claimant. Under these circumstances, it can reasonably be concluded from the evidentiary record that claimant failed to provide information as requested by RRS. The Dismissal Order does not constitute an abuse of discretion. Colclasure, supra.

We are unable to conclude that the Director's order falls within one of the circumstances listed in ORS 656.283(a) through (d). Accordingly, neither we nor the Referee have authority to modify the Director's order. ORS 656.283(2). As we have found that the Director's order should not be modified, it follows that the Referee erred in remanding the matter to the insurer for reimbursement.

ORDER

The Referee's order dated March 8, 1989, is reversed. The Director's Order of Dismissal is reinstated and affirmed in its entirety.

November 8, 1990 Cite as 42 Van Natta 2549 (1990)

In the Matter of the Compensation of
JOSEPH G. THOMAS, Claimant
WCB Case No. 89-01877
ORDER ON REVIEW
Richard O. Nesting, Claimant Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Fink's order which dismissed his request for hearing. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT

On January 30, 1989, claimant filed a request for hearing protesting the insurer's denial. A hearing was set for April 26, 1989. On April 26, 1989, claimant appeared at the hearing unrepresented. After being advised of his right to counsel, claimant decided he wished to obtain counsel and the matter was continued.

Thereafter, claimant retained counsel and a hearing was set for July 7, 1989. At the July 7, 1989 hearing the insurer submitted two physician's reports as evidence. Claimant's counsel requested a continuance in order to depose the authors of the two reports. The Referee then continued the matter pending the depositions.

On October 13, 1989, the insurer submitted a motion to dismiss pursuant to OAR 438-06-071(1). A copy of the motion was sent to claimant's counsel. Claimant's counsel was also notified by telephone of the insurer's submission of the motion to dismiss. On November 15, 1989, the Referee dismissed claimant's request for hearing. On November 24, 1989, claimant counsel's submitted a motion for reconsideration stating that he had contacted one of the physicians and obtained a report which was dated July 20, 1989. He further stated that he anticipated receipt of a report from the other physician.

The Referee did not reconsider his order of dismissal and claimant requested review.

FINDINGS OF ULTIMATE FACT

Claimant's conduct resulted in an unjustified delay exceeding 60 days.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's case pursuant to OAR 438-06-071(1). We agree.

OAR 438-06-071(1) provides:

> "A request for hearing may be dismissed 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 hearing for more than 60 days."

Claimant's original hearing was scheduled for April 26, 1989. The matter was continued for claimant to obtain counsel. Claimant obtained counsel and the matter was set for hearing on July 7, 1989. At that time, claimant's counsel requested a continuance to depose two physicians.

Approximately 102 days later, the insurer moved for dismissal. Claimant's counsel did not respond to this motion within the time allotted by OAR 438-06-045. When claimant's counsel did respond by requesting reconsideration, he had not yet deposed the two physicians, which was the ground on which the continuance had been granted. In fact, claimant's counsel had obtained a report from one physician which was dated July 20, 1989, but had not disclosed the report nor taken any other actions with regard to this matter.

Claimant's counsel offers no justification for failing to depose or otherwise attempt to submit evidence from the two physicians within 60 days of the continuance. The only justification offered relates to his delay in responding to the insurer's motion for dismissal.

Under these circumstances, we conclude that claimant's conduct resulted in a delay of more than 60 days. We further conclude that this delay was unjustified. Accordingly, the Referee properly dismissed claimant's hearing request.

ORDER

The Referee's order dated November 15, 1989 is affirmed.

Claimant sustained a compression fracture of the L2, fractures of L1, L2 and L3, underwent a spinal fusion at L2-3 and suffers from chronic pain which limits repetitive use of his back.

Claimant cannot read, write or speak English.

CONCLUSIONS OF LAW AND OPINION

The Referee granted claimant permanent total disability under the "odd-lot" doctrine. In making this determination, the Referee found it futile for claimant to seek regular gainful employment. We disagree.

Claimant must prove by a preponderance of the evidence that he is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). He can establish permanent total disability by proving he is totally physically incapacitated, or by proving, under the "odd-lot" doctrine, that the combination of his physical incapacity plus non-medical factors, such as age, education, work experience, training and mental capacity, result in his permanent total disability. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser Co., 30 Or App 403 (1977); Shaw v. SAIF, 78 Or App 588 (1986). In addition, claimant has the burden to establish that he has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

Claimant acknowledges that he is not permanently and totally disabled by his physical condition resulting from his compensable back injury. He relies on the "odd-lot" doctrine and the opinion of vocational counselor Huckfeldt. We disagree.

The only evidence addressing the issue of permanent total disability is a vocational report submitted by vocational counselor Huckfeldt. (Ex. 47). Huckfeldt reported that claimant was potentially eligible for employment in unskilled jobs in the sedentary to light categories. . ." However, after noting that claimant's "adaptability to finding work [was] severely impacted as a result of [his] limited educational and work background, as well as lack of facility in speaking, reading and writing the English language," Huckfeldt concluded that for those reasons claimant was unemployable until he received rehabilitation. Id.

We do not rely on Huckfeldt's opinion, however, as we find it unpersuasive. Somers v. SAIF, 77 Or App 259, 262 (1986); See Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

Claimant's treating physician, Dr. Keiser, and the Orthopaedic Consultants indicated that claimant was capable of returning to modified work. (Exs. 41, 42). Claimant testified that he was, at the time of hearing, capable of performing work in the light category. In fact, claimant had returned to modified work from April 1988 through October 1988. He stopped working only because the job ended, not because he was unable to perform the work.

Under the circumstances, we find that the preponderance of the evidence establishes that claimant is capable of working. Therefore, based on the lack of medical evidence, claimant's release to return to work and claimant's own testimony and work record, we do not find Huckfeldt's opinion to be persuasive. Somers v. SAIF, supra.

We acknowledge the fact that claimant is unable to read, write or speak English. This fact alone, however, does not outweigh the remaining evidence

which establishes that, regardless of this hardship, claimant is capable of performing modified work. Claimant did return to work. Furthermore, he left that work not because of his injury, but because the job ended. These facts together convinces us that efforts to obtain work at a gainful and suitable occupation are not futile.

Accordingly, we conclude that claimant has failed to establish that he is permanently and totally disabled.

Extent of Unscheduled Permanent Disability

Claimant contends that if he is not permanently and totally disabled, then he is entitled to 100 percent permanent partial disability. We again disagree.

Claimant's condition was medically stationary on September 13, 1988. His claim was closed by Determination Order dated January 17, 1989. Accordingly, the "standards" effective January 1, 1989, former OAR 436-35-001, et seq., apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent partial disability.

Age and Education

The appropriate value for claimant's age of 32 is 0. Former OAR 436-35-290(3). Claimant does not have a high school diploma or a GED. Therefore, his formal education value is 1. Former OAR 436-35-300(3). The job which claimant successfully performed during the ten years preceding the date of determination, which has the highest SVP value, was a nursery laborer (DOT # 405.687.014) with an SVP value of 3. Therefore, the appropriate skills value is 3. Former OAR 436-35-300(4).

The appropriate value to be assessed for claimant's training is dependent upon whether claimant has competence in some specific vocational pursuit. Former OAR 436-35-300(5).

We have previously held that "competence in some specific vocational pursuit" means that the claimant has acquired training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990). Therefore, if all of the jobs which a claimant has performed are entry level positions, then the appropriate training value for that claimant is a 1. Former OAR 436-35-300(5); Larry L. McDougal, supra.

Claimant has worked as a farm laborer and as a nursery laborer. We do not find claimant's position as a nursery labor to be that of an entry level position. Therefore, we find that claimant has competence in a specific vocational pursuit. Consequently, we conclude that the appropriate value for training is 0. Former OAR 436-35-300(5).

Claimant's total age and education value is, therefore, 4.

Adaptability

The physical capacity required to perform claimant's usual and customary work was in the heavy category. He returned to modified work in the light category. Therefore, the appropriate value for adaptability is 2.5. Former OAR 436-35-310(3).

Impairment

Claimant sustained permanent loss of thoracolumbar range of motion and suffers chronic pain which limits repetitive use of his back resulting from his compensable injury. He also suffered three fractures, one compression fracture and has undergone one fusion surgery. Each of these conditions are ratable under the standards. Former OAR 436-35-320(4), 436-35-350 and 436-35-360.

Claimant's ratable thoracolumbar range of motion findings include 40 degrees retained flexion (for a value of 5), 20 degrees retained extension (for a value of 1), 15 degrees retained right lateral flexion (for a value of 3) and 20 degrees retained left lateral flexion (for a value of 2). Claimant's total ratable loss of range of motion is 11 percent. Former OAR 436-35-320(4).

Claimant suffered a 30 percent compression fracture at L2. Therefore, the appropriate value for that fracture of a single vertebra is 4 percent. Former OAR 436-35-250(a).

Claimant also suffered both transverse and spinous fractures of L1, L2 and L3. A fracture of one or more of the posterior elements of a vertebra, including spinous process, is given a value of 3 percent, whether united or not. Former OAR 436-35-350(1)(c). Here, claimant suffered three such fractures, entitling claimant to a value of 3 percent for each fracture. These values are combined for a total of 8.73 percent. Former OAR 436-35-350(1)(c).

Claimant's compression fracture value under former OAR 436-35-350(1)(a) and the total value for his fractures of the posterior elements of a vertebra under former OAR 436-35-350(1) is 12.4 percent.

Claimant underwent a spinal fusion at L2-3. Because there is nothing in the record to establish whether the ankylosis is in a favorable or unfavorable position, we assume that it is in a favorable position. Former OAR 436-35-350(3). The fusion of any two lumbar in a favorable position is entitled to a value of 3 percent. Thus, claimant's spinal fusion entitles him to a fusion value of 3 percent.

Claimant contends that he is entitled to a value of 4 percent for a disc bulge at L4-5 under former OAR 436-35-350(2). We disagree. There is no evidence in the record to establish that the disc bulge is related to or caused by claimant's compensable back injury. Therefore, we give no value to claimant's disc bulge.

The total general spinal findings value is arrived at by combining the values under former OAR 436-35-350(1), (2) and (3). See Leland M. Pollock, 42 Van Natta 925 (1990); Michael E. Crist, 42 Van Natta 1093 (1990); Darrell L. Wilson, 42 Van Natta 1200 (1990).

Consequently, after combining the fracture value (12.4) with the spinal fusion value (3), claimant's total general spinal value is 15.03.

Claimant's total impairment value is arrived at by combining claimant's chronic condition value (5), his loss of range of motion value (11) and his total general spinal findings value (15.03). Former OAR 436-35-360(11). After combining, we conclude that claimant's total impairment resulting from his compensable injury is 28.16.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When

claimant's age value 0 is added to his education value 4, the sum is 4. When that value is multiplied by claimant's adaptability value 2.5, the product is 10. When that value is added to claimant's impairment value 28.16, the result is 38.16 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 39 percent.

Permanent Disability Outside the Standards

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5). The evidence must be free from confusion, fully intelligible and distinct. Riley Hill General Contractor v. Tandy Corporation, 303 Or 390, 402 (1987). In examining for clear and convincing evidence, the record is reviewed as a whole. Thomas L. Swanger, 42 Van Natta 887 (1990).

Claimant's inability to read, write or speak English is not ratable under the standards. See former OAR 436-35-001, et seq. The record establishes that claimant's inability to speak, write or read English effects, to some degree, his ability to obtain gainful employment.

Mr. Huckfeldt, vocational counselor, stated that claimant's "adaptability to finding work is severely impacted as a result of [his] limited educational and work background, as well as lack of facility in speaking, reading and writing the English language." (Ex. 41). Huckfeldt concluded that claimant's limited education, in addition to his inability to read, write and speak English, made claimant unemployable.

Contrary to Huckfeldt's ultimate conclusion that claimant's inabilities made claimant unemployable, we have found that claimant is capable of working, as he did successfully return to work. We do find, however, that this inability to read, write and speak English hampers claimant's work search. Claimant credibly testified, through an interpreter, that his inability to read, write and speak English restricts his ability to perform a work search equivalent to others with such abilities. We find this to be the case.

Huckfeldt's and claimant's credible testimony convinces us that it is highly probable that claimant suffers greater loss of earning capacity than the 39 percent awarded under an application of the standards.

After considering claimant's mild physical impairment resulting from his compensable injury, and considering claimant's relative youth, limited education and his inability to read, write and speak English, we find by clear and convincing evidence that claimant has suffered 65 percent loss of earning capacity.

ORDER

The Referee's order dated May 15, 1989, as reconsidered May 22, 1989, is modified. In lieu of the Referee's award and in addition to the Determination Order, claimant is awarded 24 percent (76.8 degrees) unscheduled permanent disability, for a total of 65 percent (208 degrees) unscheduled permanent disability. Claimant's attorney is entitled to 25 percent of the increased compensation created by this order, not to exceed $3,800. However, the insurer is permitted to credit any attorney fee paid pursuant to the Referee's award against the attorney fee awarded herein.

Board Member Myers, dissenting.

I respectfully dissent.

The majority states:

> "Under the circumstances, we find that the preponderance of the evidence establishes that claimant is capable of working. Therefore, based on the lack of medical evidence, claimant's release to return to work and claimant's own testimony and work record, we do not find Huckfeldt's opinion to persuasive."

From this statement, the majority concludes that claimant is not permanently and totally disabled because he is capable of modified work.

The majority's conclusion misses the mark. There is no disagreement over the fact that claimant, although significantly disabled, is physically capable of light work. Further, there is no disagreement over the fact that claimant would like to work and is motivated to do so. The relevant inquiry, however, is whether claimant is able to "sell his services on a regular basis in a hypothetically normal labor market" given his physical limitations combined with his age, education, adaptability to nonphysical labor, mental capacity and emotional conditions. See Wilson v. Weyerhaeuser Co., 30 Or App 403, 409 (1977).

Here, vocational counselor Huckfeldt opined that although claimant was potentially eligible for sedentary to light work, he was, in fact, unemployable due to his limited educational and work history, as well as his inability to speak, read or write English. Huckfeldt's expert opinion is unrebutted. Inexplicably, the majority finds his opinion not persuasive on the basis that claimant can perform light work and is motivated to obtain such work.

The fact that claimant is physically able to work and wishes to do so is not evidence, however, that he will be able to sell his services in a hypothetically normal labor market. It does not take into account other relevant vocational factors which affect employability. It is precisely for a situation such as this that the "odd-lot " doctrine was adopted by the Oregon courts. See Swanson v. Westport Lumber Co., 4 Or App 417, 423 (1971). To find that a claimant is not permanently and totally disabled solely on the basis that he can perform modified work, effectively circumvents 19 years of established case law.

The majority apparently puts great weight on the fact that claimant was employed from April 1988 to October 1988 by the Hispanic Rural Workers Association. However, the unrebutted testimony of Niabaldo Iriate indicates that claimant's position was a special job created to facilitate immigration laws. There is no evidence that such a position exists on the labor market and in fact this particular position ended with implementation of the new immigration law. Accordingly, it is not evidence that claimant can obtain and hold a regular gainful job. See Wiley v. SAIF, 77 Or App 486 (1986).

The majority acknowledges that this case falls under the "odd lot" doctrine. They further acknowledge that claimant has significant vocational deficiencies. Despite these acknowledgments, the majority finds claimant had not established permanent and total disability based upon the fact that he has the residual physical capacity to perform modified work. In so doing, the majority ignores the relevant vocational evidence and requires claimant to prove permanent and total disability solely on a medical basis.

I submit that this result is not supported by the case law, nor by the record in this case. Therefore, I would affirm the Referee's conclusion that claimant is permanently and totally disabled.

November 9, 1990 Cite as 42 Van Natta 2558 (1990)

In the Matter of the Compensation of
JOHN W. CROSS, Claimant
WCB Case Nos. 88-17850, 88-21281 & 88-21374
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Stafford Hazelett, Defense Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Thye's order that: (1) set aside its denial of claimant's occupational disease claim for a respiratory condition; and (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for the same condition. Claimant cross-requests review of that portion of the Referee's order which awarded a $1,000 assessed attorney fee. In his brief, claimant also contends that the Referee improperly addressed the issue of extent of permanent disability resulting from claimant's respiratory condition. On review, the issues are compensability, responsibility and attorney fees.

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

Compensability/Responsibility

Claimant has a predisposition to respiratory irritant reactions, characterized by coughing and shortness of breath. It is not clear whether his predisposition is attributable to a reactive airways condition or asthma. He experienced his first irritant reaction while working for Liberty Northwest's insured in 1987, and a second reaction while working for SAIF's insured in 1988.

The Referee concluded that Liberty Northwest was responsible for claimant's "flare-up of symptoms" with its insured in 1987. The Referee further concluded that the second reaction in 1988 was not compensable as to either SAIF or Liberty Northwest. We agree with the Referee's ultimate disposition, but we base our conclusion on the following reasoning.

To establish the compensability of his condition on an occupational disease theory, claimant has the burden of proving that his work activity was the major contributing cause of either the onset or worsening of his disease. 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 court has held that a predisposition is a "condition of special susceptibility to a disease," not a disease in and of itself. Preston v. Wonder Bread, 96 Or App 613 (1989). The claimant, in Preston, suffered from reactive airways disease and first experienced respiratory attacks after being exposed to workplace irritants. The court held that the irritant reaction itself was the disease from which claimant suffered.

We conclude that the disease in this case, as in Preston, is the irritant reaction itself. Therefore, a finding that claimant's work environment was the

major contributing cause of claimant's shortness of breath and coughing symptoms would compel the conclusion that his condition is compensable. Preston, supra.

The Referee deferred to the independent medical opinion of Dr. Montanaro, an allergy specialist. The Referee concluded that Dr. Montanaro's opinion supported a finding that claimant's occupational exposures at Liberty Northwest's insured resulted in a significant respiratory irritant reaction in 1987. We agree with the Referee's analysis of Dr. Montanaro's opinion and defer to that opinion for the reasons discussed by the Referee. Consequently, we conclude that claimant's exposure at Liberty Northwest's insured was the major contributing cause of his irritant reaction in 1987, so that Liberty Northwest is responsible for that reaction.

The Referee also found that claimant's work activity with SAIF's insured did not contribute to his irritant reaction in 1988. We affirm and adopt the Referee's finding and reasoning in this regard. We also agree with the Referee's finding that claimant's work with Liberty Northwest's insured did not contribute to his flare-up in 1988. Dr. Montanaro opined that claimant's 1987 flare-up with Liberty Northwest's insured had completely resolved prior to the 1988 attack. He stated that neither the 1987 flare-up nor claimant's work activity at that time pathologically worsened his condition or contributed to claimant's 1988 reaction. Dr. Libby, the treating physician, did not explain the basis of his contrary opinion that claimant's employment with Liberty Northwest contributed to his 1988 reaction. Therefore, we defer to Dr. Montanaro's opinion and find that claimant's work with Liberty Northwest's insured did not contribute to the 1988 reaction. Consequently, we affirm the Referee's ultimate ruling that the claim for the 1988 reaction is not compensable.

Claimant argues that the Referee's ruling that claimant's 1987 reaction at Liberty Northwest's insured has resolved, and that Liberty Northwest is not responsible for the underlying condition or the 1988 reaction, is a premature extent ruling. We disagree. The Referee's ruling was necessary to determine whether Liberty Northwest is responsible for claimant's condition in 1988. It was appropriate. However, such a ruling does not absolve Liberty Northwest of its obligations to process claimant's claim to closure.

Attorney Fee at Hearing

The Referee awarded claimant's attorney a $1,000 assessed fee for services regarding Liberty Northwest's denial of the 1987 irritant reaction, to be paid by Liberty Northwest. Claimant requests that his attorney fee be increased. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $1,000 is a reasonable fee for claimant's counsel's services at hearing. In reaching this conclusion, we have particularly considered the effort expended in obtaining medical opinions to support claimant's claim. Accordingly, we decline to increase the Referee's assessed fee.

Attorney Fee on Review

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $500 is a reasonable fee for claimant's counsel's services on review concerning the denial issue, to be paid by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to the case as indicated on the statement of services submitted by claimant's attorney.

ORDER

The Referee's order dated March 17, 1989 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $500, to be paid by Liberty Northwest.

In the Matter of the Compensation of
RONALD K. FARRIMOND, Claimant
WCB Case No. 87-06268
ORDER ON REVIEW
Rankin, et al., Defense Attorneys

Reviewed by Board Members Nichols and Crider.

The self-insured employer requests review of Referee Lipton's order that: (1) set aside its denial of claimant's occupational disease claim for mental stress; and (2) awarded claimant's attorney an assessed fee of $3,500 for prevailing against the denial. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. Claimant had received criticism regarding his job performance prior to his filing a claim on October 16, 1985 for a knee injury. A January 4, 1985 evaluation by his supervisor stated that claimant requires a lot of supervision. (Ex. 30-187). Also, in April 1985 claimant had two evaluations by his supervisor in which concern was expressed about claimant's low productivity, lack of interpersonal skills and performance of less than senior auditor level work. (Ex. 30-161, 165 & 166 and Tr. 151, 196 & 197).

FINDINGS OF ULTIMATE FACTS

Claimant reacted to the litigation over his knee injury claim by imagining that his employer harassed him as a result of that claim.

Real employment events and conditions, were not the major contributing cause of the onset of claimant's mental disorder.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's mental stress claim was compensable. We disagree.

Claims for benefits arising out of stress-caused mental disorders under former ORS 656.802(1) 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).

Considering claimant's prior history of depression and anxiety, as well as considering the variety of potential contributors to his stress condition, we conclude that 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).

The medical evidence most relevant to the causation issue was generated by Drs. Bloch and Turco, psychiatrists. We agree with the Referee that the persuasiveness of Dr. Bloch's opinion regarding causation must be discounted for lack of complete history. Dr. Bloch was unaware of any criticism of claimant's work

before October 1985 when claimant filed his workers' compensation claim for his knee injury. (Ex. 16). See Miller v. Granite Construction Co., 28 Or App 473. 476 (1977) (Medical opinions based on inaccurate histories are not persuasive).

On the other hand, Dr. Turco's opinion was based on a complete history. When Dr. Turco examined claimant on June 17, 1987, he diagnosed claimant as psychiatrically stable with a personality description of obsessive-compulsive. Dr. Turco indicated that in the past claimant had depression and anxiety; however, Dr. Turco did not state what caused this past condition except claimant's "perception of the work situation". (Ex. 23-6).

We agree with the Referee that the only "real" events claimant experienced that were capable of producing stress were the criticism of claimant's performance and the amount of time that his job required. Claimant imagined that his employer harassed him after he filed a workers' compensation claim for his knee injury. Thus, that harassment was not a real event.

The criticism of claimant's work before and after his filing a workers' compensation claim for his knee injury involved the same general subjects. In January 1985, claimant's supervisor expressed concern that claimant required a lot of supervision. (Ex. 30-187). In April 1985, claimant's supervisor expressed concern over claimant's: (1) low productivity; (2) work quality that was below that of a senior level auditor; and (3) problems with interpersonal skills. (Ex. 30-165 through 176). Claimant's supervisor also criticized him for starting a new audit before the old audit was completed. (Ex.30-162, 163).

After claimant filed the knee injury claim, these same general areas were criticized by his supervisor. On November 1, 1985, claimant was again admonished for not finishing one audit before starting another. (Ex. 30-155). On February 21, 1986, claimant's supervisor denied that claimant's filing a claim had any bearing on his job requirements or their working relationship. The supervisor stated that he was only continuing a course started the previous summer dealing with claimant's productivity problems. (Ex. 30-147). On July 18, 1986, claimant's performance evaluation stated that he needed to perform as a senior level auditor and that he required more supervision than he should. (Ex. 30-121). On September 9, 1986, claimant's supervisor again complained about claimant starting a new audit before finishing the previous one. (Ex. 30-115, 116). Again in January 1987, complaints were made that claimant was not working at a senior auditor level and required too much supervision. (Ex. 30-98 and 30-89, 90).

The consistency of the criticism before and after the filing of the knee injury workers' compensation claim indicates that claimant's perception that he was harassed after filing that claim is inaccurate. Given the inaccuracy of claimant's perceptions, Dr. Turco's opinion that claimant's perceptions were the cause of his disorder is insufficient to support a finding that real, objectively stressful events at work were the major contributing cause of claimant's mental disorder or its worsening. Therefore, claimant's mental stress claim is not compensable.

ORDER

The Referee's order dated March 23, 1988, is reversed. The self-insured employer's denial of April 15, 1987, is reinstated and upheld. The Referee's award of an assessed fee of $3,500 is reversed.

In the Matter of the Compensation of
DUANE R. PAXTON, Claimant
WCB Case Nos. 88-19070 & 88-17363
ORDER ON REVIEW (REMANDING)
Emmons, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Howell and Speer.

Aetna Casualty Co. (Aetna) requests review of Referee Myers' order that: (1) set aside its denial of claimant's occupational disease claim for carpal tunnel syndrome; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty) denial of claimant's aggravation claim for the same condition. In addition, Aetna requests remand for admission of post-surgical evidence. The issues on review are remand and responsibility. We grant the motion to remand.

FINDINGS OF FACT

Liberty's insured (Hewlett-Packard) accepted a claim for bilateral carpal tunnel syndrome in February 1986. The treating orthopedic surgeon, Dr. Van Olst, performed release surgeries in March and April of 1986. Following these surgeries, claimant had tenderness for about two months and then became asymptomatic. Claimant was released to his regular work as a tool maker, which he performed until he was laid off in September 1986. The claim was closed by carrier notice of closure in July 1986.

Claimant worked for two other employers between September 1986 and July 1987, when he began working for Aetna's insured (Boeing). Claimant's job at Boeing was similar to his job at Hewlett-Packard in that it required extensive fine motor use of the hands.

About one year after working at Boeing, claimant noticed electric shock sensations and tingling in both hands. In October 1988, Liberty denied claimant's aggravation claim and in November 1988, Aetna denied an occupational disease claim.

After the February 9, 1989 hearing, the Referee upheld Liberty's aggravation denial and set aside Aetna's denial. The Referee based his opinion on a recent diagnosis of "intraneural scarring," concluding that this new condition was a sequela of claimant's accepted carpal tunnel syndrome and claimant's subsequent employment with Boeing was a material cause of a worsening of this scarring.

Aetna made four continuing discovery demands upon claimant and three separate demands upon Liberty. The hearing record was closed on May 2, 1989 and an order issued May 8, 1989. On May 26, 1989, Aetna received information that claimant had changed his treating physician and had surgery performed on his left wrist on March 14, 1989 and on his right wrist on May 12, 1989. The operative and post-surgical reports address the question as to whether claimant has "intraneural scarring." Aetna filed a motion to reopen the record to admit this post-surgical evidence. The Referee denied the motion on June 5, 1989.

CONCLUSIONS OF LAW AND OPINION

Remand

Aetna seeks remand for the admission of surgical and post-surgical evidence. We grant the motion.

We may remand a case to the Referee for further evidence taking if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In addition, to merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986). In this regard, we consider the proferred evidence on review only for purposes of claimant's remand motion.

We are persuaded that the record concerning the responsibility issue was otherwise insufficiently developed. Here, the hearing record was closed on May 2, 1989. On May 26, 1989, Aetna received information that claimant had changed his treating physician and had further surgery performed on his wrists. The operative and post-surgical reports revealed information which was highly probative on the issue of responsibility. The question before the trier of fact concerned responsibility for ongoing disability and payment for related treatments, including surgery. The record may be reopened to admit post-surgical evidence relating to the payment of surgery. See Palmer v. Plaid Pantry #54, 76 Or App 405 (1985); Duckett v. SAIF, 79 Or App 749 (1986).

We are similarly persuaded that the disputed surgical reports were unobtainable with due diligence at the time of hearing, as well as the closure of the record. Here, Aetna made four continuing discovery demands upon claimant and three separate demands upon Liberty. Despite these persistent efforts, the information was not forthcoming until after the record was closed and the Referee's decision issued. Thus, we find that the surgical and follow-up reports are relevant evidence, without which the record would be incomplete. We conclude that the case should be remanded to the Hearings Division for further development. See Palmer v. Plaid Pantry #54, supra; Duckett v. SAIF, supra.

Accordingly, the Referee's order dated May 8, 1989, as reconsidered June 5, 1989, is vacated. This case shall be remanded to the Presiding Referee to appoint a referee to reopen the record for additional evidence regarding claimant's surgery. The appointed referee is instructed to proceed in any manner that will achieve substantial justice. ORS 656.283(7). The assigned Referee shall then issue a final appealable order reconsidering those issues raised at hearing.

ORDER

The Referee's order dated May 8, 1989, as reconsidered June 5, 1989, is vacated. This matter is remanded to the Presiding Referee for further proceedings consistent with this order.

November 9, 1990 Cite as 42 Van Natta 2563 (1990)

In the Matter of the Compensation of
DAVID R. WEDDLE, Claimant
WCB Case No. 89-09976
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Holtan's order which: (1) found that a Determination Order did not prematurely close claimant's back injury

claim; and (2) affirmed the same Determination Order award of no unscheduled permanent disability. On review, the issues are premature closure and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

The Referee found claimant not credible.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We affirm and adopt the Referee's "Opinion" regarding the issue of premature closure.

Extent of Disability

The Referee declined to award unscheduled permanent disability. We agree for the following reasons.

In exercising de novo review we generally defer to the Referee's determination of credibility when it is based on the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360, 363 (1982). However, when the Referee's conclusion is based not upon demeanor, but on an objective evaluation of the substance of a witness's testimony, the Referee has no greater advantage in determining credibility than we do. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); See Dean A. Grudzinsky, 42 Van Natta 597, 598 (1990). In this case, we agree with the Referee's finding that claimant has been impeached by surveillance films showing claimant engaging in activities beyond his testified abilities as well as testimony of the SAIF Corporation's investigator who observed claimant in these activities.

The Referee found that claimant's treating physician's opinion is not persuasive because it relies on claimant's untrustworthy subjective complaints. We agree. In addition, we note that BBV Consultants' report specifies that claimant's ranges of motion were "limited by [claimant's] complaint of low back pain." (Ex. 21-4). Due to claimant's lack of credibility, we are unable to rely upon BBV's loss of range of motion findings.

The "standards" provide that "there shall be no unscheduled disability if the injury did not result in impairment." Former OAR 436-35-280(1). Accordingly, upon our de novo review of the record and analysis of claimant's condition based upon the "standards," we find that claimant has failed to prove that he sustained permanent impairment as a result of his August 15, 1988 injury.

ORDER

The Referee's order dated October 26, 1989 is affirmed.

In the Matter of the Compensation of
ERNEST A. BROWN, Claimant
WCB Case No. CO-00201
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Aller & Morrison, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Nichols and Crider.

On October 19, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $27,500 by Louisiana-Pacific Corporation, the self-insured employer, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

We shall not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). The Board's rules require that a claim disposition agreement be in a separate document from a disputed claim settlement (DCS). OAR 438-09-020(2)(b). Any claim disposition agreement which does not comply with this rule must be returned to the drafter. OAR 438-09-020(3).

Here, along with the proposed disposition agreement, the parties submit a DCS to resolve a pending appeal before the Court of Appeals on an aggravation issue relating to this claim (WCB Case No. 88-05082; CA No. A65881). The terms of that DCS provide that claimant has remained medically stationary since 1986 and that his low back condition at the time of the alleged aggravation is unrelated to his compensable injury. Additionally, the parties submit a second DCS to resolve a pending request for Board review on a medical services issue relating to this claim (WCB Case No. 89-17003). The terms of that DCS provide that claimant's need for low back surgery is not related to the compensable injury and that the surgery is neither reasonable nor necessary.

The aforementioned DCS terms are expressly incorporated in the proposed disposition agreement (p. 3, ll. 11-25). By incorporating terms of the DCS into the claim disposition agreement, the agreement exceeds the bounds of OAR 438-09-020(2)(b). Jean E. Nealy, 42 Van Natta 2379 (1990) Accordingly, we find that the proposed disposition is unreasonable as a matter of law and set it aside. See ORS 656.236(2); Louis R. Anaya, supra.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD L. SCHILLING, Claimant
WCB Case No. 89-02631
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
John McLeod, Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation, on behalf of Brothers Landscaping (Brothers), a non-complying employer, requests review of that portion of Referee Schultz's order that set aside its denial of claimant's claim for his low back injury and related psychological condition. In its brief, SAIF contends that the Referee erred in finding "good cause" for claimant's untimely filing of his request for hearing from its September 22, 1988 denial. On review, the issues are timeliness, compensability and responsibility. We reverse.

As a preliminary matter, we note that SAIF has requested that review of this case be expedited. Inasmuch as the review process had already commenced when this request was received, SAIF's request is moot.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the exception of his findings that claimant's attorney's legal assistant asked a secretary to request a hearing on the September 22, 1988 denial and that the secretary misfiled the request for hearing. In place of those findings, we substitute the following.

SAIF's September 22, 1988 denial on behalf of Brothers was received by claimant's attorney's office. The denial was misfiled in another claimant's file. The denial was not discovered until approximately March 7, 1989.

We also find that: The September 22, 1988 denial did not encompass claimant's psychological condition. SAIF's "de facto" denial denied claimant's psychological condition.

We take official notice that: A September 13, 1990 Board order concluded that SAIF, on behalf of Brothers, was no longer responsible for claimant's low back condition.

CONCLUSIONS OF LAW AND OPINION

Good cause for failure to timely request hearing

The Referee found that claimant was not bound by the failure of his attorney's secretary to timely request a hearing on SAIF's September 1988 denial. The Referee concluded that claimant had proven good cause for his failure to timely file the request. We disagree.

A hearing on a denial of a claim for compensation shall not be granted and the claim shall not be enforceable unless a request for hearing is filed within 60 days after the claimant is notified of the denial. ORS 656.319(1)(a). This is not an absolute time limit. If claimant files a request for hearing within 180 days, he may establish that there was good cause for failure to file by the 60th day. ORS 656.319(1)(b).

"Good cause" has been defined as "mistake, inadvertence, surprise or excusable neglect" as those terms have been employed under ORCP 71B and former

ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513 (1986). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

In the present case, claimant's counsel testified at hearing that it was his office's custom to appeal each denial or Determination Order it received. Claimant's attorney first testified that there "was an indication that the legal assistant requested that the secretary request a hearing on both the Determination Order and the denial itself...." However, later the attorney acknowledged that he could not tell "exactly what had happened" and he could not "really testify for sure who did what".

Case law provides that it is at least within the range of discretion to relieve a claimant from a default caused by the mistake or neglect of an employee who is not charged with responsibility for recognizing and correctly handling the message that constitutes the legally crucial notice from which the time to respond is measured. Brown v. EBI Companies, 289 Or 455, 460 (1980). In the Brown case, the Court concluded that a finding of good cause was not foreclosed where the written notice of denial was misplaced by someone responsible for handling mail in the claimant's attorney's office. Brown, supra.

In the instant case, however, we are unable to discern whether the failure to promptly request a hearing from the denial resulted from the actions or inactions of a clerk, a secretary or a legal assistant to whom the attorney had delegated his authority in regard to the appeals of all denials and Determination Orders. On this record, we are only able to determine that the September 1988 denial was received by claimant's counsel's office and was misfiled in another claimant's file. We cannot, therefore, find whether the failure to timely file a request for hearing resulted from the excusable neglect of an employee not responsible for filing requests for hearing or from the action or inaction of a legal assistant whose neglect would not be excused.

We conclude that the facts of this case are distinguishable from the line of cases that find good cause for untimely filing due to the neglect of a specific employee who was not charged with responsibility for handling the appeal of a denial. Here, claimant has failed to meet his burden of proof and has not established that good cause existed for his untimely request for hearing on the denial. Accordingly, claimant's request for hearing on the September 22, 1988 denial is dismissed for lack of jurisdiction. The denial became final by operation of law.

Effect of September 1988 and February 1989 denials

On review, SAIF contends that the September 1988 denial denied both claimant's low back condition and his psychological condition. SAIF argues that its February 9, 1989 letter merely clarified its 1988 denial of both conditions. We disagree.

SAIF's September 1988 denial denied claimant's claim for his "low back and sequela" beyond April 16, 1982. In its February 9, 1989 letter, SAIF enclosed a copy of its September 1988 denial and stated that: "This denial encompasses Mr. Schilling's psychological condition with the addition of '...and sequela which you state is related to your original injury of October 1, 1978.'"

We are not convinced by SAIF's argument that the February 1989 letter was not a new denial because no denial rights were given. We also do not agree with SAIF's contention that the "sequela" referred to in the 1988 denial could only be claimant's psychological condition. Although the September 1988 denial clearly denied claimant's low back condition, the denial of sequela related to

the low back is not sufficiently clear to deny claimant's psychological condition. See former OAR 436-60-140(4)(a) and 438-05-060. Further, the February 1989 letter was inadequate to constitute a denial of claimant's psychological condition as it failed to comply with former ORS 656.262(8); former OAR 438-05-055 and former OAR 438-05-060.

In the present case, however, we find that there was at least a "de facto" denial of claimant's psychological condition. At hearing, claimant raised the issue of SAIF's "de facto" denial of February 9, 1989. The parties treated the psychological condition as denied and the issue was fully litigated at hearing. See Daniel L. Grousback, 41 Van Natta 2342 (1989). Under the circumstances, we conclude that SAIF effectively denied claimant's psychological condition, but it did not do so by way of its September 1988 denial, as it now contends, or by its February 1989 letter.

As claimant did not have notice that the September 1988 denial encompassed his psychological condition, we do not find that his claim is now barred by an untimely request for hearing. We therefore proceed to address his psychological condition claim on the merits.

Psychological condition

The Referee found that claimant's April 16, 1982 low back injury at Sunnyside Methodist Church (Sunnyside) independently contributed to a worsening of both the low back condition and the psychological condition. The Referee concluded that Runft v. SAIF, 303 Or 493 (1987), required that SAIF (Brothers) join Sunnyside as the subsequent employer, and that failure to join Sunnyside constituted a legal bar to any shifting of responsibility. We disagree.

Runft provides that, ordinarily, an employer may not rely on the rules governing responsibility as a defense unless other potentially responsible employers have been joined. Runft, supra. However, in a case similar to the present one, we held that an insurer was permitted to defend on the basis of the last injurious exposure rule as claimant had withdrawn his claims against two other potentially responsible insurers. See Connie A. Martin, 42 Van Natta 495 (1990).

In Martin, the claimant had accepted low back claims with his first and second employers and he had received treatment for low back pain during a third employment. Claimant filed an aggravation claim against the first employer and a new injury claim against the third employer. In addition, claimant joined the second employer as a party. Martin, supra.

At hearing, the claimant in Martin requested dismissal of his hearing requests regarding the first and third employers. The only denial at issue at the hearing, therefore, was the responsibility denial of the second employer and its insurer, F & C. We concluded that, under the circumstances, F & C bore no responsibility for the fact that the third employer was no longer a party to the hearing. Accordingly, we determined that, because claimant had withdrawn his hearing requests as to two potentially responsible employers, F & C should not be barred from using the last injurious exposure rule defensively. Martin, 42 Van Natta at 497.

In the present case, claimant first filed his psychological claim against Sunnyside. On July 19, 1986, Sunnyside issued a partial denial alleging that claimant's psychological treatment was not related to the April 16, 1982 injury. Sunnyside later issued an amended denial stating an alternative basis that, if it was industrially related, the psychological condition was the result of claimant's first industrial injury.

Claimant entered into a Disputed Claim Settlement (DCS) with Sunnyside which was approved in April 1989. The DCS specified that claimant's psychological condition was unrelated to his compensable injury of April 1982. (Of course, Brothers is not bound by that agreement, since it was not a party to it.) The DCS further provided that Sunnyside's denials of July 1986 and October 1986 remained in full force and effect.

We agree with SAIF's contention that it should be permitted to assert the last injurious exposure rule. Claimant's actions here are analagous to the actions of the claimant in Martin, and similarly, SAIF is not responsible for the fact that Sunnyside is not a party to this action. Because claimant effectively withdrew his hearing request by settling Sunnyside's denial prior to hearing, we conclude that SAIF is not barred from using the last injurious exposure rule defensively to avoid responsibility. See Clyde S. Melvin, 42 Van Natta 1313 (1990).

We must therefore address whether claimant's employment with Sunnyside independently contributed to a worsening of his psychological condition. If the subsequent employment contributed even slightly to the causation of the disabling condition, SAIF may ,hift responsibility of claimant's condition. See EBI Companies v. Grover, 90 Or App 524 (1988); Ronald C. Earl, 41 Van Natta 530 (1989).

The Referee found, and we agree, that the April 1982 injury at Sunnyside independently contributed to claimant's psychological condition. We conclude that SAIF, on behalf of Brothers, the noncomplying employer, is not responsible for claimant's psychological condition.

Low back claim

As we have found that claimant's September 1988 request for hearing on the denial of his low back injury was untimely, we are without jurisdiction to address the merits of his claim. We note that, even if we had jurisdiction over this matter, a prior Board order has held that claimant's employment with Sunnyside independently contributed to his current low back condition. Ronald L. Schilling, 42 Van Natta 1974 (1990). In our prior order, we found that SAIF, on behalf of Brothers, the noncomplying employer, was no longer responsible for claimant's low back condition. Our previous order would therefore preclude us from reaching any different result.

ORDER

The Referee's order dated October 30, 1989, is reversed in part. Claimant's request for hearing on the September 22, 1988 denial of his low back injury is dismissed. The SAIF Corporation's denial (on behalf of Brothers Landscaping) of claimant's low back injury is reinstated and upheld. SAIF's "de facto" denial of claimant's psychological condition is upheld. The Referee's award of a $2,400 assessed attorney fee for claimant's counsel is reversed.

In the Matter of the Compensation of
LINDA F. WRIGHT, Claimant
WCB Case No. 89-10549
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Baker's order which: (1) found that her bilateral epicondylitis claim had not been prematurely closed; (2) affirmed the Determination Order award of 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of each arm; and (3) declined to award unscheduled permanent disability for a shoulder condition. On review, the issues are premature closure, and extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant filed a claim for hand, wrist and neck conditions on September 14, 1987, stating that she had experienced a "gradual onset of symptoms." (Ex. 1). This was accepted as a nondisabling "injury" on November 25, 1987. (Ex. 1).

Claimant's condition is diagnosed as bilateral epicondylitis. (Ex. 3A; 16; 23).

Claimant's treating physician, Dr. Young, M.D., referred her to Dr. Lawton, orthopedist, who treated claimant from December 1987 until around October 11, 1988. (Ex. 3A & 7). On November 8, 1988, Dr. Lawton, and on December 12, 1988, Dr. Young, approved a proffered modified job for claimant. (Ex. 12).

Claimant was found medically stationary on April 13, 1989 and her claim closed by Determination Order on May 18, 1989. (Ex. 26).

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee held that because claimant had not proven by a preponderance of the evidence that her compensable condition was likely to improve with further treatment or the passage of time, her claim had not been prematurely closed. We agree that claimant's claim was not prematurely closed.

In order to prove that her claim was prematurely closed, claimant must demonstrate that she 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 determination of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985). 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 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., supra.

In support of her contention that her claim was prematurely closed, claimant points to the opinions of her treating physician, Dr. Young, M.D. Prior to closure, on February 6, 1989, Dr. Young described his understanding of the definition of "medically stationary" as "requir[ing] that [claimant] will not benefit materially from the passage of time or treatment." However, Dr. Young then opined that claimant was not medically stationary because claimant could return to work only in a modified position and that her condition "may require further treatment." (Ex. 20). Subsequent to closure, Dr. Young reported on June 23, 1989 that claimant was not then medically stationary nor had she been at the time of closure. (Ex. 26D). Dr. Young based this opinion on the fact that on June 23, 1989, claimant's condition was worse since she had been in a modified work program and further tests were required to determine a physical cause of her symptoms. Although we usually defer to the opinion of the treating physician, we do not find Dr. Young's reasoning persuasive. A need for continuing palliative treatment and diagnostic measures does not preclude a medically stationary status. Kenneth W. Meyers, 41 Van Natta 1375 (1989). Furthermore, Dr. Young's post-closure opinion does not address claimant's condition at the time of closure, only her condition as it was post-closure on June 23, 1989.

We note that on October 11, 1988 Dr. Lawton, claimant's other treating physician, while advising claimant that "her condition had stabilized," wrote that claimant's "condition can often be a prolonged one and it may be as long as 6 to 12 months before we see more resolution." (Ex. 7-7). This statement suggests that Dr. Lawton may have expected improvement in claimant's condition with the passage of time. However, it is not clear from the context of Dr. Lawton's chart notes from which this statement was taken, that it was Dr. Lawton's intention that this statement should be taken as his opinion regarding whether claimant was medically stationary. Additionally, the evidence indicates that Dr. Lawton did not see claimant after November 1988. Accordingly, we conclude that this statement alone is not sufficient to persuade us that claimant's condition was not medically stationary as of May 18, 1989.

On the other hand, there is persuasive medical opinion indicating that claimant's condition was medically stationary on or before May 18, 1989. On January 4, 1989, the Orthopaedic Consultants, in a thorough and well-reasoned report, concluded that claimant's condition was stationary and that she could return to her regular job with modifications or some other job as necessary. (Ex. 16-4).

Accordingly, we find that claimant has failed to prove that she was not medically stationary on May 18, 1989.

Extent of Permanent Disability

Scheduled

The Referee, finding that claimant is limited in her ability to engage in repetitive use activities, concluded that the Determination Order award of 5 percent adequately compensates claimant, and that there was no clear and convincing evidence that claimant is entitled to more disability than indicated under the standards. We agree.

Because claimant became medically stationary on April 13, 1989, and her claim was closed by Determination Order on on May 18, 1989, the "standards" adopted effective January 1, 1989, former OAR 436-35-010 through 436-35-260, apply to the rating of claimant's scheduled permanent disabilities. Scheduled permanent disability is rated on the permanent loss of use or function of a body part due to the compensable injury. Former OAR 436-35-010.

Claimant argues that she has sustained loss of range of motion of the wrist joint. As evidence of this, claimant points to a physical therapist's report indicating his range of motion findings. However, under former OAR 436-35-005(1), "'Impairment' means a decrease in the function of a body part or system as measured by a physician...." Therefore, the physical therapist's measurements may not be used to assign impairment values under the standards. The record contains no physician's documentation indicating claimant has sustained a loss of range of motion. Additionally, the record contains no physician's documentation indicating claimant has sustained loss of sensation. Under former OAR 436-35-010(2)(b), pain is considered in the rules only to the extent it results in measurable impairment. If there is no measurable impairment, no award of scheduled permanent partial disability is allowed. Therefore, claimant is not entitled to a value for pain.

A value of 5 percent is given where a compensable condition results in limited repetitive use of a scheduled body part. Former OAR 436-35-010(7). The medical documentation indicates that claimant's condition is chronic and that claimant cannot sustain long periods of production typing, claimant's normal work activity, which is a repetitive activity. Therefore, we find that the record supports a finding that claimant has lost repetitive use of her arms resulting in a value of 5 percent for loss of use or function.

Unscheduled

The Referee concluded that claimant's alleged right shoulder problems are not compensable and, therefore, that claimant is not entitled to an award of unscheduled permanent disability. We agree.

Medical and legal causation are requirements for every workers' compensation claim. Legal causation requires the existence of an on-the-job injury. Medical causation requires evidence connecting the accidental injury and the condition for which medical benefits are being claimed. Claimant carries the burden to establish each of these elements by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 288 Or 51 (1979). Claimant offers no evidence connecting her shoulder condition to her accepted condition.

ORDER

The Referee's order dated October 26, 1989 is affirmed.

November 14, 1990 Cite as 42 Van Natta 2572 (1990)

In the Matter of the Compensation of
STEVE A. ALEXANDER, Claimant
WCB Case No. 88-16136
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of those portions of Referee McWilliams' order which found claimant to be a subject worker under Oregon law.

ISSUES

The insurer moves to remand to the Referee for receipt of additional evidence.

In the alternative, the insurer contends that claimant is not a subject worker under Oregon law.

Finally, the insurer contends that even if claimant is a subject worker, he is not entitled to recover benefits under Oregon law because he has already recovered benefits under Washington's workers' compensation system.

MOTION TO REMAND

The insurer moves to remand for evidence of the current status of claimant's claim in Washington. We deny the motion.

We have reviewed the insurer's affidavit for which it seeks remand solely for the purposes of this motion. We conclude that this evidence is not relevant to the inquiry here; therefore, the motion to remand is denied.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Conclusions of Law and Opinion with the following supplementation. The insurer argues that even if claimant is a subject worker, he should be precluded from receiving benefits under Oregon law because he has received benefits under Washington's workers' compensation system for the same injury. We disagree.

We have held that an accepted claim in another jurisdiction does not preclude a claimant from obtaining Oregon benefits for the same injury. Dennis J. Blanchard, 41 Van Natta 483 (1989). Furthermore, the insurer's argument against "double recovery" is rendered moot by claimant's concession at page 3 of his brief that "an insurer may offset Oregon benefits with amounts actually received by claimant from another state claim, not including attorney fees awarded by the other state."

Considering the factors enumerated in OAR 438-15-010(4), particularly the time expended and the results obtained, we conclude that claimant's attorney is entitled to a reasonable assessed fee of $1,000 for services on review.

ORDER

The Referee's order dated December 7, 1989 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
RICHARD A. COLCLASURE, Claimant
WCB Case No. 89-05949
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Nichols' order that declined to direct the self-insured employer to provide vocational assistance to claimant pending its appeal of a prior Opinion and Order that found claimant eligible for vocational assistance. On review, the issue is entitlement to vocational services pending appeal. We affirm.

We adopt the Referee's "Findings of Fact" and "Opinion and Conclusion," but add the following comment.

Claimant was awarded vocational assistance by a prior Opinion and Order dated January 18, 1989. In that order, the earlier referee ordered that claimant was eligible for vocational assistance. We note that claimant's vocational assistance did not include entitlement to "compensation payable to a claimant," i.e., temporary disability. As such, we find that claimant's ordered vocational assistance is not the type of compensation required to be paid pending review. See ORS 656.313(1) & (4).

ORDER

The Referee's order dated August 11, 1989 is affirmed.

In the Matter of the Compensation of
DILLARD J. GRAVES, Claimant
WCB Case No. 89-13561
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham, and Crider.

Claimant requests review of Referee Gruber's order that declined to assess penalties and attorney fees for the SAIF Corporation's failure to provide discovery of payroll records. The issue on review is penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant's attorney wrote to SAIF on April 28, 1989 requesting discovery. General claims documents were forwarded to the attorney on May 23, 1989. On June 16, 1989, claimant's attorney again wrote to SAIF thanking them for the documents but reminding them that the April 28th letter contained an addendum which specifically requested payroll records, and they had not been included in the packet of documents sent by SAIF. On July 14, 1989, claimant's attorney filed a request for hearing on the issue of failure to provide discovery. The request for hearing form also requested that SAIF provide claims "documents and other information pertaining to this claim." On August 7, 1989, the attorney made another specific request for payroll records. The hearing was held on

August 14, 1989. No payroll records had been provided at the time of the hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee agreed with SAIF's argument that he had no authority to assess a fee for its noncompliance with claimant's initial discovery requests because the Board rule regarding discovery, OAR 438-07-015, did not apply to requests for discovery made prior to a request for hearing. He further found that if the rule that did apply was the Director's rule, OAR 436-10-030(10), he had no jurisdiction in the matter.

The Referee went on to conclude that the Board's discovery rule did apply once the hearing request was filed. The Referee found that the first request for the payroll records was August 7, 1989, so that the 15 days which SAIF has to provide the documents had not yet expired at the time of the hearing. Consequently, he concluded that SAIF had not violated the Board's rule pertaining to discovery.

Jurisdiction

We disagree with the Referee's jurisdictional ruling. Since the Referee issued his order, we have issued Lawrence A. Durette, 42 Van Natta 413 (1990), in which we held that a request for hearing on an issue of discovery did place claimant's right to receive compensation directly at issue and thus was a matter concerning a claim. Accordingly, we have jurisdiction over this matter, regardless which discovery rule applies.

Penalties and Attorney Fees

We agree with the Referee's ultimate ruling that claimant is not entitled to a penalty and attorney fee, but we base our decision on the following reasoning.

The record is clear that claimant made a request for payroll records at least by June 16, 1989. At the time those records were requested, there was no request for a hearing. The Board rule regarding discovery, OAR 438-07-015(2), does not become effective until a request for hearing has been filed. Lawrence A. Durette, supra. If any rule applied at that time it would be the Director's rule, OAR 436-10-030(10). However, that rule relates only to medical documents and, thus, SAIF's failure to provide the documents was not a violation of the rule.

It is arguable, however, that once the request for hearing was filed, the Board's rule became operative and SAIF had a duty to process claimant's previous requests for payroll documents. SAIF would then have 15 days to provide the requested records from the date of the request, which it failed to do.

Even if we assume that to be the case, there is no evidence that there was anything then due upon which to base a penalty; nor is there any evidence that there was a resistance to the payment of compensation to support the award of an attorney fee, Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). Consequently, there can be no award of a penalty or attorney fee.

ORDER

The Referee's order dated August 25, 1989 is affirmed.

Board Member Crider, concurring.

The majority notes that an argument can be made that SAIF's conduct, in failing to produce the requested payroll records within 15 days of claimant's request for hearing, was unreasonable. I agree and would so find. Nonetheless, the record is so bare that it fails to establish that there were any amounts then due at the time of the violation or that there was a resistance to compensation. Consequently, neither a penalty nor a fee may be assessed.

November 14, 1990 Cite as 42 Van Natta 2576 (1990)

In the Matter of the Compensation of
STANLEY R. LIBEL, Claimant
WCB Case No. 88-0230M
OWN MOTION ORDER
Quintin B. Estell, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

On July 27, 1988, we issued an Own Motion Determination closing claimant's claim which had been voluntarily reopened by the SAIF Corporation. At that time, we deferred consideration of claimant's request for penalties and attorney fees concerning SAIF's allegedly unreasonable claims processing. Such an action was taken to permit us to review this matter in tandem with claimant's request for Board review of a Referee's order which pertained to the same issue. WCB Case No. 87-13297.

This date we have affirmed and adopted the Referee's order, which held that the Hearings Division lacked authority to consider claimant's request for penalties and attorney fees arising from the allegedly unreasonable processing of a claim that was in own motion status. In so doing, we relied on David L. Waasdorp, 38 Van Natta 81 (1986). We now proceed with our review of claimant's request for own motion relief.

On May 12, 1987, SAIF authorized claimant's physician's request to perform arthroscopic surgery. Claimant's aggravation rights from a May 1980 injury claim had expired. The surgery was performed on June 10, 1987.

When claimant did not receive a check for temporary disability, he contacted SAIF's claim examiner who was responsible for processing the claim. Claimant was advised that, since the own motion claim had been voluntarily reopened, SAIF was under no obligation to pay within a certain period and would provide benefits "when [the examiner] got around to it."

On June 25, 1987, SAIF advised claimant's counsel that it had voluntarily reopened the claim. SAIF further stated that claimant's temporary disability benefits would be paid from April 1, 1987 until claim closure. That day, claimant was paid temporary disability from April 1, 1987 through June 18, 1987. On July 9, 1987, SAIF paid temporary disability from June 19, 1987 through July 2, 1987.

Claimant seeks penalties and attorney fees for SAIF's failure to provide temporary disability within 14 days after it voluntarily reopened the claim. Asserting that SAIF would have been required to pay such benefits within 14 days had a Board order reopened the claim, claimant contends that SAIF should not be permitted to flaunt its claim processing obligations by choosing to voluntarily reopen the claim.

There is no "right" to receive compensation after the expiration of aggravation rights. Clifford D. Howerton, 38 Van Natta 1358, 1359 (1986). Yet, the Board has the continuing authority to award compensation on a discretionary basis. Id. In addition, rules and standards contained in the statutes covering awards of disability are not abrogated by ORS 656.278. Edward Hines Lumber Co. v. Kephart, 81 Or App 43, 46 (1986).

Here, even assuming that SAIF was obligated to comply with statutory claim processing prerequisites prior to the issuance of a Board order, the record does not establish that SAIF failed to pay temporary disability in a timely manner. We reach such a conclusion because we are unpersuaded that SAIF did not pay temporary disability benefits within 14 days of its decision to voluntarily reopen the claim.

As documented by Dr. Poulson's January 18, 1988 note, SAIF authorized claimant's surgery on May 12, 1987. However, such a pronouncement does not indicate when SAIF agreed to voluntarily reopen the claim. Providing authorization to perform surgery and voluntarily reopening a claim that is in own motion status are not one in the same. Authorization to perform surgery concerns claimant's ongoing entitlement to medical services resulting from his compensable injury. See former ORS 656.245(1). Such entitlement is a lifetime right and not contingent on the existence of a claimant's aggravation rights.

Admittedly, the performance of either inpatient or outpatient surgery may entitle a claimant to temporary disability benefits, provided that there has been a worsening of the compensable injury and assuming that the claimant has not withdrawn from the work force. ORS 656.278(1)(a); Glenda J. Herring, 41 Van Natta 1763 (1989). Yet, a decision to authorize surgery does not automatically entitle a claimant to a reopening of his claim for the payment of temporary disability benefits, particularly when that claimant's aggravation rights have expired. Rather, a decision to voluntarily reopen a claim in which a claimant's aggravation rights have expired is purely a discretionary matter. See ORS 656.278(4). Applying this reasoning to the present situation, we are not persuaded that SAIF's May 12, 1987 authorization to perform surgery constituted a decision to reopen the claim for the payment of temporary disability benefits.

We turn to claimant's account of his conversations with SAIF's claims examiner. Claimant's inquiries were designed to determine when he could expect to receive temporary disability benefits. The response that he was given was certainly indifferent. However, notwithstanding the response, claimant's testimony only establishes that this conversation occurred sometime between SAIF's authorization to perform the surgery and the first payment of benefits on June 25, 1987.

We are unable to determine from claimant's testimony when SAIF's voluntary and discretionary action to reopen the claim for the payment of temporary disability benefits occurred. Instead, the most persuasive evidence on this question is the June 25, 1987 letter from SAIF's claims examiner to claimant's counsel. This letter announces that SAIF was voluntarily reopening the claim and paying temporary disability benefits to begin April 1, 1987 to continue until claim closure. That same day, SAIF issued claimant a check for benefits from April 1, 1987 through June 18, 1987.

After conducting our review of this record, we find that SAIF voluntarily reopened claimant's claim on June 25, 1987. Inasmuch as SAIF also provided temporary disability benefits on that date, we do not consider such a payment to be untimely. Moreover, SAIF's payment of benefits for a period ending 7 days before the date of payment is in accordance with OAR 436-60-150(4).

Consequently, based on the foregoing reasoning, we do not consider SAIF's actions to have been unreasonable or untimely. Accordingly, claimant's request for penalties and attorney fees is denied.

IT IS SO ORDERED.

November 14, 1990 Cite as 42 Van Natta 2578 (1990)

In the Matter of the Compensation of
JAMES E. MAREK, Claimant
WCB Case No. 87-14922
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of those portions of Referee Paulus' order that: (1) upheld the SAIF Corporation's denial of his left wrist claim on the ground that it was not timely filed; (2) declined to award interim compensation for the period from September 28, 1987 through October 27, 1987; and (3) declined to assess a penalty and attorney fee for failure to pay interim compensation. On review, the issues are timeliness of filing of the claim, interim compensation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact and make the following additional findings.

In its October 27, 1987 denial, the SAIF Corporation took the position that the claim was not compensable because notice of injury was untimely. SAIF's denial issued more than 14 days after filing of the claim.

On March 9, 1987, claimant returned to regular work following his wrist surgery. He sought no treatment for his wrist after March 9. He was laid off three weeks later for reasons unrelated to the wrist condition. Claimant drew unemployment compensation much of the time through November 1987.

FINDINGS OF ULTIMATE FACT

Claimant first gave the employer notice of a wrist injury while in its employ by letter dated September 28, 1987, addressed to SAIF.

The employer did not have actual notice of a wrist injury prior to that date.

SAIF has been prejudiced by failure to give notice within 30 days of the injury.

SAIF raised the timeliness defense at the first hearing on the claim.

Claimant was not disabled during the period September 28, 1987 through October 27, 1987.

SAIF's failure to pay interim compensation was not a delay or resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Timeliness

On review, claimant contends that the Referee erred when she upheld the denial on the ground that timely notice of accident had not been given. Claimant argues that SAIF waived the timeliness defense by failing to raise the defense within 14 days of notice or knowledge of the claim. We disagree.

ORS 656.265(5) provides that, in order to rely on the defense of failure to give timely notice, the insurer must raise the defense "at the first hearing on a claim for compensation in respect to the injury or death." The first hearing related to this claim was that which gave rise to this request for review. At hearing, SAIF contended that claimant had given untimely notice. Consequently, it would appear that ORS 656.265(5) does not bar the defense.

Claimant argues that notwithstanding the unambiguous language of subsection (5), providing only that the defense must be raised at the first hearing, SAIF waived the defense when it failed to raise the defense within 14 days after filing of the claim.

Claimant relies for this contention on Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 (1984). The issue in Van Horn concerned whether or not the claimant was entitled to a penalty and attorney fee when the insurer failed to commence interim compensation 14 days after notice of a claim. The Board held that the insurer's conduct was not unreasonable. The Board reasoned that if the insurer had timely paid interim compensation, the insurer's timeliness defense would have been waived under ORS 656.265(4)(b), which provides that failure to give timely notice does not bar a claim when the carrier has begun payment of compensation. Therefore, the Board reasoned that the legislature could not have intended that a penalty be assessed for failure to commence interim compensation. The Court of Appeals reversed, holding that an insurer clearly is obligated to commence compensation within 14 days. The court said:

> "Unlike issues concerning legal and medical causation, which the insurer has 60 days to investigate, it is relatively easy for an insurer to determine if notice is timely. If the defense is not raised within 14 days, it is waived." (Emphasis supplied.)

Van Horn v. Jerry Jerzel, Inc., supra, 66 Or App at 461. Claimant relies on this statement to support its contention that SAIF waived the defense by failing to raise it in 14 days even though SAIF did not commence payment in the claim.

We understand the Van Horn decision to say that if the insurer seeks to avoid a penalty for failure to timely commence payment of compensation while also avoiding waiver of the timeliness defense by payment of compensation, then the defense must be raised by denial of the claim within 14 days. If, however, the insurer chooses not to commence compensation, we do not believe that the insurer waives the defense by failure to deny the claim within 14 days. At most, an insurer choosing this course of action risks assessment of a penalty and attorney fee. Therefore, SAIF timely raised the defense.

We adopt the Referee's Conclusions on the timeliness issue.

Interim Compensation

The Referee concluded that, because she had found the claim untimely, it was not necessary to address claimant's contentions that he is entitled to interim compensation. We disagree and address the issue.

Claimant contends that he is entitled to interim compensation for the period beginning with the filing of the claim on September 28, 1987 and ending when the denial issued a month later on October 27, 1987. ORS 656.262(4) requires an insurer to commence payment of compensation within 14 days of notice of the claim unless the claim has been denied. Nevertheless, claimant is only entitled to such compensation if he has left work due to the injury within the meaning of Bono v. SAIF, 298 Or 405 (1984). A claimant has left work, within the meaning of Bono, if the claimant is unable to work due to the injury; this is so whether or not the claimant initially left a particular job for other reasons. See e.g., Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987); Nix v. SAIF, 80 Or App 656, rev den 302 Or 158 (1986). The question, therefore, is whether or not claimant was disabled from work at any time between September 28 and October 27, 1987.

There is no evidence that claimant was disabled after March 9, 1987, when he returned to regular work. Consequently, SAIF was under no obligation to pay interim compensation.

Penalties and Attorney Fees

Inasmuch as claimant was not entitled to interim compensation, SAIF did not delay or resist the payment of compensation. Therefore, claimant is entitled to neither a penalty nor an attorney fee.

ORDER

The Referee's order dated February 19, 1988 is affirmed.

November 14, 1990 Cite as 42 Van Natta 2580 (1990)

In the Matter of the Compensation of
STEVEN A. MURPHY, Claimant
WCB Case No. 89-24386
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Gruber's order which declined to assess a penalty and attorney fee concerning the insurer's late payment of claimant's permanent disability award. On review, the issue is penalties and attorney fees. We reverse.

FINDINGS OF FACT

We find the facts as stipulated to by the parties.

At a September 28, 1989 hearing regarding the extent of claimant's disability, claimant stated that his current address was P.O. Box 888, St. Davids, Pennsylvania 19087. That hearing was attended by the claimant, his attorney, and the insurer's attorney.

Referee Seifert issued an Opinion and Order on October 23, 1989. That Opinion and Order granted claimant increased permanent partial disability (PPD) and was mailed to claimant at the address provided to the Referee at hearing. A copy of the Opinion and Order was mailed to the insurer.

On November 13, 1989, the claims adjuster authorized the insurer's awards department to make payment of the increased disability award no later than November 20, 1989.

On November 17, 1989, claimant's attorney filed a change of address document with the insurer, indicating that claimant's address was PO Box 888, St. Davids, Pennsylvania 19087.

On November 20, 1989, the insurer mailed a check for $4,078.12, reflecting the increased PPD award, to claimant at his previous address in Eugene, Oregon.

On November 27, 1989, the check mailed to claimant's address in Eugene was forwarded by the postal service to claimant's then current address in St. Davids, Pennsylvania.

Claimant received the check on November 29, 1989.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the insurer's mailing of claimant's permanent disability award to a Eugene address, rather than a Pennsylvania address, was not unreasonable. Claimant contends that the error was avoidable and resulted in a delay in claimant receiving his compensation. Claimant seeks a penalty and attorney fee for the insurer's allegedly unreasonable action. We agree and assess a penalty and fee.

Payment of permanent disability benefits must be made no later than the thirtieth day after the litigation order. OAR 436-60-150(5). Benefits shall be deemed paid when deposited in the U.S. Mail, addressed to the last known address of the worker. OAR 436-60-150(1).

In this case, the only evidence as to the events that transpired is contained in the stipulated facts. Those facts show that claimant had a different address at the time of the hearing. This new address was recorded on the Opinion and Order. This order was received by the insurer and it was based upon this order that the insurer knew that it was required to pay additional benefits to claimant. Further, three days prior to the mailing of the disability award, the insurer received notice of the new address directly from claimant. The insurer, therefore, had direct knowledge of the new, and last known, address of claimant prior to the mailing of the disability award.

There was no evidence presented by the insurer as to why the award was sent to the old address despite the stipulated fact that the insurer had twice received notice of claimant's new address prior to the mailing of the award. Consequently, the insurer violated OAR 436-06-150(1). This violation becomes unreasonable especially in light of the fact that the award was received by claimant seven days after the the thirty day requirement of OAR 436-60-150(5). Had the insurer mailed the disability award to the correct address, the thirty day requirement of OAR 436-60-150(5) would have been met.

Because there has been a violation of a rule that resulted in a delay in the payment of compensation to claimant, we find that claimant should be awarded a 5 percent penalty. In addition to the penalty, claimant is entitled to an assessed attorney fee pursuant to ORS 656.382(1) for obtaining the penalty.

After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $200 is a reasonable assessed fee for claimant's counsel's efforts concerning this penalty issue. In reaching this conclusion,

we have particularly considered the time devoted to the case and the complexity of the issues presented and the benefits attained for claimant.

ORDER

The Referee's order dated January 11, 1990 is reversed. Claimant is awarded a penalty equal to 5 percent of the late permanent disability award. Claimant's attorney is awarded a penalty-related fee of $200, to be paid by the insurer.

November 14, 1990 Cite as 42 Van Natta 2582 (1990)

In the Matter of the Compensation of
RAYMUN B. SAVALAS, Claimant
WCB Case No. 89-01627
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employer Defense Counsel, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Mirassou's order that declined to "merge" claimant's 1980 right knee injury claim with his 1988 left knee injury claim. In its brief, the self-insured employer requests authorization for an offset of temporary total disability in the event that claimant's claims are "merged". On review, the issues are claims processing, compensability and offset. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the following correction. Dr. Bert first performed right knee surgery, a medial menisectomy, on claimant's knee on June 17, 1980.

CONCLUSIONS OF LAW AND OPINION

Compensability of right knee condition

The Referee concluded that "merger" of claimant's right and left knee claims was inappropriate and outside the scope of her jurisdiction. On review, claimant contends that the issue was not "merger," but rather, whether claimant's worsened right knee condition was a result of a material and independent contribution of his left knee condition. We agree that the Referee had jurisdiction and we conclude that the issue in this case is whether claimant's left knee strain independently contributed to a worsening of his underlying right knee condition.

In cases in which neither compensability nor responsibility is in dispute, we have previously distinguished between an aggravation and a "new injury." Teresa L. Walker, 41 Van Natta 2283 (1989). We concluded that:

> "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."

In the present case, claimant had a compensable right knee injury with this employer in March 1980. Claimant underwent right knee surgery in June 1980 and again in June 1981. An April 20, 1982 Determination Order awarded claimant 20 percent permanent disability for his right knee. The award was increased to 30 percent by an April 1983 Opinion and Order.

In June 1987, claimant's treating doctor, Dr. Bert, M.D., evaluated claimant's right knee. Dr. Bert reported that claimant had progressive pain and discomfort resulting in a lessened tolerance for walking. Claimant reported that the pain was almost intolerable and that he was unable to straighten his leg. Dr. Bert noted that x-rays showed destruction of the medial joint space and considerable narrowing laterally. On June 4, 1987, Dr. Bert diagnosed severe degenerative arthritis of the knee and he requested authorization for a right total knee replacement.

In August 1987, claimant was examined by Dr. Holbert, M.D., for a second opinion on his right knee. Dr. Holbert noted claimant's 1981 right knee surgery and claimant's reports that, since that time, he had not been able to straighten his right knee, which had been an ongoing problem. Dr. Holbert diagnosed "far advanced traumatic arthritis" and he recommended early resurfacing of the right knee.

In August 1987, Dr. Bert reported claimant's continued severe pain in his right knee. Dr. Bert again recommended a total knee replacement. In September 1987, claimant underwent arthroscopic debridement of the right knee. In November 1987, claimant returned to light duty work.

Following a February 1988 left knee injury with this employer and left knee surgery in March 1988, claimant returned to work. Soon after his return to work, he began to experience right knee pain.

In August 1988, Dr. Deaton, M.D., reported that an MRI of claimant's right knee revealed no specific abnormality. In August 1988, claimant was examined by Dr. North, M.D., who noted that claimant's x-rays indicated mild osteophytes and decreased joint space in the right knee. Dr. North opined that claimant's clinical x-ray findings did not warrant a total knee replacement.

In November 1988, Dr. Bert evaluated claimant and reported severe degeneration in both knees with virtually no joint space medially in both knees. Dr. Bert again recommended total knee replacement of the right knee. In December 1988, Dr. Bert opined that claimant had experienced accelerated deterioration and increasing symptomatology of (right knee) pain based upon his left knee problem. Dr. Bert reported that favoring of the left knee because of pain had put an increased stress on the right leg which aggravated and caused increased degeneration of the (right) knee.

In January 1989, Dr. Schroeder reported that claimant's X-rays showed no change compared to prior x-rays. Dr. Schroeder concluded that there was reasonable joint space, both in the medial and lateral compartments of both knees.

We are not persuaded by Dr. Bert's report that claimant's underlying right knee condition has worsened because of a favoring of his left knee. Claimant has a prior history of right knee injury and has undergone three surgical procedures on the right knee since 1980. Dr. Bert twice recommended total right knee replacement surgery before claimant's February 1988 left knee injury. In August 1987, Dr. Holbert recommended resurfacing of claimant's right knee. Finally, Dr. Schroeder, who treated claimant from September 1987 through October 1988, has reported that claimant's x-rays do not show a change in his right knee condition.

We conclude that claimant has not established that his compensable left knee strain independently contributed to a worsening of his underlying right knee condition. Consequently, the employer's "de facto" denial of claimant's right knee condition as part of the left knee claim is upheld.

Offset

In the event claimant's right and left knee claims were "merged," the employer requests authorization to offset any resultant overpayment of temporary disability against ongoing payments of temporary total disability and any future award of permanent partial disability. Because we did not merge the claims in issue, we do not address the employer's request.

ORDER

The Referee's order dated June 16, 1989, as reconsidered November 1, 1989, is affirmed. The self-insured employer's "de facto" denial is upheld.

November 15, 1990 Cite as 42 Van Natta 2584 (1990)

In the Matter of the Compensation of
BEN L. BROWN, Claimant
WCB Case No. 87-15171
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of those portions of Referee Hoguet's order that: (1) declined to award interim compensation from April 29, 1986 to January 14, 1988; and (2) assessed a penalty and attorney fee for an alleged untimely denial, based on interim compensation awarded from May 11, 1988 through June 30, 1988, rather than April 29, 1986 through June 30, 1988. The SAIF Corporation cross-requests review of that portion of the order that purported to set aside its May 10, 1988 denial of claimant's aggravation claim. On review, the issues are interim compensation, penalty and attorney fees, and aggravation. We modify in part, vacate in part, and affirm in part.

FINDINGS OF FACT

Claimant compensably injured his neck, head and upper back in September 1983. His claim was closed by a January 23, 1986 Determination Order that awarded 15 percent unscheduled permanent disability and temporary disability. The temporary disability award was modified by a March 17, 1986 Determination Order. Meanwhile, on March 14, 1986, the SAIF Corporation denied a claim for aggravation.

Claimant filed for hearing on the issues of, inter alia, the aggravation denial and permanent partial disability. The parties preserved the issue of elective surgery as not ripe for litigation. The hearing was held on July 26, 1986. The Referee denied all relief in a September 1986 Opinion and Order, which was affirmed by the Board. (Ex. 23, 26).

Meanwhile, on April 29, 1986, claimant consulted Dr. Smith, neurosurgeon, who diagnosed nerve root compression and a herniated disc related to the compensable injury. He requested SAIF to authorize surgery and to reopen the

claim. (Ex. 17). Receiving no response from SAIF, Dr. Smith continued to request authorization for surgery. (Ex. 20a, 22, 34, 36, 40). On October 20, 1986, he repeated his request for surgery and also requested time loss, noting that claimant had been unable to work since April 21, 1986. (Ex. 24a). SAIF neither authorized surgery nor issued a formal denial, nor paid interim compensation.

By stipulation, on January 19, 1988, SAIF agreed to: (1) formally accept or deny the request for authorization of surgery within 60 days; (2) pay claimant interim compensation from January 15, 1988 until the acceptance or denial was issued; and (3) pay claimant's attorney a fee. The parties reserved the issue of claimant's entitlement to interim compensation from April 29, 1986 through January 14, 1988. (Ex. 32).

SAIF paid interim compensation from January 15, 1988 until May 10, 1988, when it issued an aggravation denial, stating that claimant's condition had not worsened since the last arrangement of compensation. (Ex. 39). This denial did not address claimant's request for authorization of surgery.

Claimant requested a hearing, alleging that SAIF: (1) failed to timely authorize surgery; (2) failed to accept or deny surgery; and (3) failed to pay temporary total disability benefits from April 29, 1986 to January 14, 1988, and from May 10, 1988 to the time of hearing. He requested a penalty and attorney fees for failure to accept or deny the claim and for an unreasonable denial in the form of the May 10, 1988 aggravation denial.

The hearing convened on June 30, 1988.

FINDINGS OF ULTIMATE FACT

Dr. Smith's October 20, 1986 request for surgery in conjunction with his April 29, 1986 report provided notice to SAIF that claimant was entitled to additional compensation, including medical services, for worsened conditions resulting from the compensable injury. In addition, these reports provided SAIF with notice of a medically verified inability to work resulting from a worsening of his compensable condition.

SAIF's May 10, 1988 aggravation denial was not in issue at hearing.

CONCLUSIONS OF LAW AND OPINION

Claims Processing

We adopt the Referee's conclusions and opinion on the issues of SAIF's failure to timely accept or deny claimant's request for authorization of surgery as required by stipulation; the award of interim compensation from January 15, 1988 through June 30, 1988, less amounts already paid; and a penalty and related attorney fees. However, we modify the dates upon which the penalty is to be assessed as a result of our conclusion that claimant is entitled to additional interim compensation.

Interim Compensation

The Referee awarded interim compensation from January 15, 1988 through June 30, 1988, less amounts already paid, based on SAIF's stipulated agreement to pay interim compensation from January 15, 1988 until it formally accepted or denied the claim. The Referee denied claimant's request for interim compensation from April 29, 1986, the date Dr. Smith first requested authorization for

surgery, to January 14, 1988, because he interpreted the claim as one for elective surgery and not for aggravation. Claimant contends that a claim for surgery is to be processed in accordance with ORS 656.262 and 656.273(6), which require payment of interim compensation within 14 days from the time of notice of a medically verified inability to work resulting from a worsening of a compensable condition.

SAIF argues that claimant's claim was not an aggravation claim, and, therefore, it was not required to pay interim compensation on a claim that had been closed by Determination Order. SAIF further argues that claimant failed to provide medical verification that his condition worsened after the last arrangement of compensation.

We find that claimant should be awarded additional interim compensation from October 20, 1986 through January 14, 1988. We reason as follows.

A claim is a written request for compensation from a worker or someone on the worker's behalf of which the employer/insurer has notice and which is causally related to claimant's employment. ORS 656.005(6); ORS 656.005(7)(a); Michael L. Orr, 41 Van Natta 192 (1989). An aggravation claim is a claim for a worsened condition resulting from the original injury. ORS 656.273(1). A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation. ORS 656.273(3).

The physician's report itself is not required to state that the condition is worse; it is sufficient that the treatment be for other than a continuing condition. Thus, if the request for treatment does not indicate that it is for the same condition, then it should be considered a claim for aggravation and processed as such. See Krajacic v. Blazing Orchards, 84 Or App 127 (1987); Haret v. SAIF, 72 Or App 668, rev den 299 Or 313 (1985); Joanne C. Krause, 42 Van Natta 1021 (1990).

SAIF knew of claimant's claim for back surgery as of April 29, 1986, when it received Dr. Smith's report which diagnosed claimant's bilateral C5-6 nerve root compression and L4-5 herniated disc. Furthermore, SAIF had additional notice from Dr. Smith on October 20, 1986 that claimant could not work as a result of his compensable condition. Moreover, the time loss authorization in addition to the request for surgery implied a worsened condition, just as the express request to reopen implied a claim for aggravation. Accordingly, Dr. Smith's report, combined with his notice that claimant could not work, were sufficient to put SAIF on notice to determine whether a worsening had occurred, and thus were sufficient to constitute an aggravation claim and the obligation to provide interim compensation. See Haret v. SAIF, supra; Joanne C. Krause, supra. According to statute, SAIF had the choice to either pay compensation or deny the claim. Because it did not deny the claim or pay interim compensation, we therefore award claimant interim compensation from October 20, 1986 through January 14, 1988. ORS 656.273(6).

Penalty and Attorney Fees

The Referee found that the penalty for SAIF's failure to accept or deny authorization for surgery should be assessed against all of claimant's temporary disability payments. We agree. Accordingly, we modify the Referee's award and assess a penalty against claimant's interim compensation award as modified herein. ORS 656.262(10). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee award concerning this penalty issue is $500. In reaching this conclusion, we have particularly considered the value of the interest involved.

Aggravation

The Referee set aside SAIF's May 10, 1988 aggravation denial because no aggravation claim was pending between July 1986, the time of the last arrangement of compensation, and the time of hearing. We disagree. Aggravation was not in issue at hearing. Consequently, that portion of the Referee's order is vacated.

ORDER

The Referee's order dated July 18, 1988, as amended August 18, 1988, is modified in part, vacated in part, and affirmed in part. In addition to the Referee's award of interim compensation from May 11, 1988 through June 30, 1988, the SAIF Corporation is ordered to pay claimant interim compensation from October 20, 1986 through January 14, 1988. Claimant's attorney shall receive 25 percent of the increased compensation. However, the total attorney fees payable from claimant's increased compensation as a result of the Referee and Board orders shall not exceed $3,800. In addition to the Referee's assessment of a penalty equal to 25 percent of interim compensation due from May 11, 1988 through June 30, 1988, SAIF is ordered to pay claimant a penalty equal to 25 percent of interim compensation due from October 20, 1986 to May 11, 1988. For services concerning this penalty issue at both the hearing and Board levels, claimant's attorney is awarded $500, to be paid by the SAIF Corporation. That portion of the Referee's order that purported to set aside SAIF's aggravation denial of May 10, 1988 is vacated. The remainder of the order is affirmed.

November 15, 1990 Cite as 42 Van Natta 2587 (1990)

In the Matter of the Compensation of
MARTHA L. BRUNNER, Claimant
WCB Case No. 89-13777
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of those portions of Referee Schultz's order that: (1) increased claimant's unscheduled permanent disability award for a back injury from 45 percent (144 degrees), as awarded by Determination Order, to 58 percent (185.6 degrees); and (2) awarded 16 percent (24 degrees) scheduled permanent disability for the loss of use or function of her left forearm and awarded 24 percent (36 degrees) scheduled permanent disability for the loss of use or function of her right forearm, whereas a Determination Order awarded no scheduled permanent disability. On review, the issue is extent of permanent disability, both scheduled and unscheduled. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant, 47 years of age at hearing, began working as a donut maker in 1986. During 1987, claimant experienced low back and bilateral wrist pain. Claimant first sought treatment for these conditions in December 1987. Claimant stopped working on December 28, 1987, and has not returned to work since that date.

In January 1988, claimant filed an occupational disease claim for both her low back strain and bilateral carpal tunnel syndrome. The employer denied both conditions. Both denials were set aside by a June 10, 1988 Opinion and Order. That order has not been appealed.

Claimant began treating with Dr. Whitney, M.D., in February 1988. Whitney continued to treat claimant through July 7, 1989. On May 5, 1989, Whitney reported that claimant's back condition was medically stationary and released claimant to return to modified work in a sedentary capacity. On July 7, 1989, Whitney reported that claimant's bilateral wrist condition was medically stationary.

In August 1988, claimant underwent right carpal tunnel release surgery. In January 1989, claimant underwent left carpal tunnel release surgery.

Claimant's claim was closed by a July 13, 1989 Determination Order, which awarded 45 percent unscheduled permanent disability and no scheduled permanent disability. Claimant requested a hearing.

Claimant has a high school education. Claimant's highest specific vocational preparation (SVP) value during the ten years preceding the date of determination was a 6, for working as a baker (DOT # 313.381-010).

Claimant is not working as a result of the injury. No employment has been offered. She was released to perform sedentary work with restrictions in sitting, bending, standing and carrying.

Claimant sustained permanent loss of range of motion and suffers from an unoperated bulging disc, both due to her compensable back condition.

Claimant also sustained permanent loss of ulnar deviation and radial deviation in both wrists.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

We adopt the Referee's "Conclusions of Law and Opinion," as set forth in the first five paragraphs of the "Conclusions" portion of the order, which increased claimant's unscheduled permanent disability award for a back injury from 45 percent to 58 percent.

Extent of Scheduled Permanent Disability

The Referee awarded claimant 24 percent scheduled disability for the loss of use or function of her right forearm and 16 percent scheduled disability for the loss of use or function of her left forearm. However, we note that in his "Conclusions of Law and Opinion," the Referee makes clear that he intended these awards to reflect "arm" values, not "forearm" values. In making this determination, the Referee found claimant entitled to 5 percent for each forearm for a chronic condition limiting repetitive use, 20 percent for loss of grip strength in her right hand and 10 percent for loss of grip strength in her left hand, 5 percent for each forearm for bilateral carpal tunnel release surgery, and 4 percent for loss of range of motion in each hand. The Referee combined these figures for a total right hand impairment of 30 percent and total left hand impairment of 21 percent. Finally, the Referee converted claimant's hand impairment into forearm impairment, under former OAR 436-35-090, and awarded claimant 24 percent scheduled disability for her right forearm and 16 percent scheduled disability for her left forearm.

After our de novo review of the record, we modify each forearm award.

Because claimant's claim was closed by Determination Order on July 13, 1989, the "standards" effective January 1, 1989 through September 30, 1990 apply

to a rating of claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability. Scheduled permanent disability is based on permanent loss of use or function of a scheduled body part. See former OAR 436-35-010 through 436-35-260.

Decreased Range of Motion in Forearm (Wrist Joint)

Claimant sustained permanent, ratable loss of range of wrist motion, including: 15 degrees retained bilateral radial deviation, for a value of 1 for each forearm, and 25 degrees retained bilateral ulnar deviation, for a value of 1 for each forearm. Former OAR 436-35-080(5) & (7). Claimant's total loss of range of motion in each forearm is 2 percent.

Bilateral Carpal Tunnel Release Surgery

After noting that claimant was not entitled to a disability rating simply because of the surgical procedure, the Referee awarded claimant 5 percent for each forearm for her bilateral carpal tunnel syndrome condition. We disagree.

The standards allow a disability rating for certain surgeries associated with carpal tunnel syndrome, i.e., carpal bone resection, carpal bone fusion and carpal bone replacement. See former OAR 436-35-110(4)(f), (i) & (j). There is, however, no rating for either carpal tunnel release surgery or for the condition itself. Consequently, we do not award claimant disability for either the surgery or the condition.

Loss of Grip Strength

The Referee noted claimant's two most recent grip strength measurements, one in June 1989 and the other in July 1989, and concluded, based on these reports, that claimant suffered permanent loss of grip strength in both forearms. We disagree.

The record does not provide any means for determining permanent loss of grip strength due to claimant's compensable injury. The Referee noted that it was difficult to rate claimant's grip strength under the standards. But, keeping in mind that claimant was right hand dominant, the Referee concluded that claimant sustained a 20 percent loss of grip strength in her right hand and 10 percent loss of grip strength in her left hand.

Loss of grip strength is ratable when it is associated with either nerve damage, amputation, or atrophy or other anatomical changes. See former OAR 436-35-110(3)(a), (b) & (d). Decreased grip strength due to loss of range of motion in the joints of the hands or fingers receives no rating in addition to that given for the loss of range of motion. Former OAR 436-35-110(3)(c).

While claimant credibly testified to decreased grip strength, that alone is insufficient to award disability under the standards. See former OAR 436-35-005(2). Claimant has failed to establish nerve damage due to her bilateral carpal tunnel syndrome, nor did she undergo any amputation. Further, there is no evidence in the record to establish that claimant's decreased grip strength is due to atrophy or other anatomical changes.

Based on the lack of evidence in the record, we conclude that claimant has not proven entitlement to a disability rating for decreased grip strength.

Chronic Condition Limiting Repetitive Use

The Referee awarded claimant 5 percent disability for each wrist for a chronic condition limiting repetitive use. The employer contends that there is no evidence that claimant suffers from a chronic condition limiting repetitive use of her wrists, and more specifically, limiting use of her right wrist. We agree.

After our review of the record, we find that claimant does not suffer from a chronic condition which limits repetitive use of either wrist.

Former OAR 436-35-010(7) provides for a 5 percent disability award for chronic conditions which limit repetitive use of a scheduled body part. Here, however, there is no evidence to establish that claimant suffers from a chronic condition, let alone such a condition which limits repetitive use of claimant's wrists. There are no physician's reports in the record which diagnose a chronic condition, and claimant's treating physician, at no time, placed permanent or temporary restrictions on claimant's abilities to perform repetitive activities, other than those associated with claimant's compensable back condition.

Moreover, claimant specifically testified that she was not having right wrist problems, other than occasional pain and some sensory loss manifested by an inability to handle very light weight objects. (Tr. 20). She also testified that she suffered left wrist pain, which caused some loss of function when driving.

Consequently, we do not award claimant disability for a chronic condition limiting repetitive use of a scheduled body part.

Computation of Scheduled Permanent Disability

Claimant's only ratable wrist impairment is for permanent loss of range of motion. Consequently, we find that claimant is entitled to 2 percent scheduled permanent disability for the loss of use or function of each forearm.

After considering the factors setr forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the unscheduled permanent disability issue is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated November 8, 1989 is affirmed in part and modified in part. In lieu of the Referee's award of scheduled permanent disability, claimant is awarded 2 percent (3 degrees) scheduled permanent disability for the loss of use or function of her left forearm and 2 percent (3 degrees) scheduled permanent disability for the loss of use or function of her right forearm. The remainder of the order is affirmed. For services on review concerning the unscheduled permanent disability issue, claimant's attorney is awarded $500, to be paid by the employer.

In the Matter of the Compensation of
THOMAS A. ENGKILTERRA, Claimant
WCB Case No. 89-10894
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Quillinan's order that: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent disability award for his degenerative joint disease condition from 61 percent (195.2 degrees), as awarded by a Determination Order, to 80 percent (256 degrees); and (3) awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for his left hand condition and 5 percent (7.5 degrees) scheduled permanent disability for his right hand condition. The SAIF Corporation cross-requests review of those portions of the Referee's order that: (1) increased claimant's unscheduled permanent disability award; and (2) awarded claimant scheduled permanent disability. On review, the issue is extent of disability, up to and including permanent total disability. We reverse and grant permanent disability.

FINDINGS OF FACT

Claimant, 57 years old at the time of hearing, has a high school education and has completed a one-year training program in sewage treatment. His prior work experience includes employment as a millworker, manager of a sporting goods store and a department store, mobile homes sales, truckdriver, commercial fisher and maintenance manager. Between 1985 and 1987, claimant worked for the employer as a hydraulic press operator.

Claimant's preexisting conditions include tinnitus, a right elbow condition and a prior left hand injury. In June 1984, claimant had a lumbosacral strain which resulted in time loss. At that time, claimant's generalized osteoarthritis or degenerative joint disease was also diagnosed. In January 1985, claimant treated with Dr. Thompson for bilateral shoulder pain. A July 1, 1985 Determination Order awarded no permanent disability.

In May 1985, claimant injured his right hand. In September 1985, claimant's degenerative joint disease in his right hand was diagnosed. In August 1986, claimant complained of multiple joint pain while lifting at work. He sought treatment for joint and muscle aches in addition to stiffness and weakness in the upper extremities.

In March 1987, Dr. Kosterlitz diagnosed degenerative joint disease with cervical spondylosis and lumbosacral disc disease. Claimant left work in May 1987, due to his degenerative joint condition.

A March 1, 1989 Determination Order awarded claimant 61 percent unscheduled disability.

An Opinion and Order dated April 4, 1989, set aside SAIF's denial of claimant's occupational disease claim for his degenerative joint disease. The Referee's order was affirmed by a December 15, 1989 Order on Review.

In April 1989, claimant expressed motivation and interest in participating in a return-to-work plan. He indicated that he would be willing to travel to Portland, if necessary, to meet and discuss potential employment with interested employers. Claimant cooperated with his vocational counselor and would have

attended any interviews or appointments if the counselor had been able to obtain them.

ULTIMATE FINDINGS OF FACT

Claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

But for his degenerative joint disease condition, claimant would be willing to seek employment. Claimant's physical limitations, in conjunction with his limited work experience in other than heavy occupations, make a work search futile.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not totally unemployable and she therefore declined to award permanent total disability. 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 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). However, even if a work search would be futile, such a claimant must establish that he, but for the compensable injury, would have been willing to seek regular gainful employment. SAIF v. Stephens, 303 Or 41 (1989).

In the present case, we agree with the Referee's conclusion that claimant is not totally disabled based solely on his physical condition. In April 1987, Dr. Kosterlitz, a rheumatologist, reported that, because of his osteoarthritis and spondylosis conditions, claimant was not suited to performing the type of heavy physical labor required by his present employment. In May 1987, Dr. Kosterlitz opined that claimant's degenerative joint disease was definitely related to his prior job activities and was out of proportion to his age and other general physical findings.

In July 1987, Dr. Kosterlitz reported that claimant's work activities were the major cause of the conditions that he had diagnosed and had also contributed to the progressive worsening of those conditions. In December 1987, Dr. Averesano, D.O., opined that claimant was disabled and not capable of holding a job at the present time, due to his degenerative joint disease.

In April 1988, Dr. Thompson, claimant's treating physician, diagnosed advanced and severe degenerative joint disease, particularly in the hands, wrist, cervical and lumbosacral spine. Dr. Thompson also diagnosed bursitis and calcaria of both shoulders. Dr. Thompson opined, that, based on his findings and claimant's symptoms, claimant was not employable.

On October 12, 1988, claimant was evaluated by the Northwest Vocational Evaluation Center. The Center reported that claimant was capable of sedentary work but also reported that claimant's endurance for a full day of activity at that level was considered to be poor.

In July 1989, Dr. Thompson reported that claimant could participate in vocational assistance and there were probably some activities in the sedentary to light range in which claimant could participate.

In August 1989, Dr. Kinne, D.O., rated claimant's impairment as severe. Dr. Kinne opined that, because of claimant's loss of range of motion and overall loss of function, he was incapable of performing virtually all sedentary jobs. Dr. Kinne estimated that claimant could lift five pounds, carry up to ten pounds and could not push or pull any weight. Dr. Kinne also opined that claimant was unable to perform repetitive activities involving use or motion of the spine or extremities, except for walking. Dr. Kinne reported that claimant was, at the most, able to sit, stand and walk thirty minutes at a time.

We conclude that claimant has not proved that he is totally disabled based solely on his physical condition. Therefore, he must prove that, because of a combination of his physical condition and social and vocational factors, he is precluded from regular employment.

Claimant's vocational expert reported that he would be unable to find work in the state labor market. Claimant also contends that he was cooperative in vocational rehabilitation efforts, but because he had no past work experience other than heavy work and he was not released to perform heavy work, there were no jobs he was capable of performing. Claimant contends, therefore, that any work search he could have made, would have been futile.

SAIF argues that claimant is employable in the state job market. A vocational expert, Byron McNaught, reported that claimant would be limited to sedentary or light work where he could change positions frequently. He noted that claimant would not be able to work at a job involving bending, stooping, crouching or twisting and he concluded that claimant may well be limited to part-time work. Mr. McNaught stated that claimant did not have transferable skills from his past work, but theoretically, there would be entry level jobs within claimant's physical limitations, such as hotel desk clerk, tax preparer, bookkeeper and cashier.

We are not persuaded by SAIF's argument that claimant is employable at a gainful occupation. Mr. McNaught's opinion was based upon the theoretical existence of entry level jobs suitable for claimant. However, job availability cannot be based upon speculation. See Richard Johnson, 42 Van Natta 2019 (1990). Moreover, the Referee found that claimant has very weak grip and pinch strength in either hand. Claimant has also testified that he is unable to close his hands and must use both hands to do a one-hand task. Claimant's doctors have reported that, because of his compensable condition, his strength, endurance and ability to use repetitive motion are all limited. We are not convinced by Mr. McNaught's opinion that claimant could perform the entry level jobs suggested, even if they were not merely hypothetical. Instead we find claimant's vocational counsellor persuasive. We are persuaded that, because of his physical limitations and lack of transferable skills, any job search claimant could have made, would have been futile.

Taking into consideration claimant's age, education, work experience and physical condition, we conclude that he is permanently and totally disabled as a result of his compensable degenerative joint disease condition.

ORDER

The Referee's order dated September 23, 1989 is reversed. In lieu of the Referee's increased award of permanent disability, claimant is granted permanent total disability, effective September 13, 1989, the date of hearing. The SAIF

Corporation is permitted to offset permanent disability payments paid subsequent to that date against claimant's permanent total disability benefits. Claimant's attorney is awarded a fee equal to 25 percent of the increased compensation created by this order, payable by the SAIF Corporation, except that total out-of-compensation fees awarded by the Referee and the Board shall not exceed $6,000.

November 15, 1990 Cite as 42 Van Natta 2594 (1990)

In the Matter of the Compensation of
JAMES J. TREML, Claimant
WCB Case No. C0-00177
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Whitehead & Klosterman, Claimant Attorneys
Snarskis, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

On October 11, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $6,500 by Industrial Indemnity Company, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

We shall not approve a proposed claim disposition agreement if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Here, the claim disposition agreement was submitted simultaneously with a disputed claim settlement concerning the same claim. The disposition agreement provides: "It is the intent of the parties that both agreements be approved simultaneously, and that if one agreement is not approved, the other shall also not be approved" (page 3, lines 3-5). That provision exceeds the bounds of ORS 656.236.

Once a proposed claim disposition is properly filed with the Board, it must be approved in a final order unless one of three circumstances occurs. ORS 656.236(1); Louis R. Anaya, supra. Because the disapproval of a disputed claim settlement is not mentioned as one of those circumstances, we are persuaded that the statute does not permit the parties to make approval of a claim disposition agreement contingent on the approval of a disputed claim settlement. Once approved by the Board, the claim disposition agreement is valid and enforceable pursuant to ORS 656.236, regardless of whether or not the disputed claim settlement is approved.

The aforementioned provision cannot be excised from the disposition agreement without substantially altering the terms of the agreement itself. Therefore, the Board finds that the agreement is unreasonable as a matter of law and sets it aside. See ORS 656.236(2); Louis R. Anaya, supra. Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JON F. WILSON, Claimant
WCB Case Nos. 89-20090 & 89-14124
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Snarskis, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Mills' order that: (1) upheld AIAC's denial of claimant's "new injury" claim for a left knee condition; and (2) upheld Industrial Indemnity's acceptance of claimant's condition as an aggravation. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's work activities with his employer after February 1, 1987 did not independently contribute to a worsening of his left knee condition. We agree.

We briefly review the procedural posture of this case before turning to the merits. Previously, Industrial Indemnity, as opposed to Travelers Insurance Company, accepted a December 28, 1983 left knee strain, which was closed in May 1984.

In November 1988, claimant again encountered increased left knee symptoms. Claimant filed an aggravation claim against Industrial Indemnity on November 8, 1988. Although Industrial Indemnity initially denied responsibility, thinking it was a "Travelers" claim, this denial was rescinded as error and accepted in February 1989. Industrial Indemnity proceeded to process the claim until closure in June 1989.

Seven months after Industrial Indemnity's acceptance, in July 1989, claimant filed a "new injury" claim against AIAC, who had been on the risk since February 1987. AIAC denied the claim in August 1989 on the basis of timeliness and responsibility.

Inasmuch as Industrial Indemnity had accepted claimant's November 1988 aggravation claim, AIAC argues that claimant is estopped from proceeding to hearing and attempting to prove a "new injury" claim against a later carrier. We disagree.

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 carrier, AIAC, and requested a hearing from its subsequent denial. Because claimant had filed the November 1988 aggravation claim with his employer, we find the employer had knowledge of the "new injury" also alleged to have occurred in November 1988. Consequently, we conclude that AIAC had notice that workers' compensation liability was a possibility requiring further investigation. Thus, we conclude filing was timely in accordance with ORS 656.265. See Argonaut Ins. Co. v. Mock, 95 Or App 1 (1989).

We note that by proceeding to hearing under a "new injury" theory, a new five year period of aggravation rights, ORS 656.273(4)(a) would accrue if

claimant were successful. There was also the potential that a greater temporary disability rate could be at issue. Thus, claimant had benefits at stake. Therefore, claimant is entitled to prove that Industrial Indemnity was wrong in accepting the aggravation claim, and that in reality claimant had sustained a new injury for which AIAC was responsible. Accordingly, claimant was not procedurally barred from litigating his request for hearing asserting a "new injury" claim. See Karen L. Nickols, 41 Van Natta 2414 (1989).

Inasmuch as compensability is not in issue, we turn to the responsibility issue. We are not convinced that claimant sustained a new injury on November 8, 1988. Claimant's treating physician, Dr. Gripekoven, in his letter of September 1989, opined there was no specific new injury to his knee during the course of his work activities. Rather, he described claimant's condition as "increasingly symptomatic." Therefore, we conclude that this case involves an accepted compensable injury followed by a period of increased disability, as opposed to a "successive injury" case.

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

In this regard, we rely upon the opinion expressed by Dr. Gripekoven in his September 1989 letter. Dr. Gripekoven was claimant's treating physician since at least 1984. He also performed the subsequent surgeries on claimant's left knee. Although he opined that work activities had contributed to claimant's "problems," he was unable to quantify or determine the nature and scope of that contribution with any medical certainty. We also note, as did the Referee, that Dr. Gripekoven did not distinguish between the different periods of carrier coverage.

Claimant was also seen on a one time basis by Dr. North in October 1989. Although Dr. North opined that claimant's current problems were work related, like Dr. Gripekoven, he does not distinguish between the periods of employment when different carriers were on the risk in order for us to sufficiently gage independent contribution, if any. As such, we find Industrial Indemnity has failed to carry its burden of proof in order to shift responsibility to the later carrier, AIAC. See Wise, supra. For the same reasons, we further find that claimant, as proponent of the proposition, has failed to carry his burden of proof in setting aside Industrial Indemnity's acceptance of the 1988 aggravation claim. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

ORDER

The Referee's order dated November 28, 1989 is affirmed.

In the Matter of the Compensation of
ERNEST C. BLINKHORN, Claimant
WCB Case Nos. 89-10503, 89-10502, 89-02533, 89-05287 & 89-09469
ORDER ON RECONSIDERATION
Olson, et al., Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney
Stafford Hazelett, Defense Attorney

Claimant requests reconsideration of that portion of our October 30, 1990 Order on Review that declined to award or assessed fee for services rendered on review. In that order, we affirmed an Arbitrator's order which found the SAIF Corporation responsible for claimant's "new injury" claim. Claimant seeks an assessed fee under ORS 656.307(5).

ORS 656.307(5) provides:

> "If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the arbitrator may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the arbitrator to be responsible for paying the claim."

ORS 656.307(5) contains no provision for an award of attorney fees for participation on Board review. Therefore, claimant's request for an attorney fee under ORS 656.307(5) is denied.

Moreover, claimant is not entitled to an assessed fee under ORS 656.386(1) or 656.382(2). A ".307 order" issued prior to hearing, responsibility was the only issue litigated on review, and resolution of that issue did not affect entitlement to or the amount of compensation. Consequently, neither ORS 656.386(1) nor ORS 656.382(2) provide a basis for an assessed fee. Howard v. Willamette Poultry, 101 Or App 584 (1990); Francisca Garcia, 42 Van Natta 2050 (1990) James B. Lake, 42 Van Natta 2037 (1990);.

Accordingly, our October 30, 1990 is abated and withdrawn. On reconsideration, we adhere to and republish our October 30, 1990 order, effective this date

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES R. BOROVICKA, Claimant
WCB Case No. 89-04165
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Tenenbaum's order that: (1) found that it was prohibited from issuing a "back-up" denial of claimant's hernia injury claim based on a lack of coverage; and (2) set aside its denial of the claim issued on that basis. On review, the issues are the propriety of the insurer's denial. We reverse.

FINDINGS OF FACT

Claimant was the majority shareholder, president and working manager of an incorporated catering and restaurant business. He obtained workers' compensation insurance with the insurer on January 1, 1986. The application for insurance contained language that excluded executive officers from coverage and listed claimant as an officer of the corporation. (Ex. 1). The guaranty contract stated that the corporation did not elect non-subject worker coverage and provided that the policy did not cover bodily injury to any executive officer. (Ex. 2) Claimant's salary was not included in the calculations used to determine insurance premiums.

Claimant sustained a left inguinal hernia on April 20, 1986, while lifting a crate of produce at work. He filed an 801 form on May 2, 1986. The insurer accepted the claim on June 10, 1986, by marking the "accepted" box on the form. It subsequently paid medical benefits when Dr. Sandilands, M.D., performed surgery on claimant in April 1987. Claimant did not request, nor receive, temporary disability compensation or permanent disability compensation. No Determination Order was issued.

On January 11, 1989, claimant returned to Dr. Sandilands with complaints of pain and swelling in his left groin. Dr. Sandilands diagnosed recurrent left inguinal hernia and, on January 17, 1989, performed a second operation to repair the rupture.

Claimant subsequently filed an aggravation claim. On February 7, 1989, the insurer denied claimant's claim in its entirety, stating that claimant, as an executive officer of the corporation, was excluded from workers' compensation insurance.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the insurer had accepted claimant's hernia claim on June 10, 1986, when its representative checked off the "accepted" box on the 801 form. She therefore concluded that the insurer was bound by that acceptance and that its February 7, 1989 attempt to deny responsibility was an impermissible "back-up" denial under Bauman v. SAIF, 295 Or 788 (1983).

Assuming, without deciding, that the insurer "officially" accepted claimant's claim, we hold that the insurer's subsequent denial was procedurally valid. Bauman protects a claimant from vacillation on issues of compensability and responsibility. In other words, it prohibits a denial on the merits of a claim once it has been accepted. However, as the court recently stated in Oak Crest Care Center v. Bond, 101 Or App 15, 19, rev den 310 Or 121 (1990), "Bauman does not apply to invalidate such a denial or bind a carrier to a previous acceptance when there is a lack of coverage."

Here, it is undisputed that claimant was an executive officer of the corporation. He owned more than 50 percent of the outstanding shares of stock and served as president. The corporation filed no election of coverage for executive officers and paid no premiums on claimant's behalf. Consequently, he was not a subject worker under ORS 656.027(9), 656.039(4) and 656.419(3). See Ronald Sasse, 42 Van Natta 1828 (1990). Cf. Quadel Industries v. Workman, 95 Or App 612 (1989). (Employer's signing of 801 form for corporate officer and payment of premiums on the officer's behalf deemed sufficient election of coverage for non-subject workers.) Accordingly, Bauman does not prevent the insurer's subsequent denial on the basis that it did not provide coverage for claimant. Bond, supra; See also Camlu Retirement Center v. Evenhus, 102 Or App 603 (1990).

ORDER

The Referee's order dated June 19, 1989 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award of $1,500 is reversed.

November 16, 1990 Cite as 42 Van Natta 2599 (1990)

In the Matter of the Compensation of
ROBB L. BUSTER, Claimant
WCB Case No. 89-09280
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Gruber's order that: (1) directed SAIF to pay a 25 percent penalty for its failure to pay temporary total disability benefits timely; and (2) awarded an assessed attorney fee for SAIF's failure to provide discovery in a timely manner. The issues on review are penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We affirm and adopt the Referee's conclusions and reasoning regarding the penalty and attorney fee for SAIF's failure to pay temporary disability benefits in a timely manner.

The Referee awarded an assessed fee for failure to timely provide discovery because he found there had been a resistance to the payment of compensation.

At the time of the request for hearing, the 14 days SAIF had to pay the stipulated time loss had not yet run. The request for hearing listed one of the issues as penalties and attorney fees for failure to pay TTD within 14 days. The other issue listed on the request for hearing dealt with a contention that time loss was due based on a letter from Dr. Russell. At hearing, that issue was dropped and the new issue of untimely discovery was litigated.

The statute allows the Referee to award claimant an assessed attorney fee if the improper action complained of results in an unreasonable resistance to the payment of compensation. ORS 656.262(10) and 656.382(1); Ellis v. McCall Insulation, 308 Or 74 (1989).

Claimant contends SAIF violated OAR 438-07-015, the Board's rule regarding discovery. Consequently, he argues that he is entitled to an assessed attorney fee. We disagree. The failure to provide discovery did not delay payment of compensaiton. Subsequent to the filing of the request for hearing, SAIF did pay TTD four days late. However, the failure to provide discovery timely had nothing to do with the delay in the payment of the TTD benefits. In fact, the 15 days the insurer has to provide the requested discovery did not run until after the TTD had been paid. Under the facts of this case, the action complained of (delay in providing discovery) did not result in resistance to the payment of

compensation. Consequently there can be no award of an assessed attorney fee under ORS 656.382(1).

Claimant's attorney has submitted a statement of services for his services on review. Claimant is not entitled to an attorney fee for defending against the penalty and attorney fee issues. Saxton v. SAIF, 80 OR app 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Accordingly, we decline to award an assessed fee on review.

ORDER

The Referee's order dated August 25, 1989 is affirmed in part and reversed in part. That part of the order that awarded claimant's attorney an assessed attorney fee of $50 for the SAIF Corporation's failure to timely provide documents is reversed. The remainder of the order is affirmed.

November 16, 1990 Cite as 42 Van Natta 2600 (1990)

In the Matter of the Compensation of
STEVE M. CHAMBERS, Claimant
WCB Case No. 89-08874
ORDER ON REVIEW
Warren John West, Claimant Attorney
Roderick D. Peters (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Garaventa's order that set aside its denial of claimant's injury claim for his left leg and ankle. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

At the time of his injury on February 18, 1989, claimant was employed as a scramble supervisor at a ski lodge. His job duties included filling in as a cook, ordering food, setting a work schedule and supervising the daily closing of the lodge. As part of his supervisory duties, claimant was required to be present in the break room to make certain that the employees left the locker room in order and to ride the lift down the ski hill at the end of the shift.

The employer had several wheelchairs which were stored in the break room. Employees occasionally sat in the wheelchairs and rode them around in the break room. On the date of his injury and during the period which he was required to supervise the break room, claimant borrowed a skateboard and rode across the floor until he collided with another employee. Claimant's fall from the skateboard resulted in a fracture of his left ankle.

On March 28, 1989, SAIF denied claimant's left ankle injury claim, on the grounds that the injury did not arise from his employment with the employer.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's injury was sufficiently work-connected and was, therefore, compensable. We disagree.

In Rogers v. SAIF, 289 Or 633 (1980), the Court adopted a unitary "work-connection" approach, which requires a showing of a sufficient relationship between the injury and the employment, before the injury may be found compensable. See also Phil A. Livesley Co. v. Russ, 296 Or 25 (1983).

Seven factors have been identified to determine whether an injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the risk was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hann, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). All of the factors may be considered, and no one factor is dispositive. Id.

Activity for the benefit of the employer

Claimant argues that the employer encouraged its workers to have fun during work by allowing them to ride the wheelchairs during breaks. Claimant contends that the Referee found that the employer had an ongoing problem of being short-handed, and because of its low pay, attempted to increase morale by allowing benefits such as ski privileges and by encouraging managers to see that the employees "had a good time."

We are not convinced that the activity involving either the wheelchairs or the skateboard was for the benefit of the employer. In any event, such a benefit must be beyond an improvement in employee health and morale in order to constitute a benefit to the employer. See Richmond v. SAIF, 58 Or App 534 (1982). We conclude that, in this regard, claimant has failed to show any benefit to the employer.

Activity contemplated by the employer and employee

Claimant argues that, on several occasions, the skateboard was used in the break room by employees, therefore, the employer should have known of the activity. Claimant also contends that the employer knew of the use of the wheelchairs and actively encouraged such use.

We are unable to find evidence that the employer knew of the existence of the skateboard, or of its use by employees. Moreover, we do not agree that the employer actively encouraged employee use of the wheelchairs and we also decline to equate the use of a skateboard to the employees' use of wheelchairs. We conclude that the activity of skateboarding was not contemplated by the employer.

Ordinary risk of employment

The Referee found that this factor did not weigh toward a compensable work relationship. We agree that injuries sustained in skateboarding are not an ordinary risk of employment as a kitchen supervisor.

Payment for the activity

The Referee found that claimant was paid to be present in the break room during the period in which the injury occurred. We agree that, at the time he was injured, claimant was being paid for the activity of supervising other workers.

Activity on the employer's premises

The parties agree that the activity took place on the employer's premises.

Activity directed by or acquiesced in by the employer

Claimant argues that the employer acquiesced in the use of the wheelchairs and therefore, acquiesced in the use of the skateboard. We disagree.

Claimant was the only witness who testified that the employer knew of employee use of the wheelchairs. Witnesses LaBeck and Huxel testified that the employer did not know that employees rode in the chairs, although LaBeck, claimant's supervisor, knew that the employees sat in the chairs. The Referee found Huxel to be a credible witness and found claimant and LaBeck to be "essentially truthful" witnesses, who "tended to exaggerate, slant or misinterpret certain critical facts."

Although the record is not clear in regard to the employer's knowledge of the use of the wheelchairs, we conclude that such activity is not comparable to skateboarding. In the present case, the wheelchairs were kept by the employer at the lodge and were for the use of one Board member and guests of the lodge. The skateboard, however, was brought to work by an employee, and claimant has not shown any evidence that the employer knew of its presence. We therefore conclude that, because the employer did not know of the skateboard, it could not have acquiesced in its use.

Personal mission

The Referee found that claimant did not abandon his job and was not prevented from its performance by skateboarding across the room. We agree. Claimant was in the break room, as he was required to be, and we do not find sufficient evidence to establish that he was on a personal mission of his own at the time he was injured.

Under these circumstances, we conclude that claimant has not established that his injury arose out of or in the course and scope of employment. Accordingly, his claim is not compensable.

ORDER

The Referee's order dated September 12, 1989 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's award of $1,600 as an assessed attorney fee to claimant's counsel is reversed.

November 16, 1990 Cite as 42 Van Natta 2602 (1990)

In the Matter of the Compensation of
WALTER F. DREWS, Claimant
WCB Case No. 85-12763
ORDER ON REMAND
Cash Perrine, Claimant Attorney
Roberts, et al., Defense Attorneys

The matter is before the Board on remand from the Supreme Court. Drews v. EBI Companies, 310 Or 134 (1990). On March 10, 1987, the Board affirmed and adopted a Referee's order that: (1) held that claimant was barred by res judicata from challenging the amount of temporary total disability benefits due under an aggravation claim; and (2) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable failure to pay temporary total disability benefits at the correct rate. The Court of Appeals reversed that decision and remanded to the Board with instructions to address the merits of the temporary disability and penalty and attorney fee issues. Drews v. EBI

Companies, 96 Or App 1 (1989). The Supreme Court has affirmed the Court of Appeals decision. Consequently, we proceed with our consideration of the issues.

FINDINGS OF FACT

Claimant compensably injured his neck in 1980. The employer reported his wage as $8.50 per hour, and the insurer paid temporary total disability benefits based on that wage rate. The claim was closed by a September 17, 1981 Determination Order, which awarded temporary total disability but no permanent disability benefits.

In December 1983, claimant requested a hearing on matters arising subsequent to the Determination Order. Several issues were addressed at a June 13, 1984 hearing; however, neither party raised any question about the wage rate base for temporary total disability.

The claim was subsequently reopened and again closed by an October 7, 1985 Determination Order. Claimant requested a hearing concerning that order. In addition, he sought further temporary disability benefits for his attendance at a Callahan Center program. Shortly thereafter, claimant discovered that the employer had incorrectly reported his wage rate. On October 17, 1985, his attorney sent a letter to the insurer regarding the mistake and indicated that he was contacting claimant's employer to determine claimant's actual wage rate at the time of injury. (Ex. 43). On February 7, 1986, his attorney sent the insurer a notarized letter from the employer which reported that claimant's actual wage rate in 1980 was $10.50 per hour. (Ex. 45).

Claimant amended his hearing request to raise the issue of the insurer's failure to correct the rate of temporary total disability within 14 days of notice. On February 4, 1986, the insurer filed its response to the request for hearing and denied that the temporary total disability rate was incorrect. During the scheduled hearing on March 19, 1986, the insurer argued that claimant was barred by res judicata from challenging the amount of temporary total disability benefits, because that was an issue that could have been raised in the prior hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee initially found that the temporary total disability rate was in error and ordered the insurer to pay additional amounts of benefits. The Referee also found that the insurer had unreasonably delayed correction of the rate and assessed a penalty and attorney fee. However, on reconsideration, the Referee concluded that "the incorrect wage rate was an issue that could have been raised in the prior [June 1984] hearing [concerning the initial Determination Order] and, since it was not, it was then waived." The Referee accordingly amended the order to remove the penalty and attorney fee awarded.

The issue is whether claimant is entitled to a penalty and an attorney fee for the insurer's allegedly unreasonable delay and resistance to paying claimant the correct rate of temporary total disability. See ORS 656.262(10); ORS 656.382(1).

The standard for determining an unreasonable delay or resistance is whether the insurer had a legitimate doubt as to its liability. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the insurer at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

The Board addressed a similar issue in Michael L. McKinney, 37 Van Natta 688 (1985). In that case, the claimant's attorney informed the insurer of an

error in the calculation of the claimant's temporary total disability benefits and requested that the benefits be adjusted accordingly. A hearing convened five weeks later, at which time the insurer acknowledged the error and finally made the appropriate adjustment. The Board recognized that the failure to correct the rate of temporary total disability within 14 days of notice was not, in and of itself, necessarily unreasonable. However, because the insurer had offered no explanation in defense of its failure to act more promptly, the Board concluded that, under the circumstances, a penalty and attorney fee were appropriate.

As in McKinney, the insurer in this case failed to timely correct the rate of temporary total disability. However, unlike McKinney, the insurer offered an explanation in defense of its delay. During the March 1986 hearing, the insurer's counsel, while discussing the issue of amount of temporary total disability, stated:

> "And on that issue, it's also our position that that's an issue that could have been raised at the time of the first hearing in front of Referee Johnson and was not. Therefore, we're asserting the raise it or waive [it] rule." (Tr. 5).

Following a protracted period of litigation through three appellate levels, it has ultimately been determined that the insurer's reliance on that defense was incorrect. However, under the circumstances, we conclude that the insurer had a legitimate doubt as to its liability for paying a corrected temporary disability rate under the aggravation claim. Consequently, we do not consider the insurer's conduct to have been unreasonable.

Thus, we reach the following conclusions. Claimant is entitled to additional temporary total disability benefits payable under the aggravation claim and during the Callahan Center program at the corrected wage rate. Claimant's attorney is entitled to 25 percent of this increased temporary total disability, but the total approved attorney fees awarded by the Referee and Board order shall not exceed $3,800. Finally, claimant is not entitled to a penalty or attorney fees for the insurer's delayed correction of the rate.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL J. EBY, Claimant
WCB Case No. 89-04768
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Leahy's order that did not award temporary total disability benefits from August 25, 1987 through June 29, 1988. On review, the issues are res judicata and temporary total disability. We reverse.

FINDINGS OF FACT

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

On April 25, 1988, claimant's treating doctor, Dr. Morton, M.D., examined claimant and reported that he could not return to work in mid-1987, due to his mental condition. Claimant subsequently filed an occupational disease claim for his chronic toxic encephalopathy (CTE) condition.

On June 29, 1988, Dr. Morton reiterated that mental problems precluded claimant from working at his own painting business, due to his inability to bid jobs. In August 1988, claimant requested a hearing on SAIF's "de facto" denial of his occupational disease claim filed in April 1988.

On October 31, 1988, a hearing was held before Referee Hoguet. Issues litigated at hearing included compensability, penalties and attorney fees for alleged unreasonable denial, and penalties and attorney fees for failure to timely accept or deny the claim. In the process of determining whether assessment of a penalty for untimely claims processing was appropriate, Referee Hoguet found no justification for interim compensation and concluded that he was unable to find that claimant's CTE condition precluded him from working.

On December 13, 1988 Dr. Morton reported that claimant could not return to painting since early 1987 because of his CTE condition. A March 3, 1989 Determination Order awarded temporary total disability from June 29, 1988 through December 13, 1988.

In a June 27, 1989 hearing, Referee Leahy concluded, among other things, that Referee Hoguet's order precluded him from awarding temporary total disability between August 25, 1987 and June 29, 1988.

CONCLUSIONS OF LAW AND OPINION

Res judicata

Claimant argues that res judicata should not bar his claim for additional temporary total disability because the issue was not litigated in the hearing before Referee Hoguet. We agree.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988). Under the res judicata doctrine of "claim preclusion," litigation of a claim or cause of action to final judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Restatement (Second) of Judgments, Sections 17-19, 24 (1982). Under the doctrine of "issue preclusion", if a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment. North Clackamas School District, supra at 53.

As a preliminary matter, we conclude that this case involves "claim preclusion" rather than "issue preclusion," as the issue of substantive entitlement to temporary total disability benefits was not litigated at the prior hearing.

A claimant is entitled to interim compensation pending acceptance or denial of a claim for a disabling injury if he "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). Interim compensation is due beginning 14 days after the date upon which the employer or its insurer receives notice or knowledge of the claim. ORS 656.262(4).

On the other hand, whether claimant is substantively entitled to temporary total disability for a specific period depends upon whether the evidence shows that he was disabled on those dates due to the compensable injury. ORS 656.210; Botefur v. City of Creswell, 84 Or App 627 (1987).

We are not convinced that claim preclusion bars claimant's present claim for additional temporary total disability benefits. In the first hearing, claimant raised only the issue of penalties and attorney fees for improper claims processing. Even if the claim for interim compensation should have been raised at that time, we conclude that entitlement to interim compensation involves a different set of operative facts than substantive entitlement to temporary total disability benefits. The determination of claimant's substantive entitlement to temporary total disability compensation was first made by the March 1989 Determination Order. That order did not become final and, therefore, its award of compensation was properly before Referee Leahy. We therefore proceed to address the merits of claimant's temporary disability claim.

Entitlement to temporary total disability from August 25, 1987 through June 29, 1988

In April 1988, Dr. Morton noted that, for several months in 1987, claimant attempted to do his own paint contracting, but he had to quit because he was mentally unable to bid the jobs. In December 1988, Dr. Morton reported that, based on the information available to him, claimant was unable to return to painting (due to his chronic toxic encephalopathy) since early 1987, when he discovered that he was mentally unable to do painting bid estimates.

In addition to Dr. Morton's reports, claimant's wife testified that he had not worked since October 1986, except during a brief period in mid-1987 when he tried to start his own painting business. Claimant's wife also testified that his time loss payments related to his compensable back injury ended on August 24, 1987.

We conclude that claimant has established that, from August 25, 1987 through June 29, 1988, he was disabled from regular work due to the compensable CTE condition. Claimant is therefore entitled to additional temporary total disability.

ORDER

The Referee's order dated July 24, 1989 is reversed in part. That portion which affirmed the March 3, 1989 Determination Order award of temporary total disability benefits is reversed. The Determination Order is modified to award claimant temporary disability benefits from August 25, 1987 to June 29, 1988. The remainder of the Referee's order is affirmed. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $1,050, payable directly to claimant's counsel by the SAIF Corporation.

In the Matter of the Compensation of
MELBA M. MILLER, Claimant
WCB Case No. 89-04201
ORDER ON REVIEW
Richard O. Nesting, Claimant Attorney
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Davis' order that: (1) found that the self-insured employer properly recalculated claimant's temporary disability rate; (2) authorized the employer to base its payment for permanent disability pursuant to ORS 656.216 on the recalculated temporary disability rate; and (3) awarded claimant 12 percent (38.4 degrees) unscheduled permanent disability for her back condition in addition to the 26 percent (83.2 degrees) awarded by the Determination Order. The employer cross-requests review of that portion of the order which assessed a penalty and attorney fee for its allegedly unreasonable unilateral reduction of claimant's permanent disability award. On review, the issues are temporary disability, offset, extent of permanent disability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was an "on-call" employee and that her temporary disability rate was recalculated appropriately by the employer. This recalculation resulted in an overpayment that the employer was authorized to offset against the increased permanent disability granted by the Referee's order. The Referee also penalized the employer for unilaterally reducing claimant's permanent disability payments pursuant to its recalculation. We agree with the Referee in all his actions except the last one.

Temporary Disability, Overpayments, and Extent of Permanent Disability

We adopt the Referee's "Conclusions of Law and Opinion" on these issues as our own.

Penalty and Attorney Fee

The Referee concluded that the employer's action of recalculating the amount of claimant's monthly permanent disability payment was a unilateral reduction of claimant's disability compensation. The Referee then penalized the employer for its actions. We disagree.

ORS 656.230(1) provides that awards of permanent disability exceeding 64 degrees will be paid in payments pursuant to ORS 656.216. That statute dictates that the payment of permanent disability on a monthly basis shall be at 4.35 times claimant's weekly temporary disability rate.

In this case, the Determination Order awarded claimant permanent disability in excess of 64 degrees. The employer processed this award and created a payment schedule based upon ORS 656.216 and claimant's temporary disability rate. Subsequent to setting up this schedule of payments and advising claimant of it, the employer discovered that claimant had been paid at an erroneous temporary disability rate. It then recalculated claimant's rate to the appropriate

level. Since the claim had been closed by a Determination Order, the employer did not adjust the actual payment of temporary disability to claimant.

The employer, instead, adjusted the payment schedule for claimant's permanent disability. The employer had developed an overpayment due to the temporary disability rate recalculation, but the change in the permanent disability payment schedule was not an attempt to recover that overpayment. Claimant was still entitled to the same amount of permanent disability as before, it was only being paid at a lesser rate. This action of the employer was done in accordance with the requirements of ORS 656.216 and was therefore appropriate. The employer's actions were not a unilateral reduction of benefits in this case nor were they unreasonable.

ORDER

The Referee's order dated November 8, 1989, as reconsidered November 29, 1989, is affirmed in part and reversed in part. That portion of the order which assessed a penalty and a $200 attorney fee against the employer for the unilateral reduction of claimant's permanent disability payment is reversed. The remainder of the order is affirmed.

November 16, 1990 Cite as 42 Van Natta 2608 (1990)

In the Matter of the Compensation of
DAVID R. ZIMMERLE, Claimant
WCB Case No. 89-08397
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Quillinan's order which: (1) upheld the SAIF Corporation's denial of his aggravation claim; and (2) declined to assess a penalty and attorney fee for failure of SAIF to disclose claimant's statement. In his brief, claimant argues alternatively that his claim is compensable as an occupational disease. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant had an injury to his neck in 1974 which resulted in problems once or twice a year up to the time of his August 1985 injury.

Claimant's statement was videotaped by an investigator. His attorney initially requested discovery of all records pertaining to the claim. Subsequently, he filed a supplemental specification of issues requesting penalties and attorney fees for failure to disclose claimant's statement.

SAIF did not acknowledge the existence of the videotaped statement until hearing.

CONCLUSIONS OF LAW AND OPINION

Occupational Disease Claim

On review, claimant raises for the first time the issue of occupational disease as an alternate theory for compensability of his back condition. When an issue is not raised at hearing and the record is closed, that issue will not subsequently be considered. Mavis v. SAIF, 45 Or App 1059 (1980); Richard C. Centeno, 41 Van Natta 617 (1989); Randy D. Johnson, 39 Van Natta 463 (1987). We have reasoned that to address an issue that was not raised at hearing would be fundamentally unfair. Gunther H. Jacobi, 41 Van Natta 1031 (1989). We decline to consider this issue on review.

Aggravation

In this case of an unscheduled condition, a claimant is entitled to have a 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 award or arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). The worsening may be either temporary or permanent.

Claimant credibly testified that he had periodic worsening of his upper back symptoms which became particularly bad after he was laid off his job in 1988. However, the question is whether that worsening was materially related to his industrial injury of 1986.

Claimant bears the burden of proving by a preponderance of the evidence that his 1985 industrial injury materially contributed to his worsened upper back condition. Kassahn v. Publisher's Paper Co., 76 Or App 105 (1985).

Considering claimant's preexisting degenerative osteoarthritis, we conclude that the cause of his current back condition is a complex medical question. The resolution of this question largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., supra at 109. We rely on medical opinions which are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Claimant had an accepted cervical and thoracic strain in August 1985. That strain resolved with no permanent disability and was closed March 3, 1986. Claimant continued to experience periodic exacerbations in his upper back which responded to conservative treatment.

In September 1988, claimant was laid off his job. By the middle of October, his upper back symptoms were worse than they had ever been. X-rays in November 1988 revealed minimal degenerative disc disease at C6-7 and slightly greater disease at C5-6.

In March 1989, an examination was conducted by Dr. Duncan, D.C., and Dr. Cottrell, orthopedist. They found minor spondylosis in the mid-thoracic spine and opined that claimant's current complaints were related to underlying degenerative joint disease. They also suggested the possibility of a disc lesion at C5-6, which would not be related to the August 1985 injury.

Dr. Rosenbaum, neurosurgeon, examined claimant on August 28, 1989. He stated that claimant had degenerative osteoarthritis of the cervical spine, and that the degenerative condition was the cause of his current symptoms. He also

stated that the injury of 1985 caused an increase of symptomology of the pre-existing degenerative condition.

Claimant began treating with Dr. Malin, D.C., in January 1989. She first attributed claimant's current condition to a worsening of his compensable injury in April 1989, although she gave no reason for that conclusion. Subsequently, in response to an inquiry by SAIF as to whether she agreed with the report of Drs. Duncan and Cottrell, she did not concur and stated that the condition was caused by a "natural worsening of his condition including the discogenic spondylosis C5-6" and was related to his original injury. Again, she gave no reasoning for her conclusion.

We are persuaded by the reports of Drs. Cottrell, Duncan, and Rosenbaum that attribute claimant's continuing symptomology to his underlying degenerative condition, rather than his work-related injury, particularly given the fact that claimant experienced the greatest episode of worsening almost a month and a half after he was laid off work. Accordingly, we find that claimant has failed to meet his burden of proving that his compensable injury materially contributed to his current disability.

Disclosure of Claimant's Statement

The Referee declined to assess a penalty for SAIF's failure to disclose claimant's statement, reasoning that claimant's statement was not a medical or vocational record which requires immediate disclosure pursuant to OAR 438-07-015(2), as modified by OAR 438-07-017. We agree with the Referee's result, but for a different reason.

In this case, claimant's attorney was not informed until the day of the hearing that a videotaped statement of claimant existed. When claimant's counsel requested the videotape, SAIF neither produced it nor introduced it as evidence at hearing.

When withholding impeachment evidence, an offering party need not disclose such evidence in advance of hearing. OAR 438-07-017. However, upon request, such materials shall be disclosed prior to the close of the hearing, regardless of whether they were offered as evidence. Id. In Ashwani K. Grover, 42 Van Natta 2340 (1990), Iris J. Wirth, 41 Van Natta 194, 195 (1989), and Kenneth K. Kessel, 39 Van Natta 416, 417 (1987), we remanded to the Hearings Division for admission of such undisclosed and unoffered evidence. Such evidence includes videotapes. Grover, supra; William E. Wood, 41 Van Natta 2123 (1989).

Here, claimant does not request remand, nor does he indicate that the evidence was required for his case at hearing or on review. Rather, he seeks a penalty and attorney fee for failure to disclose the statement.

We find that SAIF's failure to produce the statement was unreasonable. However, because there were no amounts of compensation "then due" upon which to base a penalty, no penalty will be assessed. ORS 656.262(10). Additionally, in this case, although the failure to produce the statement was unreasonable, it was not an unreasonable resistance to the payment of compensation. Accordingly, no attorney fee may be awarded. ORS 656.262(10); 656.382(1).

ORDER

The Referee's order dated September 19, 1989 is affirmed.

In the Matter of the Compensation of
JESSIE R. RADFORD, Claimant
WCB Case No. 89-00205
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Higashi's order that: (1) approved the insurer's computation of his temporary total disability compensation, pursuant to former OAR 436-60-020(7)(f); and (2) increased claimant's unscheduled permanent disability award for a low back injury from 19 percent (60.8 degrees), as awarded by a Determination Order, to 20 percent (64 degrees). With regard to the temporary disability issue, claimant argues that the insurer improperly reduced his temporary disability benefits by the amount of his wages earned at a second at-injury job. The issues on review are rate of temporary disability and extent of unscheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

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

The SVP level for the job classification of apartment manager, DOT # 186.167-018, is 6, not 7.

Prior to injury, claimant performed a job which required the physical capacity to do heavy work. At the time of hearing, he had returned to full-time employment in the light-sedentary category.

Claimant has constant pain across the low back and burning in his legs. Seventy percent of the pain is in claimant's low back and thirty percent is in his legs. The use and function of claimant's low back and legs are effected in that he has been restricted from using stairs, climbing, sitting, bending, stooping, twisting, or lifting more than 10-20 pounds due to disabling pain.

CONCLUSIONS OF LAW AND OPINION

The Referee's "Opinion and Conclusion" is adopted with the following modifications and comments.

Temporary Disability

Claimant argues that the insurer should not benefit from the fact that he was able to work a second job. He also contends that the insurer's method of computation of his temporary disability benefits was a violation of Article 1, Section 20 of the Oregon Constitution because, as classified, injured workers who have two or more jobs do not have equal privileges and immunities as injured workers holding only one job. Claimant's argument is without merit.

Under former OAR 436-60-020(7)(f), when a claimant is compensably injured on one job but continues working on a second job, that claimant's entitlement is to temporary partial disability. Such time loss compensation is properly calculated utilizing former OAR 436-60-030(1). Id. Thus, we conclude that it was proper for the insurer to reduce claimant's temporary total disability benefits pursuant to former OAR 436-60-020(7)(f) to temporary partial disability benefits. Accordingly, we affirm the Referee's order on temporary disability.

Unscheduled Permanent Disability

Although not apparent from claimant's brief, we conclude that he is also requesting an increase in his unscheduled permanent disability award on the basis that the "standards" inadequately factor in all the variables affecting his disability. Claimant asserts that there is clear and convincing evidence of greater permanent impairment than 20 percent. Using an analysis within the standards, the Referee increased claimant's permanent disability award by 1 percent. We modify.

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

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

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". Former ORS 656.283(7) and 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

Age

The appropriate value for claimant's age of 34 years is 0. Former OAR 436-35-290.

Formal education

The appropriate value for claimant's high school education is 0. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was a 6, not 7, as an apartment manager (DOT # 186.167-018). Therefore, the appropriate value for skills is +2, not +1. Former OAR 436-35-300(4).

Training

Claimant has no documented training. Therefore, the appropriate value for training is +1. Former OAR 436-35-300(5). Claimant's total education value is +3, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

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

In this case, claimant's usual and customary work required the physical capacity to do heavy work. At the time of hearing claimant was working as an apartment manager with duties that required the physical capacity to perform at the light-sedentary level. Therefore, the appropriate adaptability value is 3 instead of 2.5, as found by the Referee. Former OAR 436-35-310(3)(a).

Impairment

Pursuant to former OAR 436-35-350(2), claimant's laminectomy with discectomy has an impact of 5 percent. Claimant's loss of thoracolumbar range of motion is rated under former OAR 436-35-360 and is found to be 15 percent.

Based on the medical record and claimant's credible testimony, we find 5 percent disabling pain that results in permanent loss of use or function. Former OAR 436-35-320(1)(a); Daniel M. Alire, 41 Van Natta 752 (1989). Claimant has constant pain across the low back and burning in his legs. Seventy percent of the pain is in claimant's low back and thirty percent is in his legs. The use and function of claimant's low back and legs are effected in that he is restricted from using stairs, climbing, sitting, bending, stooping, twisting, or lifting more than 10-20 pounds due to disabling pain.

The values for disabling pain (5), loss of thoracolumbar range of motion (15), and back surgery (5), are then combined for a total impairment value. See former OAR 436-35-360(11). These values combine for a total of 23.3 percent.

Computation of unscheduled disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we procede to that calculation. When claimant's age value, 0, is added to his education value, 3, the sum is 3. When that value is multiplied by claimant's adaptability value, 3, the product is 9. When that value is added to claimant's impairment value of 23.3, the result is 32.3 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 33 percent.

Additional Disability Outside the Standards

Claimant also contends that he has established by clear and convincing evidence that he has a greater impairment than measured by the standards. However, claimant presents no argument of what this "evidence" might be other than to say "that [the] loss to this man over his life is way more than 19 percent." (Appellant Brief, 2). We find that there is no clear and convincing evidence that claimant suffers additional permanent disability beyond that indicated by the "standards."

ORDER

The Referee's order dated April 18, 1989 is affirmed in part and modified in part. In addition to the Determination Order and Referee's award of 20 percent (64 degrees) unscheduled permanent disability, claimant is awarded 13 percent (41.6 degrees) unscheduled permanent disability, giving him a total of 33 percent (105.6 degrees) unscheduled permanent disability for his low back injury. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to him by the insurer. However, the total fee awarded by the Referee's order and this order shall not exceed $3,800.

November 19, 1990 Cite as 42 Van Natta 2614 (1990)

In the Matter of the Compensation of
BETTY SHRIER, Claimant
WCB Case No. 89-06254
ORDER OF DISMISSAL
Whitehead & Klosterman, Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Claimant requests review of Referee Garaventa's order which affirmed a Determination Order awarding no unscheduled permanent disability. We dismiss the request for review.

Claimant originally filed a claim for benefits in 1987 for her low back condition. The insurer denied the claim but was subsequently ordered to accept it by an Opinion and Order in WCB case number 87-11452. That Opinion and Order was timely appealed to the Board.

A Determination Order was issued on this claim on March 30, 1989. Claimant appealed that order and it was litigated in WCB case number 89-06254, the case presently before us. After the issuance of the Referee's order in this case, we reversed the Opinion and Order in WCB case number 87-11452, which had originally found this claim compensable. Our order has been affirmed without opinion by the Court of Appeals. Shrier v. Imperial Manor Convalescent Center, 104 Or App 218 (1990).

Consequently, since it has finally been determined that the claim is not compensable, claimant is not entitled to a review concerning the extent of permanent disability on a noncompensable claim. Tamarah L. Anderson, 41 Van Natta 198 (1989). Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN L. DANVILLE, Claimant
WCB Case No. C0-00210
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

On October 22, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $56,000 by the SAIF Corporation, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

We shall not approve a proposed claim disposition agreement if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Here, a disputed claim settlement was submitted contemporaneously with the claim disposition agreement. The disputed claim settlement concerns the same claim and is intended to resolve the pending hearing request in WCB Case No. 90-07162. The claim disposition agreement provides: "The parties agree that approval of this Disposition shall not be effective unless and until the Settlement Agreement is approved by the referee and that absent such approval, this Disposition shall be null and void" (page 2, lines 8-11). That provision exceeds the bounds of ORS 656.236.

ORS 656.236 does not permit the parties to make approval of a claim disposition agreement contingent on the approval of a disputed claim settlement. James J. Treml, 42 Van Natta 2594 (1990). Once approved by the Board, the claim disposition agreement is valid and enforceable, regardless of whether or not the disputed claim settlement is approved. See id.

The aforementioned provision cannot be excised from the disposition agreement without substantially altering the terms of the agreement itself. Therefore, the Board finds that the agreement is unreasonable as a matter of law and sets it aside. See ORS 656.236(2); Louis R. Anaya, supra. Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
NANCY C. EVENHUS, Claimant
WCB Case Nos. 87-04881, 87-03084 & 87-03085
ORDER ON REMAND
Whitehead & Klosterman, Claimant Attorneys
Snarskis, et al., Defense Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Howell and Spear.

This matter is before the Board on remand from the Court of Appeals. Camlu Retirement Center v. Evenhus, 102 Or App 603 (1990). The court has re

versed our order in Nancy C. Evenhus, 41 Van Natta 1023 (1989), which had found that Liberty Northwest's denial of claimant's September 15, 1986 left knee injury claim, which was based on a lack of coverage, was prohibited under Bauman v. SAIF, 295 Or 788 (1983). Relying on its decision in Oak Crest Care Center v. Bond, 101 Or App 15, 19, rev den 310 Or 121 (1990), the court held that Bauman does not apply to invalidate a denial based on a lack of coverage or to bind a carrier to a previous acceptance when there is a lack of coverage. Reasoning that our order did not consider the remaining issues raised by the carriers' denials, the court has remanded. We proceed with our review.

FINDINGS OF FACT

On August 25, 1980, claimant sustained a compensable left knee injury while employed by Industrial Indemnity's insured. An arthroscopy was performed, which resulted in a post-operative diagnosis of chondromalacia of the patella. This claim eventually resulted in a 12.33 percent scheduled permanent disability award.

On September 15, 1986, while working as a housekeeper for another employer, claimant's left knee buckled as she was walking along a hallway. The insurer on the risk at the time of this injury was Cigna. One day later, on September 16, 1986, Liberty Northwest came on the risk.

Claimant initially filed an aggravation claim for her current left knee condition with Industrial Indemnity. When Industrial Indemnity denied claimant's aggravation claim, she filed a "new injury" claim with the second employer. Liberty Northwest accepted the "new injury" claim and began providing benefits.

In December 1986, Dr. Shaw, orthopedist, performed a left knee arthroscopy. This procedure revealed a "complete disruption of the articular cartilage" and "a flap tear of the medial meniscus." This damage corresponded to findings during the 1980 surgery and represented progressive wear and tear in the area.

In February 1987, Liberty Northwest realized that it was not providing coverage on September 15, 1986. Thereafter, Liberty Northwest issued its denial. Claimant requested a hearing, seeking, among other things, a determination of which carrier (Industrial Indemnity, Cigna, or Liberty Northwest) was responsible for her current left knee condition.

CONCLUSIONS OF LAW AND OPINION

Applying the principles enunciated in Bauman, supra, the Referee reasoned that Liberty Northwest was precluded from issuing its denial based on a lack of coverage after it had previously accepted the claim. Consequently, the Referee found Liberty Northwest responsible for claimant's current left knee condition without addressing the merits of the responsibility issue. Had the responsibility decision been based on the evidenciary record and not the procedural validity of Liberty Northwest's denial, the Referee alternatively found that claimant's 1986 employment had not independently contributed to a worsening of claimant's underlying left knee condition. Under such circumstances, the Referee noted that, but for the procedural invalidity of Liberty Northwest's denial, Industrial Indemnity's denial of claimant's aggravation claim would have been set aside.

On review of the Referee's order, we agreed with the conclusion that Liberty Northwest's denial was prohibited under Bauman. Nancy C. Evenhus, supra. Consequently, we affirmed the Referee's responsibility decision. In so

doing, we neither addressed nor adopted the Referee's alternative responsibility finding.

The court has reversed our conclusion that Liberty Northwest's denial is invalid. Reasoning that our prior order "only considered whether Liberty could deny the claim under Bauman," the court has remanded "so that [the Board] may review the remaining issues raised by the denials." Camlu Retirement Center v. Evenhus, supra, at page 606.

Preliminarily, Liberty Northwest and Cigna contend that because the Referee's alternative finding concerning the issue of responsibility has not been challenged during the course of this appeal, such a finding is final. We disagree. No order, and, thus, no Finding within an order, has yet become final in this matter.

Our previous order neither discussed nor adopted the Referee's alternative finding concerning the merits of the responsibility issue. Nancy C. Evenhus, supra. Instead, we based our decision on the responsibility issue solely on the ground that Liberty Northwest's denial was invalid. Holding that our conclusion was error, the court has remanded. Camlu Retirement Center v. Evenhus, supra. This action was taken "so that [the Board] may review the remaining issues raised by the denials." 102 Or App at page 606. Based on the aforementioned reasoning and considering the clear directive from the court, we proceed with a determination of the responsibility issue.

In cases where there has been an accepted compensable injury followed by an increase in disability during or after employment with a later carrier, responsibility is fixed with the carrier which accepted the claim. Linda L. Wise, 42 Van Natta 115 (1990). In order to shift responsibility, the original carrier must prove affirmatively that a later employment independently contributed to a pathological worsening of the accepted condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986). The last carrier is responsible if the later employment independently contributed, even slightly, to a worsening of the underlying condition. Hensel Phelps Const., supra.

Here, Dr. Shaw performed claimant's 1980 arthroscopy, as well as her 1986 arthroscopy. Considering this unique perspective and familiarity with claimant's left knee condition, we accord Shaw's opinion great weight. Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

After the September 15, 1986 "buckling" incident and before the December 1986 arthroscopy, Shaw stated that claimant's prior knee problems had made her knee more vulnerable to such an incident. Shaw further noted that this buckling had precipitated the current problem, a medial meniscus tear, which was distinct from her 1980 problem.

However, following an opportunity to examine claimant's left knee condition during the December 1986 arthroscopy, Dr. Shaw modified his prior opinion. After examining signs of articular surface damage throughout the femoral and tibial condyles, Shaw concluded that claimant's medial meniscus tear was of a gradual, degenerative nature resulting from chronic wear and tear in the knee since the original patellofemoral lesion. Consequently, Dr. Shaw opined that claimant's current need for treatment arose as a direct result of her 1980 injury.

Based on Dr. Shaw's well informed and uncontradicted ultimate conclusion, we are persuaded that claimant's current left knee condition is attributable to her 1980 injury claim with Industrial Indemnity. We further conclude that her

1986 work activities for the second employer have not been shown to have independently contributed to a worsening of her underlying knee condition. Therefore, we hold that Industrial Indemnity is responsible for claimant's left knee condition.

Accordingly, Industrial Indemnity's denial is set aside and the claim is remanded to Industrial Indemnity for processing according to law. Industrial Indemnity is responsible for the $1,200 attorney fee awarded by the Referee to be paid by Liberty Northwest. Liberty Northwest's denial is reinstated and upheld. Cigna remains responsible for the interim compensation, penalties, and related attorney fees awarded in our June 15, 1989 order.

IT IS SO ORDERED.

November 20, 1990 Cite as 42 Van Natta 2618 (1990)

In the Matter of the Compensation of
SCOTT W. MISCHKE, Claimant
WCB Case No. TP-90047
THIRD PARTY DISTRIBUTION ORDER
Hagen, et al., Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

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 pertains to SAIF's entitlement to a "third party" lien from the settlement proceeds. We conclude that SAIF is entitled to a share of the proceeds and that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

In March 1988, claimant sustained a compensable injury when injured in a motor vehicle accident. SAIF accepted the claim and has provided compensation. To date, it has incurred actual claim costs totalling $13,339.92. These costs are comprised of $6,601.11 in medical expenses, $5,655 in permanent disability benefits, and $1,083.81 in temporary disability benefits.

Claimant secured legal counsel to consider a lawsuit against the driver of the other vehicle involved in the accident. In early January 1989, without SAIF's knowledge or approval, claimant and the third party insurer reached a $23,800 settlement. Shortly after this agreement was achieved, SAIF provided claimant with an explanation concerning his rights against the third party under the workers' compensation law. When advised of the unapproved settlement, SAIF objected to the compromise, entered into without its knowledge or permission, and also asserted its entitlement to a share of the proceeds. SAIF has since approved the settlement. However, to date, it has not received a portion of the settlement proceeds.

A distribution of the third party settlement proceeds in accordance with ORS 656.593(1) is "just and proper." Such a distribution would permit SAIF to retain the balance of the proceeds remaining after the deduction of claimant's statutory attorney fees, litigation expenses, and statutory 1/3 share.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, 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. ORS 656.593(1). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury as a result of the negligence or wrong of a third person. The claim was accepted by SAIF, who has provided compensation. Inasmuch as SAIF has paid benefits to claimant as a result of a compensable injury, it is a paying agency. ORS 656.576. As such, it is entitled to its statutory share of the third party recovery. ORS 656.593(1).

In reaching this conclusion, we reject claimant's contention that SAIF has "waived" its entitlement to share in the settlement proceeds. Specifically, claimant argues that SAIF is estopped from asserting a lien because it did not submit a third party "election form" to claimant until some 10 months after the accident.

Claimant's argument is without merit. There are no prerequisites to a paying agency's entitlement to a share of a third party recovery. A paying agency automatically has a preferred lien against the worker's cause of action and any proceeds from that action are subject to that lien. ORS 656.580(2); 656.593(1). Furthermore, the ability to assert that lien is not contingent upon the submission of a written demand to a worker to exercise the right of election to seek damages from a third party. See ORS 656.578; 656.583(1). Instead, when such a right is exercised, the onus is upon the worker to notify the paying agency of the election to proceed against the third party. ORS 656.593(1).

When claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable. Thus, the third party settlement became subject to SAIF's lien for its "just and proper" share. See ORS 656.593(3). We now proceed to a determination of a "just and proper" distribution.

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). 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).

We find no persuasive reason to depart from the aforementioned approach. Therefore, after the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, SAIF is entitled to retain the balance of the third party 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 claims under ORS 656.001 to 656.794. See ORS 656.593(1)(a), (b), & (c).

Claimant has neither contested SAIF's assertion that it has incurred $13,339.92 in actual claim costs nor its representation that such costs would exceed the remaining balance after the settlement proceeds were distributed in accordance with ORS 656.593(1). Under such circumstances, we conclude that a

distribution of proceeds from the third party settlement in accordance with ORS 656.593(1) would be "just and proper." We further hold that SAIF's "just and proper" share of such a distribution would be the remaining balance of settlement proceeds after the deduction of claimant's statutory attorney fee, litigation expenses, and statutory 1/3 share.

IT IS SO ORDERED.

November 20, 1990 Cite as 42 Van Natta 2620 (1990)

In the Matter of the Compensation of
KENNETH H. PARKS, Claimant
WCB Case No. 89-03390
ORDER ON REVIEW
Eddy R. Swearinger, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Michael Johnson's order that: (1) affirmed that portion of a Determination Order that awarded no additional scheduled permanent disability for loss of use or function of the left arm; (2) decreased claimant's unscheduled permanent disability award for a neck and left shoulder injury from 56 percent (179.2 degrees), as awarded by a Determination Order, to 46 percent (147.2 degrees). On review the issue is extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact as supplemented in our conclusions and opinion.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

Claimant argues that he is entitled to a separate award for loss of use or function of the left forearm. We disagree. The Western Medical Consultants found that claimant had a loss of use or function of his left forearm. However, they based their opinion on the atrophy in claimant's deltoid muscle. Atrophy of the deltoid muscle does not entitle claimant to a separate scheduled rating for loss of use or function of the left forearm. Accordingly, we find that claimant is not entitled to an award of scheduled permanent disability.

Unscheduled Permanent Disability

At the outset, we note that claimant argues that the Determination Order can not be reduced unless it is shown by clear and convincing evidence that his disability is less. We disagree. Michelle Griffith, 40 Van Natta 2086 (1988). We rate claimant's permanent disability pursuant to the standards in effect at the time claimant's August 26, 1988 Determination Order issued. Specifically we apply former OAR 436-35-000 et seq., adopted effective July 1, 1988, as amended by temporary rules effective August 19, 1988. Former ORS 656.295(5); OAR 438-10-010.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the

evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". Former ORS 656.283(7) and 656.295(5).

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

Age

The appropriate value for claimant's age of 60 years is +1. Former OAR 436-35-290.

Formal Education

The appropriate value for claimant's GED is 0. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 8 as a foreman of a hard rock drilling crew. Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Training

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 2, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

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

At the time of the injury, claimant was a foreman on a rock drilling crew. He retired in 1986 and has had subsequent surgery related to the accepted claim. At the time of the hearing, claimant was unable to do his job at time of injury. Between the date of his injury and the time he retired, claimant had returned to work as a maintenance supervisor. He continued to have disabling complaints and occasionally had shots from Dr. Tiley. At the time of the hearing, claimant could not do that job either.

Claimant is not working because he has retired. However, the evidence in this record indicates he could not physically do either his job at time of injury or his subsequent modified job. Therefore, it is proper to rate his adaptability under former OAR 436-35-310(4). We find claimant's physical capacity to fall within the light category, for a value of +4.

Impairment

Left Shoulder

Claimant is entitled to the following values for lost range of motion of the left shoulder. Claimant is assigned a value of 3 percent for 100 degrees of forward elevation. Former OAR 436-35-330(1). For 85 degrees of abduction claimant is entitled to a value of 4 percent. Former OAR 436-35-330(5). For 15 degrees of adduction claimant is assigned a value of 1 percent. Former OAR 436-35-330(7). For 70 degrees of external rotation claimant is assigned a value of 2 percent. Former OAR 436-35-330(11). To arrive at a total value for lost range of motion of the left shoulder the values are added (not combined) to arrive at a total value of 10 percent. Former OAR 436-35-330(17).

For resection of the acromion claimant is entitled to a value of 5 percent. Former OAR 436-35-330(14).

Claimant experiences constant pain in the left shoulder, resulting in giveway of the shoulder. Consequently, he has had to stop golfing and hunting and has difficulty with performing daily tasks of living.

Claimant is entitled to a value for disabling pain that results in a loss of function. See Daniel M. Alire, 41 Van Natta 752 (189). Former OAR 436-35-320(1)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone. The Board in Daniel M. Alire, supra, held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates him for his loss of use or function attributable to the disabling pain. Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, we consider a value of 5 percent reasonable in this case.

To arrive at a total impairment value for claimant's left shoulder, the value for claimant's lost range of motion (10), disabling pain (5) and his surgery (5) are combined for a total value of 18.8 percent.

Cervical

Claimant is entitled to a value for lost range of motion in the cervical area. For 35 degrees of left lateral flexion, claimant is assigned a value of .5. Former OAR 436-35-360(4). For 35 degrees of right lateral flexion, claimant is assigned a value of .5. Former OAR 436-35-360(4). For a total value for lost range of motion the values are added (not combined) to arrive at a total value of 1 percent. Former OAR 436-35-360(10).

Claimant is also entitled to a value for his surgical procedures and unoperated disc. We find that claimant is entitled to a value of 4 percent for his unoperated disc protrusion at C3-4 with clinically-related residual symptoms. Former OAR 436-35-350(2). For claimant's three level fusion at the C5-6-7 levels in a favorable position, claimant is entitled to a value of 5 percent. Former OAR 436-35-350(3). To arrive at an impairment value based upon claimant's surgical procedures and unoperated disc the values are combined for a value of 8.8.

Claimant also experiences disabling pain in his cervical area. Due to his neck pain, claimant has difficulty sleeping at night. Inasmuch as the standards

do not provide for a value range for impairment attributable to disabling pain, we consider a value of 5 percent to be appropriate in this case.

To arrive at a total impairment value based upon claimant's cervical loss, we combine the total for lost range of motion (1) with the value for claimant's surgical procedure (8.8) and the value for claimant's disabling pain (5) to arrive at a total value for the cervical spine of 14.2. Former OAR 436-35-360(11).

To arrive at a total impairment value, the value for claimant's left shoulder (18.8) is combined with the value for claimant's cervical area (14.2) to arrive at a total of 30.3.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (1) is added to his education value (2) the sum is 3. When that value is multiplied by claimant's adaptability value (4) the product is 12. When that value is added to claimant's impairment value (30.3) the result is 42.3 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 43 percent. However, we will not reduce claimant's award in this instance as SAIF has not requested a reduction below the 46 percent awarded by the Referee. See Daniel M. Alire, supra.

ORDER

The Referee's order dated July 6, 1989 is affirmed.

November 20, 1990 · Cite as 42 Van Natta 2623 (1990)

In the Matter of the Compensation of
GARY L. WALDRUPE, Claimant
WCB Case No. 89-01705
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Rankin, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Hoguet's order which increased claimant's scheduled permanent disability awards for both the left and right forearm from 10 percent (15 degrees), as awarded by a prior Determination Order and Stipulated Order, to 14 percent (21 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant experienced the onset of bilateral hand problems in 1985 which were subsequently diagnosed as bilateral carpal tunnel syndrome. He underwent bilateral median nerve release surgeries in 1986.

A March 4, 1987 Determination Order awarded claimant 5 percent scheduled permanent partial disability for loss to each forearm (wrist). A Stipulated Order, approved on September 10, 1987, increased claimant's scheduled permanent disability award to a total of 10 percent for each wrist.

On September 1, 1987, bilateral ulnar nerve lesions were diagnosed. Claimant underwent a decompression of the right median nerve and a complete flexor tenosynovectomy of the right wrist in November 1987. He then underwent right ulnar nerve release in May 1988, and left ulnar nerve release surgery in August 1988.

Claimant was medically stationary as of December 12, 1988. A January 20, 1989 Determination Order awarded no additional permanent disability.

Claimant has a chronic condition in each hand that limits repetitive use of his hands.

He experiences bilateral sensory loss equal to 13 percent disability of the middle finger (3 percent of the hand); bilateral sensory loss equal to 14 percent disability of the ring finger (1 percent of the hand); and bilateral sensory loss equal to 23 percent disability of the little finger (1 percent of the hand).

Claimant experiences sensory loss equal to 8 percent disability bilaterally in the thumbs (3 percent of the hand). He experiences sensory loss equal to 12 percent disability bilaterally in the index fingers (3 percent of the hand) .

Claimant has not established the extent of any loss of grip strength.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, we apply the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, we apply the version of OAR 436-35-001 et seq in effect at the time of the January 20, 1989 Determination Order.

The Referee found that claimant suffered 5 percent disability bilaterally for chronic conditions limiting repetitive use of his hands. The parties do not dispute this finding.

Sensory Loss

With reference to sensory loss, claimant argues, and the Referee agreed, that claimant is entitled to an award pursuant to former OAR 436-35-110(3)(a) rather than 436-35-110(1)(a).

We do not agree and note that former OAR 436-35-110(1)(a) relates to loss of sensation in the fingers and thumbs as determined by two point discrimination tests, whereas former OAR 436-35-110(3)(a) refers to sensory loss due to nerve impairment in the forearm/arm. We cannot say that claimant suffers nerve impairment above the hand. Consequently, because Dr. Long's two point discrimination tests are used in determining claimant's loss of sensation in the fingers, former OAR 436-35-110(1)(a) is the appropriate standard for rating loss of sensation.

We rely on the objective findings of Dr. Long (Ex. 84-2), rather than relying on Dr. Nathan's conclusory opinion that two point discrimination is intact at the tip of the digits of each hand. We note, also, that because Dr. Long's report is not specific as to location or quality of the loss of sensation, we can only find that claimant has less than normal, but more than protective sensation for 1/2 the distal phalanx of each finger and thumb, where testing was performed.

Claimant is able to discriminate 2 points at 8mm in the 3rd finger bilaterally for a 13 percent loss of each finger (3 percent of each hand); 2 points at 8mm in the 4th finger bilaterally for a 14 percent loss of each finger (1 percent of each hand); and 2 points at 8mm in the 5th finger bilaterally for a 23 percent loss of each finger (1 percent of each hand). He discriminates 2 points at 13mm in the right thumb for an 8 percent loss (3 percent of the right hand), 2 points at 12mm in the left thumb for an 8 percent loss (3 percent of the left hand). He can discriminate 2 points at 13mm for a 12 percent loss of the right index finger (3 percent of the right hand) and can discriminate 2 points at 14mm for a 12 percent loss of the left index finger (3 percent of the left hand). Former OAR 436-35-070; 436-35-110(1)(a). Combining the losses of each hand, we arrive at a figure of 10.5 percent impairment for loss of sensation bilaterally.

Grip Strength

Both Dr. Long and Dr. Nathan noted diminished grip strength, but neither indicated a normal range for grip strength. The Referee concluded, by looking at the record as a whole, that claimant suffered a loss of function due to loss of grip strength equal to 10 percent of the maximum allowed by former OAR 436-35-110(3)(a). We disagree, and note that although Dr. Long found that claimant could generate a total of 36kg of force with three squeezes on the right, and a total of 19kg of force with three squeezes with the left hand, he failed to indicate what is normal for grip strength, and we can find no standard in the AMA Guidelines for Rating Permanent Impairment. See former OAR 436-35-005(1). Accordingly, we are not able to rate grip strength.

To arrive at claimant's total impairment, we combine the 5 percent impairment for a chronic condition limiting repetitive use of each hand with the 10.5 percent for loss of sensation in each hand and arrive at a total of 15.0 percent. Former OAR 436-35-010(6).

ORDER

The Referee's order dated August 9, 1989 is modified. In addition to the Referee's award of 14 percent (21 degrees) scheduled permanent disability for both the left and right hand (forearm), claimant is awarded 1 percent (1.5 degrees) scheduled permanent disability for the left and right hand (forearm) for a total award to date for each hand (forearm) of 15 percent (22.5 degrees). Claimant's attorney is awarded an approved fee of 25 percent of the increased compensation awarded by this order, payable directly to claimant's attorney, not to exceed a total of $3,800 approved by the Referee and Board order.

November 21, 1990 Cite as 42 Van Natta 2625 (1990)

In the Matter of the Compensation of
MARIA R. PORRAS, Claimant
WCB Case No. 84-11249
ORDER ON REMAND
Olson, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990). The court has concluded that our prior order on remand, which assessed a penalty and attorney fee for the self-insured employer's allegedly unreasonable processing of the claim, Maria R. Porras, 40 Van Natta 1338 (1988), failed to address whether the employer's reliance on former OAR 436-54-232(1) was reasonable. Consequently, the court has remanded for reconsideration of that issue. We proceed to do so.

FINDINGS OF FACT

Claimant sustained a compensable injury on June 16, 1982. A January 21, 1983 Determination Order awarded her temporary total disability (TTD) but no permanent disability.

In June 1983, while in a hospital undergoing tests for the injury, claimant suffered a cerebral vascular accident (CVA). The employer denied compensability of the CVA.

A second Determination Order was issued on July 23, 1984, which awarded claimant additional TTD and 45 percent unscheduled permanent partial disability (PPD). The determination did not include the CVA. The employer began paying the PPD award in monthly installments.

On February 25, 1985, a Referee found the CVA compensable and ordered the employer to make "payment of benefits as provided by law."

In May 1985, the employer reopened the claim and unilaterally redesignated monthly installments of PPD, previously paid under the July 1984 Determination Order, as TTD payments payable under the Referee's order. It paid claimant the difference between TTD owed since the July 1984 Determination Order and PPD paid, and resumed paying TTD in monthly installments. The employer reasoned that, because the cerebral condition was not yet medically stationary, the Referee's remand of the CVA claim for acceptance effectively set aside the July 1984 Determination Order as premature.

A third Determination order was issued on November 19, 1985, which awarded additional TTD and 50 percent PPD for both the compensable injury and the CVA.

CONCLUSIONS OF LAW AND OPINION

In our prior order on remand, we concluded that claimant was entitled to the full amount of TTD benefits without an offset of previously paid PPD benefits, because the February 1985 order did not set aside the July 1984 Determination Order. We also assessed a penalty and attorney fee for the employer's withholding of the TTD. We reasoned that the employer had offered no reasonable explanation for its actions, because carriers are not allowed to unilaterally offset overpayments without prior approval.

The Court of Appeals found that our reasoning adequately explained why we rejected the employer's explanation that it had conferred with the Compliance Division <u>after</u> it had acted unilaterally. The court, however, held that we did not explain why we rejected the employer's explanation that it had relied on <u>former</u> OAR 436-54-232(1). We now proceed with our reconsideration.

ORS 656.262(10) provides for an assessment of attorney fees and penalties against an employer for an "unreasonable refusal to pay compensation," and ORS 656.382(1) requires an employer to pay an attorney fee if it "unreasonably resists the payment of compensation." The standard for determining an unreasonable denial is whether the employer had a legitimate doubt as to its liability for the payments. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the employer at that time. <u>Brown v. Argonaut Insurance Co.</u>, 93 Or App 588 (1988).

The employer contends that it relied on <u>former</u> OAR 436-54-232(1):

> "(1) When a claim is reopened as a result of an aggravation of the worker's condition and temporary total disability is due, the permanent partial disability payments shall be suspended as of the date of the reopening. Any payments made on the award of permanent partial disability after the medically established date of aggravation shall be reclassified as temporary total disability payments. A lump sum amount shall be paid the worker to adjust for any difference in the rate amounts between permanent partial disability already paid and temporary total disability currently due as a result of reclassifying the benefits. Reclassification of permanent partial disability payment shall not be made when an award has been paid in a lump sum."

Although we previously held that the Referee's order did not reopen the claim, we do not consider the employer's conduct to have been unreasonable in reaching such a conclusion. Given the facts that the CVA preceded the July 1984 award of PPD and that the employer had denied the compensability of the CVA prior to the award, we conclude that the employer could have reasonably assumed that the Referee's remand of the CVA claim for acceptance effectively set aside the July 1984 Determination Order as premature.

The question remains, however, whether the employer acted reasonably in relying on the aforementioned rule to unilaterally offset the benefits without prior approval. We previously held that there was no statutory permission for such unilateral recovery and noted that the proper course of action would have been to secure Referee approval of the offset. See ORS 656.268(4); Forney v. Western States Plywood, 66 Or App 155, aff'd 297 Or 628 (1984). Consequently, the rule could not validly authorize the employer's action. However, at the time of the employer's decision to reclassify the previously paid PPD, no case had addressed the validity of former OAR 436-54-232(1). Moreover, unlike the rule invalidated in Forney, this "reclassification" rule was phrased in mandatory rather than discretionary terms, i.e., "shall" versus "may." Under such circumstances, we conclude that the employer had a legitimate doubt as to its liability for the full amount of claimant's TTD benefits and it was not unreasonable to rely on former OAR 436-54-232(1). See Zwahlen v. Crown Zellerbach, 67 Or App 3 (1984).

On reconsideration, we conclude that the employer's conduct was reasonable and that a penalty and attorney fee are not appropriate. Accordingly, we withdraw those portions of our April 11, 1989 order which assessed a 25 percent penalty based on the temporary total disability award granted by that order and awarded a $500 penalty-related attorney fee.

IT IS SO ORDERED.

November 21, 1990 Cite as 42 Van Natta 2627 (1990)

In the Matter of the Compensation of
OLLIE D. WIGGER, Claimant
WCB Case Nos. 88-12473 & 88-09689
ORDER OF ABATEMENT
Starr & Vinson, Claimant Attorney
Beers, et al., Defense Attorneys
Brian L. Pocock, Defense Attorney

Claimant has requested reconsideration of that portion of our October 23, 1990 Order on Review that declined to award an assessed fee for services ren

dered on review. In order to allow sufficient time to consider the motion, the above noted order is abated and withdrawn. St. Paul Fire and Marine is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

November 21, 1990 Cite as 42 Van Natta 2628 (1990)

In the Matter of the Compensation of
RALPH L. WITT, Claimant
WCB Case No. 88-07709
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gerner, Myers and Cushing.

Claimant requests review of those portions of Referee Mongrain's order which: (1) awarded temporary partial disability not to exceed a two year period between June 1984 and May 1988; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claims processing beyond the aforementioned two-year period. On review, the issues are temporary partial disability, and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

Claimant worked many years as an electrician. He experienced an asbestos-related lung disease that became disabling in June 1984. (Ex. 3). His claim was denied.

Claimant was totally disabled from July 24, 1984 through September 12, 1984. He returned to modified work from September 13, 1984 through December 15, 1987. Thereafter, claimant was totally disabled from December 16, 1987 through December 23, 1987. Claimant returned to modified work from December 24, 1987 through the end of May 1988. Because of his compensable condition, claimant has not worked since May 1988.

In December 1987 an earlier Referee set aside the insurer's denial of lung condition. The insurer was ordered to process the claim in accordance with law.

On February 8, 1988, the insurer paid temporary total disability benefits for the December 1987 time loss. In early August 1988 the insurer commenced the regular payment of temporary total disability. Claimant requested a Hearing, seeking a review of the rate and duration of temporary disability benefits and penalties and attorney fees.

Claimant has never been declared medically stationary. Likewise, a Determination Order has not been issued.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's entitlement to temporary partial disability was limited, reasoning that ORS 656.212, placed a limit of two years on the payment of temporary partial disability benefits. We modify.

ORS 656.212 is the statutory authority for terminating temporary partial disability benefits after an uninterrupted two year "period." The statute provides as follows:

> "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."

Pursuant to the statute, temporary partial disability benefits are terminated after a two year "period." The language of ORS 656.212 provides for compensation when disability is partial "only." We interpret such language to mean that the two year "period" of partial disability only has to be without interruption. If such an interruption occurs, claimant is entitled to a new two year "period" upon the restarting of temporary partial disability.

This reading of ORS 656.212 assumes that the two year limit is not considered to be an aggregate amount of time for the life of the claim or a single claim opening. We believe that the reference in ORS 656.212 to "period," addresses a single episode of temporary partial disability. We reach this conclusion because if the statute had intended to combine separate intervals of temporary partial disability in reaching the two year "period," some reference would have been made to an aggregate formula. Instead, ORS 656.212 refers to a "period" of "only" temporary partial disability that extends for more than two years. Cf. Tennant v. Lyman Slack Chevrolet, 102 Or App 470 (1990). The relevant administrative rule provides further support for our conclusion. See OAR 436-60-030(3) & (4).

We conclude that the two year "period" of temporary partial disability is not to be considered in the aggregate for a single claim or claim opening. Rather, it is a limit on any uninterrupted "period" of authorized temporary partial disability.

We proceed to apply our analysis to the merits.

Claimant was initially disabled in June 1984. He received temporary total disability benefits from July 24, 1984 through September 12, 1984. Thereafter, claimant was entitled to temporary partial disability benefits for the two year "period" which ran from September 13, 1984 through September 13, 1986. Following that "period" claimant was no longer entitled to receive temporary partial disability; the two year "period" for temporary partial disability benefits had been exhausted. See ORS 656.212. Subsequently, claimant received temporary total disability benefits from December 16, 1987 through December 23, 1987. This created a new two year "period" in which claimant should receive temporary partial disability pursuant to ORS 656.212. Accordingly, claimant is entitled to temporary partial disability benefits for the "period" from December 24, 1987 through the end of May 1988.

Under the circumstances, we conclude that claimant is entitled to temporary partial disability benefits for a two year "period" from September 13, 1984 through September 13, 1986. Thereafter, claimant is also entitled to temporary partial disability benefits from December 24, 1987 through the end of May 1988.

Penalties and Attorneys Fees

The Referee awarded claimant a penalty equal to 25 percent of the temporary partial disability benefits payable to claimant for the period between June 1984 and May 1988. We modify.

Penalty and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). We have found claimant to be entitled to temporary partial disability from September 13, 1984 through September 13, 1986, and from December 24, 1987 through May 1988. We conclude that it was unreasonable for the insurer not to have paid temporary partial disability benefits for the two-year "period" from September 13, 1984 through September 13, 1986. This was unreasonable because ORS 656.212 expressly provides for the payment of temporary partial disability for a two year "period."

Accordingly, claimant is entitled to penalties for late payment of temporary partial disability benefits that are due for the "period" September 13, 1984 through September 13, 1986. Parker v. D.R. Johnson Lumber Co., 93 Or App 675 (1988). The insurer shall be assessed a penalty of 25 percent of this amount.

On the other hand, the December 24, 1987 through May 1988 "period" falls outside of the initial two year "period" set forth by ORS 656.212. The law was unclear regarding whether the insurer had a legal obligation to pay temporary partial disability benefits where, as here, there was an interval of temporary total disability benefits. Under the circumstances, we do not find the insurer's failure to pay temporary partial disability for the December 24, 1987 through May 1988 "period" to have been an unreasonable refusal to pay compensation. See Norgard v. Rawlinson, 30 Or App 999 (1977).

Finally, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing concerning the penalty issue is $700, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the value of the interest involved. Consequently, the Referee's award of a penalty-related attorney fee of $550 is modified to $700.

ORDER

The Referee's order dated May 10, 1988, as reconsidered August 10, 1989, is modified in part and affirmed in part. In lieu of the Referee's temporary partial disability award, claimant is awarded temporary partial disability benefits for the "period" between September 13, 1984 through September 13, 1986, and between December 24, 1987 through the end of May 1988. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fee awarded by the Referee and Board order shall not exceed $3,800. Claimant is also awarded a penalty in the amount of 25 percent of the temporary partial disability compensation due from September 13, 1984 through September 13, 1986. In lieu of the Referee's penalty-related attorney fee of $550, claimant's attorney is awarded a reasonable fee of $700, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MICHELLE S. CHENEY-PLACE, Claimant
WCB Case No. 89-13076
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of those portions of Referee Davis' order that: (1) found claimant's CT scan compensable; and (2) assessed a penalty-related attorney fee for an alleged failure to provide full and timely discovery materials. On review, the issues are medical services and penalty-related attorney fees. We reverse.

FINDINGS OF FACT

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

The insurer's July 15, 1987 denial letter denied claimant's "aggravation claim" and all "current and ongoing treatment" as not related to claimant's compensable injury. That denial was not timely appealed.

The insurer did not unreasonably resist the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Medical Services

Based on his interpretation of ORS 656.245, the Referee found that claimant's June 26, 1987 CT scan was a reasonable and necessary procedure to determine the relationship between claimant's compensable condition and her then current condition. Consequently, the Referee ordered the insurer to accept responsibility for the CT scan. We disagree.

Claimant's CT scan occurred on June 26, 1987, during a time when claimant was receiving treatment for an alleged aggravation of her compensable back condition. The July 15, 1987 denial letter denied claimant's "aggravation claim" and claimant's "current and ongoing problems," on the basis that her current problems were not caused by her compensable injury. (Ex. 20) (Emphasis supplied). Claimant did not appeal this denial.

We find the preponderance of the medical evidence indicates that the June 1987 CT scan was materially related to claimant's "current" problems existing at the time of the July 1987 aggravation denial. Furthermore, we interpret the aggravation denial to mean that claimant's current condition is not related to or caused by her compensable injury. Thus, we find claimant's current condition existing in July 1987 denied. Because this July 1987 denial was not appealed, we find claimant's then-current condition not compensable as a matter of law. Inasmuch as we find the CT scan to be related to the denied then-current condition, we conclude the CT was not a compensable medical service.

Penalties and Related Attorney Fees - Untimely Disclosure

The Referee assessed a penalty-related attorney fee against the insurer for an alleged failure to provide full and timely discovery materials. We disagree.

Here, we have found that claimant's CT scan is not compensable. Therefore, regardless of whether the insurer's failure to provide timely discovery was unreasonable, there is no evidence to suggest that the conduct constituted an unreasonable resistance to the payment of compensation. Accordingly, we are unable to award a penalty-related attorney fee. See former ORS 656.262(10); 656.382(1); Ellis v. McCall Insulation, 308 Or 74 (1989); Marcheta Conradi-West, 42 Van Natta 2379 (1990); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated October 31, 1989 is reversed. The insurer is not responsible for the CT scan. The Referee's $550 attorney fee award for services at hearing regarding compensability of the CT scan claim is reversed. The Referee's $150 penalty-related attorney fee is reversed.

November 23, 1990 Cite as 42 Van Natta 2632 (1990)

In the Matter of the Compensation of
JUAN A. GARCIA, Claimant
WCB Case No. 89-08301
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of Referee Mongrain's final order that: (1) found that it had no basis to terminate claimant's temporary total disability benefits; (2) assessed penalties and attorney fees for an allegedly unreasonable termination of temporary total disability; and (3) assessed penalties and attorney fees for an allegedly unreasonable delay. We also review the interim order upon which Referee Mongrain's order was based and which necessarily became a part of that final order for purposes of review. On review, the issues are temporary total disability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Temporary total disability

The Referee concluded that, because a prior Referee (Referee Brown) had, on an interim basis, ordered SAIF to pay claimant temporary disability and claimant had not been declared medically stationary, released to regular work or returned to work, it was improper for SAIF to unilaterally terminate temporary disability benefits. We disagree.

The court recently held that an insurer that initially accepted a claim was not precluded by Bauman v. SAIF, 295 Or 788 (1983), from later denying that claim when it was discovered that the insurer did not provide coverage at the time of injury. Oak Crest Care Center v. Bond, 101 Or App 15 (1990). The court held that Bauman did not apply to invalidate a denial of a claim or bind a carrier to a previous acceptance when there was a lack of coverage. Oak Crest, supra.

In the present case, SAIF initially accepted claimant's injury claim on behalf of Melvin Ferguson, who had been found by a Proposed and Final Order to be a noncomplying employer. However, in a January 24, 1989 Opinion and Order, the Proposed and Final Order was set aside. The order found that, on the date of injury, the farm claimant was working for was being operated by individuals other than Melvin Ferguson, the alleged noncomplying employer.

It has been determined that Melvin Ferguson was not the employer on claimant's date of injury. SAIF, therefore, never provided coverage in this case. ORS 656.017; 656.054. We conclude that, because there was no coverage of claimant by SAIF, on behalf of Melvin Ferguson, SAIF was not precluded from denying a previously accepted claim once the Proposed and Final Order was finally set aside. (SAIF apparently did that when it unilaterally stopped providing claimant compensation.) Accordingly, we find that Referee Brown's June 8, 1989 Interim Order ordering reinstatement of temporary disability benefits was in error.

Because we have found that the prior order that instructed SAIF to reinstate temporary disability was not a valid order, we conclude that Referee Mongrain's order, which required continued payment of temporary disability compensation, pursuant to the earlier interim order, was also in error. (This matter is treated as the review of a single appealable order - the interim order and the final order incorporating it.)

Penalties and attorney fees for unreasonable claims processing

Because we have found that SAIF was entitled to deny the claim and terminate temporary disability benefits once the Proposed and Final Order was finally set aside, we conclude that SAIF's conduct was not unreasonable. Therefore, we reverse the Referee's award of penalties and attorney fees for alleged unreasonable processing.

Penalties and attorney fees for unreasonable delay

Assuming that SAIF's delay was unreasonable, because we have found that SAIF was entitled to terminate temporary disability benefits, there are no "amounts then due" on which to base a penalty. Ellis v. McCall Insulation, 302 Or 74 (1989); Lloyd L. Cripe, 41 Van Nata 1774 (1989). Moreover, because there was no unreasonable resistance to the payment of compensation, an attorney fee is not assessable. Ellis, supra, and Cripe, supra. Therefore, we reverse the Referee's award of penalties and attorney fees for an alleged unreasonable delay.

ORDER

The Referee's order dated September 5, 1989 is reversed and vacated. The SAIF Corporation's "de facto" denial is upheld. The Referee's attorney fee award is also reversed. The June 8, 1988 Interim Order of Referee Brown is also reversed and vacated.

In the Matter of the Compensation of
KURT KRAAL, Claimant
WCB Case No. 89-09254
ORDER ON REVIEW
David Hollander, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of those portions of Referee Harri's order that assessed a penalty-related attorney fee for an allegedly unreasonable denial. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable back injury on February 16, 1987. The claim was closed September 24, 1987 with an award of permanent disability. In January 1988, claimant experienced a period of increased disability while working in California. Claimant filed an aggravation claim, which was denied. Claimant appealed and litigation ensued.

By Opinion and Order Referee Knapp found the aggravation claim compensable. An appeal of this order was timely perfected. The aggravation claim was closed in January 1989 with an additional award of permanent disability.

During the pendency of the appeal, claimant's new treating chiropractor, Dr. Cichoke, submitted a bill to the insurer for medical services for lumbar and cervical strain. The bill was received by the insurer on March 15, 1989.

On April 4, 1989, the insurer sent Dr. Cichoke a claim processing form which indicated, "Please be advised we are not paying bills as aggravation is denied and on appeal." (Ex. 4A). A copy of the claims processing form did not go to claimant, nor did the claims processing form list appeal rights.

ULTIMATE FINDINGS OF FACT

The medical services rendered by Dr. Cichoke in March 1989 were related to the February 1987 compensable claim.

The bill submitted by Dr. Cichoke in March 1989 for medical services is a claim.

The claims processing form dated April 4, 1989 is not a denial of medical services.

CONCLUSIONS OF LAW AND OPINION

The Referee construed a claims processing form, which on its face indicated that the insurer would not pay medical bills pending appeal, as a denial of medical services. The Referee found the "denial" to be unreasonable, because it was not addressed to claimant, and it did not include appeal rights in accordance with ORS 656.262(6). Inasmuch as the aggravation claim was pending appeal, the Referee found no amounts then due on which to base a penalty. However, he did assess a penalty-related attorney fee for an unreasonable denial. We agree.

We consider first whether or not the bill received by the insurer from Dr. Cichoke was a claim. A "claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of

which a subject employer has notice or knowledge. ORS 656.005(6). Such a request does not have to take any particular form. Each separate doctor's bill submitted to an insurer is a separate and distinct claim. Billie J. Eubanks, 35 Van Natta 131 (1983). Accordingly, we find the bill submitted by Dr. Cichoke in March 1989 for medical care to be a claim for medical services.

Therefore, the insurer was required to either accept or deny the claim within 60 days of notice or knowledge of the claim. ORS 656.262(6). Claimant contends, and the Referee held, that the claims processing form sent by the insurer to Dr. Cichoke on April 4, 1989 is a denial of the claim for medical services. We disagree with this characterization.

The function of the claims processing form was to notify Dr. Cichoke that payment of the bill was stayed pending appeal. Thus, the form fulfilled the statutory duty of providing medical providers notice of nonpayment on appeal as required by ORS 656.313(3). There is no indication of intent on the part of the insurer to deny a claim or a condition. Thus, we do not find the claims processing form to be a denial of a claim. See Johnson v. Spectra Physics, 303 Or 49 (1987). Accordingly, it was not necessary to provide claimant with a copy of the claims processing form with appeal rights.

Inasmuch as we do not consider the claim processing form a denial, we find that the insurer neither accepted nor denied the claim within the statutory period. We therefore construe the insurer's silence regarding acceptance or denial as a "de facto" denial of the medical services claim.

However, even though the insurer was late in accepting or denying the medical services claim, in order to warrant an assessed penalty-related attorney fee, there must be an unreasonable resistance to the payment of compensation. See ORS 656.382(2); 656.262(10). We conclude that under these circumstances, it was not unreasonable for the insurer to fail to timely accept or deny.

The preponderance of the medical record, supported by the credible testimony of claimant, indicates that the compensable February 1987 injury, was a material contributing cause of the medical care received by claimant in March 1989 for lumbar and cervical strain. Claimant's treating physician, Dr. Cichoke stated the origins of claimant's current condition derived from the compensable February 1987 injury.

The insurer contends that payment of Dr. Cichoke's medical bills is stayed pending appeal of the compensability of the aggravation claim. We note that the aggravation denial is based both upon the theory that claimant's compensable condition did not worsen and that his current condition was not caused by the compensable injury. The insurer relies upon ORS 656.313(4):

> "Notwithstanding ORS 656.005, for the purpose of this section, 'compensation' means benefits payable pursuant to the provisions of ORS 656.204 to 656.208, 656.210 and 656.214 and does not include the payment of medical services.

In essence the insurer argues that the medical services rendered in March 1989 were materially related to the aggravation claim. Therefore, since the compensability of the claim had not yet been finally decided, payment of medical bills, including the bill from Dr. Cichoke, were stayed during the pendency of the appeal.

We disagree that ORS 656.313(4) is applicable here. This statute applies where the compensability of claimant's condition for which the medical services

are rendered has yet to be conclusively decided. Wacker Siltronic Corporation v. Satcher, 103 Or App 513 (1990). That is not the situation here. Claimant has an accepted back claim, the compensability of which is not in doubt. As such, claimant is entitled to receive such medical services as the nature of the injury or the process of recovery requires. This entitlement continues for the life of the worker. See ORS 656.245(1). As previously noted, the preponderance of the evidence at this hearing indicates claimant's medical services are related to the original claim. To conclude, we find the controlling statute here to be ORS 656.245(1), not ORS 656.313(4).

In light of the above, we find the insurers' interpretation of ORS 656.313(4), although incorrect, was not unreasonable. As such, we find the insurer had a legitimate doubt regarding its legal obligation to pay bills for medical services during the pendency of the aggravation appeal. See Norgard v. Rawlings, 30 Or App 999 (1977). However, notwithstanding the fact that the insurer's belief regarding ORS 656.313(4) was not unreasonable, it does not relieve the insurer from the responsibility of processing claims. As such the insurer was required to either accept or deny the medical services claim within 60 days. See ORS 656.262(6).

Here, the insurer received the claim from Dr. Cichoke's office on March 15, 1989. The insurer neither accepted nor denied this claim. Accordingly, we find the insurer's failure to timely accept or deny the claim to be unreasonable and subject to penalty and attorney fee in accordance with ORS 656.262(10) and ORS 656.382(1). Inasmuch as the claim in issue was for medical services on an accepted injury, as opposed to medical services from an initial claim, we find the medical services in question to be compensation. See ORS 656.005(8); 656.262(6); Clinton F. Seales, Jr., 42 Van Natta 268 (1990). As such, there has been an unreasonable resistance to the payment of compensation. ORS 656.262(10); 656.382(1); Ellis v. McCall, 308 Or 74 (1989); Lloyd L. Cripe, 42 Van Natta 1774 (1989). Accordingly, claimant is entitled to an assessed penalty related attorney fee.

ORDER

The Referee's order dated September 15, 1989, as reconsidered December 1, 1989, is affirmed.

November 23, 1990 Cite as 42 Van Natta 2636 (1990)

In the Matter of the Compensation of
PAMELA L. MCPHERSON, Claimant
WCB Case No. 88-07769
ORDER ON REVIEW (REMANDING)
Vick & Gutzler, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of those portions of Referee Galton's order which: (1) set aside its partial denial of claimant's claim for a psychological condition; (2) set aside its partial denial of claimant's claim for a fibromysitis condition, and; (3) set aside its partial denial of claimant's claim for back, upper back and right shoulder problems. In its brief, the insurer requests that we remand the case to the Referee for taking of further evidence. We remand.

FINDINGS OF FACT

Claimant filed a claim for a right shoulder injury in April 1987. On June 5, 1987, the insurer denied claimant's claim on the basis that it did not arise out of her employment.

Thereafter, claimant filed a request for hearing, protesting the denial, which became WCB Case No. 87-11606. In early March 1988, the hearing scheduled in WCB Case No. 87-11606 was taken off the docket as the parties reported that it had settled. On May 9, 1988, an earlier referee approved a Stipulation in WCB Case No. 87-11606 in which the insurer rescinded its June 5, 1987 denial. The stipulation did not address the notice of closure.

On March 10, 1988, while the claim was in denied status, the insurer issued a Notice of Closure which found claimant medically stationary as of June 1, 1987. On May 6, 1988, the insurer issued a denial which denied treatment for fibromyositis and depression on the basis that it was related to claimant's new employment.

On June 10, 1988, the insurer issued a denial which denied claimant's current back, upper back and neck conditions.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside all of the insurer's denials on the basis that they were invalid preclosure denials. We disagree.

The insurer issued its Notice of Closure on March 10, 1988. At that time, claimant's claim was in denied status as the insurer's denial of her right shoulder injury had not yet been rescinded by the May 1988 Stipulation. Although the insurer was not required to close the claim while it was in a denied status, it was not prevented from doing so when claimant was medically stationary. See Vip's Restaurant v. Krause, 89 Or App 214, 217, adhered to on recon, 91 Or App 472 (1988). Therefore, the insurer's Notice of Closure was valid and was not challenged. Accordingly, as the insurer's denials were not invalid preclosure denials, they should have been decided on the merits.

Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction or other necessary action. See ORS 656.295(5). Considering the circumstances of this case, we conclude that remand is the appropriate action.

The Referee set aside the insurer's denials on a procedural basis and, therefore, found testimony from claimant or any other witness unneccessary. Further, there is little documentary evidence in the record concerning the conditions denied by the insurer, particularly with regard to the psychological condition.

Under these circumstances, we conclude that the record has been incompletely developed. Accordingly, we remand this matter to Referee Galton for further proceedings consistent with this order in any manner tht will achieve substantial justice to all parties.

ORDER

The Referee's order dated August 16, 1988 is vacated. The matter is remanded to Referee Galton for further proceeding consistent with this order.

In the Matter of the Compensation of
TIM L. MORLOCK, Claimant
WCB Case No. 88-02454
ORDER ON REVIEW (REMANDING)
Allen T. Murphy, Jr., Claimant Attorney
Barbara A. Brainard (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Thye's order on remand declining to reinstate claimant's hearing request. On review, the issue is postponement. We reverse and remand.

FINDINGS OF FACT

Claimant requested a hearing.

The case was set for hearing.

Prior to the date set for 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. He further related that claimant did not wish to be fired and therefore would not attend the hearing. Counsel indicated that he had advised his client that failure to attend would result in dismissal of the request for hearing.

On May 18, 1988, the Referee entered an Order of Dismissal; it stated that, "The Request for hearing in this matter has been withdrawn. Accordingly, the matter is dismissed."

Claimant wrote a letter addressed to the Board seeking a new hearing date. The letter was mailed within 30 days of the Order of Dismissal.

The Board concluded that the letter, having been mailed within 30 days of the Order of Dismissal, should have been treated as a request for postponement of the hearing and reinstatement of the hearing request. The Board remanded the case to the Referee to rule on the request.

On remand, the Referee entered an order denying the request for postponement.

Claimant again requests review.

CONCLUSIONS OF LAW AND OPINION

The Referee, in denying the request for postponement, concluded that an employer's threat to discharge a worker if he attends a scheduled hearing is not extraordinary circumstances warranting a postponement under former OAR 438-06-081(2). We disagree. Consequently, we reverse, grant the postponement, reinstate the hearing request, and remand the case to the Hearings Division to reset the case for hearing.

Former OAR 438-06-081 reads as follows:

> "A scheduled hearing shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement. 'Extraordinary circumstances' shall not include:
>
> * * *
>
> (2) Unavailability of a party, witness or representative due to nonemergency medical or dental appointment, occupational, personal or professional business or appointment, vacation, or unwillingness to appear..."

The Referee interpreted the rule's provision that extraordinary circumstances do not include unavailability of a party due to occupational business or unwillingness to appear to preclude postponement of a case because a worker is threatened with discharge should he appear at hearing when scheduled to work. We disagree.

The postponement rule is strict, but it is not blind. Claimant did not indicate that he would not appear simply because the hearing conflicted with his work schedule. In that case, a postponement would appropriately be denied under the rule. Rather, claimant indicated that he would not appear because his employer had threatened to fire him if he appeared.

If a claimant's rights under the Workers' Compensation Law are to have any reality at all, an employer may not be permitted to interpose itself between a claimant and his right to hearing by threat of discharge for attendance at hearing. Where the agency is advised that a worker has been instructed that he may not attend a scheduled hearing on pain of his or her employment, a request for postponement may not be summarily denied.

In this case, there is no indication that claimant's attorney's representations were disputed. Consequently, the postponement request should have been granted.

ORDER

The Referee's order on remand dated January 3, 1990, is reversed. Claimant's hearing request is reinstated and the case remanded to the Hearings Division with directions to set the case for hearing.

November 23, 1990 Cite as 42 Van Natta 2639 (1990)

In the Matter of the Compensation of
BOBBIE J. ROBITAILLE, Claimant
WCB Case No. 88-03234
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Baker's order that: (1) approved the SAIF Corporation's method of calculating her temporary total disability rate; and (2) declined to assess a penalty and related attorney fee for SAIF's allegedly unreasonable failure to properly calculate her temporary disability benefits. On review, the issues are rate of temporary total disability, penalties and attorney fees. We reverse.

FINDINGS OF FACT

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

The tipping of employees is customary in the employer's place of business. The employer normally employed more than 10 employees on a typical business day.

The employer's failure to include tips in the computation of claimant's wages was unreasonable and amounted to a resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Disability

Claimant raises two arguments on review. Claimant first argues that her time loss rate should have been computed with the inclusion of tips in her wage base. Former OAR 436-60-020(4)(g) provides in pertinent part:

> "Use regular wages actually received, plus the amount of tips required to be reported by the employer pursuant to Section 6053 of the Internal Revenue Code of 1954, as amended, or the amount of actual tips reported by the worker, whichever amount is greater." (Emphasis supplied).

In this regard, claimant failed to report tip income to her employer, and the employer did not report tips to the IRS. Claimant nevertheless argues that, under section 6053(c) of the Internal Revenue Code, her employer was "required" to report tips at 8 percent of monthly gross sales. This provision applies to "large food or beverage establishments," which are defined as any trade or business:

> "(A) Which provides food or beverages;
> (B) With respect to which the tipping of employees serving food or beverages is customary, and
> (C) Which normally employed more than 10 employees on a typical business day during the preceding calendar year."

SAIF argues that its insured is essentially a carryout donut shop not a "large food or beverage establishment." We do not agree. The employer clearly "provides food and beverages" under subsection (A). In addition, the employer testified that there were approximately 20 employees during the period claimant was employed. Thus, subsection (C) is met. The parties focus their arguments under subsection (B), i.e. whether it is "customary" to tip in the employer's establishment. We find that tipping was "customary" at this employer. Claimant herself received tips, the amount of which she kept track of on a calendar. The employer testified that one of the other waitresses reported her tips to the IRS. In addition, claimant testified that two of the other waitresses reported tips. Moreover, the employer regularly disseminated information to the waitresses regarding the reporting of tips.

Therefore, the employer was required to report tips pursuant to section 6053(c) of the Internal Revenue Code and, consequently, the amount of these tips should be included in arriving at claimant's wage rate.

Claimant also argues that she was promoted to a 34 hour-per-week job on June 21, 1987, approximately 9 weeks prior to her compensable injury. Therefore, she argues that her wages should be based upon her average weekly wages during these 9 weeks rather than her average weekly wages for the 26 weeks preceding her injury. In this regard, although she did not regularly work 34 hours per week, she argues that she was "available" for work during that time. Citing Charles M. Poole, 40 Van Natta 41 (1988), she argues that her wage rate should be based upon her being "regularly employed" for 34 hours per week.

SAIF argues that claimant's position never changed subsequent to hiring. Rather, claimant was hired as, and remained, a part-time employee with varying shifts and hours. Therefore, SAIF argues, claimant's time loss was properly calculated based upon claimant's average weekly earnings during the 26 weeks preceding her injury. Moreover, in response to claimant's argument that she was "available" for work 34 hours per week, SAIF contends that claimant was not "expected" or "required" by the employer to be available for work 34 hours per week.

ORS 656.210 provides that "for workers ... whose remuneration is not based solely upon daily or weekly wages, the director, by rule, may prescribe methods of establishing the worker's weekly wage." Because part of claimant's remuneration is in the form of tips rather than solely daily or weekly wages, her weekly wage is determined in accordance with the director's rules. The applicable rule, as noted above, is former OAR 436-60-020. See Lowry v. Du Log, Inc., 99 Or App 459 (1989).

The Referee concluded that claimant failed to prove a change in her status to "full time" 34 hours-per-week employment in June 1987. We agree and adopt his discussion of this issue.

Penalties and Attorney

Claimant clearly received tips. Moreover, the employer could not reasonably have been unaware of such tips. Application of former OAR 436-60-020(4)(g) and section 6053 of the Internal Revenue Code require that these tips be included in the computation of claimant's temporary disability rate. SAIF failed to include such tips in claimant's wage rate. We find that this failure was unreasonable. However, because of the technical nature of the issue, involving a "first impression" interpretation of the Internal Revenue Code, as adopted by administrative rule, we conclude that less than the maximum penalty is appropriate. SAIF's unreasonable conduct also constituted a resistance to the payment of compensation. Because that resistance was unreasonable, we assess a penalty-related attorney fee.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services concerning the penalty issue is $350, to be paid by SAIF. In reaching this conclusion, we have particularly considered the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated June 29, 1988 is reversed. The claim shall be remanded to the SAIF Corporation to recalculate claimant's temporary disability compensation in accordance with this order. For services at hearing and on review regarding the temporary total disability rate issue, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased compensation awarded by this order, not exceeding $3,800, payable by SAIF directly to claimant's attorney out of that compensation. In addition, SAIF shall pay to claimant a penalty equal to 10 percent of the additional compensation due as a result of this order. For unreasonable resistance to the payment of the temporary disability compensation awarded by this order, claimant's attorney is awarded a fee of $350, payable by SAIF.

In the Matter of the Compensation of
BENNY W. SAMPLES, Claimant
WCB Case Nos. 89-22172, 89-15773, 89-15774 & 89-22171
ORDER ON REVIEW (REMANDING)
Welch, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Tenenbaum's order that declined to award an assessed attorney fee for services culminating in settlement of a dispute concerning responsibility. On review the issue is attorney fees. We vacate and remand.

FINDINGS OF FACT

The Referee adopted, and the parties agreed to the following facts:

Claimant compensably injured his low back on January 12, 1982, while employed by Enrique Sotomayer, the SAIF Corporation's insured. The claim was closed and, by a Referee's order, dated March 8, 1985, claimant was awarded 25 percent unscheduled permanent disability for his low back injury.

Claimant's low back claim was reopened for an aggravation in 1988. A Determination Order closed the claim on March 29, 1989.

Claimant returned to work for a new employer, also insured by SAIF. After he worked for approximately one month, he reported new symptoms to his treating physician, Dr. King, on June 26, 1989. Two separate denials of a new injury were issued by SAIF, dated July 11, 1989 and July 12, 1989. Both denials were under the claim number 7725424B.

On August 3, 1989, a denial was issued by SAIF under the 1982 injury claim with Enrique Sotomayer. Claimant requested a hearing on each denial. An amended denial was issued on September 12, 1989 under the 1982 injury claim number 4560155B.

A .307 order issued on October 31, 1989, designating SAIF/Enrique Sotomayer as the responsible party. On November 9, 1989, SAIF, on behalf of Enrique Sotomayer, issued a notice of acceptance. On November 30, 1989, an order terminating the .307 order issued.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's attorney was entitled to an out-of-compensation fee; however, she opined that claimant's attorney was not entitled to an assessed fee. The Referee concluded that there is no statutory basis upon which to base an assessed fee. We disagree.

Since the Referee's order issued we have issued our opinion in Daniel J. Bergmann, 42 Van Natta 949 (1990). In Bergmann, we held that if a claimant participates actively and meaningfully through an attorney in a .307 "proceeding," he may be awarded a fee pursuant to ORS 656.307(5). In Bergmann, we defined "proceeding" to include not only the evidentary hearing itself but also to include the processing of the case from its commencement until the .307 order becomes final or the case falls within the jurisdiction of another tribunal. Bergmann at 950, 951. In other words, we held that an arbitration proceeding begins when the .307 order is received.

In this case, a .307 order issued October 31, 1989, designating SAIF/Enrique Sotomayer as the responsible party. It was not until November 9, 1989 that SAIF, on behalf of Enrique Sotomayer, issued a notice of acceptance.

Accordingly, an insurer-paid attorney fee may be awarded if claimant actively and meaningfully participated in the responsibility matter after the Board received the .307 order. However, this record is insufficiently developed to make such a determination. Accordingly, we remand. ORS 656.295(5). On remand, evidence shall be taken which will allow the Referee to determine whether or not claimant should be awarded a fee in this case under ORS 656.307(5) and, if so, whether such a fee should be payable by SAIF on behalf of Enrique Sotomayer. In so doing, the Referee shall proceed in any manner which will achieve substantial justice to all parties.

ORDER

The Referee's order dated January 19, 1990 is vacated. This matter is remanded to Referee Tenenbaum for further proceedings consistent with this order.

November 23, 1990 Cite as 42 Van Natta 2643 (1990)

In the Matter of the Compensation of
RUAL E. TIGNER, Claimant
WCB Case Nos. 88-00682 & 87-14482
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

EBI Companies requests review of those portions of Referee Peterson's order which: (1) set aside its denial of claimant's occupational disease claim for a mental disorder; (2) upheld Liberty Northwest Insurance Corporation's (Liberty Northwest) denial of claimant's claim for the same condition; and (3) assessed an insurer-paid attorney fee for services at hearing. In the event Liberty Northwest is found to be responsible for claimant's psychiatric condition, EBI requests that the Board order Liberty Northwest to reimburse EBI for all claim costs to date, and Liberty Northwest cross-requests review of that portion of the order which assessed an insurer-paid attorney fee for services at hearing. In addition, Liberty Northwest contends that because the Referee's order was issued pursuant to a ".307 order," the Board reviews only for questions of law. On review, the issues are standard of review, responsibility, reimbursement and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Facts" through the fifth full paragraph on page two, and supplement with the following facts.

EBI insured the school district through June 30, 1987; Liberty Northwest insured the district thereafter. Claimant experienced work-related mental stress while both EBI and Liberty Northwest were on risk.

Claimant filed an occupational disease claim with Liberty Northwest on August 18, 1987; on behalf of the school district, Liberty Northwest denied responsibility only. A claim was submitted to EBI on October 1, 1987; EBI denied responsibility for the claim.

On November 16, 1987, the Workers' Compensation Division denied designation of a paying agent via a ".307 order" because Liberty Northwest [on behalf of another insured, Mt. Hood Community College, which was later dismissed by stipulation] contested compensability. Hearing was held on March 28, 1988. At hearing, the insurers conceded that responsibility was the only issue and requested designation of a paying agent under ORS 656.307.

Claimant first sought treatment for his mental condition from Dr. Koznek, his treating osteopathic physician, on July 10, 1987, while Liberty Northwest was on risk. Claimant first missed time from work as a result of his mental condition in September 1987, when Liberty Northwest was on risk.

Claimant's work exposure and work environment in the summer of 1987, after Liberty Northwest came on risk, were stressful and contributed to claimant's mental disability and need for medical treatment.

FINDINGS OF ULTIMATE FACT

Claimant's work activities while Liberty Northwest was on risk exposed him to potentially causal conditions. Claimant's mental condition first became disabling in August 1987, when Liberty Northwest was on risk.

No .307 order issued prior to hearing because Liberty Northwest, on behalf of another employer, no longer a party to this case, denied compensability. Claimant's entitlement to compensation was at risk at the hearing.

CONCLUSIONS OF LAW AND OPINION

Standard of Review

Liberty Northwest contends that because the Referee's order was issued pursuant to a ".307 order," we review only for questions of law. We disagree. At the time this hearing was convened, no .307 order had issued. Although compensability was conceded at hearing, we have held that the special provisions of ORS 656.307 do not apply to cases in which a ".307 order" does not issue before hearing. Ronald L. Davis, 42 Van Natta 2077 (1990).[1] Thus, ORS 656.307(2) is not applicable to this case and we review de novo.

Responsibility

The Referee found that claimant experienced some potentially causal work conditions after July 1, 1987. Nevertheless, he concluded that the major cause of claimant's psychological condition occurred during his employment prior to July 1987, that his condition was most likely caused by exposure before July 1987, and that his condition did not worsen thereafter. Therefore, he found EBI to be the responsible insurer.

On review, EBI contends that the Referee misapplied the last injurious exposure rule in this occupational disease case. We agree. The last injurious exposure rule provides that, if a worker proves that an occupational disease was caused by work conditions that existed during a period when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984).

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[1] Indeed, there is no evidence in this record that a .307 order ever issued governing this dispute. Although the Referee apparently agreed to sign something relating to a .307 order at hearing, only the Director has authority to issue such an order. ORS 656.307.

The "onset of disability" is the triggering date for determination of which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date on which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983). In order to establish that an earlier carrier is responsible, the carrier on the risk when claimant became disabled must establish that the work conditions while the prior carrier was on the risk were the sole cause or that it was impossible for work conditions during the period when the last carrier was on risk to have caused the disease. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

Here, claimant first sought medical treatment for his emotional condition from Dr. Koznek on July 10, 1987. However, claimant did not suffer disability until August 18, 1987, at which time Dr. Koznek notified the school district that claimant would not be returning to school for "medical reasons." Under such circumstances, we conclude that the onset of disability for claimant's mental stress occupational disease claim was August 18, 1987. Consequently, responsibility for the occupational disease claim rests, in the first instance, with Liberty Northwest, the carrier on the risk immediately prior to the August 18, 1987 onset of disability. Boise Cascade Corp. v. Starbuck, supra; Meyer v. SAIF, supra.

Liberty Northwest can establish that responsibility should be assigned to EBI, the prior insurer, by showing that a prior employment exposure with EBI was the sole cause of claimant's disability or that it was impossible for claimant's employment exposure while Liberty Northwest was on the risk to have caused claimant's disability. FMC Corp. v. Mutual Insurance Co., supra. Here, Dr. Johnson, treating psychiatrist, concluded that claimant's stressful work experience after July 1987 would have contributed to his psychiatric problem. Similarly, Dr. Turco, examining psychiatrist, conceded that July and August 1987 work-related events worsened claimant's emotional problem and were the type of events that could have caused an emotional disorder.

Accordingly, we conclude that Liberty Northwest has established neither that claimant's work activities while EBI was on the risk were the sole cause of claimant's mental condition, nor that it was impossible for claimant's work activities while Liberty Northwest was on the risk to have contributed to his disability. Consequently, Liberty Northwest is the responsible insurer for claimant's compensable mental condition. Id.

Reimbursement

Anticipating our reversal of the Referee's responsibility decision, EBI requests that the Board order Liberty Northwest to reimburse it for claim costs associated with claimant's mental stress condition. However, our jurisdiction is restricted to matters concerning a claim, which is defined as those matters in which "a worker's right to receive compensation, or the amount thereof, are directly at issue." ORS 656.704(3); ORS 656.726(2). Reimbursement disputes between insurers are not matters concerning a claim. EBI Companies v. Kemper Group Ins., 92 Or App 319 (1988). Reimbursement between carriers is authorized by order from the Director of the Department of Insurance and Finance, not this Board. ORS 656.307(3); Liberty Northwest Insurance Corp. v. SAIF, 99 Or App 729 (1989); Roger F. Oman, 42 Van Natta 2121 (1990).

Attorney Fees

At Hearing

The Referee awarded claimant's attorney $3,100, to be paid by EBI, for services in bringing the matter to hearing and for actively and meaningfully participating in the hearing. On review, both EBI and Liberty Northwest challenge the award of any carrier-paid fee.

The insurers first contend that claimant is not entitled to a carrier-paid fee for services at hearing because claimant's right to compensation was not at risk. We disagree.

Prior to hearing, neither EBI nor Liberty Northwest, as insurers of the school district, was contesting the compensability of claimant's occupational disease claim. However, Liberty Northwest's denial of compensability on behalf of another insured, Mt. Hood Community College, prevented the issuance of a ".307 order" and, in fact, no such order had issued by the time of hearing. Under these circumstances, claimant's right to compensation was at risk against all of the potentially responsible carriers, including those which did not contest the issue of compensability. See Margaret A. Smith, 41 Van Natta 272, 274 (1989); Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). We conclude that claimant's attorney is entitled to a carrier-paid attorney fee to be paid by the responsible carrier, Liberty Northwest, for services rendered at the hearing. ORS 656.386(1).

Second, Liberty Northwest asserts that if claimant is found to be entitled to an attorney fee, it should be paid not by Liberty Northwest, but by Mt. Hood Community College as the insured which prevented issuance of a .307 order. We note that Liberty Northwest is also the insurer for Mt. Hood. This Board previously addressed the issue of Liberty Northwest/Mt. Hood's continuing involvement in this case and held that Liberty Northwest/Mt. Hood was dismissed as a party to this proceeding pursuant to the March 29, 1988 Stipulation Order, prior to the issuance of the Referee's July 21, 1988 order. Rual E. Tigner, 40 Van Natta 1789 (1988). Inasmuch as Liberty Northwest/Mt. Hood was dismissed as a party at the commencement of the hearing, the issue of its potential responsibility for claimant's claim, at hearing or on appeal, has been resolved. It is not possible for Liberty Northwest/Mt. Hood to be found responsible for the assessed fee payable to claimant's attorney. See Zurich Insurance Co. v. Diversified Risk Management, 300 Or 47 (1985).

ORDER

The Referee's order dated July 21, 1988 is affirmed in part and reversed in part. Liberty Northwest Insurance Corporation's denial of claimant's occupation disease claim for a mental disorder is set aside. The claim is remanded to Liberty Northwest for further processing according to law. EBI Companies' denial of claimant's mental disorder claim is reinstated and upheld. The Referee's assessed attorney fee award of $3,100 for prevailing on the denial of claimant's occupational disease claim shall be paid by Liberty Northwest, not by EBI. The remainder of the order is affirmed.

In the Matter of the Compensation of
GEORGE VIOLETT, Claimant
WCB Case No. 88-18898
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

The self-insured employer requests reconsideration of our September 19, 1990 Order on Review that awarded claimant a penalty for its failure to process a claim to closure in a timely manner. On October 19, 1990, we abated our order for further consideration.

The employer contends that the Board miscalculated the penalty assessed for unreasonable claim closure. Specifically, the employer argues that the "amounts then due" upon which to base the penalty should be determined upon the "installments" required to be paid under ORS 656.230, at the time of hearing. Inasmuch as we conclude that the penalty should be based on the entire amount awarded by the Determination Order, we disagree.

A carrier has a duty to close a claim under ORS 656.268 when the claimant's condition becomes medically stationary. Penalties and attorney fees may be assessed for unreasonable delay in performing that duty. Lester v. Weyerhaeuser Co., 70 Or App 307, 311-12, rev den 298 Or 427 (1984); Georgia-Pacific Corp. v. Awmiller, 64 Or App 56, 59-60 (1983). Any permanent disability or unpaid temporary disability compensation awarded by a later Determination Order constitutes "amounts then due" for the assessment of a penalty. Brenda Hinkle, 40 Van Natta 1655, 1661 (1988); Virgil E. Moon, 42 Van Natta 1003 (1990).

In Harold A. Lester, 37 Van Natta 745 (1985), the Board in an Order on Reconsideration on remand from the Court of Appeals, assessed a 25 percent penalty against the insurer for unreasonably delaying claim closure. The Board held that the delay period was the "then" referred to in the phrase "amounts then due." Therefore, the claimant was due permanent partial disability compensation that was not timely paid because of the untimely claim closure. Accordingly, the "amounts then due" were determined to be the permanent partial disability award granted by the Determination Order issued at the time of hearing.

We therefore look first to the Determination Order itself, whose issuance prior to hearing was delayed. Claimant was awarded 52 percent for 78 degrees. The Determination Order stated, "The insurer is now ordered to pay you $9,750.00." (Ex. 30). Thus, we find the clear and unambiguous language of the Determination Order demands payment of the entire sum "now." This amount is certain and is not prospective or speculative in any way. We find this strong evidence that the entire amount came due on that date, regardless of how, in fact, payment of the award was ultimately made.

However, because claimant's permanent disability exceeded 64 degrees the employer was required to pay out the award in installments. See ORS 656.230; 656.216; former OAR 436-06-060. Therefore, we examine the applicable statutes and rule to determine if claimant's entitlement was required to be deferred. ORS 656.230 provides as follows:

> "1) Where a worker has been awarded compensation for permanent partial disability, and the award has become final by operation of law or waiver of the right to appeal its adequacy, the director may, in the director's discretion, upon the worker's application order all or any part of the remaining unpaid award to be paid to the

worker in a lump sum. Any remaining balance shall be paid pursuant to ORS 656.216.

(2) In all cases where the award for permanent partial disability does not exceed 64 degrees, the insurer or self-insured employer shall pay all of the award to the worker in a lump sum."

A companion statute, ORS 656.216(1), determines the rate and the minimal monthly payment. Finally, former OAR 436-60-060 gives detailed administrative instructions under what circumstances claimant may proceed to obtain a lump sum for awards greater than 64 degrees.

We note that the above statutes and rule do not touch upon the amount of claimant's entitlement, nor do they affect when this amount is "due." Sub-paragraph (2) mandates a lump sum for awards less than 64 degrees by its use of the word "shall." Sub-paragraph (1) allows the Director discretion to pay claimant a lump sum, or some lesser amount, upon application. The administrative rule is merely an implementation mechanism. The net result of these administrative procedures is to provide for different methods of payment for permanent disability awards. They do not establish with finality what and when payments will be made.

In reality the "how" of claimant's payment is speculative. Should a claimant's penalty be determined based upon what payments were required to be made by the time of hearing, there could be a wide divergence in application. For example it is conceivable that two claimants similarly situated could receive vastly different penalty awards. We can foresee circumstances arising where claimant "A" receives a substantial penalty because he was astute enough to obtain his lump sum upon application prior to hearing, as opposed to claimant "B" who receives a negligible penalty award because he is on the "installment" plan.

For these reasons, we decline to use what are essentially "housekeeping" statutes and rules to make our determination of what is "due" for the purpose of determining a penalty award for unreasonable claims processing. We specifically decline to structure a penalty scheme upon the inequitable device of "method of payment."

In any event, how the payment pie is sliced is ultimately irrelevant. Even should we agree with the employer, and only the installments due and owing at the time of hearing under ORS 656.230 and 656.216, are used to calculate the penalty, any installment payments made subsequent to the hearing would be equally late. In other words, once the delay has occurred, which is the "then" with regard to amounts then due, it matters not whether the permanent disability award is treated as a whole or is treated as individual installments, it's all late and penalties may be assessed accordingly.

Theoretically speaking, if paid in such an incremental fashion, claimant would be entitled to request a hearing on each and every late installment then "coming due" to seek a penalty. We decline to endorse such a redundant and time consuming procedure. Accordingly, we find claimant is entitled to a penalty based on the permanent disability award as reflected on the Determination Order, and which was delayed by the employer's failure to close the claim in a timely manner.

Following review of the employer's memorandum in support of its motion for reconsideration, we conclude that we have previously considered the remainder of its argument in our prior order.

Accordingly, our September 19, 1990 order is withdrawn. On reconsideration, as supplemented herein, we republish our September 19, 1990 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 23, 1990 Cite as 42 Van Natta 2649 (1990)

In the Matter of the Compensation of
CORA M. WATSON, Claimant
WCB Case No. 88-12997
ORDER ON REVIEW
Yturri, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Wasley's order that set aside the Director of the Department of Insurance and Finance's decision which: (1) declined to implement claimant's training plan; and (2) declined to provide reimbursement to the insurer, if the training plan was implemented. On review, the issue is whether the Referee was correct in setting aside the Director's order.[1] We reverse.

BACKGROUND

Claimant sustained a compensable injury on April 10, 1981. She has not worked since December 1981. Claimant was found eligible for vocational assistance on April 13, 1987. A training plan was developed by claimant's vocational counselor at Cooley & Associates, whereby claimant would work up to four hours per day as a receptionist. The plan was signed by claimant and the counselor on October 17, 1987, and approved by the insurer on November 5, 1987.

Instead of implementing the plan, the insurer submitted it to the Rehabilitation Review Section (RRS) for reimbursement. In December 1987, RRS refused to provide reimbursement because the plan was not in conformance with the administrative rules concerning formal training plans.

On December 22, 1987, claimant requested administrative review of the decision by RRS denying approval of the training plan. Previously, claimant had requested a hearing in March 1987. The issues at hearing were extent of permanent disability and vocational assistance. By Opinion and Order, dated February 24, 1988, the Referee granted the Director's motion to dismiss the issue of vocational assistance for lack of jurisdiction. Shortly thereafter, the Director began his review.

On July 7, 1988, the Director issued his order declining to require implementation of the training plan, and reimbursement to the insurer should the training plan be implemented. The Director's conclusion was based on the following specific findings: (1) the insurer should have implemented the training plan, per the agreement, in accordance with OAR 436-120-110 (Direct Employment Plan); (2) there were no mitigating circumstances present to allow participation in a part-time training program when the rules concerning formal training under OAR 436-120-130 required full time participation; (3) claimant was not responsive to the return to work process; (4) claimant was not motivated to participate in the on-the-job evaluation which would have allowed proper assessment of

claimant's return-to-work needs; and (5) claimant's assigned vocational counselor incorrectly determined the length of time needed to accomplish the training plan. The Director made no evidentiary record.

Claimant requested review by a Referee pursuant to ORS 656.283(1). The Referee held an evidentiary hearing, and concluded that the Director had abused his discretion. Consequently, he set aside the Director's order, and remanded to the insurer to provide vocational assistance. The insurer brings this appeal.

CONCLUSIONS OF LAW AND OPINION

The insurer contends that the Referee erred in setting aside the Director's Order and remanding for specified vocational assistance. We agree.

ORS 656.283(2) provides that the Director's decision as to vocational assistance matters may be modified only if the decision: (1) violates a statute or rule; (b) exceeds the statutory authority of the agency; (c) was made upon unlawful procedure; or (d) was characterized as an abuse of discretion or clearly unwarranted exercise of discretion. A finding of one of the circumstances listed at ORS 656.283(2)(a) through (d) is mandatory before a Director's order may be modified by a Referee. See Richard A. Colclasure, 42 Van Natta 2454 (1990).

The Referee found that the Director abused his discretion based on the following reasons: (1) the Director failed to comply with the administrative rules requiring a decision within a "reasonable time;" (2) the Director incorrectly applied the administrative rules relating to formal training programs to an informal training plan; and (3) the Director incorrectly found that claimant was not motivated to actively participate in vocational efforts.

The issue here is whether the Director abused his discretion. Abuse of discretion is defined as, "A discretion exercised to an end or purpose not justified by, and clearly against, reason and evidence." In order to determine whether or not the Director has abused his discretion, we review the record made before the Referee. In so doing, we do not decide how the evidence preponderates or even if there is substantial evidence to support the Director's order. We may only modify the Director's order pursuant to ORS 656.283(2)(d) if the hearing record "as a whole" indicates that the Director acted (found fact, reached conclusions or applied the law) ... to an end or purpose not justified by, and clearly against reason and evidence." Colclasure, supra.

We turn first to consider the contention that the Director failed to conduct his review and render a written order in a "reasonable time" in accordance with OAR 436-120-210(5). We note that the request for the Director's review was made in late December 1987 and the decision was rendered in early July 1988, approximately six months later. During this interval, the Director's order indicates, and the testimonial record confirms, that the assigned vocational counselor at RRS, Paula Klahn, was advised to delay her review on behalf of the Director until it was determined whether or not the Hearings Division had jurisdiction to consider an issue concerning vocational assistance prior to issuance of a Director's order. During this period the vocational counselor attempted to set up a conference as required by OAR 436-120-210(5). However, the insurer indicated by letter that a conference was not necessary. Immediately following the Order of Dismissal in February 1988, the vocational counselor proceeded to review the case by attempting to ascertain the best vocational approach for claimant, to include gauging claimant's motivation to participate. Based upon the record we do not find the Director's delay in issuing the order to be

clearly against reason and evidence. Consequently, we do not consider such a delay to be an abuse of discretion.

Secondly, the Referee found the Director incorrectly applied the administrative rules. The Director found that the plan arranged and approved by claimant, the insurer, and the vocational counselor at Cooley & Associates was not in conformance with the administrative rules. For this reason, RRS refused to endorse the plan or reimburse the insurer. The reasoning of RRS was based upon the fact that the plan did not meet the requirements of a formal program in accordance with OAR 436-120-130. We do not find the testimony of Paula Klahn, the vocational counselor at RRS, to be in conflict with this position. On the contrary, we find congruency between the Director's order and Klahn's testimony on this point. Nor do we find that the Director's interpretation of his own rules regarding what is or what is not a formal training plan to be either a violation of statute or rule or an abuse of discretion.

Lastly, the Referee found that the Director incorrectly found that claimant was not motivated to actively participate in vocational efforts. The Director's conclusion was based on two findings: (1) claimant was not responsive to return-to-work efforts; and (2) claimant would not participate in the on-the-job evaluation. Although the testimony of Paula Klahn did not support these findings, we also note neither did her testimony discredit those findings sufficiently for us to conclude that the Director's findings were clearly against the evidence, and thus, an abuse of discretion.

Because the evidentiary record "on a whole" supports the findings, we conclude that the Director did not abuse his discretion in making his decision.

We are unable to conclude that the Director's order falls within one of the circumstances listed in ORS 656.283(a) through (d). Accordingly, neither we nor the Referee have authority to modify the Director's order. ORS 656.283(2). As we have found that the Director's order should not be modified, it follows that the Referee erred in remanding the matter to the insurer to provide specified vocational assistance.

ORDER

The Referee's order dated October 27, 1988 is reversed. The Director's order is reinstated and affirmed in its entirety.

November 23, 1990 Cite as 42 Van Natta 2651 (1990)

In the Matter of the Compensation of
DONNA L. YANCEY, Claimant
WCB Case Nos. 89-08852 & 89-08853
ORDER ON REVIEW
Charles D. Beshears, Claimant Attorney
Cooney, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of that portion of Referee Mulder's order that awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of her left leg (knee) and 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of her right leg (knee), whereas a Determination Order awarded no scheduled permanent disability. Claimant cross-requests review of that portion of the Referee's order that affirmed a Determination Order award of 30 percent (96 degrees) unscheduled permanent disability for a low back injury. On review, the issues are extent of permanent disability, both scheduled and unscheduled. We modify in part and reverse in part.

FINDINGS OF FACT

Claimant began working in the customer service department for the United Parcel Service (UPS) in 1978. She began working for UPS as a package car driver in 1985. After approximately four months of driving, claimant began experiencing a dull aching pain in both knees. In March 1986, claimant's treating orthopedist, Dr. Weintraub, released her from work because of the bilateral knee condition. She returned to light work in June 1986. Claimant last treated for knee problems in July 1987.

In September 1987, claimant suffered a compensable low back strain while still employed as a driver. After four months of no improvement, Weintraub referred claimant to Dr. Kappes, rheumatologist. Kappes evaluated a CT scan which revealed minimal central disc bulging at L4-5 and L5-S1.

In August 1988, claimant underwent a physical capacities evaluation.

In November 1988, claimant filed an occupational disease claim for bilateral chondromalacia patella. That claim was accepted as nondisabling by a stipulated order dated January 5, 1989.

Claimant's back injury claim was closed by a Determination Order dated December 29, 1988, awarding 30 percent unscheduled permanent disability. Her bilateral knee claim was closed by a January 25, 1989 Determination Order, awarding no scheduled permanent disability. Claimant requested a hearing.

Claimant, 43 years of age at hearing, has not returned to work. She graduated from high school. She successfully performed the work of a package car driver during the ten years preceding the date of injury. The specific vocational pursuit (SVP) for that position is a 3. Claimant has no documentation demonstrating competence in any specific vocational pursuit.

Claimant is capable of performing light to medium work. She is not working for reasons related to her compensable back injury. The employer "offered" work, but the job offered was not within claimant's physical capacities.

Claimant sustained permanent ratable loss of lumbar flexion and loss of lumbar rotation. She has two minimal unoperated disc derangements. She has not sustained permanent loss of use or function of her legs (knees).

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

The Referee affirmed a Determination Order award of 30 percent unscheduled permanent disability. We modify.

Claimant's back condition became medically stationary on November 22, 1988. Her claim for that condition was closed by Determination Order on December 29, 1988. Therefore, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq.) as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

Age and Education

The appropriate value for claimant's age of 43 years is 1. Former OAR 436-35-290.

Claimant has a high school diploma. Therefore, the appropriate value for claimant's formal education is 0. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). The position which claimant successfully performed during the ten years preceding the date of injury, which has the highest specific vocational pursuit (SVP) level, was a package car driver (DOT # 906.683-022), with an SVP of 3. Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Claimant has no documentation demonstrating competence in any specific vocational pursuit. Therefore, the appropriate training value is 1. Former OAR 436-35-300(5).

Adaptability

It is undisputed that claimant is off work because of her compensable injury. There is a dispute, however, whether an "offer" of employment was made. Claimant's adaptability value is dependent upon whether an "offer" was made.

The adaptability value for a worker who is unable to return to usual and customary work and who has received a work offer which the worker's attending physician has agreed is within the worker's physical capacity is based on the difference between the physical capacity necessary to perform the usual and customary work and the physical capacity required to perform the modified job or job offered. Former OAR 436-35-310(3)(b). On the other hand, the adaptability value for a worker who is not working as a result of the injury and who has not received an offer of employment is based on the worker's residual physical capacity, without regard to claimant's physical capacity prior to the injury. Former OAR 436-35-310(4). The issue, then, is whether claimant's adaptability value is to be based on subsection (3)(b) or (4).

While subsection (3)(b) defines an "offer" as an offer of a job which the worker's attending physician has agreed is within the worker's physical capacity, subsection (4) is not as precise. Subsection (4) does not define "offer."

We interpret subsection 3(b) to mean that unless the worker's attending physician agrees that the offered position is within the worker's physical capacity, no offer has been made. Here, claimant was "offered" a job. However, the evidence establishes that claimant's attending physician did not agree that the job offered was within claimant's physical capacities. Consequently, no offer was made under former OAR 436-35-310(3)(b).

Although the term "offer" in subsection (4) is not defined, we interpret the term "offer" in subsection (4) in the same manner the term "offer" is interpreted under subsection (3)(b). Therefore, where (as here) a worker is not working because of the compensable injury, and the employer has not offered employment which the worker's attending physician has agreed is within the worker's physical capacities, no employment has been offered. Thus, claimant's adaptability value is derived from former OAR 436-35-310(4).

The undisputed evidence establishes that claimant is physically capable of performing between light and medium work. For those workers with the physical capacity to do more than the requirements of one category, but not the full range of requirements for the next higher category, the adaptability value shall be the average of the values for the two categories. Former OAR 436-35-310(4).

Accordingly, after averaging the value for medium physical capacity (1) with the value for light physical capacity (4), we conclude that the appropriate adaptability value is 2.5.

Impairment

Claimant sustained permanent loss of range of lumbar flexion and lumbar rotation. Additionally, claimant has two unoperated disc derangements. She also suffers disabling pain. Each of these impairments is ratable under the standards.

Claimant's ratable loss of range of lumbar motion include: 25 percent loss of flexion, equal to 67.5 degrees retained flexion, for a value of approximately 2.25 percent; and, 50 percent bilateral loss of rotation, equal to 15 degrees retained rotation in each direction, for a value of 3 percent for loss of left rotation and 3 percent for loss of right rotation, for a total loss of rotation of 6 percent. Former OAR 436-35-360(6) & (9). After adding claimant's loss of range of motion values, we find that claimant's total loss of range of lumbar motion is 8.25 percent.

Claimant has disc derangements at L4-5 and L5-S1. The parties do not dispute that claimant is entitled to 4 percent for each disc lesion. Consequently, claimant is entitled to 8 percent impairment for her disc derangements. Former OAR 436-35-350(2).

Claimant contends entitlement to 15 percent impairment for disabling pain and loss of repetitive use of her low back. While pain which results in permanent loss of use or function of a body part is ratable under the standards, loss of repetitive use, per se, is not ratable under the standards applicable to this case. See Daniel M. Alire, 41 Van Natta 752 (1989); former OAR 436-35-001, et seq.

After our review of the record, we find that claimant has established a loss of use or function based on disabling pain. The record establishes that claimant is permanently restricted from lifting, as that activity increases claimant's pain symptoms. Based on this evidence, we find that claimant suffers disabling pain which results in permanent loss of use or function. Former OAR 436-35-320(1)(a). Therefore, we find that claimant is entitled to 5 percent based on disabling pain.

As stated earlier, the standards do not provide for loss of repetitive use of a body part. Therefore, no impairment value is granted for the loss of repetitive use, itself.

Therefore, claimant's total impairment is based on her loss of range of motion value (8.25), her disc derangements value (8) and her disabling pain value (5). After combining claimant's multiple residuals, we find that claimant's total impairment is 19.82 percent. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent Disability

When claimant's age value 1 is added to her education value 4, the sum is 5. When that value is multiplied by claimant's adaptability value 2.5, the product is 12.5. When that value is added to claimant's impairment value 19.82, the result is 32.32 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 33 percent.

Further, we find no clear and convincing evidence that claimant is entitled to disability in excess of the 33 percent awarded under the "standards."

Extent of Scheduled Permanent Disability

The Referee awarded claimant 5 percent scheduled disability for the loss of use or function of each of claimant's knees. We reverse.

Because claimant's knee claim was closed by a January 25, 1989 Determination Order, the "standards" in effect at that time apply to a rating of claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through OAR 436-35-260 apply to a rating of scheduled permanent disability.

The insurer contends that claimant failed to prove that she suffers from a chronic condition limiting repetitive use. We agree.

Former OAR 436-35-010(7) provides that chronic conditions limiting repetitive use of a scheduled body part shall be rated at 5 percent of the affected body party. Claimant contends entitlement to 5 percent value for the loss of use or function of each knee.

To determine whether such a condition exists, we examine both the medical and lay evidence. See, e.g., Hollie J. Rahim, 42 Van Natta 415 (1990).

The medical evidence does not convince us that claimant suffers from a chronic condition. Claimant began having knee symptoms in February 1986. Her complaints after July 1987 concerned only her compensable back condition. There was no mention of knee symptoms after July 1987, until, in late 1987, claimant began treating with Dr. Kappes, M.D. While Dr. Kappes noted claimant's left knee patellofemoral crepitus, no treatment was prescribed for a bilateral knee condition, nor was there any indication of a chronic condition or restrictions on knee activity.

In October 1988, claimant was evaluated by the Orthopaedic Consultants. The Consultants did not note any knee problems, nor did claimant complain of knee symptoms.

Finally, in October 1988, Dr. Weintraub, the initial treating physician for claimant's bilateral knee condition, reported that claimant's bilateral knee condition had been medically stationary for some time. He did not note the existence of a chronic condition, any loss of use or function, or restrictions relative to claimant's knees.

The only evidence of a chronic condition limiting repetitive use of claimant's knees is claimant's testimony. While claimant testified that she is restricted from repetitive bilateral knee movements, we are not persuaded by that testimony as it is inconsistent with the overwhelming medical record. Therefore, we do not find claimant's testimony to be reliable in determining either the existence of a chronic condition or whether such a condition limits repetitive use of claimant's knees.

Consequently, given that persuasive medical evidence, we find that claimant failed to establish that she suffers from a chronic condition, let alone a condition which limits repetitive use of her knees. Therefore, claimant is not entitled to an impairment value based upon a chronic condition. Former OAR 436-35-320(4).

Furthermore, there is no other basis upon which to base a scheduled disability award. Consequently, we find that claimant is not entitled to a scheduled permanent disability award.

ORDER

The Referee's order dated September 7, 1989 is modified in part and reversed in part. In addition to the December 29, 1988 Determination Order award, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, for a total of 33 percent (105.6 degrees) unscheduled permanent disability. Claimant is awarded 25 percent of the increased unscheduled permanent disability compensation created by this order, not to exceed $3,800. That portion of the order which awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of her right knee and 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of her left knee is reversed. The January 25, 1989 Determination Order is reinstated and affirmed.

November 23, 1990 Cite as 42 Van Natta 2656 (1990)

In the Matter of the Compensation of
ROBIN M. ZEARFOSS, Claimant
WCB Case No. 89-14133
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Livesley's order that affirmed a Determination Order that awarded 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the right forearm. The issues on review are evidence and extent of permanent partial disability.

The Board affirms and adopts the order of the Referee with the following comment regarding the evidence issue. Claimant argues that it was error for the Referee to allow the self-insured employer to ask claimant questions during the hearing about the limitations she has with her left hand and arm. The Referee allowed the questions for the purpose of impeachment. Claimant argues that this was for "discovery" purposes in a separate claim and should have been excluded. The questions were arguably calculated to impeach claimant's reliability, if not her credibility. While the evidence so elicited may also have served purposes of the employer extraneous to this case, because it had some impeachment purpose, we are not persuaded that the Referee erred by allowing the questions.

ORDER

The Referee's order dated November 30, 1989 is affirmed.

In the Matter of the Compensation of
CHARLES B. FALL, Claimant
WCB Case Nos. 89-05796, 89-04015 & 88-13622
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
John M. McLeod, Attorney
David Fowler (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The noncomplying employer requests review of that portion of Referee Thye's order that dismissed its request for hearing on the issue of compensability. On review, the issue is compensability. We modify in part and affirm in part.

FINDINGS OF FACT

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

By letter dated October 3, 1988, the Compliance Division referred claimant's injury claim to the SAIF Corporation for processing. On November 22, 1988, SAIF both accepted claimant's new injury claim on behalf of the noncomplying employer and notified the employer of its acceptance. The employer filed a request for hearing on January 19, 1989, within 60 days of SAIF's letter notifying it of acceptance but more than 60 days after the claim was referred to SAIF. On June 20, 1989, the noncomplying employer issued a written denial that denied both compensability adn responsibility of claimant's injury claim.

At hearing, SAIF, on behalf of an earlier employer, raised the issue of jurisdiction. The prior employer argued that, because the noncomplying employer did not object to SAIF'S acceptance within 60 days of the time the claim had been referred to SAIF, the noncomplying employer could only deny the claim with evidence of fraud. The Referee took the matter under advisement and allowed the parties to develop the record on the issue.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the noncomplying employer did not properly deny the claim until seven months after SAIF had accepted it. He further found that the employer had not proven fraud or misrepresentation and he concluded that the employer could not defeat SAIF's acceptance of the claim. We agree that the employer cannot challenge compensability, but we base our conclusion upon the following reasoning.

Where an employer requests a hearing pursuant to ORS 656.283, it is entitled to have the question of compensability determined. Whether or not the employer properly denied the claim pursuant to ORS 656.262 is irrelevant; that is SAIF's responsibility. Clark v. Linn, 98 Or App 393, 396-397 (1989). On January 19, 1989, the employer filed a request for hearing from SAIF's November 22, 1988 letter of acceptance. Therefore, even though Clark v. Linn holds that the employer's denials have no legal effect, we retain jurisdiction over the issue of compensability of claimant's back injury. Accordingly, the employer's January 19, 1989 request for hearing is reinstated.

In the case of a noncomplying employer, once SAIF has accepted the claim and more than 60 days has passed since the claim was referred to SAIF (i.e., SAIF received notice of the claim), the noncomplying employer may not be allowed to defeat the compensability of the claim without proving fraud, misrepresentation or other illegal activities capable of affecting acceptance. Kristi L. Chase, 42 Van Natta 1247 (1990).

Here, SAIF received notice of the claim by at least October 3, 1988, the date on which it received the Division's letter requesting that it process claimant's injury claim on behalf of the noncomplying employer. The request for hearing on compensability was made in a January 19, 1989 letter from the employer to the Board. Because the employer has not proven fraud, misrepresentation or other illegal activities capable of affecting acceptance, we conclude that SAIF's acceptance of claimant's claim as compensable is binding on the noncomplying employer.

Attorney Fees

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $600, payable by SAIF on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the value of the interest secured for claimant.

ORDER

The Referee's order dated July 14, 1989 is modified in part and affirmed in part. That portion of the Referee's order that dismissed the noncomplying employer's January 19, 1989 request for hearing on the issue of compensability is modified, and the employer's request for hearing is reinstated. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $600 for services on Board review, payable by the SAIF Corporation on behalf of the noncomplying employer.

In the Matter of the Compensation of
PEGGY L. RENFROE, Claimant
WCB Case No. 89-00223
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Gruber's order that: (1) found that claimant's wrist injury claim was not prematurely closed; (2) declined to award additional temporary disability for the period from December 4, 1987 through March 21, 1988; and (3) upheld the SAIF Corporation's partial denial of claimant's right shoulder, right foot and fibrositis conditions. On review, the issues are premature closure, temporary partial disability and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

The first indication of claimant's psychological problems appeared in an August 1988 chart note by Dr. Jefferson. (See Ex. 12).

Claimant was earning $241 per week during the period from December 4, 1987 through March 21, 1988, while employed at EWEB.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Reasoning," except for the portion addressing "Entitlement to Temporary Partial Disability Benefits for the Period December 4, 1987 through March 21, 1988," with the following supplementation.

Premature Closure

Claimant had a preexisting psychological condition, for which she received treatment. However, she has not proven by a preponderance of evidence that that condition was not medically stationary at the time her claim was closed in December 1988.

Temporary Partial Disability Compensation

The parties stipulated that claimant's pre-injury wages were $315 per week.

Claimant contends that she is entitled to temporary partial disability compensation for the period from December 4, 1987 through March 21, 1988, when she worked as a receptionist for an Energy Assistance Program. She argues that she is so entitled, because she was not medically stationary and earned less in this position than she had earned before her injury.

The Referee found claimant's "hearsay" evidence insufficient to establish her post-injury earnings for the purpose of calculating temporary partial disability benefits. He concluded that claimant "does not know what she was paid" at EWEB. We disagree.

Claimant testified as follows:

"Q. Okay, And how much did you make for Energy Assistance?
A. $241 a week.
Q. And that's your gross wages?
A. Yes.
Q. How'd they figure that out?
A. I can't remember. It seems like I made $6.70 something an hour or $6.80 and [sic] hour. I'm not sure.
Q. Okay. But how do your remember the $241?
A. Because I called my old employer and asked him, and he checked the files and that's what he told me.
Q. Okay. And you made that throughout your employment there?
A. Yes.
Q. That would be from December 4 of 1987, to March 21 of 1988?
A. Yes." (Tr. 25-6)

And, on cross-examination:

"Q. You testified that you weren't sure but you thought you received $6.70 of $6.80 per hour, is that correct?
A. That's correct.
Q. And that's for 40 hours per week?
A. Yes.
Q. It's a five-day-per-week job, isn't it?
A. Yes. And I'm not certain of the hourly wage I was getting.
Q. So that's an estimate, but you're not sure?
A. I know that my wage was $241 a week because I called my employer and--
Q. And that's what somebody told you?

A. That's what my employer, who got my files and read to me from my files, told me.
Q. Well, you realize that $6.80 per hour is a lot more than $241 per week, don't you?
A. I'm not sure of my hourly wage. That's why I gave you the $241. I'm certain of that." (Tr. 36-7)

We conclude, based on a preponderance of the evidence, that claimant earned $241 per week during the period in question. In this regard, we note that SAIF has offered no contrary evidence, although it had access to the employer's information. Because claimant's earnings during the period in question were less than her stipulated wages, claimant has established entitlement to temporary partial disability. ORS 656.212; see former OAR 436-60-030.

ORDER

The Referee's order dated September 26, 1989 is reversed in part and affirmed in part. That portion of the order that declined to grant temporary partial disability compensation for the period from December 4, 1987 through March 21, 1988 is reversed. SAIF is ordered to pay claimant any additional compensation due under this order. Claimant's attorney is awarded an approved fee in the amount of 25 percent of the increased compensation awarded by this order, not to exceed $3,800, payable by SAIF directly to claimant's attorney out of that compensation. The remainder of the order is affirmed.

November 26, 1990 Cite as 42 Van Natta 2660 (1990)

In the Matter of the Compensation of
DAWN M. VON POPPENHEIM, Claimant
WCB Case Nos. 89-12353 & 89-16755
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Wallace & Klor, Defense Attorneys
Stafford Hazelett, Defense Attorney

Claimant has requested reconsideration of those portions of our October 25, 1990 Order on Review that did not award claimant an assessed attorney fee for her counsel's services on Board review. Specifically, on reconsideration, claimant requests that we authorize an assessed attorney fee of $750, payable by Liberty Northwest Insurance Corporation.

On review, we affirmed and adopted the Referee's order, which upheld Crawford & Company's compensability and responsibility denial, and set aside Liberty Northwest's compensability and responsibility denial. Thus, on review, compensability, as well as responsibility, was at issue. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review. Because Liberty Northwest initiated review and claimant's compensation was not reduced or disallowed, claimant is entitled to an assessed fee under ORS 656.382(2). See Thomas S. Williamson, 39 Van Natta 1147 (1987). Because we have concluded that Liberty Northwest, as well as Crawford, has denied compensability, and because we have found Liberty Northwest to be the ultimately responsible insurer, Liberty Northwest shall be responsible for the assessed attorney fee for claimant's counsel's services on Board review.

In so holding, we note that inasmuch as appellant did not file a brief, claimant declined to submit a respondent's brief. Rather, claimant submitted a letter requesting the Referee's order be affirmed and adopted. Notwithstanding the fact claimant did not file a brief, we find the work performed by claimant

on review, as represented in her request for reconsideration, should be compensated. Claimant has provided sufficient documentation regarding these services including a statement of services. See Shirley M. Brown, 40 Van Natta 879 (1988); Dan W. Hedrick, 38 Van Natta 208 (1986).

After further considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $750, to be paid by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to this issue as represented by claimant's request for reconsideration, statement of services, the complexity of the issue, and the value of the interest involved. On this record, we conclude that claimant's attorney is entitled to a reasonable attorney fee of $750, to be paid by Liberty Northwest.

Accordingly, our October 25, 1990 order is withdrawn. On reconsideration, as supplemented and amended herein, we republish our October 25, 1990 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 27, 1990 Cite as 42 Van Natta 2661 (1990)

In the Matter of the Compensation of
EDDIE BORREGO, Claimant
And, in the Matter of the Complying Status of
MORRIS SALTER, Employer
WCB Case Nos. 88-18220 & 88-18219
ORDER ON RECONSIDERATION
Garrett, et al., Defense Attorneys
David Ray Fowler (Saif), Defense Attorney

On November 5, 1990, we withdrew our October 5, 1990 Order on Review to allow sufficient time to consider the noncomplying employer's motion for reconsideration. The remaining parties to the proceeding were granted an opportunity to submit their respective responses within 14 days of our abatement order. Inasmuch as no further submissions have been received within the aforementioned period, we proceed with our reconsideration.

The noncomplying employer requests reconsideration of our October 5, 1990 order that vacated a Referee's order that upheld the employer's denial of claimant's back injury claim. Eddie Borrego, 42 Van Natta 2311 (1990). Reasoning that the employer's "denial" was legally invalid and without effect, we concluded that the Referee lacked jurisdiction to consider claimant's hearing request from the denial. We further concluded that because the employer had not requested a hearing concerning the SAIF Corporation's subsequent acceptance of the claim, compensability was not at issue. Finally, since the only valid hearing request was the employer's objection to the Director's noncompliance order and because the Referee had not addressed subjectivity or compliance, we remanded for further proceedings.

The employer seeks reconsideration, contending that, under the law existing at the time, a noncomplying employer was obligated to issue a denial of compensability. See Derryberry v. Dokey, 91 Or App 533 (1988). We acknowledge that the Derryberry holding supported such an approach at the time of the employer's "denial." However, the court has subsequently disavowed this principle. See Clark v. Linn, 98 Or App 393 (1989). It is unfortunate that the employer was apparently misled by the Derryberry holding. Yet, ORS 656.054 has remained unchanged. Consequently, SAIF was and remains the sole processing

agent for alleged noncomplying employers. Since these were the circumstances existing at the time of the issuance of the employer's denial, its issuance was a nullity and of no legal effect.

Notwithstanding this reasoning, upon further reflection, we wish to clarify our prior conclusion that the Referee lacked jurisdiction to address claimant's hearing request concerning the employer's denial. We, as well as the Referee, have jurisdiction over the employer's denial. However, because the denial is legally invalid, claimant's hearing request from that denial does not raise the question of compensability on the merits. See Knapp v. Weyerhaeuser, 93 Or App 670 (1988). (Request for hearing from invalid denial is not subject to ORS 656.319 filing restrictions).

The employer further contends that SAIF's notice of acceptance was defective in that it failed to inform the employer of his right to request a hearing. Because of this deficiency, the employer asserts that the time for requesting a hearing from SAIF's acceptance has never begun to run. We would agree with the employer's contention to the extent that it is arguing that, where a noncomplying employer requests a hearing pursuant to ORS 656.283, it is entitled to have the question of compensability determined. See Charles B. Fall, 42 Van Natta 2657 (1990). Yet, since the employer neither requested a hearing nor raised the defective acceptance issue at the hearing, the issue cannot be considered at this time. Instead, our decision is limited to the conclusion that there was no hearing request from SAIF's acceptance before the Referee that would invoke jurisdiction to address the issue of compensability of the claim.

In reaching this conclusion, we note that it is our obligation to raise a lack of jurisdiction on our own motion. See Southwest Forest Industries v. Anders, 299 Or 205 (1985); Davis v. Aetna Casualty Company, 102 Or App 132 (1990); Duane Fresh, 42 Van Natta 864 (1990). Therefore, regardless of how vigorously the parties litigated compensability of the claim at the hearing, the Referee was without authority to decide the issue.

Finally, the noncomplying employer argues that this case is controlled by Horgen v. Martinez, 101 Or App 396 (1990), in which the court addressed the issue of compensability where the noncomplying employer had requested a hearing on compensability before SAIF had accepted the claim. We find Horgen to be distinguishable.

In Horgen, unlike the present situation, the noncomplying employer had requested a hearing on compensability. Here, the employer's hearing request pertained solely to the Director's noncompliance order, raising the issues of subjectivity and compliance. Furthermore, in the present case, no valid hearing request by any party raised the issue of compensability. Finally, while it might have been argued in Horgen that the noncomplying employer's hearing request was premature, no party objected to the proceeding on that basis. Since such a "defect" is not jurisdictional, it would not have been inappropriate for the court to address the issue of compensability under such circumstances. See Thomas v. SAIF, 64 Or App 193 (1983); Gerald J. Holmes, 41 Van Natta 2099, 2401 (1989).

Accordingly, our October 5, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 5, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT M. BRYANT, Claimant
WCB Case No. 86-01731
ORDER ON REMAND
Scott M. McNutt, Claimant Attorney
Brian L. Pocock, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Weyerhaeuser Co. v. Bryant, 102 Or App 432 (1990). The court has concluded that our order on review, which set aside the self-insured employer's denial on the ground that it improperly denied future medical benefits, Robert M. Bryant, 41 Van Natta 324 (1989), failed to address whether the condition for which claimant seeks treatment is compensable. Consequently, the court has remanded for reconsideration of that issue. We proceed to do so.

FINDINGS OF FACT

In August 1979, claimant suffered a compensable back strain. He received chiropractic treatments until July 1980, when his claim was closed as nondisabling.

In August 1984, claimant received treatment from Dr. Mang, a chiropractor, for low back pain. Claimant returned to Dr. Mang in November 1984, and was subsequently referred to Dr. Hockey, an orthopedic surgeon. Dr. Hockey concluded that claimant had a herniated disc and should have no further chiropractic treatments.

In January 1986, Dr. Howell, an osteopath, examined claimant at the employer's request. Dr. Howell found no objective basis for claimant's complaints and concluded that the 1979 back strain had resolved.

On January 30, 1986, the employer denied claimant's chiropractic treatments, contending that the treatments were not reasonable and necessary as they related to his compensable injury. Claimant requested a hearing.

Dr. Bert, an orthopedist, examined claimant on March 31, 1986. He found some disc narrowing of the lumbosacral disc space and recommended an exercise program.

At the hearing, the parties litigated the compensability of the chiropractic treatments, as well as whether the treatments were reasonable and necessary.

CONCLUSIONS OF LAW AND OPINION

Without discussing compensability, the Referee concluded that chiropractic treatments for claimant's condition were not reasonable and necessary. On review, we adopted the Referee's findings, but held that the January 30, 1986 letter was an improper denial of future medical services and set aside the employer's denial. Robert M. Bryant, supra.

The Court of Appeals held that, regardless of the propriety of the letter, the employer was entitled to deny the compensability of the condition for which treatment was sought. Weyerhaeuser Co. v. Bryant, supra. The court reasoned that the parties tried the case by agreement with compensability in mind and that we should have decided that issue. We proceed with our reconsideration.

To establish the compensability of medical treatment for a condition, claimant must prove by a preponderance of the evidence that the compensable injury was a material contributing cause of that condition. Jordan v. SAIF, 86 Or App 29 (1987).

Evidence from four doctors was presented, three of whom testified at the hearing. Claimant relies on the opinions of Dr. Mang and Dr. Bert. Dr. Mang, the treating chiropractor, noted that x-rays taken as early as 1980 indicate a slight backward displacement of the L4 vertebra over the L5 vertebra. He concluded that this backward displacement, or retrolisthesis, was produced by the compensable injury and is a contributing factor to a major portion of claimant's back complaints.

Dr. Bert, an orthopedist, examined claimant in March 1986. He believed that claimant had a chronic disc syndrome and concluded that claimant's condition was related to the compensable injury.

The employer relies on the opinions of Dr. Howell and Dr. Fechtel. Dr. Howell examined claimant in January 1986 and October 1986. He testified that the compensable injury was not a material contributing factor of claimant's need for medical services. He based his opinion on the fact that he found no objective basis for claimant's complaints of pain or other abnormality that reasonably could be contributed to the 1979 back strain. Although he agreed that the x-rays showed a mild retrolisthesis, he did not believe that the post injury x-rays could determine whether the retrolisthesis was caused by trauma or natural processes and did not believe that it was the source of claimant's complaints.

Dr. Fechtel, a chiropractor, believed that claimant had a degenerative joint disease. He testified that the compensable injury was not a material contributing cause of claimant's condition.

When there is a dispute between medical experts, we tend to give greater weight to the conclusion of claimant's treating physician. Taylor v. SAIF, 75 Or App 583 (1985). However, despite Dr. Mang's nearly two years of chiropractic manipulations, the record suggests that only two physical examinations were performed, in February 1986 and November 1986. Since Dr. Howell had similar opportunities to evaluate claimant's condition, we consider the physicians to be on equal footing in this regard.

We also give more weight to those medical opinions that are both well-reasoned and based on complete information when medical evidence is divided. Somers v. SAIF, 77 Or App 259 (1986). After our review of the record, we find that only Dr. Howell's opinion meets both criteria. Dr. Bert's opinion was conclusory and not thoroughly explained. His opinion reflects little analysis and, in its entirety, states only:

> "I do feel that, historically, his back problem relates back to an injury in 1979 and that is the material contributing cause for his present need for medical care."

Dr. Fechtel never examined claimant. He formed his opinion only from the medical records. Considering the examining physicians' greater familiarity with claimant's condition, we do not rely on Dr. Fechtel's opinion.

Dr. Mang based his opinion on the presumption that the retrolisthesis was caused by the 1979 back strain. However, he had no basis for comparison with claimant's condition prior to 1980 and did not correlate his interpretation of the x-rays with any physical findings.

In contrast, Dr. Howell's evaluation of claimant's condition and its relationship to the compensable injury was detailed and based on a complete factual history. After two physical examinations, a detailed review of claimant's medical records, including an interpretation of his x-rays, and a review of the re

sults obtained from an MMPI test, Dr. Howell concluded that claimant "has no evidence of a physical cause for complaints and no evidence of ongoing effects from his occupational activities [for the employer]." We consider Dr. Howell's opinion to be thorough and well-reasoned. Under such circumstances, we find it persuasive. Somers v. SAIF, supra.

Consequently, we conclude on reconsideration that claimant has failed to prove by a preponderance of the evidence that the compensable injury was a material contributing cause of the condition for which he seeks medical services. Accordingly, we affirm the Referee's May 13, 1987 order that upheld the employer's denial.

IT IS SO ORDERED.

November 27, 1990 Cite as 42 Van Natta 2665 (1990)

In the Matter of the Compensation of
NORMA DOMINGUEZ, Claimant
WCB Case No. C0-00123
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Coons & Cole, Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

On September 20, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. However, upon discovering that claimant had not received a complete, written notice at the time of execution of the agreement, the Board rescinded its acknowledgment and issued a new acknowledgment of the agreement on October 24, 1990, thereby recommencing claimant's 30-day right to disapprove the agreement. Pursuant to that agreement, in consideration of the payment of $20,000 by the SAIF Corporation, claimant fully releases her right to future workers' compensation benefits, except medical services, for her compensable injury.

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

We note, parenthetically, that the claim disposition agreement purports to make its validity and enforcement contingent upon approval of a disputed claim settlement involving the same claim (page 3, lines 4-7). We have previously found an agreement with similar terms to be unreasonable as a matter of law and set it aside. Robert E. Titel, 42 Van Natta 2674 (1990). In this case, however, the disputed claim settlement has already been approved by a Referee. Therefore, the objectionable language is harmless and shall not preclude approval of this agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALLEN L. FRINK, Claimant
WCB Case No. 89-03874
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of that portion of Referee Mongrain's order that granted the insurer's request for authorization to offset an alleged overpayment of temporary disability benefits. On review, the issue is the insurer's entitlement to an offset. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the insurer was entitled to offset its overpayment against future awards of permanent disability. On review, claimant recognizes that the insurer would be entitled to an offset, if the evidence at hearing showed that he was not entitled to the benefits. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). Claimant contends, however, that there was no evidence to support the amount of overpayment claimed by the insurer. We disagree.

Claimant relies on Metro Machinery Rigging v. Tallent, 94 Or App 245 (1988), in which the court denied an insurer's request to offset an alleged overpayment of compensation against any future benefits paid. The court found that the insurer had failed to present sufficient evidence at hearing to prove the amount of the overpayment alleged, because the only proof regarding the amount of overpayment, an audit sheet, had not been introduced at hearing.

In this case, however, a copy of the insurer's audit sheet was submitted by the insurer and furnished to claimant's counsel. The sheet explains how the payments of the various awards of compensation were made and details the method of calculating the claimed overpayment. The sheet was received into evidence as Exhibit 113 and made part of the record. No evidence or testimony was submitted to contest or contradict the sheet.

Based on the copy of the audit sheet, we conclude that the insurer has established entitlement to an overpayment of temporary disability. We therefore conclude that the insurer is entitled to an offset in an amount equal to the overpaid temporary total disability benefits for the period of time between November 1986 and May 23, 1988. See Desi R. Davis, 42 Van Natta 1524 (1990) (Overpayment of temporary total disability established by uncontested cancelled checks.)

ORDER

The Referee's order dated September 14, 1989, as reconsidered October 24, 1989, is affirmed.

In the Matter of the Compensation of
MELISSA J. KING-HEITZENRATER, Claimant
WCB Case Nos. 89-05120 & 89-07835
ORDER DENYING RECONSIDERATION
Welch, et al., Claimant Attorneys
Stafford J. Hazelett, Defense Attorney
David O. Horne, Defense Attorney

Liberty Northwest has requested reconsideration of our September 28, 1990 Order on Review. Contending that it, as well as its counsel, did not receive a copy of the Board's order, Liberty Northwest seeks reconsideration and republication of our order. We deny the request.

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

The Board may republish an order if it finds that it failed to mail a copy of its prior order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988); Mary J. Gates, 42 Van Natta 1813 (1990). An attorney is not a party. ORS 656.005(19); Berliner, supra, page 266, n. 1; Frank F. Pucher, Jr., 41 Van Natta 794, 795 (1989).

Here, Liberty Northwest asserts that it, as well as its counsel, did not receive a copy of the Board's September 28, 1990 order. In support of this contention, Liberty Northwest encloses affidavits from its senior claims examiner and in-house counsel attesting to the fact that they did not receive a copy of our order until after Liberty Northwest's counsel contacted the Board on November 9, 1990 and requested one.

Such circumstances do not justify the reissuance of our order. An order is not invalidated by a counsel's failure to receive a copy of the order. Berliner, supra; Pucher, supra. Even assuming that Liberty Northwest did not receive a copy of the Board's order, that also does not invalidate the order. See Berliner, supra; Pucher, supra. Rather, to prompt the reissuance of our order as Liberty Northwest requests, it must establish that a copy of the order was not mailed to it. Berliner, supra. The record does not support such a finding.

To begin, the Board's order and file indicates that copies of the order were mailed to all parties, as well as their representatives. Specifically, the Board's file contains the original Board order which carries a notation beside both Liberty Northwest's and its counsel's names indicating that a copy of the order was mailed to Liberty Northwest and its counsel at the insurer's mailing address. Moreover, these copies have not been returned to the Board as undeliverable by the postal service. Finally, there has been no contention from the remaining parties to this proceeding which would suggest that the Board's mailing was defective. Such circumstances persuade us, at a minimum, that copies of the Board's September 28, 1990 order were mailed to all parties to the proceeding.

Based on the foregoing reasoning, we are persuaded that a copy of our September 28, 1990 order was mailed to Liberty Northwest and all other parties to the proceeding. Inasmuch as our order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties, it has become final. See ORS 656.295(8); Berliner v. Weyerhaeuser Company, supra; International Paper Co. v. Wright, supra; Fischer v. SAIF, supra. Consequently, we are without authority to reconsider our order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMOND H. LOPEZ, Claimant
WCB Case Nos. 89-13215, 89-11122 & 89-07642
ORDER ON REVIEW
Charles E. Woods, Claimant Attorney
Wallace & Klor, Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Fireman's Fund requests review of those portions of Referee Irving's order which: (1) set aside its aggravation denial of claimant's current low back symptoms; and (2) upheld AIAC's denial of claimant's claim as a new injury. On review, the sole issue is responsibility.

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

The Referee relied, in part, on Donald D. Davis, 40 Van Natta 2000 (1988) in allocating the burden of proof to AIAC, the later insurer. Since the Referee's order, we have issued Linda L. Wise, 42 Van Natta 115 (1990) in which we disavowed Davis. Therefore, we apply the Wise analysis to allocate the burden of proof.

We stated in Wise:

> "Where the second injury is not accepted, then the burden of persuasion is on either the claimant or the first employer/insurer to prove that there was a work-related injury with the second employer/insurer. Crowe v. Jeld-Wen, 77 Or App 81, 86 (1985). Once that has been done, the burden shifts to the second employer/insurer to prove that the work-related injury did not independently contribute to the disability in issue." Linda L. Wise, supra at 116.

In this case, Fireman's has the burden of persuading us that claimant suffered a work-related injury. We conclude that claimant did sustain a work-related injury on February 28, 1989 when he slipped on some grease and fell to the floor thus causing increased low back pain and causing claimant to seek additional medical treatment. Thus, the burden shifted to AIAC to prove that the work-related injury did not cause a worsening of claimant's underlying condition. Hensel Phelps v. Mirich, 81 Or App 290 (1986); Linda L. Wise, supra at 116. We agree with the Referee that AIAC has carried its burden of proof. The persuasive evidence establishes that the injury with AIAC did not independently contribute to a worsening of claimant's underlying condition. Thus, the Referee correctly assigned responsibility to Fireman's.

ORDER

The Referee's order dated December 5, 1989 is affirmed.

In the Matter of the Compensation of
DWAIN M. MCCALLUM, Claimant
WCB Case No. 89-22822
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Howell and Spear.

Claimant requests review of Referee McWilliams' order which declined to assess penalties and associated attorney fees for alleged discovery violations. In his brief, claimant requests that the Board remand the case to the Hearings Division for admission of additional evidence. On review, the issues are remand and penalties and attorney fees. We reinstate claimant's request for hearing and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Remand

The Board 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, claimant argues that, by remanding the case for the admission of the requested documents to the record, the Board will be provided with additional evidence of the SAIF's Corporation's unreasonable conduct. We do not find, however, that the record has been insufficiently developed; thus, we decline to remand to the Referee.

Penalties and Attorney Fees

The Referee correctly found that the Board discovery rule, OAR 438-07-015(2), did not apply in this case before a request for hearing was filed. However, we find that the Referee did have jurisdiction to enforce the Director's discovery rule, OAR 436-10-030(10). See Robert C. Smith, 42 Van Natta 899 (1990); Lawrence A. Durette, 42 Van Natta 413 (1990).

The above-mentioned cases, which issues subsequent to the Referee's order, provide that, under the Director's rule, discovery of medical documentation must be provided within a reasonable time. Thus, although claimant's discovery request was not enforceable under the Board rule, SAIF was required, under the Director's rule, to provide discovery materials within a reasonable time following claimant's October 2, 1989 request. Nothing was provided by SAIF and again, on November 10, 1989, claimant requested discovery. The requested material was not forwarded until November 28, 1989. We find that SAIF's unexplained delay in providing discovery was unreasonable.

However, SAIF's actions did not delay payment of compensation. Because there were no amounts "then due," there is nothing on which to base a penalty. ORS 656.262(10). Additionally, because there was no showing that SAIF unreasonably resisted payment of compensation, claimant's attorney is not entitled to an

attorney fee. See Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

Claimant's request for hearing is reinstated and the Referee's order dated December 12, 1989 is affirmed.

November 27, 1990 Cite as 42 Van Natta 2670 (1990)

In the Matter of the Compensation of
LAWRENCE E. MCINTIRE, Claimant
WCB Case No. 89-12172
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Crider, Brittingham and Myers.

The SAIF Corporation requests review of that portion of Referee Velure's order that set aside its denial of reimbursement for travel expenses incurred in connection with obtaining medical treatment. On review, the issue is medical services. We affirm.

FINDINGS OF FACT

We make the following findings pursuant to stipulation:

(1) Claimant sustained a compensable injury on July 7, 1986, within the State of Oregon, and subsequent to such date he moved to Ketchikan, Alaska.

(2) Claimant's treating physician has been Dr. Carlson, M.D., who is also located in Ketchikan, Alaska.

(3) SAIF offers no objection to Dr. Carlson's treatment of claimant and has accepted responsibility for Dr. Carlson's billings.

(4) Claimant has properly submitted requests for mileage reimbursement for his treatment with Dr. Carlson to SAIF.

(5) SAIF's response to such requests was to issue the denial letter of June 20, 1989, with the basis that SAIF is not responsible for travel reimbursement outside the State of Oregon.

(6) There is no issue as to the appropriateness of the amounts submitted.

CONCLUSIONS OF LAW AND OPINION

This dispute was presented based on the foregoing stipulation; no further evidence was offered. The Referee concluded that an injured worker is entitled to all reasonable and necessary expenses associated with treatment by his attending physician and that such expenses include the cost of transportation. He rejected SAIF's contention that travel expenses associated with out-of-state treatment are not compensable and ordered payment of claimant's travel expenses.

On review, SAIF reasserts its sweeping contention that ORS 656.245 does not create an entitlement to reimbursement of travel expenses associated with reasonable and necessary medical treatment. SAIF contends that the right to travel reimbursement is a creature of administrative rule, rather than statute;

that the administrative rules address travel expenses associated with treatment by Oregon physicians only; and therefore that no injured worker is ever entitled to travel expenses associated with out-of-state treatment. SAIF did not object to claimant's selection of treating physician. SAIF does not contend that the services rendered were not reasonable and necessary. Nor does SAIF suggest that there is anything unreasonable about the distance claimant travelled to obtain services in this case. SAIF's case rests solely on the general proposition stated above.

We reject SAIF's contention that travel expenses are not compensable medical services under ORS 656.245. Therefore, claimant's entitlement to reimbursement does not depend on whether or not travel to visit an out-of-state physician is specifically addressed by the administrative rules.

Former ORS 656.245(1) provides that

> "For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires.... Such medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and, where necessary, physical restorative services." (Emphasis supplied.)

In Francoeur v. SAIF, 17 Or App 37 (1974), the Court of Appeals held that a claimant was entitled to reimbursement of travel expenses connected with reasonable and necessary medical treatment. The court did not rely on any administrative rule in so holding.

In Stritt v. SAIF, 37 Or App 893 (1978), the court interpreted ORS 656.245 to create a right to travel expenses which are necessary in connection with a "medically prescribed course of treatment." Id., 37 Or App at 897. Again, the court made no mention in its opinion of any administrative rule.

On the basis of these cases, we conclude that travel expenses are "other related services" within the meaning of ORS 656.245(1). An injured worker is entitled to all reasonable and necessary medical services, whether or not obtained within the state of Oregon. Reynaga v. Northwest Farm Bureau, 300 Or 255 (1985). The Supreme Court, in Reynaga, held that a worker cannot be denied an entire class of medical services, which are compensable when provided in the state of Oregon, simply because the services are provided outside of the state. Therefore, we hold that a worker is entitled to travel expenses required to obtain reasonable and necessary out-of-state treatment. See Donald H. Wood, 42 Van Natta 1522 (1990).[1]

Inasmuch as SAIF has conceded that claimant's choice of attending physician is appropriate and does not contend that she could obtain like services closer to her home, we do not decide whether reimbursement of travel expense is subject to a test of reasonableness and, if so, what an insurer must do to put a worker on notice that reasonableness is in issue. See SAIF v. Holston, supra, 63 Or App at 352, n. 2, in which the court also declined to address that question where the question was not raised.

ORDER

The Referee's order, entered on or about October 13, 1989, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $600, payable by the SAIF Corporation.

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[1] We note that SAIF contends that Pyle v. SAIF, 55 Or App 965 (1982), establishes that a worker is not entitled to travel reimbursement related to out-of-state treatment. We do not share SAIF's interpretation of the case. In Pyle, the court reversed an order holding that a relocated worker was not entitled to travel expenses from his out-of-state home to his longtime Oregon physician. The court required SAIF to reimburse travel expenses from the Oregon border to the treating physician's Medford office. As the court later noted in SAIF v. Holston, 63 Or App 348, n. 2 (1983), Pyle dealt only with the right of a relocated worker to claim expenses incurred in order to continue to see an Oregon treating physician, without regard to the reasonableness of the amount of travel expense involved. The court addressed itself solely to the corollary of the right to select a treating physician within the state. Given the narrowness of the issue actually addressed in Pyle, we decline to construct a rule of decision, not articulated by the court, which would govern a problem not posed in that case--that is, the right of a worker who has relocated out of state to travel expenses incurred to obtain treatment where he lives.

In the Matter of the Compensation of
THOMAS F. SCOTT, Claimant
WCB Case No. 89-03612
ORDER ON REVIEW
Baldwin & Brischetto, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Shebley's order which: (1) set aside its denial of claimant's claim for chemically-induced dermatitis and chemical sensitivity to colophony and thiuram; (2) found that claimant's claim was not precluded by an out-of-state claim; (3) found that claimant's claim was not untimely filed; and (4) awarded claimant's attorney an assessed fee of $11,101.32. On review, the issues are jurisdiction, compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

SAIF argues that the fact that claimant has an accepted Idaho claim bars him from filing a claim in Oregon or, alternatively, that claimant did not timely file his claim in Oregon.

Timeliness of Claim

With respect to the issue of timely filing in Oregon, former ORS 656.807, in effect at the time of claimant's exposure at his Oregon employment, General Spray Service (now General Tree Service), provided, in pertinent part:

> "All occupational disease claims shall be void unless a claim is filed with the State Accident Insurance Fund or direct responsibility employer within five years after the last exposure in employment subject to the Workmen's Compensation Law and within 180 days from the date the claimant becomes disabled or is informed by a physician that he is suffering from an occupational disease whichever is later." Former ORS 656.807(1).

The Referee found that the letter claimant received from the Idaho physician on July 15, 1980, informing him that he was allergic to rubber gloves worn at his Idaho employment, was sufficient to start the 180-day period running. Then, because claimant contacted his Oregon employer in December 1980 to discuss the possibility of that employment causing the dermatitis, claimant sufficiently put the employer on notice of a claim. Thus, he found claimant's "filing" was timely. We agree that claimant timely filed his claim, but for a different reason.

During the time period referred to by the Referee, claimant was notified of an occupational disease caused by his Idaho employment. (Ex. 13). There was no link to his Oregon employment suggested at that time. When claimant did discuss with his former employer in December 1980, the possibility that his Oregon employment caused the dermatitis, the employer denied such causation. At no time during the period claimant was subsequently examined and treated at Oregon Health Sciences University was he informed that his employment with the Oregon employer was the cause of his dermatitis.

It was not until December 1, 1988, that claimant was informed by Dr. Levin, immunologist, that his exposure at the Oregon employer, General Tree Service, was the cause of his dermatitis. After receiving that information from Dr. Levin, claimant filed a claim with SAIF on January 2, 1989. We conclude that claimant did timely file his occupational disease claim against the Oregon employer.

Claim Barred by Idaho Claim

SAIF, relying on Miville v. SAIF, 76 Or App 603 (1985) and Progress Quarries v. Vaandering, 80 Or App 160 (1986), argues that claimant is barred by the accepted Idaho claim from filing a claim in Oregon. SAIF's reliance on the above-mentioned cases is misplaced.

In this case, claimant's Idaho claim was accepted as an occupational disease for "skin rash on hands," caused by exposure to iodine at his dairy job in Idaho. (Ex. 14-1,2). The claim filed in Oregon, in January 1989, was for chemically-induced dermatitis (allergy to colophony and thiuram), allegedly caused by exposure at his Oregon job. We conclude that claimant's Oregon claim is a separate claim from his Idaho claim, and is related to employment with an Oregon employer, thus placing claimant under the jurisdiction of Oregon Workers' Compensation Law.

Accordingly, we find that claimant's Oregon claim is not barred by acceptance of an Idaho claim.

Compensability

The Board adopts the Referee's "Conclusions of Law and Opinion" with respect to the issue of compensability.

Attorney Fee

The Referee awarded claimant's attorney an assessed fee of $11,101.32. SAIF argues that the amount is excessive. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing concerning this matter is $8,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case, as represented in part by depositions taken and length of hearing, the complexity of the issue of compensability of claimant's contact dermatitis, and the value to claimant of the interest involved.

Additionally, on review, after considering the factors set forth in OAR 438-15-010(4) and considering the time devoted to the case as represented by claimant's briefs, we find that a reasonable fee for claimant's counsel's services on review, concerning the jurisdictional and compensability issues, is $2,000.

ORDER

The Referee's order dated October 17, 1989 is affirmed in part and modified in part. That portion of the order which awarded an assessed attorney fee of $11,101.32 is modified. Claimant's attorney is awarded an assessed fee of $8,500 for services at hearing. The remainder of the order is affirmed. For services on Board review concerning the jurisdiction and compensability issues, claimant's attorney is awarded a reasonable assessed fee of $2,000, payable by the SAIF Corporation.

November 27, 1990 Cite as 42 Van Natta 2674 (1990)

In the Matter of the Compensation of
ROBERT E. TITEL, Claimant
WCB Case No. C0-00208
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Cournoyer & Sussman, Claimant Attorneys
Kathryn L. Wilske (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

On October 22, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $1,000 by the SAIF Corporation, claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

A disputed claim settlement (DCS) was submitted contemporaneously with the claim disposition agreement. The terms of the claim disposition agreement purport to make its validity and enforcement contingent upon approval of the DCS and Order of Dismissal involving the same claim (page 5, lines 10-14). However, OAR 438-09-030(1) (Temp.) provides that acknowledgment of a claim disposition agreement suspends all other proceedings on the claim. Thus, the processing of a DCS is suspended and it cannot be reviewed or approved while the claim disposition agreement is pending. Because the DCS cannot be reviewed or approved while the claim disposition agreement is pending and because the validity of this claim disposition agreement depends upon approval of the DCS, the terms of this agreement preclude us from determining whether it can or should be approved. We conclude that an agreement which includes such terms is unreasonable as

a matter of law. Therefore, this agreement must be set aside. ORS 656.236(1)(a), (2). Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

November 28, 1990 Cite as 42 Van Natta 2675 (1990)

In the Matter of the Compensation of
JOHN H. FRANTZ, Claimant
WCB Case No. 89-12006
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Daron's order that: (1) declined to award permanent and total disability; and (2) increased claimant's unscheduled permanent disability award for a right shoulder condition from 44 percent (140.8 degrees), as awarded by Determination Order, to 52 percent (166.4 degrees). On review, the issue is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

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

The Referee found that claimant's highest skill level from prior work experience was SVP 6. We instead find that claimant's highest SVP during the ten years prior to the date of hearing was 7 for his work as a mobile home park manager.

FINDING OF ULTIMATE FACT

Claimant has sustained a 47 percent loss of earning capacity as a result of his right shoulder injury.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Board affirms and adopts the order of the Referee in regard to this issue.

Extent of Unscheduled Disability

The Referee found that claimant was entitled to a value of 52 percent under the standards for his right shoulder injury.

Claimant was medically stationary on January 11, 1989; his claim was closed by a May 26, 1989 Determination Order. In determining the extent of claimant's permanent disability, we apply the standards for evaluating permanent disability as adopted by the Director, pursuant to former ORS 656.726(3)(f). See former ORS 656.283(7). Specifically, we apply the version of former OAR 436-35-001 et seq, in effect at the time of the May 26, 1989 Determination Order.

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

Age

The appropriate value for claimant's age of 66 is 1. Former OAR 436-35-290(4).

Formal Education

The appropriate value for claimant's high school education is 0. Former OAR 436-35-300(3)(b).

Skills

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

Training

Former OAR 436-35-300(5) states:

> "Training: (a) For workers who do not have competence in some specific vocational pursuit, a value of plus one shall be allowed.
>
> "(b) For workers who do have competence in some specific vocational pursuit, no value shall be allowed."

The "standards" do not define the term "specific vocational pursuit." Because we conclude that former OAR 436-35-300(5) was intended to differentiate between those who have and those who have not acquired formal or on-the-job training sufficient to perform something other than entry level employment, we interpret "specific vocational pursuit" to mean employment other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

In this case, claimant has a certificate in small engine repair. Claimant is, therefore, entitled to no value for training.

Adaptability

When, as here, a worker has returned to modified work, the adaptability factor is based on the table found at former OAR 436-35-310(3). Claimant did landscaping and repair work at his job at injury, which we conclude was medium level work. Claimant's treating physician stated that claimant could no longer do the maintenance work at his job. Claimant's modified job is still in the landscaping business. Since he is capable and does lift 30 pounds to waist level, we find that claimant's job is now in the light category. Claimant is, therefore, entitled to a value of 2 for adaptability.

Impairment

The range of motion and strength testing performed closest in time to the hearing was performed by the Western Medical Consultants. We rely on those measurements in determining claimant's impairment rating.

We conclude that claimant is entitled to the following values for lost range of motion. For 80 degrees of abduction claimant is assigned a value of 4 percent. Former OAR 436-35-330(5). For 15 degrees of adduction claimant is assigned a value of 1 percent. Former OAR 436-35-330(7). For 15 degrees of external rotation claimant is assigned a value of 7.5 percent. Former OAR 436-35-330(11). For 60 degrees of forward elevation claimant is assigned a value of 5 percent. Former OAR 436-35-330(1). Adding these values produces a sum of 17.5 percent.

Former OAR 436-35-330(19) allows up to 48 percent impairment where, as here, loss of strength of the shoulder is a result of physical damage to the shoulder rather than the spine. When Dr. Schachner operated on claimant's shoulder, the rotator cuff was torn and peeled back so far that Schachner could not repair it. The Western Medical Consultants noted that claimant has little use of his shoulder. In light of these facts, we conclude that a value of 30 percent for loss of strength is appropriate.

These values are combined for a total impairment value of 42.5 percent for loss of strength and lost range of motion.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 1, the sum is 2. When that value is multiplied by claimant's adaptability value, 2, the product is 4. When that value is added to claimant's impairment value of 42.5, the result is 46.5 percent unscheduled permanent disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the "standards" is, therefore, 47 percent.

SAIF does not seek reduction of claimant's award under the disability standards. Therefore, the award will not be altered. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated November 3, 1989 is affirmed.

November 28, 1990 Cite as 42 Van Natta 2677 (1990)

In the Matter of the Compensation of
LAWRENCE D. KRUSE, Claimant
WCB Case No. 88-12603
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Jim Dodge (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Higashi's order that awarded claimant permanent and total disability, whereas a Determination Order

did not award additional permanent disability beyond the 20 percent (64 degrees) claimant had previously received for a left shoulder injury. On review, the issue is extent of permanent disability, including permanent and total disability. We reverse and modify.

FINDINGS OF FACT

On August 21, 1984, claimant compensably injured his left shoulder and cervical and thoracic spine while employed for SAIF's insured.

Claimant has several preexisting conditions which include thoracolumbar scoliosis that was not worsened by his compensable left shoulder and thoracic injury. In addition claimant has preexisting cervical spondylosis, and Perthe's disease in the left hip, which he had as a child and which resulted in deterioration of the head of the left femur. In 1976, claimant was involved in a nonwork-related automobile accident where he lost the tip of his right thumb and fractured his pelvis near the right hip. In 1981 claimant had a bilateral total hip joint replacement. Claimant was found medically stationary following this accident on May 9, 1984. Claimant was able to walk well, and he had good range of motion; however, he experienced some persistent upper back problems and numbness in his thumb. Claimant was able to return to his usual and customary work.

Following his compensable 1984 injury, claimant was treated conservatively by Dr. Bert. In December 1984, claimant had good range of shoulder motion, good grip strength, a slight reduction in shoulder abduction and muscle spasm in the shoulder or upper back. Claimant was considered able to perform light work involving maximum lifting of 20 pounds and no frequent lifting over ten pounds.

A Determination Order issued March 6, 1985 awarding claimant 15 percent unscheduled permanent partial disability for his left shoulder injury. Claimant appealed that Determination Order and on June 6, 1986, Referee Howell issued an order increasing claimant's unscheduled permanent partial disability award to 20 percent for his left shoulder injury.

Claimant sought treatment from Dr. Bert for low back discomfort and hip pain on February 4, 1987. On April 6, 1987, SAIF denied treatment for claimant's low back and hip conditions as not being related to his compensable injury. On November 4, 1987, SAIF rescinded its denial by stipulated order. The parties stipulated that a denial of a low back and hip condition was premature, and that SAIF did not accept these conditions.

Claimant continued to receive conservative treatment from Dr. Bert for his low back and hip discomfort.

On December 15, 1987, SAIF denied an aggravation claim, stating that claimant's current need for treatment for his cervical and thoracic spine was not the result of his compensable injury. On April 29, 1988, Referee Foster issued an opinion and order, setting aside SAIF's denial. In particular, Referee Foster concluded that the injury contributed to a symptomatic increase in claimant's thoracolumbar scoliosis and that claimant's scoliosis pain was only exacerbated temporarily and had resolved.

Dr. Bert found claimant's condition to be medically stationary on October 9, 1987. Dr. Bert recommended that claimant not do construction work but limit himself to light work. Claimant had full range of motion of his neck with pain at the extremes of flexion, extension and side bending. No motor, sensory or circulatory impairment was detected in claimant's arms, his grip strength in both hands was good, and there was no atrophy. Dr. Bert released claimant to return to work in regards to his neck.

A Determination Order issued June 30, 1988, awarding claimant temporary disability benefits only.

Claimant is 44 years old. He has an associate degree in Automotive Mechanics. He worked for five years as a journeyman auto mechanic. His other past employment includes, working as a pole and piling scaler, and working in unskilled positions as a construction laborer. Claimant is unable to return to his prior occupations due to his compensable injury.

As a result of his compensable injury, claimant is limited to light and sedentary work. Claimant has the skills to perform such occupations as small parts assembler. In addition, claimant is capable of performing sedentary occupations such as motel desk clerk, gate tender, parking lot cashier and alarm monitor.

Claimant is currently not employed and has not looked for part-time jobs. Claimant has made two employment inquiries during the last year.

FINDINGS OF ULTIMATE FACT

Claimant is not permanently incapacitated from regularly performing work at a gainful and suitable employment due to a combination of medical and nonmedical factors.

Claimant did not make reasonable efforts to find work and a work search would not have been futile as a result of his compensable injury.

Claimant has a 20 percent loss of earning capacity as a result of his compensable neck injury.

CONCLUSIONS OF LAW AND OPINION

Permanent and Total Disability

The Referee found that claimant was permanently and totally disabled. The Referee concluded that claimant was permanently and totally incapacitated from regularly performing work at a gainful and suitable occupation. Furthermore, based upon the opinion of claimant's treating physician, Dr. Bert, the Referee found that claimant had established that it would be futile for him to look for work. We do not agree that claimant is entitled to permanent total disability.

To establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful and suitable occupation. 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 remain capable of performing work of some kind, but still 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).

First, we determine whether claimant has established through medical evidence that he is physically incapacitated from performing gainful and suitable employment. We find that claimant has failed to meet his burden. In reaching our conclusion we consider any permanent impairment which resulted from his compensable August 1984 injury to his left shoulder, neck and upper back. Additionally, any preexisting disability must be considered. ORS 656.206(1)(a). However, any post-injury progression of claimant's preexisting conditions are

not considered if the worsening is not related to the compensable injury. Emmons v. SAIF, 34 Or App 603, 605 (1978).

A significant portion of claimant's disability is due to his preexisiting thoracolumbar scoliosis. We find this condition was not disabling prior to his compensable injury. Moreover, the medical evidence establishes that claimant's preexisting scoliosis is a naturally progressive disease and was not permanently worsened, either pathologically or symptomatically, by claimant's compensable injury. Accordingly, we do not consider claimant's scoliosis condition in determining whether he is precluded from gainful and suitable employment.

The Referee, in awarding permanent and total disability, relied upon the opinion of claimant's treating physician, Dr. Bert. We disagree. Dr. Bert stated that claimant was permanently and totally disabled. However, in reaching his conclusion, Dr. Bert stated that there are a number of factors keeping him from working on a regular basis. These factors, Dr. Bert stated, included severe scoliosis, which would continue to be progressive in causing deterioration of claimant's spine. As Dr. Bert based his opinion of permanent and total disability on claimant's noncompensable scoliosis condition, we find his opinion is not persuasive.

We find that the evidence establishes that claimant is not permanently and totally incapacitated from performing suitable and gainful employment as a result of his compensable injury. In reaching our conclusion we rely on the well reasoned and complete opinion of the Western Medical Consultants. After examining claimant, the Consultants opined that, based upon claimant's compensable injury and its residuals, he was capable of pursuing employment on a regular basis.

Accordingly, we find that claimant has not established that he is physically incapable of regularly performing work at a gainful and suitable employment.

Next, we determine whether claimant has established an entitlement to permanent and total disability through the odd-lot doctrine.

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Welch, supra, 70 Or App at 701; Livesay v. SAIF, 55 Or App 390, 394 (1981). Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206(3); SAIF v. Orr, 101 Or App 612, (1990); SAIF v. Simpson, 88 Or App 638, 641 (1987); Welch, supra. However, even if a work search would be futile, a claimant must establish that, but for the compensable injury, he would have been willing to seek regular gainful employment. SAIF v. Stephen, 303 Or 41 (1989).

In this case, we find that the evidence neither establishes that it would be futile for claimant to seek employment nor that claimant has made reasonable seek work efforts. Only Dr. Bert found that claimant was physically incapable of performing regular and gainful employment. However, as stated above, we find the opinion of Dr. Bert not persuasive. Rather we rely on the opinion of the Western Medical Consultants that found claimant was capable of performing work in the light category. In addition, Dr. Kho, neurologist, who performed an independent medical examination, opined that claimant was capable of performing light work with a limit of lifting 20 pounds and restricted twisting or bending at the waist. Moreover, we find that claimant has the transferable skills and

education which will allow him to perform light to sedentary work. Therefore, we find that a work search in this case would not have been futile. Accordingly, claimant is not excused from the seek work requirement. Considering claimant's transferable skills and physical capabilities, we do not consider two employment inquiries over the last year to constitute a reasonable attempt to find work. In light of these facts, we find that claimant has not established permanent total disability status under the "odd lot" doctrine.

In sum, claimant has not shown that he is foreclosed from gainful employment due to his physical incapacity or under the "odd lot" doctrine. Therefore, we hold that claimant is not permanently and totally disabled.

Extent of Permanent Partial Disability

In rating the extent of claimant's permanent disability, we consider his permanent impairment attributable to 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).

The Western Medical Consultants concluded that claimant has a minimal permanent cervical impairment as a result of his compensable August 1984 injury.

On de novo review, after considering claimant's permanent minimal impairment in light of his age of 44, his associate degree and past work experience in automotive mechanics, and his transferable skills qualifying him to perform occupations within his light and sedentary physical limitations, such as small parts assembler, we conclude that claimant has sustained an additional 20 percent loss of earning capacity as a result of his cervical injury.

ORDER

The Referee's order dated April 24, 1989 is reversed. In lieu of the Referee's award of permanent total disability and in addition to claimant's award of 20 percent (64 degrees) unscheduled permanent disability for his left shoulder injury, claimant is awarded 20 percent (64 degrees) unscheduled permanent disability for his cervical injury, giving him a total award of 40 percent (128 degrees) unscheduled permanent disability for his left shoulder and cervical injuries. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. However, the SAIF Corporation is permitted to credit any attorney fee paid pursuant to the Referee's award against the attorney fee awarded herein.

November 28, 1990 Cite as 42 Van Natta 2681 (1990)

In the Matter of the Compensation of
RICHARD C. MOSMAN, Claimant
WCB Case No. 89-10057
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Myzak's order that upheld the SAIF Corporation's denial of reimbursement for travel expenses incurred in connection with obtaining medical treatment out of the state of Oregon. On review the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the following facts as stipulated to by the parties.

Claimant has an accepted aggravation claim and is currently residing out of the state of Oregon.

SAIF has not objected to claimant's choice of his out-of-state treating physician. By letter dated May 19, 1989, SAIF denied claimant's request for reimbursement for mileage to obtain medical treatment from his out-of-state physician.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not entitled to reimbursement for his transportation expenses associated with his treatment from an out-of-state medical provider. The Referee, reasoned that OAR 436-60-050 was the substantive entitlement rule regarding payment of medical services and choice of attending physician, and insofar as this rule did not provide for transportation reimbursement for travel to an out-of-state medical service provider, claimant was not entitled to reimbursement for such expenses. We disagree.

On review, SAIF argues that out-of-state mileage is not reimbursable under ORS 656.245(1). SAIF asserts that "other related medical service" as defined by ORS 656.245(1) do not include travel expenses, that OAR 436-60-050(5) (which does not authorize reimbursement for out-of-state travel) is controlling in this case, and that claimant is not entitled to travel expenses under OAR 436-60-070 as that rule gives no substantive rights and provides for procedures only. Therefore, SAIF asserts, that transportation costs are only reimbursable when claimant is receiving medical treatment from a treating physician within the state.

In Lawrence C. McIntire, 42 Van Natta 2670 (1990), we concluded that travel expenses are "other related services" within the meaning of ORS 656.245(1). We further held that a worker is entitled to travel expenses required to obtain reasonable and necessary out-of-state treatment. See Donald H. Wood, 42 Van Natta 1522 (1990).

Based on our reasoning in McIntire, supra, we reverse the Referee's order.[1]

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the reimbursement of travel expenses is $1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's brief, his statement of services, and the length of hearing), the complexity of the issues and the value of the interest involved.

ORDER

The Referee's order dated September 19, 1989 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for further processing in accordance with the law. For services at hearing and on review regarding the reimbursement of travel expenses, claimant's attorney is awarded an assessed fee of $1,500, payable by SAIF.

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1. We need not determine whether travel expenses, as distinct from the underlying treatment, must be reasonable and necessary. ORS 656.245(1). SAIF does not contend that the services rendered were not reasonable and necessary. Nor does SAIF suggest that there is anything unreasonable about the distance claimant traveled to obtain services in this case.

In the Matter of the Compensation of
TROY L. CRAPSER, Claimant
WCB Case No. 89-17254
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of Referee Mills' order that awarded 18 percent (4.32 degrees) scheduled permanent disability for loss of use or function of the left index finger and 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of the left foot, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the first two paragraphs and the first two sentences of paragraph three of the Referee's Findings of Fact on page 1. We make the following additional findings of fact.

Dr. Rabie, M.D., who treated the finger, released claimant to regular work on July 18, 1988. Dr. Manley, who treated the foot, released claimant to return to work on September 6, 1988.

FINDING OF ULTIMATE FACT

Claimant has not sustained any measurable loss of the use or function of his left index finger or his left foot.

CONCLUSIONS OF LAW AND OPINION

Based on his finding that claimant's testimony was credible, the Referee awarded scheduled permanent partial disability for loss of the use and function of claimant's left index finger and his left foot. The Referee discounted Dr. Manley's opinion that claimant had no permanent impairment, reasoning that Manley would not have documented the kind of left foot impairment that the Referee observed claimant to have, and that Manley had not treated claimant's finger.

The insurer argues that there is no medical evidence of permanent impairment. We agree.

Under the standards applicable to this case, former OAR 436-35-001 et seq, amended effective January 1, 1989, where the claimant fails to establish any measurable impairment resulting from his or her compensable injury/condition, no award of disability is allowed. Former OAR 436-35-010(2)(b) and OAR 436-35-280(1).

An impairment is the decrease in the function of a body part as measured by a physician. Former OAR 436-35-005(1). Neither Dr. Manley nor Dr. Rabie measured any decrease in the function of claimant's finger or foot. Claimant's testimony, even if credible, is insufficient to establish impairment under the standards. Claimant has therefore failed to establish measurable impairment resulting from his compensable injury. See Linda F. Wright, 42 Van Natta 2570 (1990). Accordingly, we find that claimant has failed to establish entitlement to an award of permanent disability under the standards.

ORDER

The Referee's order dated January 3, 1990 is reversed. The Determination Order is affirmed in its entirety.

In the Matter of the Compensation of
SHAWN M. HUKARI, Claimant
WCB Case No. 89-08125
ORDER ON REVIEW
Allen, Stortz, et al., Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Gruber's order which set aside its denial of claimant's stress-related Crohn's disease flare-up. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Excluding his discussion regarding "a series of traumatic events" on page two, fifth paragraph, we adopt the Referee's "Findings of Fact" with the following supplementation.

On October 14, 1988, a formal complaint was made against claimant who, it was alleged, made "improper racial remarks" to two hispanic Oregon Department of Transportation employees on October 4, 1988. (Ex. 3B). Between October 14, 1988 and January 5, 1989, the Department proceeded to investigate the incident. On January 5, 1989, a formal reprimand was made and placed in claimant's personnel file. (Ex. 3B).

Claimant filed an "801" Form on January 31, 1989, claiming a "flareup" of her preexisting Crohn's condition at "noon" on October 17, 1988. (Ex. 3). The employer "deferred" the claim as a disabling "injury" on February 16, 1989. (Ex. 3).

Claimant's treating physician, Dr. Melnyk, Director of Gastroenterology, Oregon Health Sciences University, reported on February 14, 1989 that claimant had a "recurrence of the Crohn's disease." (Ex. 3c). On March 13, 1989, Western Medical Consultants report that claimant "had a recurrence of Crohn's disease." (Ex. 8).

A psychological evaluation was made by Western Medical on March 13, 1989. (Ex. 9). Claimant told Dr. Friedman, psychiatrist, that she had a "recurrence" of her Crohn's disease symptoms beginning in October 1988 as the result of stress experienced on the job. (Ex. 9-1).

Claimant, at hearing, did not argue that her condition was compensable as an occupational disease. Claimant stated, "The issue is compensability of this aggravation of Crohn's disease." (Tr. 2).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's condition is compensable as an occupational disease under ORS 656.802(1). We agree that claimant's condition is compensable but as an "injury" rather than as an occupational disease.

An injury is distinguished from an occupational disease both by the fact that the former is said to be unexpected, and the fact that where an occupational disease is gradual in onset, an injury is "sudden in onset." James v. SAIF, 290 Or 242, 248 (1981); Clark v. Erdman Meat Packing, 88 Or App 1 (1987); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975).

In determining whether claimant's condition was "unexpected," we consider the likelihood that the condition would result from the kind, rate and duration of activity or exposure related to her employment as a survey technician. See O'Neal v. Sisters of Providence, supra at 17.

In determining whether claimant's condition was "sudden in onset," we consider whether the condition occurred as a result of a "discrete period" of work activity or exposure. Valtinson v. SAIF, 56 Or App 184, 188 (1982). If the condition resulted from a sufficiently discrete period of work activity, an industrial injury rather than an occupational disease is indicated. In this regard, the Court of Appeals has characterized a condition as an "injury" where the initial onset of symptoms occurred within a discrete period of time and continued to gradually worsen over a period of several weeks. Donald Drake Co. v. Lundmark, 63 Or App 261 (1983). Similarly, the Board has found a compensable "injury" where claimant's back condition, caused primarily by an off-the-job accident, remained relatively constant until it was worsened suddenly by two days of work activity. Carol A. Fisher, 40 Van Natta 458 (1988), reconsidered 42 Van Natta 921 (1990).

Here, claimant's condition had been asymptomatic for three years while she worked for SAIF's insured until the investigation. Two or three days after she was notified that there was an investigation of her October 14, 1988 conduct, claimant's Crohn's disease symptoms recurred. In January 1989, after she was told a reprimand had been placed in her personnel file, claimant became severely ill with Crohn's disease symptoms. The employer's investigation, a work-related activity, was not a regular part of claimant's occupational activity. Consequently, we conclude that the onset of claimant's Crohn's disease symptoms attributable to the stressful investigation was unexpected, thereby supporting analysis of the claim as an injury.

Additionally, although her condition worsened progressively during the investigation, the initial onset of her symptoms -- abdominal pain and bloating -- began two or three days after she was informed of the investigation. Claimant took time off from work "to get away from it all, to let things settle down." (Tr. 23). She was disturbed enough about the incident that she considered turning in a letter of resignation. (Tr. 23). When claimant was told of the reprimand in her file, her condition worsened markedly -- she developed a fever, was in extreme pain, had inordinately frequent bowel movements, and quickly lost ten pounds. (Tr. 30-36). A lower GI series showed severe Crohn's disease of the distal small intestine; claimant was placed on prednisone. (Ex. 8). Under these circumstances, we conclude that the "flare-up" of claimant's Crohn's disease, just as the claimant's back condition in Donald Drake Co. v. Lundmark, supra, took place within a discrete period of work activity, was "sudden in onset" and should be categorized as an injury.

Because claimant's Crohn's disease preexisted the injury, claimant must show that her current condition resulted from an event or series of events within a discrete time period which are a material contributing cause of her disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254 (1983); Carol A. Fisher, supra. Claimant need not show a pathological exacerbation of her underlying condition in order to prevail on an industrial injury theory. Harris v. Albertson's, Inc., supra.

Western Medical Consultants' report indicates that stress does not cause Crohn's disease, but Crohn's disease "can be aggravated by the work environment. People with Crohn's disease can have an exacerbation of their Crohn's disease related to stress...." (Ex. 8). There is no medical evidence to the contrary. Although a possibility is not sufficient to prove causation, the report indicates that claimant's increased stress due to the investigation and subsequent reprimand, in fact, did cause her to be more symptomatic. Furthermore, Dr. Friedman, noting that claimant's Crohn's disease flare-up coincided chronologically with the filing of the complaint against her and the subsequent investigation, reported that it did not appear that there had been any nonwork-related stress occurring in claimant's life during this same time period.

Accordingly, we conclude that claimant's condition is compensable as an industrial injury.

ORDER

The Referee's order dated October 6, 1989 is affirmed.

November 29, 1990 Cite as 42 Van Natta 2686 (1990)

In the Matter of the Compensation of
ROBERTA A. KILE, Claimant
WCB Case Nos. 87-14041 & 87-14042
ORDER ON REVIEW
Cynthia Cumfer, Claimant Attorney
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

EBI Companies ("EBI") requests review of those portions of Referee Smith's order which: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) awarded claimant's counsel a $500 attorney fee in association with a penalty for late payment of interim compensation. Claimant cross-requests review of those portions of the order which: (1) set aside EBI's aggravation and responsibility denial of her low back condition; (2) upheld CNA Insurance Companies ("CNA") denial of her "new injury" claim for the same condition; (3) awarded her counsel a $5,000 assessed attorney fee for prevailing against EBI's aggravation denial; (4) did not award claimant interim compensation, payable from EBI, from June 24, 1988 through July 2, 1988; (5) assessed penalties for late payment of interim compensation and for a late denial against EBI based on late-paid interim compensation rather than based on "amounts then due and owing to claimant;" (6) did not award interim compensation, payable by CNA; (7) declined to assess a penalty against CNA for an allegedly untimely denial; and (8) declined to assess a penalty or related attorney fee against CNA for an allegedly unreasonably failure to timely pay interim compensation. On review, the issues are compensability, responsibility, interim compensation, attorney fees and penalties and attorney fee. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

In June 1983, claimant sustained a compensable low back injury while working for EBI's insured. She was treated for this injury by Dr. Erde, M.D. Her claim was last closed by an October 1986 Stipulation which awarded her 12.5 percent unscheduled permanent disability. She was medically stationary as of August 30, 1985.

Claimant continued to experience low back and left leg pain following claim closure. In September 1985, she began working for Horizon Recovery, CNA's insured, as a drug and alcohol counselor. She continued to experience low back pain, but attempted to use biofeedback and self-hypnosis to deal with the pain rather than seeking medical treatment.

On May 16, 1987, claimant was refereeing a volleyball game at work when she was knocked down by a large patient. The patient stepped on her left hand and bruised it. She sought treatment at the emergency room and a wrist contusion was diagnosed. On or about May 25, 1987, claimant twisted to pick up her backpack while at work, heard a "pop" in her back, and experienced immediate low back pain. The pain increased over the following two weeks and on June 9, 1987 she sought treatment from Dr. Erde. Dr. Erde released claimant from work due to severe low back pain.

On June 24, 1987, Dr. Erde provided EBI with an 827 form indicating that claimant had sustained a worsening and was released from work. EBI received this report on July 2, 1987.

In late July 1987, Horizon Recovery went out of business. On August 20, 1987, claimant's counsel sent certified letters to Horizon Recovery and the Director of the Department of Insurance and Finance in order to serve notice of a new injury claim. At that time, claimant's counsel did not know who had insured Horizon Recovery. On November 30, 1987, EBI denied claimant's aggravation claim on the basis that her accepted condition had not materially worsened. In September 1987, claimant filed a request for hearing concerning EBI's denial.

In early December 1987, claimant's counsel was contacted by a representative of CNA who indicated that they had insured Horizon Recovery. On December 9, 1987, claimant's counsel filed a claim with CNA for the low back condition. CNA began paying interim compensation within 14 days of receipt of this letter. On January 8, 1988, CNA's attorney denied all allegations in claimant's request for hearing, including the new claim against CNA. CNA did not formally deny claimant's claim.

EBI received medical verification of claimant's inability to work due to its accepted injury on July 2, 1987. It paid the first installment of interim compensation on July 29, 1987 for the period from July 2, 1987 through July 28, 1987. EBI continued to pay interim compensation on a timely basis through the date of its November 30, 1987 denial. At hearing, EBI conceded that its payment of interim compensation was underpaid by $120.

FINDINGS OF ULTIMATE FACT

In June 1987, claimant experienced a symptomatic worsening of her compensable low back condition. As a result of this symptomatic worsening, claimant was totally disabled for more than 14 days.

The May 1987 incident did not independently contribute to a worsening of claimant's underlying low back condition.

CNA's failure to accept or deny claimant's "new injury" claim was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability

In compensability/responsibility cases, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163 (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).

Aggravation-EBI's insured

The Referee found that claimant had sustained a compensable aggravation. We agree.

In an unscheduled disability case, a claimant is entitled to have her claim reopened under ORS 656.273 when, as a result of either a pathological worsening or a symptomatic worsening of her compensable condition, she is less able to work than at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). In those cases which the last arrangement of unscheduled permanent partial disability anticipated future exacerbations, accompanied by diminished earning capacity, the claimant must also prove that her earning capacity was diminished longer or in greater degree than was anticipated or that her exacerbation resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, 41 Van Natta 2272 (1989).

Claimant's last arrangement of compensation was the October 1986 Stipulation which awarded her 12.5 percent unscheduled permanent disability. At that time claimant was working as a drug and alcohol counselor for CNA's insured. Although she experienced low back pain, she was able to perform her job duties.

Dr. Erde released claimant from work in early June 1987 due to increased symptoms in her low back. Erde diagnosed a soft tissue injury. Dr. Erde's release from work was corroborated by Dr. Hard, a consulting chiropractor, who reported in June 1987 that claimant was totally disabled due to an acute low back condition.

The Orthopaedic Consultants examined claimant in October 1987 and reported that claimant had no objective findings to support her subjective complaints and opined that claimant's change in symptoms was due to psychological factors.

After review of the evidence, we are persuaded that claimant suffered an increase in symptoms resulting in a diminishment of her earning capacity. Prior to June 1987, claimant was able to perform her work as a drug and alcohol counselor. As a result of the June 1987 symptomatic increase, claimant was totally disabled from performing this job in excess of 14 days. As the treating physician who has followed claimant since the 1983 compensable injury, we are persuaded by Dr. Erde's opinion, as supported by Dr. Hard. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Accordingly, claimant has established a compensable aggravation.

New Injury-CNA's insured

The Referee concluded that claimant had sustained a compensable injury while employed by CNA's insured. In doing so, he relied on claimant's testimony regarding the May 16, 1987 incident. We agree.

On or about May 16, 1987, claimant injured her wrist when she was knocked down on her buttocks and her wrist was stepped on by a patient. Approximately 9 days later, she bent over to pick up her backpack, felt a "pop" in her back and experienced immediate low back pain. This pain increased until she finally sought treatment from Dr. Erde on June 9, 1987.

Dr. Erde, although noting that claimant had not felt immediate low back pain on May 16, 1987, opined that the fall caused claimant's symptoms to increase. She reported that claimant's wrist injury was significant and that

claimant had focused on her wrist pain rather than her chronic back condition. She further opined that the "popping" on May 25, 1987 may have been created by two bone surfaces rubbing against each other indicating a spasm in the joints and already a back problem.

The only contrary medical evidence is from Dr. Logan who opined that it would be unusual for someone to experience low back pain a week after the incident.

We are persuaded by Dr. Erde's explanation. As noted above, Dr. Erde has a greater knowledge of claimant's condition due to her protracted treatment and Erde's explanation is consistent with claimant's testimony. By contrast, Dr. Logan saw claimant once and makes a general conclusion without explanation. Accordingly, claimant has established a compensable injury as to CNA's insured.

Responsibility

The Referee found that the May 16, 1987 incident caused a symptomatic worsening of claimant's accepted low back condition. We have herein concluded that claimant's low back condition was only symptomatically worsened by the May 16, 1987 injury. Accordingly, responsibility for claimant's low back condition remains with EBI. See Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986).

Interim Compensation

EBI

The Referee declined to grant claimant interim compensation between June 24, 1987 and July 2, 1987. We agree.

Entitlement to interim compensation depends on whether, before the denial of an aggravation claim, there was a medical verification of a claimant's inability to work due to the worsened condition. ORS 656.273(6); Berkey v. Fairview Hospital, 94 Or App 28, 31 (1988). If the employer has notice or knowledge of verification, payment of interim compensation must begin within 14 days. ORS 656.273(6).

Although Dr. Erde's report is dated June 24, 1987, it was not received by EBI until July 2, 1987. Accordingly, EBI's obligation to pay interim compensation did not begin until 14 days after July 2, 1987. Therefore, claimant was not entitled to interim compensation prior to July 2, 1987.

CNA

Claimant contends that she is entitled to interim compensation payable from CNA as of August 20, 1987. We agree.

ORS 656.265(3) provides that notice of an accident:

> ". . . shall be given to the employer by mail, addressed to the employer at the last-known place of business of the employer, or by personal delivery to the employer or to a foreman or other supervisor of the employer. If for any reason it is not possible to so notify the employer, notice may be given to the director and referred to the insurer or self-insured employer."

Here, claimant attempted to notify CNA's insured of the injury claim, but was unsuccessful due to the fact that it was no longer in business. Thereafter, on August 20, 1987, claimant's counsel wrote the Director providing notice of the injury pursuant to ORS 656.265(3). Under these circumstances, we find that claimant's letter to the Director satisfied that statutory requirement for notice set out in ORS 656.265(3). Therefore, pursuant to that provision, the insurer is deemed to have notice as of August 20, 1987. Accordingly, we conclude that claimant is entitled to interim compensation, payable by CNA, from August 20, 1987.

In reaching this conclusion, we are aware that CNA did not receive actual notice of the claim until December 9, 1987. However, the statutory scheme was intended to insure processing of a claim made by an injured worker. See Nix v. SAIF, 80 Or App 656, 660 (1986).

Penalties and Attorney Fees

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonable 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 denial. Brown v. Argonaut Insurance Company, 93 Or Ap 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985).

EBI

The Referee assessed a 25 percent penalty, payable by EBI, for delay in payment of interim compensation. He based that penalty on $120 which represented a miscalculation of the rate of interim compensation and which was due at the time of hearing. We agree.

Claimant contends that the penalty should also be based first upon interim compensation due between June 24, 1987 and July 2, 1987 and second upon amounts of temporary total disability benefits resulting from the Referee's decision to set aside EBI's aggravation denial.

We have herein found that EBI was not obligated to pay interim compensation between June 24, 1987 and July 2, 1987. Accordingly, we cannot assess a penalty based on interim compensation between those dates.

With regard to claimant's second basis, "amounts then due" in the context of an untimely denial refers to compensation owing at the time of the denial. See Weyerhaeuser Co. v. Knapp, 100 Or App 615 (1990); Wacker Siltronic Corporation v. Satcher, 91 Or App 654 (1988). Accordingly, the only amount due at the time of EBI's denial was the $120 resulting from EBI's miscalculation of interim compensation. Therefore, the Referee correctly based the penalty on this amount.

CNA

The Referee declined to assess a penalty, payable by CNA, for an allegedly untimely denial. Although he found CNA's action unreasonable and awarded a $500 penalty-related attorney fee, he found that there were no amounts owing by CNA on which to base a penalty. We agree with and adopt the Referee's reasoning with regard to CNA's untimely denial and the attorney fee award. Further, we have herein found that claimant was entitled to interim compensation, payable by CNA from August 20, 1987. Accordingly, there are amounts payable by CNA on which to base a penalty and we find it appropriate to do so in this instance.

Therefore, claimant is awarded a 25 percent penalty on the amount of interim compensation created by this order, payable by CNA.

Claimant also contends that CNA should be assessed a penalty and related attorney fee for an allegedly unreasonable failure to pay interim compensation from August 20, 1987. We disagree.

Although we have found that CNA received statutory notice of the claim pursuant to ORS 656.265(3), it did not receive actual notice until December 9, 1987, at which time it began paying interim compensation. Further, the employer did not receive any actual notice of the claim, due to the fact it had gone out of business. Under these circumstances, we do not find that CNA's failure to pay interim compensation from August 20, 1987 was unreasonable. Accordingly, penalties and attorney fees are not warranted.

Attorney Fees

The Referee awarded claimant's counsel a $500 attorney fee, payable by EBI, in conjunction with the $120 miscalculation of interim compensation. We modify.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services concerning the penalty for miscalculation of the rate of interim compensation is $100. In reaching this conclusion, we have particularly considered the fact that EBI conceded the miscalculation and the relatively minimal amount involved. We further note that the Referee concluded that a $100 attorney fee was appropriate in the opinion section of his order, but awarded a $500 fee in the order section.

Claimant also contends that she is entitled to a greater fee for prevailing against EBI's denial of her aggravation claim. We find that the Referee's award of a $5,000 attorney fee for this issue to be appropriate and adopt his reasoning as set forth in the "Order" section of his order in regard to this issue.

Finally, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning EBI's request for review regarding the aggravation issue is $1,000, to be paid by EBI. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated April 27, 1988, as amended May 3, 1988, is reversed in part, modified in part and affirmed in part. That portion which declined to grant claimant interim compensation payable by CNA is reversed. Claimant is awarded interim compensation, payable by CNA, from August 20, 1987. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. That portion which declined to award a penalty against CNA for an untimely denial is reversed. Claimant is awarded a penalty equal to 25 percent of all compensation payable by CNA as a result of this order. That portion which awarded claimant's counsel a $500 assessed attorney fee, payable by EBI for unreasonable calculation of interim compensation benefits is modified. In lieu of the Referee's award, claimant's counsel is awarded an assessed attorney fee of $100, payable by EBI for unreasonable

calculation of interim compensation benefits. The remainder of the order is affirmed. For services on review concerning EBI's request for review regarding the aggravation issue, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by EBI.

November 29, 1990 Cite as 42 Van Natta 2692 (1990)

In the Matter of the Compensation of
RONALD M. LYDAY, Claimant
WCB Case No. 88-04125
ORDER ON REVIEW
Mark R. Malco, Claimant Attorney
Miller, Nash, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of those portions of Referee Quillinan's order that: (1) set aside its denial of claimant's occupational disease claim for a mental disorder; and (2) awarded claimant's attorney a fee of $18,168 and the insurer's former attorney a fee of $13,227.50. In his brief, claimant seeks dismissal, arguing that the Board lacks jurisdiction due to an untimely appeal. On review, the issues are jurisdiction, compensability and attorney fees. We deny claimant's motion and, on the merits, reverse in part and affirm in part.

We deny claimant's motion to dismiss. In so doing, we adhere to the reasoning set forth in our September 7, 1989 Order of Dismissal (Remanding), which upheld the Referee's authority to abate her order. Accordingly, the insurer's request for Board review was timely filed and we have jurisdiction to consider the merits of this case.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the last sentence, which we replace as follows.

Sunnetta Smith was Unit Owner Association Manager and one of claimant's supervisors. She was also claimant's confidant, until their relationship deteriorated markedly after claimant was required to hire Smith's boyfriend as a maintenance worker. Claimant resigned soon thereafter.

CONCLUSIONS OF LAW AND OPINION

Compensability

The date of "injury" for purposes of determining the compensability of an occupational disease is the date upon which the claimant was last exposed to the employment conditions that potentially caused the disease. Johnson v. SAIF, 78 Or App 143, 146-48, rev den 301 Or 240 (1986). Here, claimant's occupational disease claim for his current psychological condition alleges exposure to potentially causal employment conditions occurring after January 1, 1988. His last such work exposure occurred just before his resignation on March 31, 1988. He filed this claim after January 1, 1988, on January 18, 1988. We therefore apply ORS 656.802 as amended effective January 1, 1988 (See Oregon Laws 1987, Chapter 713, Section 4) and before its amendment on July 1, 1990 (See Oregon Laws 1990, (Special Session) Chapter 2, section 43). Ellen L. Crawford, 41 Van Natta 1257 (1989).

Claimant alleges that he suffered work-related stress resulting in a compensable mental condition under former ORS 656.802(1)(b). To prevail, he must prove that he has a mental disorder diagnosis generally recognized in the medical or psychological community, and that the employment conditions which were the cause of his mental disorder existed in "a real and objective sense." Former ORS 656.802(1)(b) and 656.802(2)(a) & (c). Moreover, he must prove by clear and convincing evidence that his condition arose out of and in the course of his employment. Former ORS 656.802(2)(d). To establish that his condition arose out of and in the course of his employment, claimant must prove that his work exposure was a material cause of his condition. Ronald V. Dickson, 42 Van Natta 1102 (1990); Deborah Anderson, 42 Van Natta 514 (1990); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Ellen L. Crawford, supra.

Due to claimant's longstanding preexisting psychological problems, resolution of the causation issue is a complex medical question, requiring reliance on expert medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publisher's Paper Co., 76 Or App 105, 109 (1985). In this case, Drs. Kauffman, M.D., and Davies, clinical psychologist, offer potentially reliable opinions. The threshold question is whether stress at work was a material cause of claimant's Character Disorder with Antisocial, Explosive and Paranoid Features, with underlying Borderline Personality Organization. (See Ex. 27-12). We conclude that it was not.

The Referee did not make an expressly demeanor-based credibility finding. In the absence of such a finding, we are in as good a position as the Referee to evaluate claimant's credibility based on objective evidence. International Paper Co. v. McElroy, 101 Or App 61 (1990); Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Dr. Kauffman, treating physicain, stated that he had no reason to doubt the possibility that claimant's current psychological problems stem from work stress. However, Kauffman admitted that the accuracy of his conclusions about the existence and causation of any stress problems claimant had in January 1988 is entirely dependent upon claimant's veracity in reporting. (Ex. 26A-19-20). In this regard, we note Davies' opinion that claimant is not a reliable historian. In reaching this conclusion, Davies detailed significant omissions from claimant's reporting, which he discovered upon reviewing the documented medical history. (Ex. 27-9). Neither Kauffman nor Maislen, social worker, reviewed claimant's records before forming their opinions.

Claimant's medical records reflect five (and reference eight) psychiatric hospitalizations including an involuntary commitment in 1981. (Ex. 27-6). Claimant's behavioral problems are documented since childhood. Because claimant did not tell Davies (or Kauffman or Maislen) about his longstanding problems, Davies concluded that claimant's reporting was not reliable. In addition, Davies opined that claimant misperceives reality. (Tr. 19, 24). Based on Davies' qualified, well-informed and well-reasoned opinion, we are unwilling to find that claimant's reporting is accurate. Consequently, we do not rely on it either.

Kauffman was claimant's treating physician for his numerous physical complaints. Regarding claimant's psychological complaints, Kauffman reported "fatigue due to stress," on April 28, 1986 (Ex. 21) and "stress" on November 3, 1987. His chart notes do not reflect causation until January 19, 1988, when he reported: "Claimant comes in complaining of stress due to his job and wishes to generate an industrial claim form for same. Has symptoms of acute anxiety manifested by feeling flushed, hot all the time, nervousness, epigastric stomach upset and frequent sweating." (Ex. 23). In an April 13, 1988 letter, Kauffman stated: "[C]laimant indicated that most of his stress in his life stemmed from his employment. . . and I have no reason to question this possibility." (Ex.

26). Claimant did not discuss particular work stressors with Kauffman. Kauffman referred claimant to Marilyn Maislen, social worker, for counseling and stress management.

We are not persuaded by Kauffman's opinion, for several reasons. First, he did not treat claimant before this employment. He is, therefore, unable to make first-hand observations regarding the nature of claimant's condition before this job. Kauffman did not review any prior medical records, nor did he elicit any history from claimant beyond his then-current complaints. (Ex. 26A-7-8). Consequently, he was not in a position to offer expert analysis comparing claimant's alleged job stress to other potential stressors. Furthermore, even if Kauffman's opinion was otherwise persuasive, he framed his conclusion as a "possiblity." (Ex. 26). A mere possiblity of a causal relationship is not sufficient to carry claimant's burden. See Gormley v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). This is particularly true where, as here, claimant's burden is proof by clear and convincing evidence. See e.g., Riley Hill General Contractor, Inc., v. Tandy Corp. 303 Or 390 (1987).

Finally, as noted above, Kauffman did not know that claimant had a pre-existing psychological condition, which had been previously diagnosed as manic depression and treated with Lithium for several years. For these reasons, we find that Kauffman's opinion was necessarily based on an incomplete and inaccurate history. We do not rely on his opinion. See Somers v. SAIF, 77 Or App 259, 262 (1986).

We do not rely on Maislen's opinion regarding causation, for the same reasons that we do not rely on Kauffman's opinion. In particular, we note that Maislen consulted no sources other than claimant in forming her hypotheses.

Davies, on the other hand, reviewed claimant's documented history, evaluated claimant's reporting and analyzed the purported stressors individually. He concluded, unequivocally, that he "found no evidence of any acute symptomatology that could be attributed to work related stress." (Ex. 27-12). We are persuaded by Davies' thorough well-reasoned opinion.

Claimant has not established that his current complaints are materially related to his work. Therefore, on this record, he has not sustained his burden of establishing, by clear and convincing evidence, that his current psychological problems arose out of his work. His claim is not compensable.

Attorney Fees

Because claimant did not finally prevail at the hearing regarding the insurer's denial, his attorney is entitled to no fee. ORS 656.386.

In determining an appropriate fee for the insurer's previous attorney's services at hearing, we consider those factors set out in OAR 438-15-010(4). Those factors are: "(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 proceeding; (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."

The hearing in this matter took place over much of three days and part of a fourth. In addition, depositions were taken. Both counsel submitted lengthy, well-reasoned written arguments following the hearing. The insurer's former attorney also filed a motion for reconsideration raising, inter alia, a legitimate question as to which version of ORS 656.802 should have been applied. The

insurer's former attorney devoted well over 100 hours to this case -- almost the same as the time spent by claimant's attorney.

This case was unusually complex, in that it required presentation of evidence and argument concerning whether and how ORS 656.802, as amended January 1, 1988, applied. No court opinions have yet addressed that law and few orders by this Board had considered it at the time of hearing.

This matter involves claimant's occupational disease claim. At the time of hearing, claimant asserted entitlement to medical services and disability due to his claimed disease. Had the claim been ultimately found compensable, claimant would have been potentially entitled to all benefits provided for occupational diseases under ORS Chapter 656.

Both counsel are skilled and each demonstrated that skill during these proceedings. The hearing was strongly adversarial and strenuously and competently litigated by both attorneys. The insurer's former attorney presented a defense to claimant's claim which resulted in the insurer prevailing.

Defense counsel bore little or no risk of his efforts going uncompensated. Finally, there is no allegation regarding the assertion of frivolous defenses and we are aware of none.

Considering the above factors, we find that the fee approved by the Referee was appropriate.

ORDER

The Referee's order dated April 20, 1989 is reversed in part and affirmed in part. That portion of the order which set aside the insurer's denial of claimant's occupational disease claim and awarded an assessed fee of $18,168 is reversed. The insurer's March 10, 1988 denial is reinstated and upheld. The remainder of the Referee's order is affirmed.

November 29, 1990 Cite as 42 Van Natta 2695 (1990)

In the Matter of the Compensation of
LAYTON N. MOORE, Claimant
WCB Case No. 89-25085
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Gruber's order that found that the SAIF Corporation had properly included claimant's income from the Oregon National Guard for purposes of calculating temporary disability payments. The employer cross-requests review concerning the compensability of claimant's claim. On review, the issues are temporary disability payments and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Payments

We affirm and adopt the order of the Referee on the issue of temporary disability payments.

Compensability

Claimant filed a request for hearing on the temporary disability payments issue. Although it appears that the employer wrote to the SAIF Corporation raising the issue of compensability, this issue was not before the Referee at hearing.

The employer, pro se, filed a timely cross-request for review on the issue of compensability. The Board will consider only those issues raised by the parties at hearing. Mavis v. SAIF, 45 Or App 1059 (1980); Elsie L. Hobkirk, 40 Van Natta 778 (1988). Because compensability was not in issue at hearing, it is not appropriately before the Board on review.

ORDER

The Referee's order dated February 12, 1990 is affirmed.

November 29, 1990 Cite as 42 Van Natta 2696 (1990)

In the Matter of the Compensation of
PAMELA R. PHILLIPS, Claimant
WCB Case No. 89-11224
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Irving's order that increased claimant's unscheduled permanent disability award for a low back condition from 14 percent (44.8 degrees), as awarded by a Determination Order, to 15 percent (48 degrees). The issue on review is extent of permanent disability. We modify.

FINDINGS OF FACT

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

Thirty-four-year-old claimant was working as a nurse's aide/assistant when she was compensably injured in October 1987. She injured her back, right arm, shoulder and leg attempting to catch a falling patient. Her duties as a nurse's aide entailed medium-heavy work. Claimant was declared medically stationary in December 1988 and was released to limited light duty work.

In June 1989, claimant had an unsuccessful (due to her disability) work attempt as a "wood packer and grader." Her job duties were in the "light" work category. Claimant also worked part-time as a housekeeper for four hours per week which she quit because of the low wages. The job description is characteristic of positions classified at the "light" exertional level. Claimant also worked for one month as a waitress in a tavern, which she quit because it involved working around alcohol and she is a recovering alcoholic. She was having some physical discomfort when lifting such items as beer pitchers. Claimant's duties as a waitress involved no lifting in excess of 10 pounds and accordingly this position was also "light" work.

Claimant was awarded an unscheduled permanent disability award of 14 percent in a May 1989 Determination Order.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion and Conclusions" except as modified below.

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See former ORS 656.283(7). Specifically, the Referee applied the version of OAR 436-35-001 et seq, in effect at the time of the January 25, 1989 Determination Order. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. These are the rules we apply as well in our de novo review of the hearing record.

The sole contested issue on review is what adaptability rating is appropriate when a claimant returns to modified work and then voluntarily quits such work for reasons unrelated to her injury.

The Referee concluded that claimant's situation was covered under subsection (3) of former OAR 436-35-310 because she had returned to modified work. We concur. However, we disagree with the Referee's finding regarding the physical capacity necessary to perform the modified jobs.

Here, claimant had returned to modified work; however, she was not working at the time of hearing. Her former employer had no "light" duty jobs available and she had quit one "light" duty job due to her disability and left two other jobs primarily for reasons unrelated to her injury-related impairment. Under the circumstances where a claimant returns to modified work and later voluntarily quits for reasons unrelated to the compensable injury, the proper adaptability standard is former OAR 436-35-310(3). See Barbara L. Partridge, 42 Van Natta 1193 (1990).

Applying the matrix in subsection (3) of former OAR 436-35-310, the Referee found that the waitress and housekeeper jobs were medium-light work and that the usual and customary work as a nurse's aide required a physical capacity of medium-heavy. She accordingly assigned an adaptability value of 1.5. We disagree. The descriptions of both the waitress and housekeeper jobs performed by claimant place them in the "light" physical capacity range. Thus, the adaptability value is 2.

Since the remainder of the "standards" factors were not contested or improperly analyzed, we proceed to the calculation.

Computation of Unscheduled Disability

When claimant's age value, 0, is added to her education value, 4, the sum is 4. When that value is multiplied by claimant's adaptability value, 2, the product is 8. When that value is added to claimant's impairment value, 8.5, the result is 16.5 percent unscheduled permanent partial disability. That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 17 percent.

ORDER

The Referee's order dated September 29, 1989, as amended October 12, 1989, is modified. In lieu of the Referee's award and in addition to the 14 percent (44.8 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, giving her a total award to date of 17 percent (54.4 degrees) unscheduled permanent disability for her low backcondition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

In the Matter of the Compensation of
AUDREY RUDD, Claimant
WCB Case No. 89-07280
ORDER ON RECONSIDERATION
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

The self-insured employer requests reconsideration of those portions of our October 9, 1990 Order on Review by motion of clarification. It its motion the employer asks that: (1) we clarify the "amounts then due" upon which the 15 percent penalty is assessed; and (2) reduce the carrier paid penalty-related attorney fee. On October 29, 1990, we abated our order for further consideration.

The employer contends that the "amounts then due" upon which to base the penalty should be determined upon the "installments" required to be paid as provided by ORS 656.216 and 656.230, at the time of hearing. Inasmuch as we conclude that the penalty should be based on the entire amount awarded by the Determination Order, we disagree.

A carrier has a duty to close a claim under ORS 656.268 when the claimant's condition becomes medically stationary. Penalties and attorney fees may be assessed for unreasonable delay in performing that duty. Lester v. Weyerhaeuser Co., 70 Or App 307, 311-12, rev den 298 Or 427 (1984); Georgia-Pacific Corp. v. Awmiller, 64 Or App 56, 59-60 (1983). Any permanent disability or unpaid temporary disability compensation awarded by a later Determination Order constitutes "amounts then due" for the assessment of a penalty. Brenda Hinkle, 40 Van Natta 1655, 1661 (1988); Virgil E. Moon, 42 Van Natta 1003 (1990).

In Harold A. Lester, 37 Van Natta 745 (1985), the Board in an Order on Reconsideration on remand from the Court of Appeals, assessed a 25 percent penalty against the insurer for unreasonably delaying claim closure. The Board held that the delay period was the "then" referred to in the phrase "amounts then due." Therefore, the claimant was due permanent partial disability compensation that was not timely paid because of the untimely claim closure. Accordingly, the "amounts then due" were determined to be the permanent partial disability award granted by the Determination Order issued at the time of hearing.

In George Violett, 42 Van Natta 2647 (1990), we had occasion to address a similar issue. In that case we decided that the permanent disability awarded by the Determination Order constituted the "amounts then due" upon which to base the penalty. In Violett, the Board considered the language of the Determination Order to be controlling. The Board noted that ORS 656.230; 656.216; and former OAR 436-06-060 concerned the method of payment of permanent disability awards. Claimant's entitlement to permanent disability, including when the disability award became due, was not affected by the above cited statutes and administrative rule. Therefore, the fact that claimant's disability award was being paid out in installments was not relevant to the collateral issue of penalties. Violett, supra.

We therefore look first to the Determination Order itself, whose issuance prior to hearing was delayed. Claimant was awarded 29 percent for 92.80 degrees. The Determination Order stated, "The insurer is now ordered to pay you $9,280.00." (Ex. 29). Thus, we find the clear and unambiguous language of the Determination Order demands payment of the entire sum "now." This amount is certain and is not prospective or speculative, and thus, came due upon issuance of the Determination Order.

Because claimant's permanent disability exceeded 64 degrees, the employer was required to pay out the award in installments in accordance with ORS 656.230; 656.216; and former OAR 436-06-060. However, as noted above, the method of payment is not relevant to the assessment of penalties for an untimely claim closure. Accordingly, we find claimant is entitled to a penalty based on the permanent disability award as reflected on the Determination Order, and

which was delayed by the employer's failure to close the claim in a timely manner. Because the entire amount of the permanent disability award of $9,280 was delayed, this sum constitutes the "amounts then due" for assessment of claimant's 15 percent penalty.

The employer also contends that inasmuch as the Board reduced the penalty awarded by the Referee from 25 percent to 15 percent, the penalty related attorney fee should be reduced as well. We note that the employer did not raise or argue the issue of claimant's entitlement to an assessed penalty related attorney fee for its unreasonableness under ORS 656.262(10), until after the Board's October 9, 1990 order. We decline to entertain issues raised in the first instance on reconsideration. See James D. Tate, 42 Van Natta 112 (1990).

Accordingly, our October 9, 1990 order is withdrawn. On reconsideration, as supplemented herein, we republish our October 9, 1990 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 29, 1990 Cite as 42 Van Natta 2699 (1990)

In the Matter of the Compensation of
JAY A. SCHECK, Claimant
WCB Case No. 89-07699
ORDER OF ABATEMENT
Roberts, et al., Defense Attorneys

The insurer requests reconsideration of those portions of our October 31, 1990, Order on Review (Remanding) by motion of reconsideration/clarification. It its motion, the insurer asks that we instruct the Referee on remand to allow the employer to make its "full" case, including access to the claimant for testimony.

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 this matter under advisement.

IT IS SO ORDERED.

November 29, 1990 Cite as 42 Van Natta 2699 (1990)

In the Matter of the Compensation of
THOMAS E. STEFFL, Claimant
WCB Case No. 87-16434
ORDER ON REVIEW
Allen T. Murphy, Jr, Claimant Attorney
Richard C. Pearce, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of Referee Irving's order that: (1) set aside its denial of claimant's medical services claim for his bilateral forearm condition; (2) assessed a penalty for an allegedly unreasonable denial; and (3) awarded claimant's attorney a $1,200 assessed fee. On review the issues are compensability, penalties and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

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

Claimant suffered a compensable left wrist injury in November 1976. Claimant's initial condition was a left wrist injury which caused loss of motion. He also suffered paresthesias and tingling in the left hand which orthopedic surgeon Backhuber, then claimant's treating physician, related to an ulnar nerve problem. The insurer initially accepted only the wrist and not the hand symptoms. In 1978, Dr. Keist diagnosed left median and ulnar nerve problems creating paresthesias and pain extending from elbow to wrist and related them to the compensable injury. In an October 1978 stipulation, the insurer accepted claimant's current condition (as of 1978).

Subsequent overuse of claimant's right hand, compensating for left hand limitations, caused compensable right median nerve compression. A May 1980 stipulation awarded claimant an additional 20 percent for loss of his left forearm (for a total of 40 percent) and 20 percent disability for loss of his right forearm.

Claimant saw treating orthopedist Keist twice in 1981 for recurrent right arm and neck pain. From 1981 to 1987 there are no medical reports regarding claimant's right hand/arm. Claimant was self-employed and operated a berry farm. He has been physically limited due to continued disabling pain in both forearms. There are no intervening injuries. In March 1987 claimant returned to Dr. Keist complaining of his inability to use his right hand.

On October 12, 1987, the insurer denied claimant's medical services claim for his current bilateral forearm condition.

FINDINGS OF ULTIMATE FACT

Claimant's current right forearm condition is not materially related to his compensable 1976 injury.

Claimant's current left forearm condition is the same condition the insurer accepted in 1978.

The insurer's denial of claimant's bilateral forearm condition was not unreasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability of the Left Forearm Condition

The issue posed by the 1987 denial is compensability of medical services in March and April 1987. The medical services were for a bilateral condition, not just a right forearm condition. Therefore, we disagree with the Referee's designation of this case as a right forearm issue only.

By stipulation in October 1978, the insurer accepted claimant's left median and ulnar nerve problems and related paresthesias and pain from elbow to wrist. In February 1979, Dr. Keist found that claimant had persistent ulnar nerve compression symptoms at the left wrist. In 1987, Dr. Keist diagnosed the same problem: ulnar and medial nerve compression. Claimant has had continuous left hand symptoms since the 1976 injury. Because the paresthesia problem which was accepted in 1978 is the same as claimant is currently experiencing, we find that the problem is related to the accepted left forearm condition.

We do not find the report of hand surgeon Nye, who was the independent medical examiner, persuasive as it applies to the left forearm. First, Dr. Nye's report is primarily directed to the right forearm. Second, while he opined that the ulnar palsy on the left is probably unrelated to the original injury, he did not discuss whether it is related to the condition accepted in 1978. Finally Dr. Nye's opinion on relationship is inconsistent with the parties stipulation that claimant's condition in 1978 was causally related to the 1976 accepted injury.

The Referee did not address claimant's left forearm condition in her opinion. We find that this problem is related to claimant's compensable injury and modify the Referee's order to set aside the denial of medical services for the left forearm condition.

Compensability of the Right Forearm Condition

The Referee compared the current right forearm condition to claimant's right forearm condition as reported prior to the May 1980 stipulation. The Referee was persuaded that there were sufficient similarities of symptoms and test results to conclude that the current condition was causally related to the right forearm condition addressed in the stipulation. Accordingly, she concluded that the current condition was compensable. She further concluded that the 1987 denial was an improper backup denial under Bauman v. SAIF, 295 Or 788 (1983). We disagree with the Referee's analysis and reverse.

In 1979 Dr. Keist diagnosed a right carpal tunnel syndrome (compression of the median nerve) that he related to the compensable left wrist injury via consequential overuse. On May 8, 1980, claimant and the insurer entered into a stipulation awarding permanent disability for ". . . loss of [claimant's] right forearm." The insurer did not accept claimant's current right forearm condition in that stipulation. Cf. Hannum v. EBI Companies, 83 Or 346 (1987). Consequently, it is not prohibited from now denying that condition.[1]

In April 1987, neurologist Wilson reported that claimant experienced severe pain from the right elbow to the wrist; Dr. Wilson opined that this was due to a polyneuropathy with tardy ulnar palsy, and this diagnosis was confirmed by neuromuscular electrodiagnosis. Claimant's polyneuropathy/palsy and related pain is not equivalent to the right carpal tunnel syndrome which was originally diagnosed. Therefore, the insurer was procedurally entitled to challenge its compensability.

We address the merits of claimant's right forearm claim. As claimant's polyneuropathy/palsy condition involves different nerves than the accepted right carpal tunnel condition, causation of the polyneuropathy is a complex medical question. The resolution of this issue turns largely on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109, rev den 300 Or 546 (1986).

Dr. Keist stated only that he saw claimant for increasing distress of both arms attributable to his job injury of 1976. We give little weight to Dr. Keist's opinion because he did not explain the basis for his opinion.

Dr. Keist referred claimant to Dr. Wilson, who did not render an opinion regarding the causation of claimant's right arm condition.

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[1]Assuming, for the sake of argument, that a stipulated award of permanent partial disability, standing alone, is a formal acceptance, we could not read the stipulation as an acceptance of anything more than the carpal tunnel syndrome diagnosed at that time.

Dr. Nye opined that claimant's right arm condition is unrelated to his 1976 injury. He attributed claimant's condition to increased sensitivity to nerve compression problems with repeated elbow flexion over the years, eventually causing problems with ulnar nerve compression syndrome at the elbow. We defer to Dr. Nye's position because he explained the basis for his opinion.

For these reasons, we find that claimant has failed to establish the compensability of his current right forearm condition.

Penalty

The Referee found that the insurer's denial of claimant's current right forearm claim for medical services was a "back up" denial under Bauman v. SAIF, supra. Based on such a finding, the Referee assessed a penalty for an unreasonable denial. We disagree.

Whether a denial is reasonable depends upon an evaluation of all the evidence available to the insurer when it acted. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988). In addition to Dr. Keist's and Dr. Wilson's reports, the insurer evaluated Dr. Nye's report which stated there was no causal relationship between the current condition and the 1976 injury. Therefore, based upon the information available to it at the time of its denial, we conclude that the insurer had a legitimate doubt concerning the compensability of claimant's current condition. Accordingly, we hold that the insurer's denial of claimant's right forearm condition was not unreasonable.

Assessed Fee At Hearing

The insurer requested that the Board reverse the Referee's $1,200 assessed fee award in the event the Board upheld the insurer's denial. We have upheld the denial as it applies to the right forearm condition, but not the left forearm condition. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case we find that $1,200 is a reasonable fee for claimant's counsel's services at hearing concerning the denial of the left forearm condition. In reaching this conclusion, we have particularly considered the time devoted to the case as evidenced by the documentary record and hearing transcript. Accordingly, we affirm the Referee's $1,200 assessed fee award.

Assessed Fee On Review

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the denial of the left forearm condition is $375, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this issue, as represented by claimant's statement of services, and the complexity of the issue.

ORDER

The Referee's order dated March 11, 1988 is modified in part, reversed in part, and affirmed in part. The insurer's denial is reinstated and upheld to the extent it addresses medical services for claimant's right forearm condition. The Referee's assessment of a penalty is reversed. The remainder of the order is affirmed. For services on review regarding the denial of the left forearm condition, claimant's attorney is awarded a $350 assessed fee, payable by the insurer.

In the Matter of the Compensation of
CLARISSA J. CANNADY, Claimant
WCB Case No. 89-17397
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Tenenbaum's order which affirmed a Determination Order which granted no award for permanent disability. On review, the sole issue is extent of permanent disability.

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

Claimant argues that it is "the law of the case" that claimant had no impairment as a result of her previous compensable injury; therefore, she reasons, all her current impairment must be due to this compensable injury. We reject claimant's premise.

The doctrine of preclusion by former adjudication (res judicata) does not act to bar any finding in Referee Tenenbaum's order. The litigation which claimant argues has preclusive effect is an Opinion and Order of Referee Davis, in which he set aside this insurer's denial of responsibility and upheld the responsibility denial of the insurer on the risk at time of the earlier compensable injury. We conclude that the insurer is not barred by either claim preclusion or issue preclusion from arguing that claimant had permanent impairment from the earlier compensable injury.

Issue preclusion applies only where an issue of fact or law was actually litigated and was essential to the final decision. Drews v. EBI Companies, 310 Or 134, 139 (1990). The issue of whether claimant had permanent impairment was not necessary to Referee Davis' final decision.

Claim preclusion only applies where the claim in the second action is one which is based on the same factual transaction that was at issue in the first claim and where the remedy sought in the second action could have been litigated in the first action. Drews, supra at 140.

Claimant essentially contends that Referee Tenenbaum's finding that claimant had permanent impairment due to the earlier compensable injury is barred by Referee Davis' decision. The remedy which claimant now seeks is an award for permanent disability due to this injury. The facts necessary to decide whether claimant is now entitled to permanent disability are different than the facts necessary for Referee Davis to decide which insurer was responsible for claimant's condition at the time of his hearing. Accordingly, claim preclusion does not bar Referee Tenenbaum's finding.

ORDER

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

In the Matter of the Compensation of
ROBERT J. MURRAY, Claimant
WCB Case No. 89-12225
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee T. Lavere Johnson's order that dismissed claimant's hearing request without prejudice. In its brief, SAIF requests that the order be modified to reflect a dismissal with prejudice. On review, the sole issue is whether this dismissal should have preclusive effect.

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

In the section entitled "Summary Resolution of Issues," the first sentence is replaced as follows: Claimant, by and through counsel, withdrew the Request for Hearing and requested that the Order of Dismissal be entered without prejudice.

When the party requesting a hearing moves for a dismissal (and there is no cross-request for hearing), the Referee has discretion to set the terms and conditions of an order of dismissal as he or she deems proper. We will not disturb the terms and conditions imposed by the Referee except upon a showing of abuse of discretion. Julie Mayfield, 42 Van Natta 871, 872 (1990). We find no abuse of discretion here.

ORDER

The Referee's order dated September 26, 1989 is affirmed.

In the Matter of the Compensation of
MAVIS A. THOMPSON, Claimant
Own Motion No. 90-0496M
OWN MOTION ORDER DENYING RECONSIDERATION
Starr & Vinson, Claimant Attorneys
VavRosky, et al., Defense Attorneys

The insurer requests reconsideration of the Board's October 31, 1990, order which dismissed its request for rescission of Determination Orders issued in this claim on June 9, 1990, and August 12, 1982. The insurer seeks clarification of the prior order.

Though not expressly stated in our prior order, we are without own motion authority to rescind prior determination orders. Our own motion authority under ORS 656.278 only permits us to award medical benefits for compensable injuries occurring before 1966 and to award temporary disability benefits when aggravation rights have expired and there is a worsening of a compensable injury requiring surgery or hospitalization. Absent those circumstances, we lack the authority to grant own motion relief. ORS 656.278.

Accordingly, the insurer's request for reconsideration is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID F. BOWEN, Claimant
WCB Case No. 89-10387
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of that portion of Referee Gruber's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for his right knee condition. In the alternative, claimant contends that the Referee improperly declined to leave the record open to admit an additional medical report from claimant's orthopedic surgeon, and claimant moves that this matter be remanded for admission of that evidence. On review, the issues are remand and compensability. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. On August 17, 1989, two weeks before the scheduled August 31, 1989 hearing date, claimant's attorney contacted his treating orthopedic surgeon, Dr. Freudenberg, and requested a narrative report detailing a complete history of claimant's at-work and off-work activities and a discussion of causation of claimant's condition. Between August 18 and 27, the attorney's office called Dr. Freudenberg's office at least twice. At the August 31, 1989 hearing, counsel had not received the requested report. The Referee declined to leave the record open for receipt of the pending report.

FINDINGS OF ULTIMATE FACT

Claimant did not exercise due diligence in acquiring an additional medical report from Dr. Freudenberg. Moreover, the record has not been improperly, incompletely or otherwise insufficiently developed.

Claimant's work activity did not materially contribute to his current right knee disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee denied claimant's motions to leave the hearing record open for the admission of Dr. Freudenberg's report both at hearing and on reconsideration. He then found the medical evidence did not establish that claimant's work activities materially contributed to his disability or need for medical treatment beyond that caused by claimant's October 1988 injury that had been denied and not timely appealed.

Remand

Renewing his argument that a supplemental report from his treating orthopedic surgeon should be admitted into the record, claimant moves for remand. We deny the motion.

The Board may remand to the Referee should we find that the record has been "improperly, incompletely, or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must clearly be shown that the material evidence was not obtainable with due diligence at the time of 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).

In this case, claimant requested a hearing on March 30, 1989. He was aware of the necessity of coming to the hearing prepared to litigate the issue of compensability. Claimant did not seek to obtain a medical opinion on causation until a mere two weeks prior to the hearing. We conclude that claimant did not exercise due diligence in acquiring Dr. Freudenberg's additional report.

Moreover, we are not persuaded that the record concerning the compensability issue has been improperly, incompletely or otherwise insufficiently developed. The Referee properly declined to keep the record open for admission of Dr. Freudenberg's report. Accordingly, the request for remand is denied.

Compensability

We affirm and adopt the Referee's reasoning and conclusion that claimant's employment activities did not materially contribute to his current right knee condition.

ORDER

The Referee's order dated December 19, 1989 is affirmed.

December 4, 1990 Cite as 42 Van Natta 2706 (1990)

In the Matter of the Compensation of
ALLEN H. HOWARD, Claimant
WCB Case No. 90-09204
ORDER OF DISMISSAL (REMANDING)
Welch, et al., Claimant Attorneys
Stafford Hazelett, Defense Attorney

Claimant has requested Board review of Referee Menashe's October 22, 1990 "Order on Reconsideration Withdrawing Opinion and Order and Deferring Case." We have reviewed the request to determine whether the Referee's order is a final order which is subject to review. Because we conclude that that the Referee's order is not a final order, we dismiss the request for review for lack of jurisdiction.

FINDINGS OF FACT

On September 11, 1990, Referee Menashe issued an Opinion and Order. Pursuant to the order, claimant was awarded 12 percent unscheduled permanent disability. On October 8, 1990, the insurer submitted a Motion for Reconsideration of the Referee's order. Noting that a recent Board order had held that it was error to rate a claimant's condition for permanent disability while the claim had been reopened for the payment of temporary disability, the insurer contended that the case should be deferred until claimant's permanent disability could be evaluated. On October 9, 1990, the Referee abated his September 11, 1990 order.

On October 22, 1990, the Referee issued an Order on Reconsideration. Specifically, the Referee withdrew the September 11, 1990 order and placed the case in a deferred status pending closure of claimant's aggravation claim and an assessment of permanent disability. The order did not contain a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3).

On October 30, 1990, claimant requested that the Referee abate his October 22, 1990 order and reissue an order on reconsideration with appeal rights. On November 17, 1990, the Referee replied that the October 22, 1990 was an interim order and that review could be requested when a final order was entered. On November 20, 1990, claimant requested Board review of the Referee's October 22, 1990 order.

ULTIMATE FINDINGS OF FACT

The Referee's October 22, 1990 order did not finally deny or allow the claim, nor did it fix the amount of claimant's compensation.

CONCLUSIONS OF LAW

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

Here, the Referee's October 22, 1990 order neither finally disposed of nor allowed the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order vacated the Referee's September 11, 1990 order and deferred the matter pending the closure of claimant's aggravation claim and an assessment of permanent disability.

Inasmuch as further action before the Hearings Division is required as a result of the Referee's order, we conclude that it was not a final order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Therefore, we lack jurisdiction to consider the issues raised by claimant's request.

Accordingly, this case is returned to Referee Menashe for further action consistent with this order and the Referee's October 22, 1990 order.

IT IS SO ORDERED.

December 4, 1990 Cite as 42 Van Natta 2707 (1990)

In the Matter of the Compensation of
VICTOR F. LAMBERT, Claimant
WCB Case No. CO-00273
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bottini, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

On November 6, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $20,000 by Aetna Casualty Company, claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury. In addition, claimant agrees to return this consideration to the insurer in the event that a subsequent "violation" of the agreement "causes the assessment of any increased claims costs to the employer or insurer under this claim other than for medical benefits." Finally, claimant agrees that the disposition resolves "all issues currently raised or raisable" concerning "outstanding claims for workers' compensation benefits, whether filed or not." We set aside the proposed disposition.

ORS 656.236(1) permits parties, by agreement, to make "such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable," subject to the terms and conditions prescribed by the Director. The Director's rules define a "claim disposition agreement" as a written agreement in which a "claimant agrees to release rights, or agrees to

release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim." OAR 436-60-005(9). See also OAR 438-09-001(1).

Here, the proposed disposition purports to release claimant's rights and obligations not only under his accepted claim, but it also attempts to resolve all issues raised or raisable under any other outstanding claims for workers' compensation benefits, whether filed or not. The latter portion of this release does not pertain to an accepted claim and, as such, is not a proper matter for disposition under ORS 656.236 and the aforementioned administrative rules.

We also consider another portion of the proposed disposition contrary to statutory and administrative prerequisites. Specifically, the agreement provides that in the event of "any violation of this Stipulation which causes the assessment of any increased claims costs to the employer or insurer under this claim other than for medical benefits, [the violation] shall vest with the employer or insurer certain contractual rights and civil remedies for the return of its money, the sum of $20,000 which is payable hereunder." Page 3, Lines 17 - 24. Yet, once approved, a claim disposition is final. ORS 656.236(1), (2). Furthermore, it is impermissable to make approval of a claim disposition agreement contingent on a subsequent event. See James J. Treml, 42 Van Natta 2594 (1990) (ORS 656.236 does not permit approval of a claim disposition agreement to be contingent on the approval of a disputed claim settlement). We consider this rationale to be equally applicable to a provision purporting to effectively make disapproval of a disposition contingent on a subsequent event.

Inasmuch as the offensive portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, the disposition is set aside. Following our standard procedures, we would be willing to consider a revised agreement which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09-001 et seq.

IT IS SO ORDERED.

In the Matter of the Compensation of
KATHLEEN McQUIGGIN, Claimant
WCB Case No. 89-14199
ORDER ON REVIEW
Brown & Tarlow, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of Referee Schultz's order that: (1) found that claimant was a subject worker; (2) set aside its denial of claimant's injury claim; and (3) assessed a penalty-related attorney fee for the employer's allegedly unreasonable denial. On review, the issues are whether claimant is a subject worker and attorney fees. We reverse.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

Claimant was an independent contractor at the time she was injured.

CONCLUSIONS OF LAW AND REASONING

Subject Worker

The question is whether claimant, who serviced and maintained plants for a florist, was a subject worker or an independent contractor at the time she was injured. The Referee determined that she was a subject worker. We disagree.

For purposes of the Workers' Compensation Act, the test for determining who is a subject worker is the employer's right to control the performance of the services. See former ORS 656.005(25) and (27). That test requires an application of the traditional "right to control" analysis and a consideration of the "nature of the work." Woody v. Waibel, 276 Or 189 (1976). The principle factors showing right to control 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. Castle Homes, Inc. v. Waite, 95 Or App 269 (1989).

The evidence reveals that claimant was independent in most of her job activities and that the employer in fact exercised little control over her work. Claimant was free to service and maintain the plants at her own convenience, provided she visit each business twice a month and that the visits were no more than 12 days apart. She was not required to work specific hours or spend a specific amount of time at each store. The employer did not check on her work and would not have done so unless there had been complaints from its customers. The employer originally had required claimant to submit monthly reports of the businesses she had serviced; however, she was not required to do so after a few months.

Further evidence of the parties' relationship is found in their written agreement, which provided that claimant was an "independent contractor," that the employer would pay her as a "sub-contractor" and that taxes were not to be deducted from her pay. The fact that the parties considered their relationship to be that of an independent contractor is not controlling. Woody v. Waibel, supra. However, a plain statement of the parties' intent remains a consideration and should not be disregarded. Henn v. SAIF, 60 Or App 587, 592 (1982), rev den 294 Or 536 (1983). 1C Larson, Workman's Compensation Law, Section 46.30.

Claimant was paid a flat rate of $15.00 per month per store location. When payment is based on quantity or percentage, the method of payment factor largely becomes neutral. Nonetheless, to the extent that the method of payment lessens an employer's interest in the details of how the worker spends her time, it suggests an independent contractor relationship. Henn v. SAIF, supra.

The employer provided garden supplies and equipment necessary for claimant to service and maintain the plants. However, claimant was required to furnish the primary equipment of the business, her car, and did not receive any reimbursement for mileage or fuel. Moreover, if claimant failed to maintain the proper interval of visits, she was obligated to replace plants at her own expense if they became unpresentable.

There is nothing to suggest that the employer had an unqualified right to fire, a factor indicative of an employer-employee relationship. The contract signed by claimant merely required satisfactory performance of the agreement and provided that either party may terminate the relationship by 30 days written

notice. The right to discharge claimant for violations of the agreement is consistent with the idea that a satisfactory end result is all that is aimed for by the contract. See Marcum v. SAIF, 29 Or App 843 (1977).

Additionally, there is nothing to suggest that claimant was an essential and regular part of the employer's business. Compare Castle Homes, Inc. v. Waite, supra. The leasing of plants to retail businesses was an not an integral part of the employer's florist trade. Moreover, claimant worked only part-time, usually one or two days a week of her choice, and, although she did not service and maintain plants for other florists, she was not prohibited from doing so. After our review of the record, we conclude that claimant was an independent contractor at the time of her injury and, therefore, not a subject worker under the Workers' Compensation Act.

Attorney Fee

The employer contends that the Referee erred in assessing an attorney fee for the employer's allegedly unreasonable delay to accept or deny claimant's claim. We agree.

ORS 656.382 provides that attorney fees are to be assessed based on unreasonable resistance to the payment of compensation. Because the claim was not compensable, the delay in accepting or denying it did not delay any compensation. Therefore, there was no unreasonable resistance to the payment of compensation. No attorney fee may be assessed. Lloyd L. Cripe, 41 Van Natta 1774 (1990).

ORDER

The Referee's order dated December 15, 1989 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's assessed attorney fee awards of $250 on the penalty issue and $2,500 on the compensability issue are reversed.

December 4, 1990 Cite as 42 Van Natta 2710 (1990)

In the Matter of the Compensation of
CHERYL R. OSBERG, Claimant
WCB Case No. 89-09178
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of those portions of Referee Fink's order that: (1) declined to award temporary total disability from May 13, 1988 through January 16, 1989; and (2) declined to assess penalties and attorney fees for alleged unreasonable claims processing. On review, the issues are temporary total disability, penalties and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following correction and supplementation. In July 1988 claimant mailed a copy of Dr. Sinnott's release from work as of June 30, 1988 to the SAIF Corporation. In July 1988, SAIF received 827 forms from Dr. Sinnott and Dr. Maeyens releasing claimant to return to regular work. Both 827 forms indicated claimant was not medically stationary. Claimant was not medically stationary until June 20, 1989.

After claimant returned to Dr. Maeyens on January 16, 1989, he determined that claimant could not work where she would be exposed to chemicals, a lot of water or manual labor. Her regular work involves exposure to chemicals and manual labor. Claimant has not been released to return to her regular work, nor is she able to do that type of work.

ULTIMATE FINDINGS OF FACT

Claimant was unable to work, due to the compensable injury, commencing May 13, 1988. Claimant was not able to return to her regular work after May 13, 1988.

SAIF's nonpayment of compensation for temporary total disability was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Temporary Total Disability

The Referee found that claimant was entitled to temporary total disability compensation commencing January 16, 1989 and continuing until claim closure. We disagree and find that claimant is entitled to temporary total disability beginning May 13, 1988 and continuing until claim closure.

As a preliminary issue, SAIF argues that because claimant did not raise the issue of temporary total disability in the March 1989 stipulation, she is now foreclosed from raising the issue. We disagree.

The doctrine of res judicata precludes litigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50; modified 305 Or 468 (1988). The only issue decided by the stipulation was the compensability of claimant's atopic dermatitis condition. Since the issue of temporary total disability was not previously adjudicated, the res judicata doctrine of "issue preclusion" does not apply. Id. Moreover, compensability of claimant's atopic dermatitis involved different operative facts than the current claim for temporary disability compensation. Consequently, the res judicata doctrine of "claim preclusion" does not apply. Carr v. Allied Plating Co., 81 Or App 306, 309 (1986).

We turn to the merits. Claimant is entitled to temporary disability for the entire period of her disability, including any period of disability prior to the time she first sought treatment. Botefur v. City of Creswell, 84 Or App 627 (1987); Silsby v. SAIF, 39 Or App 555, 562 (1979). Furthermore, an injured worker is entitled to temporary disability compensation until the worker is released to regular work and medically stationary or the worker becomes medically stationary and the claim is closed. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988).

Claimant had not worked since May 13, 1988 when she left work because of her compensable skin condition. Although she did not seek medical treatment until June 30, 1988, the undisputed testimony establishes that she was not able to return to her regular work after May 13, 1988 due to her compensable skin condition. Specifically, claimant's testimony, as supported by that of her ex-husband and ex-mother-in-law, supports the conclusion that claimant's hands were swollen, cracked, and bleeding commencing in May 1988. This lay testimony further establishes that claimant's hand condition prevented her from performing activities which required the repetitive use of her hands.

The testimony of these three individuals is consistent with the medical opinion of claimant's family physician, Dr. Sinnott, M.D. When Dr. Sinnott examined claimant on June 30, 1988, he concluded that she was incapable of being

employed in any fashion at that time. (Ex. 7-2 & 15). Moreover, claimant's treating dermatologist, Dr. Maeyens, M.D., on January 16, 1989, determined that claimant could not work where she would be exposed to chemicals, a lot of water or manual labor. Claimant's regular work involves exposure to chemicals and manual labor. (Ex. 2-2, 7 & Tr. 28-31).

Based on the credible testimony of claimant, her ex-husband and ex-mother-in-law and the later medical documentation, we are persuaded that claimant was unable to perform her regular work when she left work on May 13, 1988. Therefore, we find that claimant is entitled to temporary total disability commencing May 13, 1988 and continuing until claimant returns to, or is released to regular work and medically stationary or her claim is closed.

Penalties and Attorney Fees

The Referee declined to assess penalties and attorney fees for nonpayment of temporary total disability. He reasoned that because the medical documentation regarding time loss was not precise and SAIF had accepted the claim as nondisabling, it was not unreasonable for SAIF not to pay temporary total disability. We disagree.

SAIF accepted claimant's claim for bilateral atopic dermatitis of the hands by stipulation on March 21, 1989. At that time, SAIF should have known that claimant was or had been disabled for periods of time. In July 1988, claimant had mailed SAIF a report from Dr. Sinnott indicating that claimant could not work as of June 30, 1988. (Ex. 3A). Also, the record shows that in July 1988 SAIF had received 827 forms from Dr. Sinnott and Dr. Maeyens. These documents put SAIF on notice that claimant's condition was disabling.

Under these circumstances, we conclude that it was unreasonable for SAIF not to begin paying temporary total disability when the stipulation was made on March 21, 1989. On this basis, we assess a penalty of 25 percent of the unpaid temporary total disability due between June 30, 1988 and the date of hearing.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services concerning the penalty issue is $300, to be paid by SAIF. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case and the value of the interest involved.

ORDER

The Referee's order dated August 28, 1989 is modified in part and reversed in part. In lieu of the Referee's award of temporary disability, claimant is awarded temporary total disability compensation from May 13, 1988 until such compensation can be lawfully terminated. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total out-of-compensation fee paid under the Referee and Board orders shall not exceed $3,800. That portion of the Referee's order that declined to assess a penalty is reversed. The SAIF Corporation shall pay to claimant a penalty of 25 percent of the unpaid temporary total disability due between June 30, 1988 and the date of hearing. Claimant's attorney is also awarded a penalty-related attorney fee of $300, to be paid by SAIF.

In the Matter of the Compensation of
EDNA L. SCHOONOVER, Claimant
WCB Case Nos. 88-18906 & 88-16195
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Harri's order that: (1) set aside its denial of claimant's aggravation claim for a left arm and neck condition; and (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for the same condition. On review, the sole issue is responsibility.

We affirm and adopt the order of the Referee.

No order issued pursuant to ORS 656.307 in this case. Nor does the record indicate a concession of compensability by both insurers. Because Liberty Northwest initiated review and claimant's compensation was not reduced or disallowed, claimant is entitled to an assessed fee under ORS 656.382(2). Because Liberty requested review, Liberty is responsible for the assessed attorney fee for claimant's counsel's services on Board review. See Cigna Insurance Companies v. Crawford & Co., 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $200, to be paid by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief), the complexity of the issue, the fact that compensability was not actually contested and the minimal to no risk to claimant.

IT IS SO ORDERED.

In the Matter of the Compensation of
PHILLIP R. BUXTON, Claimant
WCB Case No. 89-17400
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Livesley's order that increased claimant's scheduled permanent disability award for a left leg (knee) injury from 5 percent (7.5 degrees), as awarded by Determination Order, to 30 percent (45 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant suffered a prior compensable left leg (knee) injury in 1984 when he was shot in the left knee by a power nail driver. That injury fully resolved by mid-1985.

In April 1988, claimant suffered a second compensable injury when his left knee was struck by a large piece of wood while working as a chaser. Claimant treated with Dr. James, M.D., who prescribed physical therapy. Despite ongoing pain, claimant continued to work.

In November 1988, after continuing complaints of pain, claimant returned to Dr. James, who released him from work. A November 1988 MRI revealed some degeneration, but was otherwise normal. Physical therapy was again prescribed. In January 1989, James released claimant to return to light duty work.

Claimant again returned to Dr. James in April 1989, with continuing complaints of pain. James reported full left knee range of motion, and noted no swelling or tenderness in claimant's left knee.

In Dr. James' July 1989 closing report, James reported, based on claimant's representations, that claimant was limited in his ability to use his left leg because of ongoing pain. That same month, Dr. James released claimant to return to his usual and customary work.

An August 24, 1989 Determination Order closed claimant's left leg claim and awarded 5 percent scheduled permanent disability for the loss of use or function of his left leg (knee). Claimant requested a hearing.

Claimant suffers from a chronic condition limiting repetitive use of his left leg (knee) resulting from his compensable injury.

CONCLUSIONS OF LAW AND OPINION

After acknowledging that claimant suffered from a chronic condition limiting repetitive use of his left leg, and after noting that the applicable standards did not allow for a disability award based on disabling pain, the Referee increased claimant's scheduled permanent disability award by 25 percent by finding clear and convincing evidence that claimant suffers permanent disability in excess of that calculated under the standards. We disagree.

Because claimant's condition became medically stationary on July 24, 1989, and his claim was closed by Determination Order on August 24, 1989, we apply the "standards" effective at the time of the Determination Order in rating the extent of his permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

The parties agree that claimant's only impairment under the standards is a chronic condition which limits repetitive use of his left leg; i.e., claimant's ongoing dull aching left knee pain which restricts repetitive use of his left leg. Therefore, we find that claimant is entitled to 5 percent for the loss of use or function of his left leg (knee). Former OAR 436-35-010(7). Claimant's total award under the standards, therefore, is 5 percent.

The parties dispute, however, whether or not claimant has established by clear and convincing evidence disability in excess of that awarded under the standards.

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards." Former ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 302 (1987).

The only evidence that claimant suffers disability which exceeds that indicated under an application of the standards is claimant's testimony that he suffers approximately 30 percent loss of use or function of his left leg (knee) and claimant's treating physician's report adopting claimant's assessment of loss of function.

While claimant urges us to rely on Dr. James' report of a loss of function, we find that Dr. James' July 1989 report includes only a statement that claimant "feels that he is limited to about 70% effort as far as overall function of his knee is concerned." (Ex. 16). Dr. James' report specifically finds that claimant had excellent range of motion, no swelling and no tenderness about his left knee. Id. Regardless of the fact that there were no objective findings of impairment, Dr. James briefly concluded that claimant's "estimate of about 70% normal functions seem[ed] appropriate. . ." Id. Because we find that Dr. James' adoption of claimant's assessment of left leg limitation is, at best, conclusory, we do not find it persuasive. Moe v. Ceiling Systems, 44 Or App 429 (1980).

The only remaining evidence is claimant's testimony. Claimant testified that he suffered ongoing pain that limits his working abilities. Claimant admitted, however, that he had returned to his usual and customary work as a chaser.

Based on the aforementioned reasoning, we conclude that claimant has failed to establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by him is more than the entitlement indicated by the "standards." Former ORS 656.283(7); 656.295(5). Therefore, we do not award claimant disability based on clear and convincing evidence.

ORDER

The Referee's order dated January 16, 1990, as reconsidered February 16, 1990, is reversed. In lieu of the Referee's award, the August 24, 1989 Determination Order award of 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left leg (knee) is reinstated and affirmed.

December 5, 1990 Cite as 42 Van Natta 2715 (1990)

In the Matter of the Compensation of
KENNETH W. CALKINS, Claimant
Own Motion No. 66-0202M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation voluntarily reopened the above claim for additional medical benefits related to claimant's August 26, 1957, injury under ORS 656.278. Claimant's aggravation rights have expired. SAIF asks the Board to authorize reimbursement from the Reopened Claims Reserve. Also, claimant is requesting reopening of his 1957 claim for the payment of related medical expenses, surgery and temporary disability benefits. SAIF has no objection to providing the requested medical benefits as they are appropriate for the injury sustained and related to the August 26, 1957 injury. SAIF has also accepted responsibility for the proposed surgery and recommends that claimant"s claim be reopened for the payment of temporary disability benefits.

In cases involving pre-1966 injury claims, as here, we may exercise our "own motion" authority to reopen a claim for payment of further medical benefits. ORS 656.278(1)(b). We conclude that claimant's claim should be reopened

to reimbursement SAIF for voluntarily paid medication in an amount not to exceed $47.95 and his injury-related medical services in an amount not to exceed $400.36. In addition, the Board also authorizes payment and reimbursement for claimant's injury-related medication in an amount not to exceed $89.18. Further, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date he is hospitalized for the proposed knee surgery. SAIF shall continue paying temporary total disability benefits until one of the following events first occurs: (1) claimant is medically stationary and claim is closed; (2) claimant returns to regular or modified work; (3) the attending physician gives claimant a written release to return to regular employment; or (4) the attending physician gives claimant a written release to return to modified work, such employment is offered in writing to claimant and claimant fails to begin such employment. We also approve reimbursement for the medical expenses, related to the surgery, until such time as claimant's claim is closed. 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.

In the Matter of the Compensation of
SALVADOR CERVANTES-OCHOA, Claimant
WCB Case No. 89-13027
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Nichols and Crider.

The employer requests review of Referee Daron's order that set aside the SAIF Corporation's denial of compensability of claimant's back injury, issued on behalf of the employer at the direction of the Department of Insurance and Finance. On review, the issue is compensability (subjectivity). We affirm.

FINDINGS OF FACT

The employer is a corporation engaged in reforestation work under contracts with various timber and paper companies. The employer is incorporated in both Washington and Oregon. The employer's headquarters is in Monmouth, Oregon. The employer's bank accounts are with a Monmouth, Oregon bank. Payroll checks are issued on that bank. Oregon income tax is withheld from employee payroll checks.

All of the employer's insurance, except its workers' compensation insurance, is purchased in Oregon. The employer carries Washington workers' compensation insurance which covers Washington employees temporarily working in Oregon.

All of the employer's employees live in the mid-Willamette Valley. They are transported from Monmouth to job sites at varying locations in Washington and Oregon. They are transported in the employer's vehicles; the vehicles are licensed and insured in the state of Oregon. Employees work at a remote job site for a few days at a time and then return to Monmouth.

Eighty percent of the employer's reforestation work is done in Washington; 20 percent is done in Oregon.

The employer, in addition to its owner and management employees, employs foremen and key men on a year-round basis. Other workers, including claimant, are hired each year during a season which commences in January or February. Seasonal workers are hired as needed for a certain job. They continue working, moving from job to job with the crew as the needs of the employer dictate. At the time the worker is hired, he is handed a piece of paper which indicates that the work is seasonal. The worker is not told where he will work. Nonetheless, the employer begins each season working under a contract with Longview Fibre. The employer generally ends the season in June or July, with its last crews working in the Wenatchee area of Washington.

Claimant was hired in February 1987 on a crew under foreman Juan Ceja. His first assignment was to a job for Longview Fibre, in Washington. He worked most of February and March at unspecified Washington locations. In April, the crew began work at a location near Detroit, Oregon. After several days of work on that job, claimant was injured on the job.

The injury occurred on April 27, 1987. A claim was filed for the injury in Washington. Claimant received workers' compensation benefits under the employer's Washington coverage.

The State of Washington has acknowledged the employer as a Washington employer.

FINDINGS OF ULTIMATE FACT

Claimant was an Oregon worker when injured on the job.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not temporarily working in Oregon incident to permanent Washington employment. Hence, as he was not nonsubject under ORS 656.126(2), the Referee held that claimant was a subject Oregon worker and the claim was compensable.

Like the Referee, we believe the central question is whether or not claimant's Oregon work was incidental to employment in another state; for only then may a worker be denied Oregon coverage for an otherwise compensable job injury that occurs in Oregon. However, the Referee concluded that no seasonal worker is regarded as "a worker from another state" within the meaning of former ORS 656.126(2). By that reasoning, any injury to a seasonal worker which occurs in Oregon is compensable under chapter 656. We do not read the statutory phrase so restrictively; nevertheless, we conclude that claimant is not a Washington worker.

Former ORS 656.126(2) reads as follows:

> "(2) Any worker from another state and the employer of the worker in that other state are exempted from the provisions of ORS 656.001 to 656.796 while that worker is temporarily within this state doing work for the employer:
>
> (a) If that employer has furnished workers' compensation insurance coverage under the workers' compensation insurance or similar laws of a state other than Oregon so as to cover that worker's employment while in this state;

(b) If the extraterritorial provisions of ORS 656.001 to 656.794 are recognized in that other state; and

(c) If the employers and workers who are covered in this state are likewise exempted from the application of the workers' compensation insurance or similar laws of the other state."

The flip side of this provision is that of ORS 656.126(1) which provides that when an Oregon worker suffers a job injury while temporarily working out of state incident to his Oregon employment, he is entitled to benefits under the Oregon workers' compensation law.

Whether a worker is an Oregon worker or an out-of-state worker depends on numerous facts. Power Master, Inc. v. Blanchard, 103 Or App 467 (September 26, 1990). The primary consideration is whether claimant's work in Oregon was only temporary. See Hobson v. Ore Dressing, Inc., 87 Or App 397, 400, rev den 304 OR 437 (1987)(interpreting ORS 656.126(1)).

As the Referee noted, by virtue of his seasonal employment, claimant is a temporary employee of the employer. Nevertheless, we are persuaded that if the record establishes that the primary locus of the employment relation, temporary though it be, was in Washington, then, under the permanent employment relation test enunciated in Kolar v. B & C Contractors, 36 Or App 65 (1978), claimant was a Washington worker and thus a nonsubject worker under ORS 656.126(2). That said, considering all of the factors, we do not conclude that claimant was a Washington employee.

The employer contends that because the bulk of its reforestation work was in Washington, each of its seasonal employees is necessarily a Washington worker. The employer relies in particular on Phelan v. HSC Logging, Inc., 84 Or App 632 (1987) In that case, as here, the worker was hired in Oregon by an employer 80 percent of whose work was in Washington. The worker was hurt in Oregon; yet the court held that he was not a subject worker because he was temporarily in Oregon. In that case, however, claimant had been told that following his first job in Oregon, he would be likely to be working in Washington. Moreover, the employer's main office and base of operations was in Washington.

In contrast, here all of the factors relevant to the permanent relation issue, with the sole exception of the percentage of work performed in Washington, point to a finding that claimant was an Oregon employee. We rely in particular on the fact that the employer's base of operations is Monmouth, its employees are all from that area, and employees marshall in that area for transport to particular work sites. These factors, together with the fact that claimant was not hired with the understanding that he would work in any particular location after the initial job was completed, lead us to our conclusion. Therefore, we affirm the Referee's order.

ORDER

The Referee's order dated November 21, 1989 is affirmed.

In the Matter of the Compensation of
MICHAEL P. CORTINAS, Claimant
WCB Case No. 89-14625
ORDER ON REVIEW
Darell E. Bewley, Claimant Attorney
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Schultz's order which: (1) found that claimant was not a subject worker; and (2) upheld the SAIF Corporation's denial of his shoulder injury claim. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

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

The Referee questioned the credibility of claimant's rendition of facts and found that, although claimant worked in the orchards of SAIF's insured, there was not sufficient evidence of a "meeting of the minds" to create the existence of an employment relationship. Claimant argues that, although there may not have been an express employment contract, there was at least an implied contract because the foreman, who was not available to testify at hearing, knew claimant was working on SAIF's insured's orchard.

Even if the foreman had been present to testify as claimant alleges he would, this would not necessarily be sufficient to prove that an employer and subject worker relationship existed. Where the existence of an employment relationship is in question, we first focus on claimant's perspective of the employment relationship. Newport Seafood v. Shine, 71 Or App 119, 124 (1984). Because ORS 656.005(27) provides that "worker" means any person who engages to furnish services for a remuneration, one of the crucial factors of this case is whether claimant expected to be paid by SAIF's insured.

Our de novo review of the evidence leads us to conclude that claimant did not expect to be paid by SAIF's insured. Claimant was a volunteer and, as such, is not a subject worker within the definition of ORS 656.005(27). See Hix v. SAIF, 34 Or App 819 (1978); John Dayton, 37 Van Natta 210 (1985).

ORDER

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

In the Matter of the Compensation of
EDWIN C. ELLIOTT, Claimant
WCB Case No. 89-12032
ORDER ON REVIEW
S. David Eves, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Michael Johnson's order that increased claimant's unscheduled permanent disability award for a right shoulder injury from 44 percent (140.8 degrees), as awarded by a Determination Order, to 54 percent (172.8 degrees). On review, the issue is extent of permanent partial disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following modifications. Claimant was 48 years old at hearing. The third sentence of finding number 2 should read: "Dr. Ellison disagreed with a physical capacities test that suggested claimant only attempt left-handed work." Finding number 6 should read "Dr. Orwick limited claimant from lifting more than 10 pounds. (Ex. 27)."

FINDING OF ULTIMATE FACT

Claimant has experienced a 55 percent loss of earning capacity as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, we apply the standards for evaluating permanent disability as adopted by the Director, pursuant to former ORS 656.726(3)(f). See former ORS 656.283(7). Specifically, we apply the version of former OAR 436-35-001 et seq, in effect at the time of the June 7, 1989 Determination Order.

The Referee awarded claimant 54 percent unscheduled permanent disability for his low back injury. Specifically, the Referee assigned claimant the following values: age (1), education (5), adaptability (6), and impairment (18) for a total disability award of 54 percent. We adopt the Referee's reasoning and conclusions as to the values for age, education and adaptability. Accordingly, we only address the issue of impairment.

Dr. Ellison, M.D., claimant's treating orthopedic surgeon, stated that claimant presented so much psychological interference and symptom magnification that it would be difficult to determine how much disability really existed. (Exs. 12, 20-1 & 4). Dr. Orwick, M.D., claimant's longtime family physician and current treating physician, agreed with Ellison's statement that claimant presented symptom magnification and moderate to severe subjective pain. (Ex. 23). A vocational evaluator also confirmed claimant's amplified pain behavior was inhibiting rehabilitation efforts. (Exs. 24A-6, 24A-9, 24A-10).

Thus, the record shows that claimant presented significant psychological interference when he was examined and he magnified his symptoms. Therefore, we look skeptically at any findings concerning his lifting ability and loss of strength based upon his subjective complaints.

Impairment

The Referee did not award claimant a separate value for loss of strength in his right shoulder. We agree.

Mr. Hart, physical therapist, had seen claimant on a regular basis since his surgery and on April 4, 1989, Mr. Hart stated that claimant had a 54 percent loss of strength in his shoulder. (Ex. 16-1). However, Mr. Hart is not a physician and former OAR 436-35-005(1) requires a physician's documentation for impairment. Linda F. Wright, 42 Van Natta 2570 (1990).

On April 18, 1989, Dr. Ellison examined claimant and stated that his muscle strength was normal with equal ability bilaterally. (Ex. 20-2). On July 25, 1989, Dr. Ellison stated that claimant's symptom magnification made the decreased strength found by Mr. Hart questionable. (Ex. 25).

Dr. Orwick stated that he was unable to prove that claimant had normal strength as Dr. Ellison claimed. (Ex. 23). On April 17, 1989 Dr. Orwick examined claimant and found that his right hand grip strength was about half of his left and that he was weaker in his right wrist and forearm, partly due to pain. (Ex. 19). Claimant testified that his right arm was at least 50 to 75 percent weaker than his left arm. (Tr. 20).

For the reasons previously discussed, we find neither claimant's testimony nor his strength tests persuasive. Instead, we rely on his treating surgeon's ultimate conclusion that claimant's strength was normal.

The Referee assigned claimant the following figures as the individual components of his impairment value: loss of range of motion (8.5), chronic condition limiting repetitive use (5), and surgery (5). The Referee then combined these figures for a total impairment value of 18.

We agree with these individual components. However, these components should have been added, rather than combined, for a total impairment value of 18.5. Although the calculation for both hip and spine impairment requires that multiple residuals be combined rather than added (former OAR 436-35-340(15) and former OAR 436-35-350(11) respectively), the calculation for a shoulder impairment contains no such provision. Therefore, multiple residuals regarding a shoulder impairment are added, not combined. Former OAR 436-35-330 et seq.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (1) is added to his education value (5), the sum is (6). When that value is multiplied by claimant's adaptability value (6), the product is (36). When that value is added to claimant's impairment value (18.5), the result is 54.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 55 percent.

ORDER

The Referee's order dated October 30, 1989 is modified. In addition to the Referee's award of 54 percent (172.8 degrees), claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability for his right shoulder injury, giving him a total award to date of 55 percent (176 degrees). Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total out-of-compensation fees awarded under the Referee and Board orders shall not exceed $3,800.

In the Matter of the Compensation of
GERALD S. GAAGE, Claimant
Own Motion No. 66-0136M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for additional medical benefits related to his June 7, 1959, injury. Claimant's aggravation rights have expired. Claimant is requesting reopening of his 1959 injury claim for the purchase of a replacement "Safe" foot and related services. SAIF recommends denial of claimant's request.

In cases involving pre-1966 injury claims, as here, we may exercise our "own motion" authority to reopen a claim for payment of further medical benefits. ORS 656.278(1)(b). No worsening is required. Nevertheless, lifetime medical care for pre-1966 injuries is entirely within the discretion of the Board. We reserve our discretion in these pre-1966 claims for circumstances in which a claimant's need for services, the expense of the service or other factors warrant reopening. Here, SAIF purchased a new prosthesis for claimant with a "Seattle" foot on April 10, 1989. Claimant evidently was dissatified with the new foot on rough ground and therefore, had his prosthesis modified. SAIF was not asked to authorize these modification, nor did a physician prescribe the modificaion as reasonable or necessary. Nevertheless, after review of the record, we conclude that claimant's claim should be reopened to provide reimbursement for the payment of the modification to his prosthesis and the interest charged in an amount not to exceed $596.70. In the future, SAIF may request that claimant receive prior authorization or a prescription by a physician for prosthetic replacement and/or repair. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. By this order, the claim is again closed.

IT IS SO ORDERED.

In the Matter of the Compensation of
VERNA A. HOCKETT, Claimant
WCB Case Nos. 89-17532 & 89-16561
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Ken Russell (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation, as insurer for Waagmeester Canvas, requests review of that portion of Referee Peterson's order that required it to process claimant's April 5, 1989 left shoulder injury as a "new injury" claim. SAIF, as insurer for Beach Pancake House, requests review of that portion of Referee Peterson's order that set aside its denial of a June 9, 1989 injury claim for a left shoulder injury. On review, the issues are claims processing, entitlement to temporary disability benefits and responsibility. We reverse.

FINDINGS OF FACT

Claimant compensably injured her right knee on April 20, 1977, when she was struck in the knee by a heavy roll of canvas material. Claimant was treated conservatively following her injury. However her condition did not improve and two arthroscopic right knee surgeries were performed. Claimant's claim was

closed by a Determination Order that issued March 28, 1980. The Determination Order awarded claimant 25 percent scheduled permanent partial disability for loss of use or function of the right knee.

Following the closure of claimant's right knee claim she continued to experience occasional give way which caused her to fall.

On April 5, 1989, claimant was going down stairs in her home when her right knee unexpectedly gave way causing her to fall down the stairs. As a result of the fall claimant broke her left shoulder. Claimant was treated in the emergency room at Tillamook Hospital. Thereafter, claimant received conservative treatment from Dr. Scheinberg, orthopedist. SAIF accepted responsibility for claimant's broken shoulder under her 1977 right knee claim. SAIF did not pay any temporary total disability compensation, as claimant's aggravation rights under the 1977 claim had expired.

Claimant was released by Dr. Scheinberg to return to modified work as a cook on June 5, 1989. On June 9, 1989, while at work for SAIF's insured, Beach Pancake House, claimant felt a snap in her left shoulder with an immediate onset of left shoulder pain when she lifted a pot weighing approximately 15 pounds. Claimant was taken off work by Dr. Scheinberg and treated conservatively. Claimant was hospitalized on September 26, 1989, and her shoulder joint was manipulated under a general anesthetic. SAIF continued to accept responsibility for claimant's shoulder condition under her 1977 right knee claim.

On June 30, 1989, SAIF, as insurer for Beach Pancake House, denied responsibility and compensability of claimant's left shoulder condition.

CONCLUSIONS OF LAW AND OPINION

Claims Processing/Temporary Disability Benefits

SAIF, as the insurer for Waagmeester Canvas, accepted responsibility for claimant's April 5, 1989 left shoulder injury. Therefore, the only issue before us in regard to this injury is whether the claim should have been processed as a new injury or an aggravation of the 1977 knee injury.

The Referee concluded that claimant's April 1989 left shoulder injury was a new and independent injury. In reaching that conclusion, the Referee relied on the court's decision in SAIF v. Partible, 98 Or App 88 (1989). In that case, the court affirmed a Board order instructing the insurer to process a neck and upper back injury during a vocational rehabilitation program as a new injury, rather than an aggravation of the initial low back injury.

SAIF asserts that claimant's left shoulder injury should be processed as an aggravation of her initial right knee injury. SAIF reasons that if claimant's knee condition had not caused claimant's broken shoulder, the latter injury would not have been compensable since it occurred at home and outside the course and scope of her employment.

We agree with SAIF's argument. This case is distinguishable on its facts from SAIF v. Partible, supra. There, the claimant's neck and upper back injury was the result of work activity during a training program. This work activity was, in effect, an extension of claimant's at-injury employment. The neck and upper back injury was compensable because it occurred during this work activity, not because it was causally related to the claimant's accepted low back injury. Here, claimant injured her left shoulder at home when her knee gave way and she fell on the stairs. The left shoulder injury is compensable solely because it was caused by the compensable knee injury. Absent that causal relationship, the

left shoulder injury would not be compensable. Accordingly, it should be processed as an aggravation of the 1977 knee injury.

Responsibility

In addition to her left shoulder injury of April 5, 1989, claimant, after returning to work in June 1989, experienced an increase in symptoms in her left shoulder. The Referee found that this was a new injury and that claimant's employment in June 1989 independently contributed to a worsening of her underlying condition. We disagree.

On April 5, 1989 while at home, claimant fell, when her right knee gave out, causing her to fracture her left shoulder. Claimant was treated at the emergency room at the Tillamook Hospital, where she was placed in a shoulder immobilizer. On April 10, 1989, claimant began treating which Dr. Scheinberg. Dr. Scheinberg diagnosed a fracture of the surgical neck of the humerus. On May 6, 1989, Dr. Scheinberg released claimant to return to modified work. He restricted claimant to no work above the shoulder level for the left arm and no lifting over 10 pounds with the left arm.

Claimant returned to work as a cook with SAIF's insured, Beach Pancake House. On June 9, 1989, while lifting a pot weighing approximately 15 pounds, claimant experienced a sudden onset of left shoulder pain. Claimant treated with Dr. Scheinberg who diagnosed adhesive capsulitis secondary to her fracture. In a subsequent report, Dr. Scheinberg stated that claimant's June 1989 work incident was "more or less" independent of claimant's April 1989 left shoulder injury.

In August 1989, claimant was examined by the Western Medical Consultants. The Consultants opined that claimant's June 9, 1989 work incident represented a transitory aggravation of the April 5, 1989 fracture of the left shoulder. The Consultants concluded that claimant experienced only a temporary aggravation of a preexisting problem, i.e. her April 5, 1989 left shoulder fracture.

We are not persuaded by the record that claimant's employment in June 1989 independently contributed to a worsening of her underlying condition. In reaching our conclusion, we find that the opinions of Dr. Scheinberg are contradictory and not well reasoned. Therefore, we rely on the well reasoned and complete opinions of the Western Medical Consultants. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we find that claimant suffered an aggravation of her compensable 1977 claim. SAIF accepted responsibility for this left shoulder condition. Therefore, we conclude that SAIF properly accepted this claim as insurer for Waagmeester Canvas, and we reverse the Referee's ruling on this issue. Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986).

ORDER

The Referee's order dated December 15, 1989 is reversed. The SAIF Corporation's denial, as insurer for Beach Pancake House, is reinstated and upheld. The claim is remanded to SAIF, as insurer for Waagmeester Canvas, for processing under the 1977 injury claim. SAIF, as insurer for Waagmeester Canvas, is responsible for the Referee's $1,450 attorney fee award.

In the Matter of the Compensation of
FRED W. HODGEN, Claimant
WCB Case Nos. 89-07722 & 89-07721
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Bonnie V. Laux (Saif), Defense Attorney
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Nichols, Brittingham and Crider.

Puget Sound Trucklines, a self-insured employer, requests review of Referee Menashe's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld the SAIF Corporation's denials of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured his low back in 1981, 1982 and 1985 while driving a truck for SAIF's insured. He quit this employment in September 1987. He began working as a wood chip hauler for Puget Sound Trucklines (Puget Sound) in September 1988. Beginning in November 1988, he put chains weighing 35 to 40 pounds each on the truck approximately twice a day for five or six days a week. He had no specific incident on the job.

On January 28, 1989, a professional carpet cleaning company cleaned the carpets in claimant's home. On January 29, 1989, claimant woke up with increased low back and hip pain. He worked only a part of the next day. He went to an emergency room for immediate treatment and on February 2, 1989 saw Dr. Smith, his treating orthopedic surgeon. Smith reported no incident or strain except for the chaining. He diagnosed chronic lumbosacral strain with an acute lumbosacral strain superimposed. SAIF denied responsibility.

Dr. Waldram, orthopedic surgeon, examined claimant on March 2, 1989. Dr. Waldram diagnosed a herniated disc.

About a month after the onset of his acute symptoms, claimant told Puget Sound that he had hurt his back moving furniture at home. Puget Sound denied responsibility and compensability. No .307 order issued.

FINDINGS OF ULTIMATE FACT

Claimant's compensable injury with SAIF's insured and his work activity with Puget Sound each materially contributed to his current low back symptoms.

Claimant's employment with Puget Sound did not independently contribute to a pathological worsening of his accepted condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm and adopt the Referee's opinion on the issue of compensability with the following revision. The Referee concluded that if claimant's condition is not due to the SAIF injury, it is due to the work activity with Puget Sound. We instead conclude that claimant's low back symptoms are materially related to both the SAIF injury and the work with Puget Sound.

Responsibility

Because no .307 order issued in this case, the Board's scope of review is de novo.

Claimant sustained a compensable injury to his low back followed by a new period of disability. The Referee found that claimant's disability was caused by one or the other of the work exposures, but was unconvinced that either employment was the more likely cause of the disability. He then applied the last injurious exposure rule as set forth in Champion International v. Castilleja, 91 Or App 556, rev den 306 Or 661 (1988), and found Puget Sound responsible.

However, subsequent to the Referee's order, we held that Castilleja does not apply where there is an accepted compensable injury or occupational disease followed by an increase in disability, without a descrete injury, during or after employment with a later employer/insurer. Linda L. Wise, 42 Van Natta 115 (1990). The Referee's conclusion is inconsistent with Linda L. Wise and is therefore in error. Instead, the current case is the type of responsibility case identified in Wise which fixes responsibility with the employer/insurer which accepted the claim unless it proves affirmatively that a later employment independently contributed to a pathological worsening of the accepted condition. See Spurlock v. International Paper Co., 89 Or App 461 (1988); Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986); Crowe v. Jeld-Wen, 77 Or App 81, 86 (1985).

We proceed to determine whether SAIF proved affirmatively that claimant's employment with Puget Sound independently contributed to a pathological worsening of his accepted condition. SAIF accepted claimant's low back injuries in 1981, 1982 and 1985. SAIF argues that claimant's underlying condition worsened when he worked for Puget Sound because he was diagnosed with one or more herniated discs over a year after he left SAIF's insured.

After our review of the medical records, in particular exhibits 4, 9, 10, 10A, 10B, 10D, and 15, we adopt the Referee's opinion in the first three full paragraphs and the first two sentences of the fourth paragraph on page 5 of the Opinion and Order, and find that the evidence is inconclusive as to whether the work at Puget Sound independently contributed to a pathological worsening of claimant's condition. Absent affirmative proof, we find responsibility remains with SAIF. Hensel Phelps Construction v. Mirich, supra; Linda L. Wise, supra. Accordingly, we reverse the Referee on the responsibility issue.

Claimant is entitled to an assessed attorney fee for his counsel's services on review. Puget Sound requested review of the Referee's ruling that the claim was compensable. Because the Boart affirmed the Referee's ruling, claimant's compensation was not disallowed or reduced. Accordingly, claimant is entitled to an assessed fee regarding the compensability denial payable by Puget Sound. Cigna Insurance Company v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $1,000, to be paid by Puget Sound. In reaching this conclusion, we have particularly considered the time devoted to the case as represented by claimant's respondent's brief, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 28, 1989 is affirmed in part and reversed in part. The SAIF Corporation's February 28, 1989 and May 4, 1989 denials are

set aside and the claim is remanded to SAIF for processing as required by law. Puget Sound Trucklines, March 28, 1989 denial is reinstated and upheld insofar as it addresses the responsibility issue. For services on review regarding the compensability denial, claimant's attorney is awarded a $1,000 assessed fee, payable by Puget Sound. The remainder of the order is affirmed.

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

I agree with the Board's decision to award an insurer-paid fee for services related to the compensability issue. However, unlike the majority, I would affirm and adopt the Referee's order as regards responsibility. See Linda L. Wise, 42 Van Natta 115 (1990) (dissenting opinion of Board Member Crider).

December 5, 1990 Cite as 42 Van Natta 2727 (1990)

In the Matter of the Compensation of
CYNTHIA L. MCHENRY, Claimant
WCB Case No. 89-11304
ORDER ON REVIEW (Remanding)
Willard Bodtker, Claimant Attorney
Sandra Haynes, Defense Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The noncomplying employer requests review of Referee Quillinan's order that dismissed its request for hearing contesting the SAIF Corporation's acceptance, as processing agent, of claimant's left shoulder and upper back injury. On review, the issues are timeliness of the request for hearing and res judicata. We reverse and remand.

FINDINGS OF FACT

Claimant filed a claim for a May 2, 1988 injury to the neck and left shoulder. The claim was submitted to the Department of Insurance and Finance.

After investigation, the Department issued a Notice of Proposed and Final Order finding the employer to be noncomplying from September 1, 1987 to May 24, 1988. The Order has not been challenged.

By letter of June 7, 1988, the Department referred the claim to SAIF for processing on behalf of the noncomplying employer.

SAIF accepted the claim on July 25, 1988, and notified the noncomplying employer of the acceptance two days later.

The claim was closed by Determination Order dated March 7, 1989 with an award of permanent disability. Claimant requested a hearing, raising the issue of extent of permanent disability. The hearing was conducted on June 14, 1989.

On June 15, 1989, the noncomplying employer requested a hearing for the purpose of challenging SAIF's acceptance of the claim.

The Referee convened a hearing and admitted exhibits. She dismissed the request for hearing without affording the noncomplying employer the opportunity to present testimonial evidence.

FINDINGS OF ULTIMATE FACT

The noncomplying employer requested a hearing on the compensability issue more than 60 days after the referral of the claim to SAIF for processing.

The noncomplying employer has not been afforded an opportunity to establish that claimant engaged in fraud, misrepresentation or other illegal activity that could have affected SAIF's decision to accept the claim.

CONCLUSIONS OF LAW AND OPINION

A noncomplying employer may request a hearing to challenge SAIF's acceptance of a claim. Clark v. Linn, 98 Or App 393 (1989).

The Referee dismissed this noncomplying employer's request for hearing on two grounds. First, she rejected the noncomplying employer's contention that the time for challenge to an acceptance is unlimited. She held that, by analogy to a claimant's time for challenge to a denial, a noncomplying employer must request a hearing within 60 days of the acceptance or, with good cause shown, within 180 days of the acceptance. See former ORS 656.319. Because the request herein was not made within 180 days of the acceptance, she found it untimely. Second, the Referee held that the noncomplying employer's failure to raise the compensability issue at the hearing on extent of disability resulted in waiver of that claim.

Since the Referee's order issued, we also have rejected the proposition that a noncomplying employer may challenge acceptance of a claim at any time. We have held, however, that, absent fraud, misrepresentation or other illegal activity justifying a backup denial, a noncomplying employer must request a hearing within the time in which SAIF, as processing agent, is required to accept or deny the claim. Kristi L. Chase, 42 Van Natta 1247 (1990).

Under ORS 656.054(1), the time for acceptance or denial by SAIF as a processing agent is the same as the 60 days (90 days under SB 1197, enacted May 7, 1990) provided for acceptance or denial by an insurer except that the time period runs from date of referral of a claim rather than date of notice or knowledge of the claim. Therefore, a noncomplying employer's request for hearing which is not filed within 60 days of referral of the claim to SAIF is untimely unless the noncomplying employer contends and establishes that claimant engaged in fraud, misrepresentation or other illegal activity and that the acceptance decision could reasonably have been affected by that conduct. Ebbtide Enterprises v. Tucker, 303 Or 459 (1987).

The request for hearing in this case was filed more than one year after the referral. Therefore, the request should be dismissed as untimely unless the conditions for issuance of a backup denial can be established. The Referee ruled before giving the noncomplying employer an opportunity to put on its case. Consequently, we are unable to determine whether or not the hearing request was timely.

Therefore, we reverse and remand. On remand, the Referee shall ascertain whether or not the noncomplying employer contends that it can establish the conditions for issuance of a backup denial. If the employer does so contend, proceedings shall be convened for the taking of evidence on that issue and the compensability issue. After hearing, the Referee shall determine, in light of our order in Kristi L. Chase, supra, whether the request for review is timely and, if so, whether the claim is compensable.

ORDER

The Referee's order dated March 14, 1990 is reversed and this matter is remanded for further proceedings consistent with this order.

In the Matter of the Compensation of
CAROL TUGGLE, Claimant
WCB Case No. 89-16868
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Neal's order that increased claimant's unscheduled permanent disability award for an upper back injury from 1 percent (3.2 degrees), as awarded by a Determination Order, to 5 percent (16 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact and supplement with the following.

Claimant completed high school.

As a result of her compensable upper back injury, claimant is precluded from repetitively lifting 50 pounds.

Claimant has acquired on-the-job training sufficient to perform something other than entry level employment. Claimant's job at injury required heavy lifting. She has returned to work for the employer at injury where her current job requires no more than medium work. Claimant achieved her highest specific vocational pursuit (SVP) level of 6 for her work as chief clerk in a print shop.

FINDING OF ULTIMATE FACT

Claimant has sustained an 8 percent loss of earning capacity as a result of her compensable injury.

CONCLUSIONS OF LAW AND OPINION

It appears the Referee rated claimant's permanent disability under the standards effective January 1, 1989. Former OAR 436-35-001 et seq. We apply these standards as well.

The Referee correctly rated claimant's unscheduled impairment at 5 percent under former OAR/436-35-320(4) because she is restricted from repetitive lifting. However, the Referee did not rate claimant's age, education and adaptability because he found that she returned to her regular work. Claimant contends that she is entitled to ratings under those categories because she has returned to modified work. We agree with claimant.

"Usual and customary work," as defined in the standards for rating unscheduled permanent disability, means the job held at the time of injury. Former OAR 436-35-270(3)(a). "Modified work" means some job other than the job held at the time of injury, or the job held at the time of injury with any modification of duties or the conditions under which those duties are performed. Former OAR 436-35-270(3)(b). Here, claimant held a job that required only occasional heavy lifting. She was not doing that job when she was injured. Instead, at the employer's request, she performed a delivery truck driver's job loading and unloading 50 pound boxes. (Tr. 5, 6). We find that claimant's job at the time of injury required heavy work.

Claimant's treating chiropractor stated that she should not perform heavy lifting on a repetitive basis. (Tr. 9, ex. 6). Accordingly, we find that claimant is no longer able to perform heavy work. Claimant returned to a modified job where she is currently working within her chiropractor's lifting restrictions. Consequently, we proceed to rate claimant's age, education and adaptability.

Age and Education

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

The appropriate value for claimant's 12 years of formal education is 0. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position that claimant successfully performed during the ten years preceding the date of hearing was as a chief clerk in a print shop (DOT # 207.137-010) which has the SVP level of 6. Therefore, the appropriate value for skills is +2. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990). Here, claimant has acquired on-the-job training sufficient to perform something other than entry level employment, thus, demonstrating competence in a specific vocational pursuit. Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5).

Adaptability

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

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work required a medium physical capacity. Therefore, the appropriate adaptability value is 1. Former OAR 436-35-310(3)(a).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 1 is added to her total education value of 2, the sum is 3. Former OAR 436-35-280(4). When that value is multiplied by claimant's adaptability value of 1, the product is 3. Former OAR 436-35-280(6). When that value is added to claimant's impairment value of 5, the result is 8 percent

unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 8 percent.

ORDER

The Referee's order dated December 22, 1989 is modified. In addition to the Determination Order and Referee's awards claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, giving her a total award to date of 8 percent (25.0 degrees) unscheduled permanent disability for an upper back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

December 6, 1990 Cite as 42 Van Natta 2731 (1990)

In the Matter of the Compensation of
JON A. HISSNER, Claimant
WCB Case No. 89-18100
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Terrall & Miller, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Podnar's order that: (1) upheld the self-insured employer's denial of his aggravation claim; and (2) declined to assess penalties and attorney fees for the employer's allegedly late and unreasonable denial. On review, the issues are evidence, compensability, penalties and attorney fees. We affirm.

We affirm and adopt the Referee's order with the following additional findings and comments concerning the evidentiary issue.

Claimant argues that the Referee erred by considering the videotape identified as Exhibit 52. Claimant asserts that the videotape was viewed, but not offered nor admitted into evidence; therefore, the Referee improperly relied upon the videotape. We disagree.

Prior to viewing the videotape, claimant's attorney raised the same objection regarding the document and nondisclosure of the videotape marked Exhibit 52 as he had to Exhibit 51, which was admitted. The Referee overruled the objection and proceeded to view the videotape. We have no explanation as to why the transcriber wrote not admitted for Exhibit 52; nevertheless, by relying on Exhibit 52 in his order, the Referee, in effect, admitted it into the record. Therefore, Exhibit 52 is properly part of the record and we rely on this exhibit to reach our conclusion.

In addition claimant argues that Exhibit 51, a videotape, is not a "document" within the meaning of OAR 438-07-017; and therefore, it is subject to the general disclosure rule of OAR 438-07-015. We disagree. In Ashwani K. Grover, 42 Van Natta 2340 (1990), we applied OAR 438-07-017 to videotapes for impeachment purposes. In this case, we also find that videotapes are "documents" within the meaning of OAR 438-07-017. Therefore, we conclude that inasmuch as Exhibit 51 was offered and admitted solely for impeachment evidence, we find that the Referee correctly admitted it for that purpose and we have considered it on review.

ORDER

The Referee's order dated January 19, 1990 is affirmed.

In the Matter of the Compensation of
MICHAEL R. CIGLER, Claimant
And, In the Matter of the Complying Status of
CANDE, INC., dba
C. and E. Kirby, Stanley M. Colflesh, Individually and,
Susan D. Colflesh, Individually, Employer
WCB Case Nos. 87-11001, 87-11000, 87-10519 & 87-00803
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Meyers & Radler, Attorneys
Gary T. Wallmark (Saif), Defense Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Podnar's order that: (1) found that his back injury claim with Aetna Casualty Company (Aetna) was not prematurely closed by a March 10, 1987 Determination Order; (2) upheld Aetna's "de facto" denial of his claim for aggravation of the same injury; (3) upheld Aetna's denial of his claim for a psychological condition; (4) upheld Aetna's partial denial of his medical services claim for pain center treatment; (5) affirmed the above Determination Order that awarded no permanent disability for the back injury; (6) found that he was not a subject worker when he allegedly sustained a "new injury" to his back on April 4, 1987, while working for Cande, Inc. (Cande), the alleged noncomplying employer; and (7) declined to assess a penalty and attorney fee for the SAIF Corporation's allegedly unreasonable refusal to acquiesce in the issuance of an order designating paying agent pursuant to former ORS 656.307 while acting as processing agent on Cande's behalf.

ISSUES

As between claimant and Aetna:

1. Premature claim closure.
2. Aggravation.
3. Compensability of a psychological condition.
4. Compensability of pain center treatment.

As between claimant and SAIF, as processing agent for Cande:

5. Compensability of a new injury claim (claimant's status as a "subject worker").
6. Penalty and attorney fee for unreasonable claim processing.

FINDINGS OF FACT

Claimant compensably injured his back in September 1986, while working as a construction laborer for Aetna's insured. The diagnosis was lumbosacral sprain, though claimant also complained of neck and upper back pain. He was taken off work and treated conservatively by Dr. Cichoke, a chiropractor. A lumbar CT scan in October 1986, and a bone scan of the lower spine and pelvis in November 1986, revealed no abnormalities. The claim was accepted as a disabling injury.

In November 1986, claimant saw a panel at the Orthopaedic Consultants for an independent medical examination (IME). He complained of pain in the neck, low back, buttocks and occasionally in the middle back. The IME could not be completed due to severe functional overlay. The panel diagnosed "[p]psychological factors affecting recovery" and recommended a psychiatric examination. (Ex. 9).

Dr. Duff, orthopedist, examined claimant twice in December 1986, and reported that a bone scan was entirely negative for any sign of fracture in claimant's lumbar spine or any other bony abnormality. (Ex. 12).

On January 2, 1987, Aetna denied the compensability of "psychological factors affecting recovery." Claimant was found medically stationary on January 21, 1987 by the Independent Chiropractic Consultants. (Ex. 16).

On March 6, 1987, chiropractor Cichoke requested authorization for treatment at the the Northwest Pain Center.

The claim was closed by Determination Order on March 10, 1987, with an award of temporary total disability through January 21, 1987, and no permanent disability award. (Ex. 20).

Aetna denied Dr. Cichoke's pain center referral on March 12, 1987, stating that such treatment for claimant was not reasonable and necessary. (Ex. 21). Dr. Cichoke referred claimant to Cascade Athletic Club for an exercise program. After one month of swimming, hot tubs, hot and cold pools, exercise bicycle and calisthenics, claimant was told that because he was not progressing, he could not be treated there any longer. (Ex. 36-d1).

In March 1987, claimant applied to Cande for an advertised position as a vacuum cleaner dealer. Mr. and Mrs. Colflesh are the officers and shareholders of Cande. Cande's business is vacuum cleaner sales through recruitment of dealers. After full company training, dealers are consigned vacuum cleaners for 30 days. Within that time, the dealer must either sell the vacuum cleaner, return it, or purchase it at cost. Dealers are responsible for setting appointments with prospective purchasers, though Cande sets some appointments at a charge to particular dealers. Cande does not provide any transportation or equipment to dealers. Dealer profits are earned by selling the cleaner at a price exceeding cost. Proceeds from sales are paid to Cande, which then pays profits to dealers once per week. Dealers are permitted to draw against their anticipated profits. Cande also pays dealer bonuses based on sales. Dealers bear their own expenses and pay their own taxes. Cande has no employment payroll and pays no employment taxes. Cande does not provide workers' compensation insurance coverage for dealers.

After passing a free aptitude test, claimant interviewed with Mr. Colflesh, president of Cande, and was selected for training. Prior to training, claimant signed a "Statement of Understanding" which provided that he understood that he was not "an employee," was under no obligation to attend meetings, to perform any functions, or to follow the instructions or supervision of the company. (Ex. 28a-15). During more than three days of formal training, he was instructed on how to perform home demonstrations of the vacuum cleaner. After formal training, he began performing practice demonstrations at the homes of friends whom he had enlisted as prospective purchasers. The demonstration vacuum cleaner was consigned to him, and he drove his own car. Pursuant to company instructions, claimant phoned the main store three times during each practice demonstration. The phone calls allowed the main store to check on claimant's progress and to answer any questions.

On May 29, 1987, claimant filed an "801" form indicating that on April 4, 1987 he felt a sudden onset of severe pain in the neck and back demonstrating a vacuum cleaner. (Ex. 29). Claimant listed Cande on the "801" form as his employer at the time of injury and that he had worked for Cande for two days. Claimant did not complete the training with Cande necessary to qualify as a dealer.

MRI scans in May 1987, revealed slight wedging of T12 (consistent with old trauma), degenerative disc disease at L4-5 with mild bulging and slight wedging of L1 (consistent with old trauma). Magnetic resonance imaging of the thoracic spinal cord and canal was negative.

After an investigation, the Compliance Division found that claimant was a subject worker of Cande on the date of the alleged injury. A Proposed and Final Order issued on June 19, 1987, declaring Cande a noncomplying employer.

Acting as statutory claims processing agent for Cande, SAIF initially conceded compensability and denied responsibility for claimant's "new injury" claim on July 2, 1987. SAIF requested designation of a paying agent pursuant to former ORS 656.307 and forwarded its claim file to Aetna. Aetna neither accepted nor formally denied claimant's aggravation claim. Later, SAIF, through the Justice Department, acknowledged that compensability was an issue; the Workers' Compensation Division denied the request for a paying agent on August 25, 1987, based on information that compensability would be an issue.

In July 1987 claimant saw Dr. Colistro, psychologist, for a psychological evaluation. Colistro diagnosed adjustment disorder with depressed mood. (Ex. 36).

Upon referral by Dr. Kemple, rheumatologist and internist, claimant began treatment at the Northwest Physical Therapy Clinic in August 1987. (Ex. 36d).

ULTIMATE FINDING OF FACT

Claimant's relationship with Cande was that of an independent contractor and not a "subject worker."

CONCLUSIONS OF LAW AND OPINION

Premature claim closure

The Referee found that claimant had failed to establish that his claim was prematurely closed. We agree.

To determine whether a claim was prematurely closed, we determine whether claimant's condition was medically stationary on the date of closure, without considering subsequent changes in his condition. Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (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).

It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981); Dale R. Bennett, 40 Van Natta 843 (1988). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985).

In support of his contention that he was not medically stationary on March 10, 1987, claimant points to medical opinions issued prior to closure indicating that claimant would benefit from an exercise program and that he remained under the care of his treating chiropractor. The term "medically stationary," however, does not mean that there is no longer a need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984).

On December 23, 1986, Dr. Duff, orthopedist, reported that although claimant was obtaining some relief from chiropractic treatments, he would receive no more than palliative benefit from further treatment. (Ex. 12). On January 12, 1987, Dr. Cichoke, claimant's treating chiropractor, wrote that claimant's condition was improving and that claimant needed two more months of

further treatment before claimant would be ready for permanent disability evaluation. On the other hand, in a thorough and well-reasoned report, the Independent Chiropractic Consultants, who thought that claimant would benefit from an exercise program, reported that claimant was, nevertheless, medically stationary on January 21, 1987. (Ex. 16). Although Dr. Cichoke later disputed the findings of the Independent Chiropractic Consultants, he gave no substantiation or basis for his disagreement.

We interpret the Consultants' recommendation for an exercise program as indicating potentially palliative benefit rather than curative treatment. We are more persuaded by the opinions of Dr. Duff and the Consultants. Accordingly, we find that claimant has failed to prove that he was not medically stationary as of March 10, 1987, the date his claim was closed.

Aggravation

The Referee concluded that claimant had failed to prove that his condition aggravated as of April 4, 1987. We agree.

Claimant has the burden to establish a compensable aggravation. He must show that he has sustained a worsened condition resulting from the compensable, September 1986 injury. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). It is unclear whether claimant asserts a pathological worsening or a symptomatic worsening of his condition. For purposes of establishing a compensable aggravation, "worsened conditions" may take the form of either a worsening of the underlying condition or a symptomatic worsening. Smith v. SAIF, 302 Or 396 (1986). If a worsening involves a symptomatic exacerbation, and if the prior award contemplated symptomatic exacerbations, then claimant must also prove that his increased symptoms lasted longer or were greater in degree than was anticipated and that, as a result, he suffered a diminished earning capacity; or that his worsened condition 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); Edward D. Lucas, 41 Van Natta 2272 (1989).

Claimant alleges that his condition worsened on April 4, 1987 while demonstrating a vacuum cleaner. (Tr. 12-14). The baseline for measuring a worsening of claimant's condition is claimant's level of disability on March 10, 1987, the date his claim was closed by Determination Order. On January 21, 1987, the Independent Chiropractic Consultants found claimant medically stationary, capable of returning to his regular working activities without restrictions or limitations other than being involved in home exercising programs and education on proper methods of spinal hygiene and body biomechanics. (Ex. 16-5). Further, the Consultants found that claimant's complaints were "... out of proportion to our examination findings." (Ex. 16-5).

At the time of claim closure, Dr. Cichoke continued to treat claimant in the chiropractic treatment program he had begun with claimant at the time of the initial injury. On May 8, 1987, subsequent to the time claimant alleges his condition worsened, Dr. Cichoke wrote that claimant's "on-going therapeutic stage" of care had been accomplished, that his "chronic therapeutic care phase" had been "successfully accomplished," and that claimant had reached the "maximum correction in rehabilitation" that could be anticipated. (Ex. 26). Further, Dr. Cichoke, opined that:

> "... some degree of symptomatology and or objective finding has been present with each and every office visit. In spite of this, [claimant] seems to be doing relatively well, symptomatically depending on his daily activities and emotional stress." (Ex. 26-4 & 5).

On May 11, 1987, an MRI scan indicated, "slight anterior wedging vertebral body of T12 consistent with old trauma, magnetic resonance imaging of thoracic spinal cord and canal-negative." (Ex. 27).

There is no medical evidence of either a symptomatic or pathologic worsening of claimant's condition. 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, however, claimant's testimony is not consistent with the objective medical evidence, nor consistent with his treating chiropractor's opinion. Furthermore, the medical evidence indicates that claimant tends to exaggerate his symptoms. Under these circumstances we find claimant's testimony unreliable and unpersuasive towards a conclusion that claimant has sustained a worsening of his condition. Further, even if claimant had experienced a worsened condition, we find that he had failed to prove any increased loss of earning capacity as a result.

Accordingly, claimant has not carried his burden to prove that he sustained a compensable aggravation.

Compensability of Psychological Condition

The Referee found that claimant had failed to prove that his psychological condition was compensable. We agree.

In order for us to find that claimant suffers from a compensable psychological condition, claimant must show by a preponderance of the evidence that his compensable back injury is a material cause of a psychological condition from which he suffers. Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985).

Claimant cites the opinion of Dr. Colistro, psychologist, as support for his claim that he is in need of treatment for a compensable psychological condition. Dr. Colistro reported that claimant, "who has been only marginally adjusted socially prior to his injury," suffered mild depression following various disruptions related to his injury. (Ex. 36-3). He added that, although the injury contributed to claimant's current state of restlessness and anxiety, the majority of his psychological problems appeared to preexist the injury. Dr. Colistro recommended against treatment, explaining that claimant's lack of cooperation and motivation and his poor psychological insight made him a poor psychotherapy candidate. He concluded, therefore, that claimant was "technically" psychologically stationary.

A finding that claimant's psychological condition preexists his compensable injury is supported by documentation from the Orthopaedic Consultants. On November 21, 1986, two months after claimant's compensable injury, the Orthopaedic Consultants wrote that they were unable to do a complete physical examination of claimant because of interference from a functional disturbance manifested by claimant's exaggerated tenderness, frequent grunting, groaning, grimacing and sighing. (Ex. 9-4). Additionally, they noted that claimant's subjective complaints were not supported by objective orthopedic or neurologic abnormality.

Accordingly, we conclude that claimant has not shown by a preponderance of the evidence that his compensable September 1986 injury materially contributed to his preexisting psychological condition. We also conclude that claimant has failed to prove that any injury-related restlessness or anxiety constituted a compensable condition, requiring medical services or resulting in disability.

Compensability of Pain Center Treatment

Claimant is entitled to all reasonable and necessary diagnostic, curative and palliative medical care required for a compensable injury. See former 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); Kenneth M. Simmons, 41 Van Natta 378 (1989). Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

Only Dr. Cichoke considered claimant a candidate for pain center treatment. His sole explanation for his opinion was that claimant would have "... to live with a certain level of pain. Therefore, a pain center could aid and train [claimant] to cope with his residual level of pain." (Ex. 32-1).

On the other hand, the Independent Chiropractic Consultants opined in January 1987 that claimant was in no further need of care or treatment. (Ex. 16). Furthermore, claimant was referred to an exercise program and after only a month of attendance he was terminated from the program because of a lack of any progress.

On our de novo review of the evidence, we are not persuaded that a preponderance of the evidence establishes that treatment of claimant at a pain center was reasonable or necessary.

Permanent Partial Disability

The Referee found that claimant was capable of returning to his previous employment without restriction and that he had failed to prove any permanent, injury-related impairment. We agree.

Claimant bears the burden of proving permanent disability. Hutcheson v. Weyerhauser Co., 288 Or 51 (1979). In order to prove entitlement to an award of unscheduled permanent disability, claimant 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 claimant's physical impairment and all the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply the Department's former rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

The great weight of the evidence indicates that claimant tends to exaggerate his symptoms and has sustained no impairment as a result of his compensable September 1986 injury. The Orthopaedic Consultants were unable to complete their examination of claimant due to a severe degree of interference from claimant's functional disturbance. Bone scans indicate no abnormality. Dr. Duff found no impairment and could not recommend further treatment other than palliative care. The Independent Chiropractic Consultants, in a thorough and well-reasoned report, recommend that claimant could return to his regular work activities without restrictions. Dr. Colistro found that claimant's psychological problems preexist his compensable injury and that claimant is not amenable to treatment. We have interpreted Dr. Colistro's report as a whole as indicating that claimant's psychological problems were not materially caused by his compensable condition.

Claimant's treating chiropractor, Dr. Cichoke, without adequate substantiation or explanation, argues that claimant is not medically stationary, cannot return to his regular employment, and needs further treatment.

Claimant has not proven that his subjective complaints of pain are, in fact, due to the compensable injury. Claimant has not proven that he has sustained a permanent loss of earning capacity in the broad field of general occupations due to the compensable injury.

Compensability of a new injury

Claimant must be a "subject worker" in order to receive "compensation" under the Workers' Compensation Act. ORS 656.027. Here, the issue of whether claimant suffered a compensable injury as a Kirby vacuum cleaner salesman depends, initially, upon whether he was a "subject worker" of Cande. The Referee found that claimant was not a subject worker. We agree.

Claimant has the burden to prove, by a preponderance of the evidence, that an employer/employee relationship exists. "Employer" means "any person ... who contracts to pay a remuneration for and secures the right to direct and control the services of any person." ORS 656.005(13). "Worker" means "any person ... lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer ..." ORS 656.005(27). Accordingly, the test for determining who is a subject worker within the meaning of the Workers' Compensation Act is the employer's right to control the performance of the worker's services. The test requires an application of the traditional "right to control" analysis. Woody v. Waibel, 276 Or 189, 196 (1976); Castle Homes, Inc. v. Whaite, 95 Or App 269, 271 (1989).

The factors to be considered under the traditional test of the right to control include: (1) 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 at will without liability. Castle Homes, Inc. v. Whaite, supra.

Here, the evidence supports a finding that Cande exercised little, if any, control over claimant's day-to-day sales activities. Claimant's objective was to sell vacuum cleaners he received on consignment from Cande -- after 30 days, he either sold a vacuum cleaner, returned it or purchased it himself. Claimant chose the time, place and persons to whom he would demonstrate a vacuum cleaner. Claimant argues that because Cande required him to call into the office several times during his vacuum cleaner demonstrations, Cande exercised control over his activities. We disagree. Claimant was in a vacuum-cleaner-sales training program at the time of injury. The phone call requirement was a training tool offered to aid claimant in perfecting his sales techniques, not a permanent requirement nor a method of control.

Cande provides no equipment to its dealers. Claimant used his own car and purchased his own gas.

Claimant earned money from this arrangement only if he sold a vacuum cleaner. Claimant made a profit only if he sold a vacuum cleaner for an amount over his own costs. Claimant could draw against his anticipated profits, but the amount drawn had to be paid back to Cande. Although Cande did promise to pay a bonus, such bonus would only be paid if and when claimant sold a certain number of cleaners. This bonus was an incentive tool and not a salary or method of payment for services. Cande had no employment payroll and paid no employment taxes. Claimant paid his own taxes.

Claimant signed an agreement whereby he acknowledged that he should not consider himself "an employee," and that either he or Cande could terminate the relationship "at any time without obligation to the other party." (Ex. 28a-15).

Weighing the relevant factors, particularly the right to control, we conclude that claimant was an independent contractor and not a "subject worker." Any injury he suffered as an independent contractor is not compensable as to Cande.

Penalty and Attorney Fee

The Referee declined to assess a penalty and related attorney fee concluding that SAIF did not act unreasonably by not acquiescing to the issuance of ORS 656.307 order. We agree. We have concluded that claimant did not sustain a new injury or an aggravation of his compensable back condition on April 4, 1987. We find that compensability was reasonably treated as in doubt and at issue by SAIF. Its failure to consent to a .307 order was not unreasonable.

ORDER

The Referee's order date January 29, 1988 is affirmed.

December 7, 1990 Cite as 42 Van Natta 2739 (1990)

In the Matter of the Compensation
DONNA S. COLIRON, Claimant
WCB Case No. 89-01023
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Schultz's order that: (1) declined to grant permanent total disability; and (2) increased her unscheduled permanent disability award for her current low back injury from 43 percent (137.6 degrees), as awarded by Determination Order, to 50 percent (160 degrees). The insurer cross-requests review of the Referee's order, contending that claimant is not entitled to any unscheduled permanent disability. On review, the issue is extent of permanent disability, including permanent total disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact", as set forth on pages one through six, and the first paragraph of page seven, of the Referee's order, as our own, with the following supplementation.

Claimant has not returned to work as a result of her compensable back injury. She has the physical capacity to perform, and is capable of performing, sedentary to light work. She is not permanently and totally disabled.

Claimant's chronic pain and permanent loss of lumbar range of motion are the result of claimant's earlier 1972 back injury and her degenerative back condition, and not caused by her March 1988 compensable back injury.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

We adopt the Referee's Conclusions of Law, as set forth on pages 7 and 8 of the Referee's order, which found claimant not permanently and totally disabled.

Extent of Unscheduled Permanent Disability

The Referee increased claimant's unscheduled permanent disability award from 43 percent to 50 percent. We reverse.

Claimant's back claim was closed by Determination Order on February 15, 1989. We apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Therefore, former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability. Where the claimant fails to establish any measurable impairment resulting from his or her compensable injury/condition, no award of disability is allowed. Former OAR 436-35-280(1).

Claimant argues that she suffered permanent impairment resulting from her March 1988 back injury and relies on a December 1988 testing report of Dr. Christensen, D.C., and a March 1989 report authored by claimant's current treating chiropractor, Dr. Holman. The insurer, on the other hand, argues that based on the medical reports of Dr. Harris, claimant's original treating orthopedist; Dr. Duncan, D.C., independent medical examiner; and the Orthopaedic Consultants, claimant suffered no measurable impairment resulting from her March 1988 compensable back injury. We agree with the insurer.

We first note that while Dr. Holman's reports include both thoracic and cervical range of motion findings, claimant's March 1988 back injury involved only her low back. Therefore, claimant is not entitled to disability for a loss of cervical range of motion.

There is no question that claimant has lost a certain amount of range of motion in her thoracolumbar spine. All of the medical reports substantiate that fact.

The issue here is whether claimant's lost range of motion and chronic pain are causally related to claimant's compensable back injury. It is claimant's burden to prove that existing impairment is due to her current compensable back injury. ORS 656.214. We find, after our de novo review of the record, that claimant has failed to meet her burden.

The Board generally gives greater weight to the conclusions of a treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Further, where the causation of a claimant's condition is of sufficient medical complexity, we do not decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, the record establishes that claimant sustained an earlier compensable back injury in 1972 which resulted in a laminectomy at L4-5 and L5-6 and a two level bilateral transverse process fusion from L4-S1. In 1977, claimant received a total of 40 percent unscheduled permanent disability for that back injury claim.

The record also establishes that claimant has continued to have ongoing back pain, as well as leg weakness, up until the time of the March 1988 back injury and continuing through the time of hearing.

Under the circumstances, we find that the determination of whether claimant's current loss of range of motion and chronic pain are caused by her March 1988 back injury is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Therefore, claimant's testimony regarding the causation of her loss of range of motion and chronic pain is insufficient to make a final determination on causation.

The record includes medical reports authored by Dr. Harris, Dr. Duncan, the Orthopaedic Consultants and Dr. Holman.

Dr. Holman, chiropractor, began treating claimant in late August 1988, approximately six months after claimant's March 1988 back injury. After referring claimant to Dr. Christensen, chiropractor, for testing in November 1988, Holman reported that, based on Christensen's testing report, claimant was totally disabled. Later, in March 1989, Holman again, relying upon Christensen's testing, authored a brief report indicating that claimant suffered 100 percent loss of range of motion and suffered 90 percent loss of strength. Holman did not specifically opine whether or not claimant's current condition, including loss of range of motion and the chronic pain, were caused by claimant's March 1988 back injury.

While Dr. Holman was claimant's most recent treating chiropractor, we do not find his opinion regarding claimant's condition to be persuasive. First, Holman did not begin treating claimant until six months after the compensable injury. Further, Holman based his ultimate findings of impairment on testing which he, himself, did not conduct. At no time did Dr. Holman make independent range of motion findings. Finally, based upon the medical record, we no not find Dr. Holman's determination that claimant lost 100 percent range of motion persuasive. Therefore, based on the above findings, we do not rely on the opinion of Dr. Holman in determining the extent of disability. Weiland v. SAIF, supra; Nancy E. Cudaback, supra.

The remainder of the record consists of medical reports by Dr. Harris, claimant's initial treating orthopedist; Dr. Duncan, D.C., independent medical examiner; and the Orthopaedic Consultants. The consensus reached by these physicians is that claimant has a chronic pain syndrome and sustained a moderately severe degree of loss of lumbar range of motion. However, they each specifically reasoned that because claimant's March 1988 compensable back injury was a muscular or ligamentous injury, which, by the time of their examinations, had, or should have, resolved, claimant's current loss of function could not be related to or caused by her March 1988 low back injury. (Exs. 17, 19 and 29).

Given the facts that claimant had ongoing back problems since 1972 up through the time of the hearing, and that claimant was diagnosed with a degenerative back condition due to the earlier laminectomy and fusion surgeries, and in light of the characterization of claimant's current back injury as muscular or ligamentous, we find the concurring opinions of Dr. Harris, Dr. Duncan and the Consultants to be persuasive as they are well-reasoned and based on a complete and accurate record. Consequently, we rely upon them in determining the causation of claimant's loss of range of motion and chronic pain. Somers v. SAIF, 77 Or App 259, 262 (1986); See Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

There is no persuasive evidence in the record to establish that claimant's March 1988 back injury resulted in a loss of range of motion or a chronic condition. In fact, the preponderance of the evidence establishes that claimant's lost range of motion and chronic pain were not related to or caused by claimant's March 1988 compensable back injury, but were caused, instead, by her prior back condition.

We find, therefore, that claimant has failed to meet her burden of proving that she suffered permanent measurable impairment resulting from her March 1988 compensable injury. Consequently, no award of unscheduled permanent disability is made.

ORDER

The Referee's order dated May 26, 1989 is affirmed in part and reversed in part. That portion of the Referee's order that increased claimant's unscheduled permanent disability award is reversed. That portion of the February 15, 1989 Determination Order that awarded 43 percent (137.6 degrees) unscheduled permanent disability for claimant's March 1988 back injury is reversed. The remainder of the order is affirmed.

December 7, 1990 Cite as 42 Van Natta 2742 (1990)

In the Matter of the Compensation of
JOHN G. DAVISON, Claimant
Own Motion No. 66-0199M
OWN MOTION ORDER OF DISMISSAL
Meyers & Radler, Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for additional medical benefits related to his September 25, 1962. Claimant's aggravation rights have expired. He was awarded permanent total disability benefits in 1964. We dismiss for lack of jurisdiction.

ORS 656.278(1)(b) authorizes the Board to award, on its own motion, medical benefits for injuries occurring prior to January 1, 1966. See also OAR 438-12-037. That authority is discretionary and is intended to provide relief to injured workers who do not have a right to medical benefits for their injuries. Workers who were injured on or after January 1, 1966, have a lifetime right to medical benefits under ORS 656.245. In addition, however, workers who were injured from August 5, 1959, through December 31, 1965, and were found permanently and totally disabled also have a lifetime right to medical benefits. See Or Laws 1959, ch 589, 2. Here, claimant was injured in 1962 and was found permanently and totally disabled; therefore, he has a lifetime right to medical benefits for his injury.

Inasmuch as claimant has the right to medical benefits, his claim for such benefits should be processed under the regular claims processing procedures prescribed in ORS 656.262. If the claim is denied, claimant may then request a hearing on the denial pursuant to ORS 656.319. Claimant may not, however, maintain a concurrent request for medical benefits under the Board's own motion authority. That would effectively circumvent the aforementioned claims processing and hearings procedures, and ultimately contribute to jurisdictional confusion, processing delays and uncertainty.

The Board is mindful that OAR 438-12-037 does not distinguish pre-1966 injuries resulting in permanent total disability from other pre-1966 injuries which qualify for own motion relief. However, that omission resulted from oversight and does not reflect any intent by the Board to exercise concurrent own motion jurisdiction of pre-1966 injuries resulting in permanent total disability. On the contrary, the Board's own motion authority to award medical benefits under ORS 656.278(1)(b) is intended to complement, not overlap with, the right to medical benefits under ORS 656.245. That is, only those injured workers who do not have the right to medical benefits may petition for those benefits through own motion relief. Accordingly, because claimant has the right to medical benefits, the Board lacks own motion authority to grant him own motion relief. Claimant's request for relief is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALICE M. DERRICK, Claimant
WCB Case No. 89-09756
ORDER ON REVIEW
Royce, Swanson & Thomas, Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Mulder's order which found claimant had established good cause for an untimely filing of a hearing request. On review, the issue is timeliness of the hearing request. We affirm.

FINDINGS OF FACT

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

On August 31, 1988, claimant strained her low back while lifting a 58 pound speaker at work. She sought medical treatment from Dr. Breitenstein, who filed a worker's compensation claim on her behalf in September 1988. SAIF denied benefits in a December 22, 1988 letter.

After receiving the denial letter, claimant telephoned a claims examiner with SAIF because she did not understand the denial notice. This call took place on January 20, 1989. After the telephone communication with SAIF's employee, claimant was left with the impression that the claims examiner was going to set up a hearing and that she (claimant) did not have to take further action because "everything would be handled." Claimant referred to SAIF as the "State Industrial" which she believed was comparable to the state of Washington's worker's compensation system. Claimant had worked in Washington for a number of years processing the payroll for the worker's compensation program. Consequently, claimant was under the mistaken belief that the claims examiner was a state worker who was protecting her interests.

In contrast, SAIF's claims examiner could not recall relevant portions of the conversation and he could only say that it was very "unlikely" he would have told claimant he would arrange a hearing.

Ten days after the telephone call with SAIF's employee, claimant received another notice from SAIF advising her that an independent medical examination was scheduled for March 1, 1989, more than 60 days following SAIF's denial. Claimant also learned during this period that her doctor had been paid for medical services and she received mileage expenses incurred from September 1988 through February 13, 1989. The claims examiner acknowledged that it was an uncommon practice for SAIF to schedule an independent evaluation after the 60-day appeal period, but he was attempting to assist the claimant. He also agreed that paying for medical and travel expenses was unusual when a claim is in denied status.

Well-intentioned reassurances from SAIF's claims examiner, plus the subsequent scheduling of a medical examination and the payment of medical and travel expenses, reasonably misled claimant to erroneously believe her denial was withdrawn or that her right to a hearing was protected. Claimant was lulled into inaction by this mistaken belief.

Claimant's treating doctor eventually advised her that she had to request the hearing herself. Thereafter, she retained an attorney and, on May 17, 1989, claimant requested a hearing.

The Referee found claimant entirely credible.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions of Law and Opinion" with the following supplementation and comments.

A request for hearing must be filed no later than the 60th day after claimant is notified of a denial of a claim. ORS 656.319(1)(a). Nevertheless, a hearing request that is filed after 60 days, but within 180 days of a denial, may be excused if claimant had good cause for the late filing. ORS 656.319(1)(b). 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). Lack of diligence does not constitute good cause and claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

SAIF argues that the denial letter notice that claimant had 60 days in which to file a hearing was clear on its face and claimant's confusion over her responsibility in that regard is not "good cause" as contemplated by ORS 656.319 or the type of "mistake" recognized in Anderson, supra. We disagree.

Here, claimant was more than just confused by the oral statements of a SAIF employee. See e.g., Debra A. Smith, 42 Van Natta 1531 (1990); Diane T. Lindholm, 42 Van Natta 447 (1990). Rather, well-intentioned reassurances from SAIF's claims examiner, plus the subsequent actions on the part of the insurer, reasonably misled claimant to mistakenly believe her denial was withdrawn, or that her right to a hearing was protected. This constitutes "good cause" within the meaning of ORS 656.319(1)(b). See Cary O. Miller, 42 Van Natta 618 (1990). In this regard, we are more persuaded by claimant's version of events. She was found credible by the Referee and her description of how she was lulled into inaction is entirely plausible. On the other hand, SAIF's employee does not recall relevant portions of the telephone conversation and is only able to guess at what he probably did not say. Accordingly, we affirm the Referee's determination that claimant has established good cause for her failure to file a timely hearing request.

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

ORDER

The Referee's order dated September 29, 1989 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable assessed fee of $800, to be paid by SAIF.

In the Matter of the Compensation of
MERLYN E. LANGLEY, Claimant
WCB Case No. 89-09355
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Acker, Underwood, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Myzak's order that: (1) upheld the self-insured employer's denials of his bleeding ulcer condition; (2) declined to award interim compensation pending the denial; and (3) declined to assess penalties and attorney fees for failure to pay interim compensation. The issues on review are compensability, interim compensation, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's finding of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion and conclusion on the issue of the compensability of the bleeding ulcer condition.

Interim Compensation

The Referee found that the employer's letter that was sent to claimant's attorney on December 27, 1988, in response to claimant's request to reopen his claim, was a valid denial issued within 14 days and no interim compensation was then due. We disagree. The letter to claimant's attorney was not a formal denial nor did it give claimant his statutory rights. ORS 656.262(8). We find instead that this claim was not denied until the formal denial was issued in April 1989.

Claimant's petition to reopen his claim states that claimant has been hospitalized for treatment of Motrin-induced stomach bleeding. This petition was mailed to the employer on December 20, 1988. Interim compensation for an aggravation claim is to be paid within 14 days after the employer receives medical verification of authorized time loss unless the claim has been denied. Interim time loss is to be continued until the claim is formally denied.

The employer was aware at the time of the December 14, 1988 hearing that claimant had been hospitalized and intended to file an aggravation claim. It is unclear from the evidence however, when the employer received medical verification of an inability to work resulting from a worsening of the compensable injury. It is to be inferred that when claimant was in the hospital he was unable to work.

In this case, it is unclear if the employer received actual direct medical verification from the doctor of claimant's inability to work prior to Dr. McAndrews' January 30, 1989 report. There were hospital reports of claimant's December 9, 1988 hospitalization for bleeding ulcers, but it is unclear when those reports were sent to the employer. However, claimant's December 20, 1988 petition for reopening provided notice of claimant's admission to the hospital on December 9, 1988, for Motrin-induced stomach bleeding. The employer had previously received notice that claimant's treating physician was prescribing Motrin for his compensable back injury. Further, the employer acknowledged by letter dated December 27, 1988, that it was aware that claimant had been

hospitalized and that claimant was contending the need for that hospitalization was due to the medication he was taking for his compensable injury.

In Berkey v. Fairview Hospital, 94 Or App 28 (1988), the court found a vocational counselor's letter to the insurer wherein reference was made to the treating doctor's authorization of time loss, to be adequate notice to trigger the insurer's duty to pay interim compensation. ORS 656.273(6) requires payment of interim compensation within 14 days after notice or knowledge of medically verified inability to work. (Emphasis provided). Medical verification of inability to work need not come directly from the physician. Id.

In this matter, we have inferred that claimant was unable to work while hospitalized. Once a claim for aggravation had been made, the employer's actual knowledge that claimant was hospitalized would trigger the duty to pay. We find that the earliest date the employer had the knowledge as it related to the aggravation claim would be December 20, 1988, when the petition to reopen was filed with it by claimant's attorney. Thus, claimant is entitled to interim compensation from December 20, 1988 until the denial was issued on April 11, 1989.

Penalties and Attorney Fees

The Referee found that there was no basis for penalties or a penalty-related attorney fee because no interim compensation was due. We disagree. We have found that the employer should have paid interim compensation. Its failure to pay interim compensation was based on the contention that the request to reopen was denied by its December 27, 1988 letter to claimant's counsel. We have found this letter to not meet the requirements of a formal denial. We additionally find it was unreasonable for the employer to rely on this letter in meeting its obligation to either deny the claim or to begin paying interim compensation. A penalty based on the amount of interim compensation due pending the denial is appropriate, as is an attorney fee because failure to pay interim compensation was a resistance to the payment of compensation.

ORDER

The Referee's order dated December 14, 1989 is affirmed in part and reversed in part. That portion of the order that upheld the denials of the self-insured employer is affirmed. Claimant is entitled to interim compensation from December 20, 1988 to April 11, 1989. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800. Claimant is further entitled to a penalty of 25 percent of the amount of interim compensation due but not paid and a penalty-related fee of $350, payable by the employer. The remainder of the Referee's order is affirmed.

December 10, 1990 Cite as 42 Van Natta 2746 (1990)

In the Matter of the Compensation of
ERNEST L. RIDLEY, Claimant
WCB Case No. 89-04159
ORDER ON REVIEW
Bottini & Bottini, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of those portions of Referee Podnar's order which: (1) upheld the insurer's denial of his medical services claim for a low

back injury; (2) found that claimant was not substantively entitled to temporary disability benefits; (3) declined to assess a penalty or attorney fee for an allegedly unreasonable failure to timely accept or deny the aggravation claim; (4) found that claimant was not procedurally entitled to interim compensation; and (5) declined to assess a penalty or attorney fee for an allegedly unreasonable failure to pay interim compensation. On review, the issues are medical services, temporary disability benefits, interim compensation and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

In 1959, claimant underwent a 3-level fusion from L3 to the sacrum. In 1980, he sustained a compensable low back injury. The employer was insured by Industrial Indemnity at that time. As a result of this injury, he underwent a lumbar laminectomy at right L3-4. The claim was closed by an April 1982 Determination Order which awarded 15 percent unscheduled permanent disability.

In 1983, claimant sustained a worsening of his low back condition. The employer at that time was insured by Fireman's Fund. Both Industrial Indemnity and Fireman's Fund denied responsibility for claimant's low back condition. This matter came before an earlier Referee in September 1984. The earlier Referee found that Fireman's Fund was responsible for claimant's condition. Thereafter, the claim was closed by a January 1985 Determination Order which increased claimant's total unscheduled permanent disability award to 50 percent and also awarded 5 percent scheduled permanent disability for each leg.

Claimant did not return to work following the 1983 injury. He was referred to a work hardening program in 1984, but left the program before completion. Vocational assistance was provided in 1984, but was not successful. In 1985, claimant moved to the Washington coast. In 1986, he applied for and received Social Security benefits.

On July 25, 1988, claimant telephoned a Fireman's Fund claims examiner and informed her that he had recently seen a physician and that the physician wanted to perform low back surgery. He requested that his claim be reopened. Claimant also informed the claims examiner that he had been retired since 1983.

On August 3, 1988, Dr. Guyer, the physician that claimant had seen in conjunction with his request for reopening, wrote Fireman's Fund. In his letter, Dr. Guyer stated that claimant is:

> "trying to reopen his claim with your company in connection with his most recent back injury. I think this is reasonable, as his present changes are sequalae of his previous injuries and their treatment. I have recommended to claimant that he consider a decompression of the lateral recess at L4-5 and L3-4 bilaterally."

In September 1988, Dr. Guyer performed the surgical procedure on claimant. On January 31, 1989, the insurer issued a denial of medical services on the basis that claimant's current low back condition was not related to his compensable injury. The insurer has not paid for the cost of claimant's surgery.

FINDINGS OF ULTIMATE FACT

Claimant's current low back condition and need for medical treatment is materially related to his accepted low back injury.

The insurer was not provided with medical verification of claimant's inability to work due to the industrial injury.

The insurer's delay in denying claimant's claim was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's current low back condition and need for medical treatment was not materially related to his compensable low back injury. We disagree.

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to his disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). 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).

Dr. Guyer, who performed surgery on claimant in 1988, acknowledged that claimant's previous surgeries contributed to claimant's low back condition, but opined that the 1983 injury was a material contributing cause of his current condition. Dr. Rosenbaum opined that claimant's current low back condition was causally related to his prior surgeries and the aging process. We find Dr. Guyer's opinion persuasive inasmuch as he has treated claimant and performed the latest surgery on his low back. See Givens v. SAIF, 61 Or App 490 (1983). Accordingly, claimant has established that his current low back condition and need for medical treatment is materially related to his 1983 injury.

In reaching this conclusion, we note that Fireman's Fund became responsible for claimant's condition in 1983, which included residuals from the 1981 surgery, by virtue of the earlier Referee's opinion. In this regard, Dr. Rosenbaum's opinion also supports a material relationship between claimant's current low back condition and the claim accepted by Fireman's Fund.

Temporary Total Disability

The Referee concluded that claimant was not substantively entitled to temporary total disability benefits on the basis that he had removed himself from the work force. We agree.

In order to receive temporary total disability benefits for a worsening of a compensable injury, claimant must have been in the work force at the time of the disability. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989); Cutright v. Weyerhaeuser, 299 Or 290 (1985). In order to prove that he was in the work force at the time of the worsening, claimant must establish that he is engaged in regular gainful employment; or although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or 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. Dawkins, supra at 258.

Claimant has not been gainfully employed since the 1983 injury. In 1984, he was referred to a work hardening program but did not complete the program due to pain complaints. Vocational assistance was offered in 1984, but claimant felt he was unable to work, despite his physician's opinion that he was capable of sedentary work. Thereafter, claimant moved to the Washington coast where no work was available. In 1986, claimant applied for and received Social Security

benefits. Finally, in 1988, when he spoke to the claims examiner from Fireman's Fund, he indicated that he had been retired since 1983.

Although claimant testified that he was currently willing to try some work within his physical capabilities, we find his actions following the 1983 injury more persuasive. We find no persuasive evidence that claimant is willing to work or has made reasonable efforts to obtain work. Accordingly, we conclude that claimant was not in the work force at the time of his March 1988 worsening. Therefore, he is not substantively entitled to temporary total disability benefits resulting from this worsening. Id.

Penalties and Attorney Fees

The Referee declined to award a penalty or related attorney fee for the insurer's untimely denial on the basis that claimant had not made an aggravation claim. We disagree.

After the last arrangement of compensation, claimant is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. ORS 656.273(1). A physician's report is an aggravation claim, so long as it, at a minimum, requests additional medical services or additional compensation resulting from the compensable injury. Haret v. SAIF, 72 Or App 668 (1985).

Here, Dr. Guyer's report of August 3, 1988 did not necessarily establish that claimant's condition had worsened, but it did put the insurer on notice that treatment for more than a continuing condition was indicated. The insurer, however, did not deny the claim until January 31, 1989. The insurer offers no explanation for this delay and we find it unreasonable. Under these circumstances we conclude that a 25 percent penalty, based upon the amount of the surgery, and a related attorney fee is appropriate. See Clinton F. Seals, 42 Van Natta 268, 269 (1990).

Interim Compensation

The Referee found that claimant was not entitled to interim compensation and declined to assess a penalty or attorney fee for an allegedly unreasonable failure to pay interim compensation. We agree.

Entitlement to interim compensation depends on whether, before the denial of an aggravation claim, there was a medical verification of a claimant's inability to work due to the worsened condition. ORS 656.273(6); Berkey v. Fairview Hospital, 94 Or App 28, 31 (1988). If the employer has notice or knowledge of verification, payment of interim compensation must begin within 14 days. ORS 656.273(6).

Here, Dr. Guyer notified the insurer that he was recommending surgery for claimant's low back condition. Dr. Guyer, however, did not report that claimant was unable to work due to his low back condition. Under these circumstances, we conclude that the insurer did not receive medical verification of an inability to work. ORS 656.273(6). Accordingly, claimant has not established entitlement to interim compensation.

As we have concluded that claimant has not established entitlement to interim compensation, it follows that the insurer's failure to pay interim compensation was not unreasonable. Therefore, assessment of penalties and attorney fees is not warranted.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the medical services issue is $2,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved.

Further, after considering the aforementioned factors, we find that a reasonable attorney fee for claimant's counsel services concerning the penalty issue is $500, to be paid by the insurer.

ORDER

The Referee's order dated December 1, 1989, is reversed in part and affirmed in part. That portion which upheld the insurer's denial is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning the medical services issue, claimant's counsel is awarded an assessed attorney fee of $2,000, payable by the insurer. Claimant is further awarded a penalty equal to 25 percent of the cost of his surgery, payable by the insurer. Claimant's counsel is also awarded a penalty-related assessed attorney fee of $500, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
SHARI HALLBERG, Claimant
WCB Case No. 89-08893
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Harri's order that assessed a penalty-related attorney fee for SAIF's allegedly untimely claims processing. The issue on review is penalty-related attorney fees. We reverse.

FINDINGS OF FACT

Claimant has an accepted back injury claim. In connection with treatment for that accepted condition, she traveled from Tillamook to Lincoln City to see Dr. Scheinberg. While there, he took x-rays of her upper and lower back. As of the date of hearing, August 31, 1989, SAIF had not reimbursed claimant for her mileage expense to attend that examination or for the cost of the x-rays. The record does not establish if, or when, SAIF received a request for reimbursement of those expenses.

On May 17, 1989, claimant's counsel wrote SAIF requesting clarification of a denial letter from SAIF dated March 22, 1989. The record does not indicate when SAIF received that clarification request. SAIF responded to that request on June 22, 1989.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant sought a penalty-related attorney fee for SAIF's alleged failure: (1) to pay or deny claimant's mileage reimbursement expense and x-ray bill; and (2) to clarify its March 22, 1989 denial. The Referee concluded that, pursuant to Mischel v. Portland General Electric, 89 Or App 140

(1987), rev den 305 Or 671 (1988), a penalty-related fee was due. We conclude otherwise.

We first note that, only a few days prior to issuance of the Referee's order, we concluded in Lloyd L. Cripe, 41 Van Natta 1774 (1989), that the Supreme Court's then-recent decision in Ellis v. McCall Insulation, 308 Or 74 (1989), is directly contrary to the Court of Appeals' holding in Mischel, supra. Ellis requires that there be an unreasonable resistance to the payment of compensation as required by ORS 656.382(1) before an attorney fee can be awarded under ORS 656.262(10).

Here, we find no evidence from which we can determine if or when SAIF received claimant's travel reimbursement and x-ray billings. Nor has claimant established when the billings were mailed in order to be able to take advantage of the presumption of receipt under ORS 40.135(1)(q). In this regard, claimant submitted an affidavit stating that she twice "submitted" the billings to SAIF more than 60 days prior to the hearing. However, her affidavit does not establish that her submissions were "duly directed and mailed" or the date of such mailing. Absent that information, we cannot determine if SAIF delayed acceptance or denial or otherwise unreasonably resisted payment of the billings. Accordingly, no penalty-related attorney fee can be assessed for SAIF's alleged failure to timely process those billings.

Claimant also alleges entitlement to a penalty-related attorney fee for SAIF's alleged failure to timely respond to her May 17, 1989 request for clarification of SAIF's March 22, 1989 denial. In particular, claimant inquired as to which conditions had been accepted and under which claim numbers. On June 22, 1989, within 60 days of claimant's requested clarification, SAIF sent a letter of clarification to claimant's counsel. Although brief, SAIF's response indicated a claim number, date of injury, and the nature of the accepted condition. We, therefore, conclude that SAIF did respond to claimant's clarification request within 60 days. We find no unreasonable action on SAIF's part nor did SAIF's action constitute an unreasonable resistance to the payment of compensation under ORS 656.382(1). Accordingly, no penalty-related attorney fee can be assessed for SAIF's alleged failure to timely respond to claimant's request for clarification.

ORDER

The Referee's order dated October 27, 1989 is reversed in part and affirmed in part. That portion of the Referee's order that assessed a penalty-related attorney fee of $1,075 is reversed. The remainder of the order is affirmed.

December 11, 1990 Cite as 42 Van Natta 2751 (1990)

In the Matter of the Compensation of
ELDON E. HUNT, Claimant
WCB Case No. 89-17086
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Daniel J. DeNorch (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Menashe's order that: (1) declined to grant permanent total disability; and (2) authorized an offset of an overpayment of temporary total disability against permanent partial disability. On review, the issues are permanent total disability and offset. 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 Conclusions of Law and Opinion, with the following supplementation.

Permanent total disability

The Referee found that claimant was not totally incapacitated on a physical basis and that it would not be futile for him to seek work. He concluded that claimant could not refuse to seek work at positions that paid less than $10 per hour and he declined to award permanent total disability.

On review, claimant contends that there is no gainful or suitable work that he is capable of performing. Claimant argues that the definition of gainful employment requires employment that bears a reasonable relationship to an individual's experience and background, including prior earnings. Frame v. Crown Zellerbach, 63 Or App 827 (1983). Although Frame involves eligibility for vocational rehabilitation services, claimant contends that the reasoning should be applicable in his case.

Claimant argues that, because his wage at the time of injury was $17.56 per hour with full medical benefits, he should not be required to give up that income level in order to seek employment at a lower wage level. He also contends that there is no evidence in the record that he has refused an offer of gainful employment.

We do not agree with claimant's assertion that the standards for gainful employment in a permanent total disability case should be identical to those in a vocational assistance case. In a recent permanent total disability case, Walter R. Searles, 41 Van Natta 627, 629 (1989), aff'd 101 Or App 589 (1990), we applied the following rationale:

> "The purpose of awarding permanent total disability benefits is to maintain claimant, not to restore him to preinjury wage status (as is the purpose of vocational rehabilitation, for example.) Steven E. Puttie, 40 Van Natta 1069, 1072 (1988); Walter R. LaChappelle, 36 Van Natta 1565, 1566 (1984). Given that purpose, it is not improper to deny claimant the maintenance benefits of permanent total disability when he is capable of earning a living, even at a rate below his original wage." Searles, supra.

In the present case, claimant's own vocational expert stated that it would be difficult, but not futile, for claimant to obtain work. SAIF's vocational expert, Ms. Blackorby, testified that there were jobs which claimant could perform that would require only on-the-job training. She also testified that, after training, claimant could reasonably expect to earn between $6 and $8 per hour. Finally, Ms. Blackorby stated that her last attempt to set up an interview for claimant was in February 1987, because claimant had refused to continue in a job search unless he could obtain employment for $10 per hour and full medical benefits.

We conclude that the record shows claimant is capable of performing suitable, gainful employment within the meaning of ORS 656.206(1)(a). In addition,

we agree with the Referee's conclusion that claimant has not demonstrated a willingness to seek employment or that he has made reasonable efforts to obtain employment.

Offset

The Referee found that SAIF had overpaid temporary total disability paid from November 3, 1987 to February 19, 1988 and from August 5, 1988 to June 22, 1989. He concluded that SAIF was entitled to offset the overpayment against the increased permanent partial disability award. We agree.

The August 1989 Determination Order awarded temporary total disability from September 17, 1986 through December 10, 1986, and from February 20, 1988, through August 4, 1988. Exhibit 58 is a detail payment listing, provided by SAIF, that lists the amount and date of bi-monthly time loss payments under claimant's name.

We conclude that SAIF has shown evidence consistent with its argument that temporary total disability was paid continuously during the gap in the Determination Order. Although we agree with claimant that SAIF has the burden to prove entitlement to an offset, we find that it has done so in the present case. Moreover, claimant has not alleged that the payments were not received, nor has he provided rebuttal evidence that shows that SAIF's requested offset has been miscalculated. We therefore affirm the Referee's conclusion that SAIF is entitled to offset the overpayment against the increased permanent partial disability award.

ORDER

The Referee's order dated January 18, 1989 is affirmed.

December 11, 1990 Cite as 42 Van Natta 2753 (1990)

In the Matter of the Compensation of
RAY McDONALD, Claimant
WCB Case No. 89-04963
ORDER ON REVIEW
Robert G. Doltan, Claimant Attorney
Leeroy O. Ehlers, Attorney
Shelley McIntyre (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Peterson's order that found him to be a nonsubject worker and the employer to be a nonsubject employer. In his brief, claimant contends that the Referee was without jurisdiction to review a Proposed and Final Order that found the employer to be noncomplying and claimant to be a subject worker. In its brief, the employer contends that it did not receive notice of the Proposed and Final Order. The employer also moves for submission of additional evidence not admitted at hearing. We treat the motion as a request for remand. On review, the issues are jurisdiction, remand and compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Claimant contends that the Referee did not have jurisdiction in this matter, as the alleged employer failed to request a hearing from a Proposed and Final Order which found that the alleged employer was a noncomplying employer and that claimant was a subject worker. The employer contends that it did not receive notice of the Order and it argues that the Board should find that the Order never became final. The employer also argues that records show that the Department was aware that the employer was out of the country for several months and nothing indicates that he ever received the Order.

At the outset, we disagree with the contentions that the Referee reviewed the Proposed and Final Order. The Referee set forth as the issues before him the compensability of claimant's claim, which had been denied by SAIF, and claimant's entitlement to a penalty for SAIF's allegedly unreasonable denial. The Referee neither reviewed nor considered the Proposed and Final Order, which was not raised as an issue and was not a part of the hearing record. Rather, he properly heard and decided only the issues of compensability and entitlement to a penalty.

We also disagree with claimant's assertion that the Referee was without authority to determine whether claimant was a subject worker for purposes of his claim for compensation. Being a subject worker is a necessary prerequisite to entitlement to compensation under Workers' Compensation Law. See ORS 656.005(26); 656.027. The Proposed and Final Order had no preclusive effect on the Referee's determination of claimant's status as a subject worker.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50 (1988). "Claim preclusion" bars the assertion of a claim which was previously made or which could have been made as part of a valid, final judgment between the same parties. Under the doctrine of "issue preclusion," if a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment. North Clackamas School District, supra at 53.

Here, the prior proceedings on compliance involved only an enforcement proceeding between the Department and the employer. See ORS 656.017, 656.052 and 656.735. No claim for compensation was involved with the Proposed and Final Order nor does claimant's present "claim" for compensation arise out of the same transaction as gave rise to the order finding the employer to be noncomplying. Therefore, "claim preclusion" does not apply.

Because the parties involved in the Proposed and Final Order proceeding were different parties than those to the present hearing (i.e., claimant is a party to this proceeding but was not a party to the enforcement proceeding between the Department and the alleged noncomplying employer), we conclude that issue preclusion cannot apply. Further, because no issue was actually litigated which was essential to the establishment of a compensable claim as a result of the Proposed and Final Order, issue preclusion cannot apply. Lastly, it has not been shown that the Proposed and Final Order became a final order. ORS 656.740 allows a person to request a hearing from a proposed order declaring that person to be a noncomplying employer within 20 days of receipt of notice thereof. Here, there is no evidence as to whether, or when, the alleged employer received notice of the Proposed and Final Order.

We conclude that the Referee properly heard and decided the compensability of claimant's claim and that there was no bar to the essential determination of whether claimant was a subject worker at the time of his alleged injury.

Remand

The Board may remand a case for the admission of additional evidence if 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).

In the present case, the employer has submitted records from the Department which pertain to proceedings relating to its noncompliance status. As noted above those documents are not relevant to the issues before us. Furthermore, the employer has failed to show that the documents were unavailable at the time of hearing. Finally, we are unable to find that the record was otherwise insufficiently or improperly developed. Accordingly, the request for remand is denied.

Compensability

The Referee found that claimant was a casual worker, as both he and his wife made less than $200 per month working for the employer. Claimant contends that his employment was not casual and the Referee should not have found that he was a nonsubject worker under ORS 656.027(3). Claimant cites Hunnicutt v. Dollarhyde, 95 Or App 375 (1989), which holds that casual employment does not deprive an employee of protection if the employment is in the trade, business or profession of the employer.

ORS 656.027 provides that all workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

> "(3)(a) 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.
>
> "(b) For the purposes of this subsection, "casual" refers only to 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."

We agree with the Referee's conclusion that claimant's employment was casual. However, we must also address whether claimant's employment was in the course of the trade, business or profession of a nonsubject employer.

In this case, claimant has not shown that the employer had other employees working for him. The employer, therefore, has not been shown to have been a subject employer within the meaning of ORS 656.023. Because claimant's employment was casual and the employment was in the course of the trade of a nonsubject employer, claimant is not a subject worker for purposes of the workers' compensation act. ORS 656.027(3)(a).

In arriving at our conclusion, we reiterate that claimant may not rely on an order of noncompliance to establish that the employer was a subject employer. The prior proceedings did not involve the same parties or the same claim, the matter was never actually litigated, and we cannot determine if a final order resulted. Therefore, preclusion by prior adjudication does not apply.

ORDER

The Referee's order dated July 6, 1989 is affirmed.

December 11, 1990 Cite as 42 Van Natta 2756 (1990)

In the Matter of the Compensation of
SHELDON MOUNT, Claimant
WCB Case No. 89-10510
ORDER ON REVIEW
Dwayne R. Murray, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The alleged employer (Ron Gillian), pro se, requests review of Referee Brown's order that: (1) found that claimant was a subject worker; and (2) set aside the SAIF Corporation's denial, on Gillian's behalf, of claimant's shoulder injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings" and "Ultimate Findings fo Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was a subject worker of Gillian. We agree.

"Employer" means "any person ... who contracts to pay a remuneration for and secures the right to direct and control the services of any person." ORS 656.005(13). "Worker" means "any person ... lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer...." ORS 656.005(27). Accordingly, the test for determining who is a worker within the meaning of the Workers' Compensation Act is the employer's right to control the performance of the worker's services. The test requires an application of the traditional "right to control" and a consideration of the "nature of the work" analysis. Woody v. Waibel, 276 Or 189, 196 (1976); Castle Homes, Inc. v. Whaite, 95 Or App 269, 271 (1989).

The factors to be considered under the traditional test of the right to control include: (1) 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 at will without liability. Castle Homes, Inc. v. Whaite, supra.

The Referee concluded that the "right-to-control" factors in this case are in equipoise. Turning to the "nature-of-the-work" test, he concluded that claimant was a subject worker. We conclude that the evidence regarding "right to control" weighs heavily in favor of finding an employer/employee relationship.

The Exercise of Control

Gillian exercised control over claimant as an employee. He gave instructions to claimant as to what jobs were to be performed and in what manner, such as how to set headers over the windows and how to set joists. Gillian visited the job sites on weekends to check claimant's progress and make notes for further instructions. We conclude that Gillian had, and exercised, a sufficient amount of control over claimant's performance to indicate an employer-employee relationship.

The Right to Fire

Claimant was hired on a trial basis. As the Referee noted, the fact that claimant was hired on a trial basis implies that he could have been fired at will had he not performed to Gillian's expectations and specifications. This, too, suggests an employer-employee relationship.

The Method of Payment

Claimant was paid on an hourly basis. In general, payment of an hourly wage suggests an employer-employee relationship. Bowser v. State Ind. Acc. Comm., 182 Or 42, 60 (1947).

Equipment

Claimant supplied and used his own tools. This factor supports an independent contractor relationship.

We conclude that weighing the factors considered above regarding the traditional "right-to-control" test supports finding that claimant was a "worker." We find it unnecessary to apply the nature-of-the-work test. Claimant was a "worker" for workers' compensation purposes. ORS 656.027 provides that all workers are "subject workers" except these expressly exempted. See ORS 656.005(25). Claimant has not been shown to fall within any exemption. Accordingly, we agree with the Referee that claimant sustained a compensable injury arising out of and within the scope of his employment as a subject worker of Gillian.

ORDER

The Referee's order dated September 29, 1989 is affirmed.

December 11, 1990 Cite as 42 Van Natta 2757 (1990)

In the Matter of the Compensation of
KIRK D. MYERS, Claimant
WCB Case No. 89-13889
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Menashe's order which: (1) upheld the insurer's denial of claimant's claim for a left knee injury; and (2) declined to reopen the record for admission of additional evidence. On review, the issues are compensability and remand. We affirm.

FINDINGS OF FACT

Claimant allegedly injured his knee at work on April 17, 1989. He first saw Dr. Stringham on April 19, 1989, and reported that he had injured his knee playing basketball. Claimant stated to the doctor that his knee had been popping out for the past two years.

Claimant did not report to the physician that he had been injured at work, allegedly because his employer told him not to.

Claimant was fired from employment with this employer on May 1 or 2, 1989.

Claimant gave his statement to the insurer on June 28, 1989. He did not tell the investigator that his employer had told him to lie to the emergency room doctor, nor did his attorney, who was present during the interview. At hearing, claimant could give no reason why he did not explain the circumstances to the investigator.

Claimant filed an 801 form on June 28, 1989.

The evidence that claimant seeks to admit after reopening the record was available prior to hearing.

Claimant was not a credible witness.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant moved to have the case remanded to the Referee for admission of testimony from co-employees, and additional evidence concerning a workers' compensation claim filed by a co-employee. The Referee declined to reopen the record, noting that the evidence was available prior to hearing, and that claimant had failed to produce it. We agree with the Referee that the evidence was available prior to hearing. See Compton v. Weyerhaeuser, 301 Or 641 (1986). Accordingly, we decline to remand the case for admission of additional evidence.

Compensability

The Referee found claimant not credible. He also stated that he drew a negative inference from the fact that claimant allegedly had witnesses in his favor, but did not call those witnesses at hearing. In support of that, we note that the Court of Appeals has previously held that a common jury instruction charging that, "if weaker and less satisfactory evidence is offered when it appears that stronger and more satisfactory was within the power of the party, the evidence offered should be viewed with distrust," applies in workers' compensation cases as well. Roberts v. SAIF, 18 Or App 590 (1974).

Considering the fact that claimant originally gave a false story to the emergency room physician and then subsequently failed to correct the story while making a statement to the insurer's investigator, and the fact that claimant did not produce evidence at hearing to substantiate his claim that he was injured at his job, we conclude that claimant has failed to sustain his burden of proving that he injured his knee in the course and scope of his employment.

ORDER

The Referee's order dated November 14, 1989, as reconsidered December 7, 1989, is affirmed.

In the Matter of the Compensation of
BRYAN G. OGDEN, Claimant
WCB Case Nos. 88-17878 & 88-14296
ORDER ON REVIEW
Max Rae, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Seifert's order which: (1) upheld the SAIF Corporation's denial of a low back injury on July 29, 1987; (2) upheld SAIF's denial of an April 7, 1988 incident as either a "new injury" or as an aggravation of the prior injury; (3) declined to assess a penalty and attorney fee for SAIF's alleged failure to process the July 1987 claim after a legally sufficient claim was completed; (4) declined to assess a penalty and attorney fee for failure to accept or deny post-December 28, 1987 medical services; and (5) declined to assess a penalty and attorney fee for unreasonable claims processing of the April 7, 1988 claim. On review, the issues are compensability, responsibility and penalties and associated attorney fees. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

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

Claimant's claim for a back injury, dated August 8, 1987, was denied by SAIF on December 28, 1987. Claimant did not request a hearing from that denial.

Claimant did not file a claim for the April 1988 injury until June 27, 1988. SAIF denied the claim on July 25, 1988.

CONCLUSIONS OF LAW AND OPINION

Compensability--July 29, 1987 Injury

Claimant was injured on July 29, 1987. He filed a claim on August 12, 1987, which was denied by SAIF on December 28, 1987. Claimant argues that SAIF's December 1987 denial is a nullity because SAIF denied the claim on the basis that no claim was made. However, a careful reading of SAIF's denial shows that SAIF denied the claim as not compensable, because there were no medical services required. Alternatively, claimant argues that the claim became legally sufficient when medical bills were submitted after the April 1988 injury. We disagree with both of claimant's characterizations of the claim for the following reasons.

A compensable injury is an injury "requiring medical services or resulting in disability or death." ORS 656.005(7)(a). The statute does not require that an insurer pay for the required medical services or disability in order to make the claim compensable. Here, claimant required and received medical services for his July 29, 1987 injury prior to SAIF's denial. He timely filed a claim which was denied by SAIF. However, claimant did not request a hearing from that denial, thus, it became final as a matter of law. ORS 656.319.

The Referee properly found that the Hearing Division did not have jurisdiction over the August 1987 claim. The employer's payment of compensation does not alter the fact that a hearing may not be granted. Despite the employer's payments for medical services, SAIF remained solely responsible for claim processing. ORS 656.262(1). The employer's payments did not waive or transfer

SAIF's duty in that regard. ORS 656.262(5). Claimant did not request a hearing from SAIF's denial thus, claim preclusion bars claimant's present assertion of the August 12, 1987 injury claim. ORS 656.319; Drews v. EBI Companies, 310 Or 134 (1990).

Compensability--April 7, 1988 Injury

The Referee found that the medical evidence indicated that claimant suffered an aggravation, in April 1988, of his July 1987 injury. However, because SAIF denied the claim and that denial became final, the Referee found that there could be no compensable aggravation of the first injury.

We agree with the Referee that there can be no compensable aggravation. However, because the issue of occupational disease was alternatively before the Referee, we now address that issue. Destael v. Nicolai Co., 80 Or App 596 (1986).

An occupational disease is "any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death." Former ORS 656.802(1)(c). In order to establish a compensable occupational disease claimant must show that his work exposure was a material contributing cause of either increased symptoms or a worsening of his underlying condition requiring medical services or resulting in disability. Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Dr. Utter, claimant's treating chiropractor, had treated claimant for several years for minor musculoskeletal problems. He noted that, in July 1987, claimant suffered more severe injury than those for which he had previously treated claimant. A subsequent MRI revealed a bulging disc at L5-S1. (Ex. 17). The Orthopaedic Consultants noted that claimant had bulging discs at multiple levels of the lumbar spine. They suspected that the bulges antedated the injury of 1987, but stated that it could not be proven. Nevertheless, the physicians interpreted claimant's history as indicative of a lumbar strain in July of 1987 with a recurrent strain in the same area in April 1988. (Ex. 23-7).

Claimant has suffered back problems for many years, which were usually successfully treated with conservative treatment. In April 1988, after having worked at limbing fallen trees for approximately four to six weeks, claimant's low back pain became so intense that he had to leave work and seek medical treatment. We find that the medical evidence is persuasive that claimant's work activities limbing trees were a material contributing cause of increased symptoms of his low back condition. Because claimant's work activities consisted of a series of events which proved traumatic and which required medical services, we conclude that claimant has established a compensable claim under former ORS 656.802(1)(c).

Responsibility

Claimant contends that if both the July 29, 1987 injury and the April 7, 1988 injury are compensable, the Board will have to determine which of the two injuries is responsible for claimant's condition after April 7, 1988. Because we have found that SAIF's denial of the July 29, 1987 injury became final by operation of law, claimant has a single occupational disease and we need not address the issue of responsibility.

Penalties and Attorney Fees

Claimant seeks penalties and attorney fees for SAIF's allegedly unreasonable failure to accept or deny the July 1987 claim after a "legally sufficient

claim was completed." He argues that receipt of medical bills after the December denial, resulting from the April 1988 exacerbation, required SAIF to process the July 1987 claim. However, as discussed above, because claimant did not request a hearing from the December 1987 denial, that denial became final and the claim was unenforceable. ORS 656.319(1). Subsequent claims for the same injury were barred. Drews v. EBI Cos., supra. Thus, even if SAIF had acted unreasonably, no compensation was "then due" and SAIF did not resist the payment of any compensation. Therefore, neither a penalty, under ORS 656.262(10), not an attorney fee, under ORS 656.382(1), may be assessed.

Claimant also seeks a penalty and attorney fee for unreasonable resistance to the payment of compensation because SAIF did not accept or deny the July 1987 claim until December 28, 1987, more than 60 days after the claim. ORS 656.262(10). However, because claimant's bills had been paid, there were no amounts "then due" upon which to base a penalty. ORS 656.262(10). Additionally, because SAIF did not unreasonably resist payment of compensation, no attorney fee is warranted. ORS 656.382(1).

Claimant also seeks penalties and attorney fees for SAIF's unreasonable failure to accept or deny the April 7, 1988 claim within 60 days of the time the employer learned of the claim. ORS 656.262(6). Here, the employer knew of the injury on April 7, 1988, because claimant himself is the president of the employing corporation, even though claimant did not file a claim for the April 1988 injury until June 27, 1988. Consequently, the denial, dated July 25, 1988, was late and there were medical bills outstanding on which to base a penalty. Accordingly, we find that claimant is entitled to a penalty equal to 25 percent of any compensation due, and a reasonable attorney fee. We note, however, that the unreasonable delay in denying or accepting the claim was attributable to the employer because it did not notify SAIF within 5 days after notice or knowledge of the injury. See ORS 656.262(1) & (3). Because of that, there is statutory authority that may entitle SAIF to recover the penalty amount from the employer. ORS 656.262(3).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services concerning the penalty issue is $200, to be paid by SAIF. After further considering the aforementioned factors, we conclude that a reasonable fee for claimant's counsel's services at hearing and on review concerning the issue of claimant's occupational disease claim is $2,500, to be paid by SAIF. In reaching these conclusions, we have particularly considered the complexity of the issues, the time devoted to the issues, and the value, to claimant, of the interests involved.

ORDER

The Referee's order dated March 20, 1989 is affirmed in part, modified in part and reversed in part. That portion which upheld the SAIF Corporation's denial of December 28, 1987 is modified. Claimant's request for hearing with respect to that denial is dismissed. That portion which upheld SAIF's denial of July 22, 1988 is reversed. That claim is remanded to SAIF for processing according to law. That portion of the order which declined to award a penalty and attorney fee for SAIF's unreasonable delay in accepting or denying the April 7, 1988 injury claim is reversed. Claimant is awarded a penalty equal to 25 percent of all compensation due on July 25, 1988. Claimant's attorney is awarded an associated fee of $200, to be paid by SAIF. For services at hearing and on Board review for prevailing on the occupational disease issue, claimant's attorney is awarded an assessed fee of $2,500, payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
KENNETH L. ORR, Claimant
WCB Case No. 89-15730
ORDER ON REVIEW
Klosterman & Whitehead, Claimant Attorneys
Employer Defense Counsel, Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Garaventa's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award from 34 percent (108.8 degrees), as awarded by Determination Order, to 41 percent (131.2 degrees) for a pelvis and sacroiliac injury. On review, the issue is extent of unscheduled permanent disability, including permanent total disability.

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

Permanent Total Disability

In order to prove entitlement to permanent total disability compensation, claimant must show that he is not "employable or able to sell his services on a regular basis in a hypothetically normal labor market." Harris v. SAIF, 292 Or 683, 695 (1982). Because claimant is not totally disabled, based on physical factors alone, he also has the burden of proving that he has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that such efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

In this case, Mr. Rees, vocational expert, testified that no appropriate jobs were available to claimant in the Mehama area where claimant lives. (Tr. 43). We are not persuaded by Rees' opinion. He conducted no labor market survey in Mehama or in nearby towns, before reaching his conclusion. (Tr. 38). Even if Rees' opinion were persuasive, it would not carry claimant's burden, because there is no showing that the Mehama area represents claimant's "normal" labor market as required by Butcher. Moreover, even if no suitable job is available in Mehama, claimant has not proven that it would be futile to look for work outside Mehama, but within a reasonable radius of his home. Inasmuch as we are unwilling to assume that claimant's job search ought to be geographically limited to Mehama, we conclude that claimant has not proven that he has made reasonable efforts to seek employment. For these reasons, and those relied upon by the Referee, claimant is not permanently totally disabled.

Permanent Partial Disability

Neither party challenges the Referee's rating under the standards. However, claimant contends that he is entitled to more disability than indicated by the standards' rating process. In this regard, claimant again relies on Rees' opinion that no suitable jobs are available to him in Mehama. He asserts that this evidence is clear and convincing, because Rees is a vocational expert. As we have stated, we are not persuaded by Rees' opinion.

Considering the record as a whole, we do not find clear and convincing evidence that claimant suffers greater disability than provided by application of the standards. See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

ORDER

The Referee's order dated January 18, 1990 is affirmed.

In the Matter of the Compensation of
LYNDEE A. (LEIBELT) PARIS, Claimant
WCB Case No. 89-14884
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Myzak's order that affirmed a Determination Order that awarded no permanent disability for claimant's compensable head and neck injuries. The issue on review is extent of unscheduled permanent disability, if any. We reverse.

FINDINGS OF FACT

Claimant was in a work-related automobile accident in April 1988. She sustained head and neck injuries, including a lacerated scalp and concussion. She was on time loss benefits for about one month. Claimant was declared medically stationary on May 5, 1988 with no work restrictions. She returned to her regular employment as a loan officer on May 2, 1988.

Sometime in September or October of 1988, claimant began to experience headaches that increased in frequency and intensity. The headaches were associated with blurred vision and loss of balance. Prior to the compensable injury claimant had intermittent headaches; however, she had missed no work due to these headaches. After the compensable injury, claimant had to leave work early due to headaches and she missed approximately one week of work because of her headaches in the year preceding the hearing.

Claimant's history of migraine-type headaches goes back to high school. She was 24 years old at the time of hearing. On a scale of 1 to 10, the frequency of claimant's pre-injury headaches was a 2 or 3. The frequency of headaches after the compensable injuries is a 7 to 8, on a 10-point scale. Similarly, the pre-injury intensity of headaches was a 3, whereas the pain had increased to an 8 or 9 after the accident. (Tr. 16).

Claimant's increased headaches, and symptoms of blurred vision and imbalance are associated with the head trauma sustained in the industrial accident.

Determination Orders which issued in January and March 1989 awarded temporary disability only.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the Determination Orders, concluding that claimant had no permanent impairment as a result of her compensable injury. We disagree.

Prior to the compensable injuries, which included head trauma sustained in an industrial accident in April 1988, claimant had infrequent nondisabling migraine headaches that were self-treated. Subsequent to the industrial accident, claimant experienced an increase in the frequency and intensity of migraine headaches. Blurred vision and loss of balance are associated with the headaches. The treating neurologist, Dr. Bernstein, unequivocally diagnosed claimant's condition as migraine headaches, with post-traumatic exacerbation. Claimant has missed work due to the headaches and now requires the ongoing treatment of a neurologist to control the headaches.

The Western Medical Consultants opined that factors other than the compensable injuries were operating to exacerbate claimant's headaches. However, they offer no medical explanation other than noting that the American Headache Association does not recognize new onset headaches or changes in headache symptoms which occur more than six weeks after trauma. Here, claimant first noticed a change in the frequency and intensity of her headaches 16-20 weeks after the compensable injury.

The treating neurologist, Dr. Bernstein, disagrees with the Western Medical Consultants' conclusion. Rather, he observes that migraine headache disorders are often accelerated slowly over a period of months or even years. Dr. Bernstein also notes that, other than the head trauma in April 1988, claimant's medical history is otherwise totally noncontributory.

Based on demeanor, the Referee found claimant entirely credible. We defer to this finding. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). However, the causation of claimant's exacerbation of migraine headaches is a complex medical question. Thus, while her testimony is probative, the resolution of this matter turns primarily on the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986). When the medical evidence is divided, as it is here, we give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Because of Dr. Bernstein's first-hand exposure to and knowledge of claimant's condition, we give the treating neurologist's opinion greater weight in this case. Argonaut Ins. v. Mageske, 93 Or App 698, 702 (1988). Accordingly, we conclude that claimant's exacerbation of migraine headaches is causally related to the compensable injuries.

Unscheduled Permanent Partial Disability

Having determined the causal-link between claimant's compensable injuries and her migraine headaches, we next evaluate the extent of claimant's disability due to the compensable injury.

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

Because claimant's condition became medically stationary on May 5, 1988, and her claim was closed by Determination Order on March 8, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Age, Education and Adaptability

Where the claimant has returned to his or her usual and customary work, no value is assigned to the age, education and adaptability categories under former OARs 436-35-290(2)(a), 436-35-300(2)(a) and 436-35-310(2)(a).

Here, claimant has returned to her usual and customary work as a loan officer. Therefore, no values will be assigned to the categories of age, education and adaptability.

Impairment

Claimant's injuries were to the head and neck; however, there is no reported ongoing pathology of either of these "body parts" that is covered by the "standards." Similarly, we do not find a basis for giving claimant a value under "chronic conditions limiting repetitive use." Former OAR 436-35-320(4). Accordingly, no impairment value is given under the "standards."

Computation of Unscheduled Disability Under the Standards

Since claimant has no ratable value for age, education, adaptability, or impairment under former OAR 436-35-270 through 436-35-440, she has no calculable disability under the "standards."
Former OAR 436-35-320(1).

Clear and Convincing Evidence of Permanent Disability

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 302 (1987).

The record as a whole clearly establishes that the frequency and intensity of claimant's headaches, together with blurred vision and loss of balance, are disabling and result in lost earning capacity, albeit minimal. Claimant's credible testimony in that regard is unrebutted. We, therefore, conclude that claimant has shown by clear and convincing evidence that she suffers an unscheduled permanent disability of 5 percent due to an exacerbated migraine headache condition.

ORDER

The Referee's order dated December 8, 1989 is reversed. Claimant is awarded 5 percent (16 degrees) unscheduled permanent partial disability for a migraine condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

December 11, 1990 Cite as 42 Van Natta 2765 (1990)

In the Matter of the Compensation of
MARY E. WILLIAMS, Claimant
WCB Case No. 87-00078
ORDER ON REMAND (REMANDING)
Olson Law Firm, Claimant Attorneys
John Motley (Saif), Defense Attorney

This matter is before the Board on remand from the Supreme Court. Williams v. SAIF, 310 Or 320 (1990). The Supreme Court has affirmed, on different grounds, the Court of Appeals' decision, 99 Or App 367 (1989), which reversed our order affirming and adopting a Referee's order that had dismissed claimant's hearing request for her failure to appear at a scheduled hearing. In dismissing the hearing request, the Referee cited former OAR 438-06-085, which pertains to dismissals where the party requesting the hearing occasions a delay of more than 90 days and fails to show good cause why the hearing request should not be dismissed.

The Court of Appeals applied OAR 438-06-071, which pertains to the dismissal of a hearing request where the party requesting the hearing or the party's representative does not appear at the hearing. Noting that claimant's attorney was present at the hearing, the Court of Appeals held that it was error to dismiss the hearing request. Reasoning that claimant was entitled to offer the remainder of her evidence, even if she chose not to testify personally, the Court of Appeals remanded.

Stating that OAR 438-06-071 was not relied upon by either the Board or the Referee, the Supreme Court expressed no opinion on the applicability of OAR 438-06-071 or the Court of Appeals' interpretation of the rule. Nonetheless, concluding that the Referee and the Board had erroneously interpreted a provision of law by attempting to apply an inapplicable rule (OAR 438-06-085), the Supreme Court agreed with the Court of Appeals' opinion that the Referee was not entitled to dismiss claimant's hearing request. Consequently, the Supreme Court has remanded for further proceedings not inconsistent with its opinion.

FINDINGS OF FACT

Claimant did not appear at her scheduled hearing. Her attorney was present at the hearing and moved for postponement. This request was based on a telephone conversation the previous day between claimant and her counsel in which claimant indicated that she would be unable to attend the hearing due to financial considerations. The Referee denied the motion for postponement, reasoning that claimant's explanation did not constitute extraordinary circumstances beyond her control.

The Referee also denied claimant's motion to dismiss her hearing request without prejudice, concluding that such an action would circumvent the postponement rule. Turning to the SAIF Corporation's request for authorization to offset an alleged overpayment against future permanent disability, the Referee reserved the matter to be raised at a later time.

Accordingly, the Referee dismissed claimant's hearing request for her failure to appear at the hearing. The Referee relied on former OAR 438-06-085. In addition, SAIF's offset request was reserved "to be raised and decided at a later hearing." On review, the Board affirmed and adopted the Referee's decision to dismiss claimant's hearing request. However, reasoning that SAIF had properly raised the offset request and presented evidence supporting its request, the Board held that SAIF was entitled to receive authorization to recover its overpayment against future permanent disability awards.

CONCLUSIONS OF LAW

As previously discussed, the Supreme Court has held that our reliance on former OAR 438-06-085 in affirming the dismissal of claimant's hearing request was misplaced. Consequently, our order has been reversed and the case remanded for further proceedings.

To begin, we note that claimant objects to the Referee's refusal to grant her motion to dismiss the hearing request without prejudice. Inasmuch as SAIF had effectively cross-requested a hearing by seeking authorization to recover an overpayment, a dismissal of claimant's hearing request without prejudice would not have been appropriate. See Julie Mayfield, 42 Van Natta 871, 873 (1990) (When the party requesting a hearing moves for a dismissal and there is no cross-request for hearing, the Referee has discretion to set the terms and conditions of an order of dismissal as he or she deems proper).

We turn to an interpretation of former OAR 438-06-071. We have recently held that we will continue to apply the Court of Appeals' interpretation of OAR 438-06-071 as recited in the Williams decision. Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990). That interpretation provides that a Referee is not authorized to dismiss a hearing request for the failure of a claimant to appear if claimant's counsel appears on his or her behalf. Therefore, because claimant's counsel appeared at the hearing, the Referee was without authority to dismiss the hearing request.

Concerning claimant's motion for postponement, we have previously held that a claimant's inability to afford the cost of attending a hearing does not constitute an "extraordinary circumstance" justifying postponement. Richard A. Hogenson, 42 Van Natta 579 (1990). Thus, we agree with the Referee's conclusion that claimant failed to establish extraordinary circumstances beyond her control to warrant a postponement of her hearing. The effect of this decision is that claimant has waived her right to testify at the hearing. Anthony B. Beardslee, 42 Van Natta 965 (1990); Denette D. Dale, 41 Van Natta 2179 (1989).

Consequently, the Referee's dismissal order is vacated and this matter is remanded to the Presiding Referee with instructions to assign this case to another Referee. The designated Referee shall schedule a hearing concerning the issues raised by claimant's hearing request, as well as SAIF's offset authorization request. At that hearing, the Referee will determine what exhibits should be received, but no exhibits shall be received which were not submitted as evidence in the prior hearing, nor shall any witness, including claimant, be permitted to testify who was not prepared to testify at the prior hearing.

Accordingly, the Referee's order dated September 30, 1987 is vacated. This matter is remanded to Presiding Referee Daughtry for further action consistent with this order.

IT IS SO ORDERED.

December 12, 1990 Cite as 42 Van Natta 2767 (1990)

In the Matter of the Compensation of
ORVAL W. BARFKNECHT, Claimant
WCB Case Nos. 90-12883 & 90-12884
ORDER OF DISMISSAL
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

The insurer has requested Board review of Referee Myzak's order dated October 29, 1990. We have reviewed the request to determine whether we have jurisdiction to consider it. We conclude that jurisdiction rests with the Hearings Division.

FINDINGS OF FACT

The Referee's Opinion and Order issued October 29, 1990. On November 27, 1990, Referee Myzak issued an Order of Abatement to consider the insurer's October 31, 1990 request for reconsideration. That same day, the insurer filed its request for Board review.

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).

Here, since the Referee abated her order simultaneously with the insurer's request for Board review, we shall give effect to the Order of Abatement. Accordingly, the request for Board review is dismissed as premature. This matter is remanded to the Referee for further consideration.

IT IS SO ORDERED.

December 12, 1990 Cite as 42 Van Natta 2768 (1990)

In the Matter of the Compensation of
OVID D. BROWN, Claimant
WCB Case No. 89-20907
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Irving's order that affirmed a Determination Order award of 2 percent (6.4 degrees) unscheduled permanent partial disability for a low back condition. On review, the issue is extent of permanent disability.

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

The Referee concluded that claimant was not entitled to an additional award of permanent disability, because she found that there was no causal link between claimant's impairment and the compensable injury. We note that, even assuming a causal link exists, there is no impairment on which to award additional disability.

Claimant first contends that he is entitled to an additional 4 percent permanent partial disability for an unoperated disc derangement. Former OAR 436-35-350(2) allows 4 percent permanent disability for "any unoperated rupture bulge or other disc derangement." In this case, however, the only evidence concerning a disc derangement is Dr. Tsai's 1984 diagnosis of a resolved traumatic disc herniation of L4-5. (Ex. 6) Although claimant may have at one time had the disc herniation, the herniation has now subsided. The standards make no allowance for a resolved disc herniation.

Moreover, even if claimant continued to have the herniation, he must prove by a preponderance of the evidence that there were some residual symptoms associated with the disc herniation. Dale K. Bolling, 42 Van Natta 2001 (1990). At the time of hearing, no residual symptoms were noted. Accordingly, no impairment value for an unoperated disc derangement is warranted.

Claimant next contends that he is entitled to an additional 5 percent permanent partial disability for chronic residuals in his back. Former OAR 436-35-320(4) allows 5 percent permanent disability for chronic conditions limiting repetitive use of an unscheduled body part. In this case, however, the only evidence concerning such chronic conditions is claimant's testimony that, if he sits for a long period of time, his back becomes "uncomfortable." There is no evidence of any restrictions relating to bending, carrying, lifting, twisting or walking. Thus, there is no evidence from which a fact finder could determine that there are chronic conditions which warrant additional permanent disability.

ORDER

The Referee's order dated February 28, 1990 is affirmed.

In the Matter of the Compensation of
RICHARD S. HOOKLAND, Claimant
Own Motion No. 90-0370M
2ND OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
SAIF Legal Department, Defense Attorney

Claimant requests that the Board reconsider its November 23, 1990, Own Motion Order on Reconsideration in the aforementioned case. Claimant contends that his request for reconsideration was timely submitted.

Here, the request for reconsideration is dated November 19, 1990. Pursuant to OAR 438-12-062(2), claimant had (30) days to request reconsideration. The only exceptions are when a request is filed within (60) days and good cause has been demonstrated or if extraordinary circumstances are deemed to have existed. OAR 438-12-065(2).

In this case, the thirtieth day fell on Saturday, November 17th. Oregon Statutes provide that "Any act authorized, required or permitted to be performed on a holiday as designated in this section may be performed on the next succeeding business day" ORS 187.010(3). The statue does not include Saturdays as a legal holiday. Further the rules of civil procedure and appelate practice, argued by claimant, do not apply.

We do not agree with claimant that the expiration of the appeal time on a weekend, (Saturday), is good cause.

We also fail to find that extraordinary circumstances exist in this case to extend the filing period. OAR 438-12-063.

Therefore, reconsideration is denied. The parties rights of reconsideration and appeal shall continue to run from the date of our prior order.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRED H. RITCHERSON, Claimant
WCB Case No. 89-13150
ORDER ON REVIEW
Moomaw, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Bennett's order that upheld the self-insured employer's denial of claimant's back and right shoulder injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the injury received by claimant on his way to work was not compensable. We agree.

A compensable injury is an accidental injury "arising out of or in the course of employment." ORS 656.005(7)(a). As a general rule, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987). However, as the Court recently reiterated in Cope v. West Americans Ins. Co., 309 Or 232 (1990), there are exceptions to the "coming and going rule."

In Montgomery Ward v. Cutter, 64 Or App 759 (1983), a claimant was injured on her way to work in an employee parking lot. The court found the injury compensable, because of the employer's control over the area:

> "[I]njuries that occur in parking lots that are owned and maintained by the employer arise out of and in the course of employment and are compensable. If the injury occurs in a parking lot or other off-premises area which the employer has no control, it is generally not compensable." 64 Or App at 762.

In Nelson v. Douglas Fir Plywood Co., 260 Or 53 (1971), a claimant was injured on her way to work at the intersection of a public road and her employer's private road leading to the plant. The Court found the injury compensable, because the road was the only means to enter the plant and most of the traffic in the area consisted of employees' automobiles and the employer's trucks:

> "If the employee's employment requires him to use an entrance or exit to or from his work which exposes him to hazards in a greater degree than the common public, he is regarded as being within the course of his employment." 260 Or at 57.

Therefore, the Court in Cope v. West Americans Ins. Co., supra, concluded that an injury may be compensable, even if it occurs while the claimant is going to or coming from work, if the employer exercises some "control" over the place where the injury occurs. 309 Or at 239. The Court added that it is immaterial whether such "control" is demonstrated by the employer's property rights to the premises or by increased, employer-created hazards. Some form of employer control of the area demonstrates the work-connection necessary to make the injury compensable. Id.

In this case, claimant was injured in a motor vehicle accident which occurred at the intersection of a public road and a driveway leading to the employee parking lot. Claimant first contends that his employer exercised "control" over the area insofar as that term is used to mean ownership, maintenance or influence. We disagree. There is no evidence that the employer regularly exercised control over the street, driveway or parking lot. Rather, the street was maintained by the City of Portland. ARCO leased the parking lot, which was maintained by the Port of Portland. The Port of Portland also maintained the driveway and provided security for the area. Claimant's assertion that his employer had posted a construction speed limit sign in the area is unsubstantiated and we do not find it persuasive.

Claimant next contends that the use of the parking lot exposed him to increased, employer-created hazards. He argues that, in order to enter the parking lot, he was required to cut across two lanes of traffic over a very short distance. We disagree. The entrance claimant used on the day of the accident was not the only means for employees to enter the parking lot. Compare Nelson v. Douglas Fir Plywood, supra. Rather, a second entrance was located further down the street, the use of which would not have required claimant to dart across traffic. Although that entrance is marked "exit" when the parking

lot is closed during working hours, it is commonly used as an entrance during shift changes and has arrows painted on the pavement indicating that traffic flow in both directions is permitted.

We conclude that claimant was not required to use an entrance to his work that exposed him to hazards in a greater degree than the common public. The decision to use that particular entrance was his, not his employer's. We therefore conclude that the connection between the injury and the employment is insufficient to make the injury compensable.

ORDER

The Referee's order dated December 6, 1989 is affirmed.

December 12, 1990 Cite as 42 Van Natta 2771 (1990)

In the Matter of the Compensation of
EDWIN A. STEINBORN, Claimant
WCB Case No. 87-03249
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Claimant initially requested review of Referee Daron's order that upheld the self-insured employer's denial of claimant's claim for coronary artery disease, peptic ulcer disease, gastritis, diabetes and obesity. The Board remanded the case to the Referee with instructions to include in the record a copy of the employer's acceptance of claimant's 1986 claim for respiratory difficulties. The Board instructed the Referee to issue an interim order discussing any effect the acceptance had on his prior order. The Referee held a hearing on the acceptance issue and, as a result, issued an Interim Order On Remand reversing his prior order and setting aside the employer's denial. The Referee's Interim Order On Remand is now before us on review. The issue on review is compensability. We affirm.

FINDINGS OF FACT

Claimant is an asthmatic who began working for the employer in 1969. He subsequently experienced increased asthma symptoms. In 1971, he was first prescribed prednisone to control his symptoms. Prednisone is a corticosteroid which causes numerous side effects. Beginning in 1974, claimant was diagnosed with numerous other conditions, including coronary artery disease, a peptic ulcer, gastritis, diabetes and obesity. Claimant's asthma condition worsened further in 1986 and his treating physician, Dr. Bardana, took him off work. The first notice to claimant that his work contributed to his condition was at the time he was taken off work by Dr. Bardana.

Claimant submitted his claim to the employer on an "Employee's Report of Occupational Injury or Disease." (Ex. 61). He stated that his complaints began a "long time ago" (Box 14), and began "about 1967 or so" (Box 22). The nature of the disease was "bronchial asthma" (Box 15), and the part of body affected was "lungs" (Box 16). He also stated, "Can't breathe in air. No room for air in lungs. Very painful. Gets my heart to hurting if I try to breathe too hard" (Box 21). From this report, the employer prepared a Form 801, in which the claim was identified as one for "respiratory difficulties." (Ex. 40). The claim was initially deferred on the Form 801. The employer concedes that it

later accepted the claim, although it did not issue a standard acceptance form. It did issue a Form 1502, dated August 27, 1986, with the following notice directed to claimant: "Claimant--Based On Medical Evidence Your Claim Has Now Been Accepted As A Compensable Claim." (Ex. 60). The employer sent a carbon copy of this Form 1502 to claimant. On February 25, 1987, the employer denied compensability for coronary artery disease, peptic ulcer, gastritis, and obesity. On July 8, 1987, the employer denied the diabetes condition.

FINDINGS OF ULTIMATE FACT

The employer accepted claimant's long-standing asthma condition dating back to 1969.

Claimant's coronary artery disease, peptic ulcer disease, gastritis, diabetes and obesity are not the result of an independent, nonindustrial cause. These conditions are materially related to the accepted asthma condition and related use of prednisone.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that his coronary artery disease, peptic ulcer, gastritis, obesity and diabetes are compensable because they were caused by the prednisone he took for his asthma. Claimant argues that the conditions are compensable as direct and natural consequences of his compensable asthma condition, and are not the result of an independent, nonindustrial cause. Christenson v. SAIF, 270 Or App 595 (1966).

The employer argues that it only accepted claimant's asthma condition as of 1986, at which time it became disabling, and that claimant's work activity prior to that time did not contribute to the condition. The employer contends the coronary artery disease, peptic ulcer, gastritis, obesity and diabetes are not compensable under the "range of compensable consequences" doctrine because they were caused by treatment for an unaccepted, noncompensable predisability asthma condition, and were not worsened by prednisone treatment after the asthma became compensable in 1986.

The Referee found in his Interim Order on Remand that the employer's notice of acceptance on the Form 1502, the only written notice in evidence issued by the employer, was a formal acceptance. The Referee further found that the condition accepted by the employer was the "long existing bronchial asthma" referenced on the "Employee's Report of Occupational Injury or Disease" filed by claimant. Based on this broad acceptance, the Referee concluded that the denied conditions were compensable.

The employer has conceded that it accepted claimant's claim for his asthma condition. Accordingly, the Referee's conclusion that the notice to claimant on the Form 1502 was a binding acceptance was unnecessary, and we do not adopt that portion of the Referee's order. We concur in the Referee's conclusion that the denied conditions were compensable, based on the following reasoning.

The uncontradicted medical evidence indicates that claimant's prescribed steroid regimen for his asthma condition either caused or worsened each of the denied conditions. Dr. Bardana, M.D., Head, Division of Allergy and Clinical Immunology, Oregon Health Sciences University, who treated claimant since 1974, reported that from claimant's earliest exposure to corticosteroids, his appetite increased, as is typical with this drug, which caused a 50 pound weight gain. This weight gain unmasked a diabetic proclivity resulting in adult onset diabetes; thus, claimant's insulin dependent diabetes was a direct result of his steroid therapy. (Ex. 4, 19-1, 49).

Claimant's weight gain was also associated with hypertension, which in turn contributed to the development of claimant's coronary artery disease. (Ex. 44, 49, 51, 54). Peptic ulcer disease was also unmasked, as a result of the use of corticosteroids. Thus, claimant's peptic ulcer disease was exacerbated by his steroid regimen. (Ex. 49). Dr. Bardana concluded that prednisone was a major contributor to the development of claimant's obesity, peptic ulcer disease, hypertension and diabetes. Dr. Rudin, M.D., a pulmonologist who performed an independent medical examination, agreed with Dr. Bardana's description of the mechanism of causation. In addition, she noted that prednisone is a gastric irritant and thus aggravated claimant's gastritis. (Ex. 54).

Accordingly, we conclude that claimant's coronary artery disease, peptic ulcer, gastritis, obesity and diabetes are materially related to his prednisone use and are not the result of an independent, nonindustrial cause. See Christenson v. SAIF, supra. Therefore, these conditions are compensable if the long-standing asthma condition treated with prednisone is an accepted condition. See Bauman v. SAIF, 295 Or 788 (1983). We conclude that the employer accepted claimant's asthma condition in its entirety. Consequently, it is responsible for the denied conditions resulting from the prednisone treatment.

The employer stated on a Form 1502, dated August 27, 1986: "Claimant--Based On Medical Evidence Your Claim Has Now Been Accepted As A Compensable Claim." (emphasis added). The only claim filed by claimant was the "Employee's Report of Occupational Injury or Disease" for long-standing bronchial asthma, worsened by work exposure to smoke and dust. The Form 801 was prepared by the employer and was not signed or otherwise approved by claimant. Accordingly, in accepting "your claim" we conclude that the employer accepted the claim filed by claimant for his long-standing bronchial asthma.

In summary, we conclude that the employer accepted claimant's asthma condition in its entirety. We further conclude that claimant's coronary artery disease, peptic ulcer, gastritis, obesity and diabetes are materially related to the prednisone prescribed for the accepted asthma condition, and are not the result of an independent, nonindustrial cause. Consequently, the employer is responsible for those conditions as direct and natural consequences of the accepted asthma condition. See Christenson v. SAIF, supra. Accordingly, we agree with the Referee's ultimate ruling setting aside the employer's denial of these conditions.

ORDER

The Referee's order dated November 6, 1987, as amended August 20, 1990, is affirmed.

December 12, 1990 Cite as 42 Van Natta 2773 (1990)

In the Matter of the Compensation of
SHIRLENE E. VOLCAY, Claimant
WCB Case No. 89-11517
ORDER ON REVIEW
Mark A. Lansing, Claimant Attorney
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The noncomplying employer requests review of that portion of Referee Brown's order which declined to set aside the SAIF Corporation's acceptance, on its behalf, of claimant's bilateral carpal tunnel syndrome claim. In its brief, the noncomplying employer also argues that the Referee erred in admitting into

evidence an exhibit. On review, the issues are admission of evidence and compensability. We affirm.

FINDINGS OF FACT

Claimant has worked as a field worker, primarily cutting/pruning plants for the noncomplying employer, since July 6 1987. (Ex. 2A-2). Claimant worked seven days a week. The chore that caused claimant the most trouble to her arms and hands was cutting plants. This job required her to use a "belly bender" -- a hand-operated tool which claimant had to squeeze with her hands approximately 15-20 times per minute. (Tr. 22-23).

Claimant saw Dr. Shames, M.D., on March 3, 1989, for numbness and pain in her hands. (Ex. A-1). Dr. Shames referred claimant to Dr. Appleby, orthopedic surgeon, who diagnosed bilateral carpal tunnel syndrome on March 29, 1989. (Ex. 1). The employer was found to be noncomplying on April 14, 1989, by Proposed and Final Order. (Ex. 2C). By letter dated April 14, 1989, a copy of which was sent to the noncomplying employer by certified mail, the Compliance Division referred claimant's claim to SAIF for processing . (Exs. 2B & 2D). SAIF accepted claimant's bilateral carpal tunnel syndrome as a disabling claim on May 24, 1989. (Ex. 3). The noncomplying employer, challenging the compensability of claimant's claim, requested a hearing on June 16, 1989, more than 60 days from the date the claim was referred to SAIF.

CONCLUSIONS OF LAW AND OPINION

Evidence

In its brief, the noncomplying employer argues that the Referee erred in admitting exhibit 5, an unsigned report by Dr. Appleby, orthopedic surgeon, written on Dr. Appleby's letterhead stationary with the closing:

> "DICTATED BUT NOT SIGNED
> TO EXPEDITE DELIVERY TO YOU
> David M. Appleby, M.D."

The noncomplying employer, appearing pro se at the hearing, argues that Dr. Appleby's report should not have been admitted as evidence without further authentication and Dr. Appleby's presence at the hearing for cross-examination. We agree with the Referee's ruling to admit exhibit 5.

ORS 656.283(7) sets the standard by which evidence is admitted in workers' compensation hearings. The statute specifically states that "the referee is not bound by common law or statutory rules of evidence or by techinical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice." Referees have great discretion to allow and deny admission of evidence at hearing and, if the testimony has some probative value, the Referee may admit it. Rodney R. Rouse, 38 Van Natta 448 (1986).

Exhibit 5 is a report dictated by Dr. Appleby and written on his letterhead stationary. There is no reason to question its authenticity. We conclude that the Referee did not abuse his discretion in admitting exhibit 5 into evidence.

Compensability

Where a noncomplying employer requests a hearing challenging the compensability of a claim more than 60 days after the claim was referred to SAIF, SAIF's acceptance may not be set aside absent a showing of fraud, misrepresentation or other illegal activities capable of affecting SAIF's acceptance. ORS 656.262(6); Bauman v. SAIF, 295 Or 788 (1983); Kristi L. Chase, 42 Van

Natta 1247 (1990). As this request came after the expiration of the 60-day period and no showing has been made on the record of fraud, misrepresentation or other illegal activity, the claim remains compensable and in accepted status.

We note further that, even if the noncomplying employer had shown that SAIF's acceptance had been based upon fraud, misrepresentation or other illegal activity, claimant has established the compensability of her claim on the merits. Former ORS 656.802; Donna E. Aschbacher, 41 Van Natta 1242 (1989).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $500, to be paid by SAIF, on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 3, 1989 is affirmed. Claimant's attorney is awarded an assessed fee of $500, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

December 13, 1990 Cite as 42 Van Natta 2775 (1990)

In the Matter of the Compensation of
KATHIE L. BLAIR, Claimant
WCB Case No. 89-11848
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Knapp's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for stress-induced migraine headaches. The issue on review is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

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

Therefore, to be compensable, claimant's occupational disease must fall within one of the subsections of former ORS 656.802(1). In pertinent part, former ORS 656.802(1) defines occupational disease as:

> "(a) any disease or infection arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other substances to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein,

> and which requires medical services or results in disability or death.
>
> (b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical disability or death.
>
> (c) Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

The Referee analyzed claimant's claim under subsection (1)(a) of former ORS 656.802 and concluded that claimant had failed to carry her burden of proof establishing that work-stress aggravated her migraine headache condition. We agree that claimant has not established an occupational disease, but we do so based on different grounds.

There is no claim or evidence that claimant's headaches were caused by working conditions which included ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation, or other toxic or contact-type conditions. See Ronald V. Dickson, 42 Van Natta 1102, 1106 (1990). Accordingly, claimant's headaches are not appropriately analyzed as a compensable occupational disease under former ORS 656.802(1)(a).

Turning next to former ORS 656.802(1)(b), physical conditions (such as migraine headaches):

> "resulting from work-related 'stress' are not compensable under paragraph (b), unless a 'mental disorder' has been diagnosed as the underlying condition. Only in that situation, where physical conditions directly result from a diagnosed mental disorder, can a stress-related physical condition be found compensable under [former] ORS 656.802(1)(b) and (c)."

Dickson, supra at 1108-09.

Here, claimant allegedly experienced work-related stress in October 1987 which resulted in an adjustment disorder that in turn increased her migraine headaches. A subsequent claim, based on the adjustment disorder, was denied in February 1988 and, in a disputed claim settlement, claimant received $9,000; however, the denial remained in force. Now, claimant's attorney unequivocally states: "This is not a mental condition case. The claimant does not have a mental condition or a psychiatric condition we're claiming." (Tr. 15). Furthermore, the only psychological evaluation in the record pertaining to the present matter states that claimant has no current psychiatric condition.

There is no present claim or evidence that claimant has a mental disorder arising out of and in the course of her employment which caused the migraine headaches. Thus, claimant's headaches are not a compensable occupational disease under former ORS 656.802(1)(b).

Finally, claimant's headaches are not a compensable occupational disease under former ORS 656.802(1)(c). Claimant does not point to any series of traumatic events or occurrences other than a stressful work environment. In Dickson the Board held that a "series of traumatic events," as that phrase is used in subsection (1)(c) of former ORS 656.802, was intended to mean physical trauma. See Dickson, supra at 1107. Consequently, disabling headaches caused by a

series of physically traumatic events, as opposed to stress-related headaches, are compensable as an occupational disease. Laverne K. McCormick, 42 Van Natta 1781 (1990), citing Dickson, supra. Here, claimant has plainly failed to establish a series of physically traumatic events.

We conclude that claimant has shown that job stress probably increased the frequency of her headaches. However, because the work-related stress is not properly characterized as an exposure to environmental substances; did not result in a mental disorder; and was not a series of traumatic events, claimant has not proven a compensable occupational disease under former ORS 656.802. Therefore, we affirm the Referee.

ORDER

The Referee's order dated October 30, 1989 is affirmed.

December 13, 1990 Cite as 42 Van Natta 2777 (1990)

In the Matter of the Compensation of
GARY A. KOCH, Claimant
WCB Case No. 88-19110
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Myzak's order that: (1) increased his unscheduled permanent disability award for a low back injury from 25 percent (80 degrees), as previously awarded by an August 1984 Determination Order, to 34 percent (108.8 degrees), whereas an October 1988 Determination Order awarded no additional unscheduled permanent disability; (2) affirmed the October 1988 Determination Order award of 6 percent (9 degrees) scheduled permanent disability for his right leg injury; and (3) authorized the SAIF Corporation's request for an offset against permanent disability. On review, the issues are extent of unscheduled and scheduled permanent disability, and offset. We affirm.

FINDINGS OF FACT

The Board affirms the Referee's Findings of Fact, with the following supplementation.

As a result of his compensable injury, claimant has reduced thoracolumbar flexion (60 degrees) and reduced thoracolumbar extension (10 degrees). Also as a result of his injury, claimant underwent a lumbar laminectomy at L5-S1 and has an unoperated disc derangement at L4-5. As a result of his injury, claimant has disabling pain which restricts his activity.

CONCLUSIONS OF LAW AND OPINION

Extent of unscheduled disability

The Referee awarded claimant 9 percent additional unscheduled permanent disability for his low back condition. The Referee arrived at the disability figure by applying the "standards" only to those factors that had changed after the last award or arrangment of compensation. We disagree. In calculating claimant's disability award and applying the "standards," we consider claimant's

previous awards of permanent disability made under this injury claim and his current permanent injury-related disability.

Claimant's current claim was closed by an October 31, 1988 Determination Order. Therefore, we are required to apply the "standards" adopted effective July 1, 1988 (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, to the rating of claimant's permanent partial disability. Former ORS 656.283(7) and former OAR 436-35-270(1).

We find that the applicable "standards" for rating permanent disability are designed to rate an injured worker's total permanent disability on the date of the evaluation. The Referee's method of applying the "standards" to only those factors which changed after the last award of compensation is a reasonable one. However, after careful consideration, we do not believe that the "standards" were intended to be applied in such a manner nor that, as a pratical matter, they are capable of application in such a manner in most cases. Instead, we believe that we are required to determine a worker's total injury-related permanent disability under the applicable "standards." We must then reduce the total disability by the amount of previous awards of permanent disability made as a result of the same compensable injury or disease. This is true even though the prior awards may have been determined by application of longstanding guidelines rather than disability rating standards adopted pursuant to ORS 656.726(3)(f). Our first task, then, is to determine claimant's total, permanent, injury-related disability at the time of hearing.

Explanation of "standards" equation for unscheduled disability

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

Age

The appropriate value for claimant's age of 49 years is 1. Former OAR 436-35-290.

Education

The appropriate value for claimant's GED is 0. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 4 as a commercial fisherman (DOT 441.684-010). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training

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

4, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability where claimant has returned to modified work

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

In this case, claimant's usual and customary work required the physical capacity to do heavy work. The Referee found, and we agree, that claimant successfully returned to medium capacity work for one year after his aggravation. Therefore, the appropriate adaptability value is 2. Former OAR 436-35-310(a).

Impairment

The final element necessary to determine disability under the "standards" is the impairment value. For reduced thoracolumbar flexion (from 90 degrees to 60 degrees), claimant is entitled to an impairment value of 3 percent. Former OAR 436-35-360(6). For reduced thoracolumbar extension (from 30 degrees to 10 degrees), claimant is entitled to an impairment value of 2 percent. Former OAR 436-35-360(7). The values for lost range of motion in claimant's spine are added (not combined) to obtain a single value. Former OAR 436-35-360(10). In this case, the sum of the impairment values for lost thoracolumbar spinal motion is 5 percent.

In addition to reduced spinal motion and as a result of his industrial injury, claimant underwent a lumbar laminectomy. For his laminectomy with a singe discectomy, claimant is entitled to an impairment value of 5 percent. Former OAR 436-35-350(2). For his unoperated disc at L4-5, claimant is entitled to an impairment value of 4 percent. Former OAR 436-35-350(2). These values are added. Leland M. Pollock, 42 Van Natta 925 (1990). The sum of impairment values for general spinal findings is, therefore, 9 percent. Former OAR 436-35-350(2).

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

Here, we find that the evidence demonstrates that claimant has a loss of use or function in his low back attributable to disabling pain. Claimant's treating chiropractor, Dr. Carlock, opined that, as a result of his compensable injury, claimant suffered from pain which required him to restrict some daily activities. Claimant testified that twisting at the waist causes his back to become painful, and sitting and bending also cause tightness and stiffness in his back. He is unable to pick up objects from off the floor and cannot walk more than one and one-half miles. Due to disabling pain, claimant has been unable to participate in usual recreational activities, such as backpacking, hunting, motorcycle riding and ocean fishing.

Under the circumstances, we conclude that claimant is entitled to a value of 10 percent for disabling pain attributable to the compensable injury.

The impairment values for claimant's lost spinal motion (5 percent), general spinal findings (9 percent), and disabling pain (10 percent), are combined (not added) to obtain a single impairment value for the spine. Former OAR 436-35-360(11). Here, 5 percent, 9 percent and 10 percent combine to a value of 22.2 percent.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to the calculation. When claimant's age value (1) is added to his education value (4), the sum is 5. When that value is multiplied by claimant's adaptability value (2), the product is 10. When that value is added to claimant's impairment value (22.2), the result is 32.2 percent unscheduled permanent partial disability. That value is rounded to the next higher whole number. Former OAR 436-35-280(7). Claimant's total, present, unscheduled, permanent disability under the "standards" is 33 percent.

Claimant contends that he has established by clear and convincing evidence that his diability is more than is indicated by application of the "standards." Claimant argues that he could previously perform occupations in the heavy range, but now he can no longer perform his past work as a chaser. Although claimant bought a share of a plywood co-op and became an employee of the co-op, he contends that he was unable to obtain employment in other wood products industries.

On this record, we do not find clear and convincing evidence that claimant's disability is more or less than 33 percent. Because claimant previously received 25 percent unscheduled permanent disability for this injury, he is entitled to an additional 8 percent unscheduled permanent disability.

Although we have found that claimant is entitled to an additional 8 percent unscheduled disability, SAIF has not requested a reduction in the Referee's award of an additional 9 percent unscheduled disability. We, therefore, affirm the Referee's award.

Extent of scheduled disability

The Referee affirmed the October 1988 Determination Order award of 6 percent scheduled disability for claimant's right leg. We adopt the Referee's conclusions and opinion in regard to the award of scheduled disability.

Offset

The Referee concluded that SAIF was entitled to offset its overpayment of temporary total disability against the permanent disability awarded by the order. We agree. We adopt the Referee's conclusions and opinion, as set forth in the amended opinion and order, in regard to the offset issue.

ORDER

The Referee's order dated August 7, 1989, as amended September 5, 1989, is affirmed.

In the Matters of the Compensation of
RICHARD D. RAY, Claimant, and
WAYNE L. GARRISON, Claimant
And, in the Matter of the Complying Status of
Larry E. Kling and Richard E. Obendorf, dba,
TRANSIT HOMES OF AMERICA, Employer
WCB Case Nos. 89-10829, 89-09362, 89-03516 & 89-06551
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
John A. Anderson, Attorney
Roger J. Leo, Attorney

Reviewed by Board Members Howell and Speer.

In this consolidated proceeding, the alleged noncomplying employer requests review of those portions of Referee Mills' orders that: (1) found that the employer was a subject employer and claimants were subject workers; (2) set aside the SAIF Corporation's denial of claimant Ray's low back injury claim; (3) upheld SAIF's acceptance of claimant Garrison's claim for a shoulder injury which occurred in the state of Washington; and (4) affirmed the Department's Proposed and Final Order which found the employer to be a noncomplying employer. On review, the issues are compliance and compensability, including the question of subjectivity.

We affirm and adopt the orders of the Referee, with the following exception and supplementation regarding the subjectivity question.

The Referee opined that the contracts between Transit Homes of America (TNHA) and claimants were contracts for the leasing of claimants' trucks and not for the performance of labor or services. Therefore, the Referee concluded that former ORS 656.029 does not impose a duty on TNHA to provide workers' compensation coverage. We disagree.

Former ORS 656.029(1) provides:

> "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, other than those exempt under ORS 656.027, 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. * * * *"

TNHA's business is transporting mobile homes. The leases let to claimants indicated that the tractor owners would "provide" drivers. Therefore, the contracts between TNHA and claimants "involved the performance of labor." Moreover, TNHA's business purpose would not be accomplished if the leased trucks were not driven. Consequently, such labor is a normal and customary part of TNHA's business. By entering into an agreement whereby the lessors/claimants promised to perform the labor and provide the service of driving the leased vehicles, TNHA contracted for labor. Accordingly, we conclude that, even if claimants had been independent contractors, TNHA was required to provide coverage pursuant to former ORS 656.029.

After considering the factors set forth in OAR 438-15-010(4) and applying them to these cases, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $2,000, to be paid by the SAIF Corporation on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the complexity of the issues, the time devoted to the cases as represented by claimant's brief and statement of services, and the value of the interests involved.

ORDER

The Referee's orders dated October 27, 1989 are affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,000, to be paid by the SAIF Corporation, on behalf of the noncomplying employer.

In the Matter of the Compensation of
AUDREY RUDD, Claimant
WCB Case No. 89-07280
SECOND ORDER ON RECONSIDERATION
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

The self-insured employer requests reconsideration of those portions of our November 29, 1990 Order on Reconsideration that declined to reduce the penalty-related attorney fee assessed by the Referee. Specifically, the employer contends that inasmuch as the 25 percent penalty was reduced to 15 percent by our October 9, 1990 Order of Review, the assessed attorney fee should be correspondingly reduced. Claimant in his response to the employer's motion for reconsideration seeks reconsideration of those portions of our: (1) October 9, 1990 Order on Review which declined to award an assessed fee to claimant; and (2) November 29, 1990 Order on Reconsideration that declined to award an assessed fee for services rendered by claimant in responding to the employer's motions for reconsideration.

In denying the employer's request for reduction of the penalty-related attorney fee, we concluded that the employer had not raised the issue on review. However, after further consideration, we find that the employer's appellant's brief does contain one sentence which can be interpreted as seeking a reduction of the penalty-related attorney fee in the event the Referee's penalty assessment was modified. Consequently, we turn to a determination of that issue.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that, despite our reduction of the Referee's penalty assessment from 25 percent to 15 percent, a reasonable attorney fee concerning the issue of the employer's untimely claim closure remains $1,150 as awarded by the Referee, to be paid by the employer. In reaching this conclusion, we have particularly considered the value of the interest involved, the time devoted to the issue as represented by claimant's counsel's statement of service and the record, and the complexity of the issue.

We next address claimant's request for an assessed fee for services on review. We note that the issues on Board review were dismissal for failure to appear, overpayments, penalties and attorney fees. The issues on reconsideration were penalty and assessed attorney fee. Inasmuch as claimant's compensation was not at risk on Board review or reconsideration, we find claimant's counsel is not entitled to an additional assessed fee. ORS 656.382(2). See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 29, 1990 order, effective this date. The parties' rights of appeal shall begin from the date of this order.

IT IS SO ORDERED.

December 14, 1990 Cite as 42 Van Natta 2783 (1990)

In the Matter of the Compensation of
RICARDO AGUAS, Claimant
WCB Case No. 89-07959
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Myzak's order that found that claimant had withdrawn from the work force at the time of his aggravation claim and was not entitled to temporary total disability. On review, claimant contends that the Referee lacked authority to address the temporary disability issue. We agree and reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact and Findings of Ultimate Fact except for the Findings of Ultimate Fact number 5.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not entitled to temporary disability compensation because, at the time of the aggravation of his work-related injury, claimant had withdrawn from the work force to become a student. Therefore, the Referee reasoned, claimant was no longer a "worker" within the meaning of ORS 656.005(27) and Cutright v. Weyerhaeuser, 299 Or 290 (1985).

On review, claimant argues that the Referee did not have jurisdiction to decide the temporary disability issue because this issue was first brought up in the insurer's closing argument, after the evidentiary portion of the hearing had closed.

We have 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 rule on a causation question raised for the first time at the commencement of a hearing on an aggravation denial. See Dennis C. Redden, 41 Van Natta 166, 169-70 (1989). We reasoned that claimant waived any right he had to the litigation of the issue.

Here, although the record was reopened after the closing arguments, thereby giving claimant an opportunity to object on the record or request a continuance, the issue of temporary total disability (TTD) was not introduced until the closing arguments. Claimant did not list TTD as an issue either on his specification of issues form or at the beginning of the hearing. (Tr. 2). Also, the insurer explicitly stated at the commencement of the hearing that it had no cross-issues. Id. Furthermore, when the insurer raised the TTD issue, claimant objected. Finally, claimant's comments after the Referee reopened the

record amount to a continuation of his objection to the introduction of the TTD issue. Karel L. Nelson, 42 Van Natta 1206 (1990).

In Edward A. Rankin, 41 Van Natta 1926 on recon 41 Van Natta 2133 (1989) we held that it was not proper to address an issue first raised during unrecorded closing arguments. We reached this conclusion because the parties expressly agreed to the issues before the hearing as recited by the Referee and did not alter their positions during the hearing. Id. at 2134.

Here, too, the parties were given an opportunity to state the issues at the beginning of the hearing. Claimant listed the issues as entitlement to medical services for his current condition and an aggravation claim. (Tr. 2). As noted above, the insurer stated it had no cross-issues. Also, here, the parties did not alter their positions during the hearing and the insurer introduced the new issue of TTD denial in its closing argument. The only difference is that here the closing argument was recorded. We do not find that difference significant and adhere to the reasoning expressed in Rankin.

For the reasons set forth above, we find that the Referee lacked authority to address the temporary disability issue. Therefore, we reverse that portion of the Referee's order which addressed that issue.

ORDER

The Referee's order dated August 25, 1989 is reversed in part and affirmed in part. That portion which addressed the issue of claimant's entitlement to temporary total disability is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

December 14, 1990 Cite as 42 Van Natta 2784 (1990)

In the Matter of the Compensation of
DONNA L. BARTRUFF, Claimant
WCB Case No. 89-14710
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Holtan's order that affirmed a Determination Order award of 25 percent (80 degrees) unscheduled permanent disability for a cervical spine condition. On review the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant has restrictions in pursuing work activities that require prolonged postural stances such as sitting and standing. She is also limited to working only at waist level and must be afforded the opportunity to move about as needed to reduce her symptoms and discomfort. (Ex. 16-14).

An offer of employment was made and claimant was released to modified light/sedentary work in May 1989. The employment offered was for a position in

Portland while claimant resided in Salem. The job description, with the extensive commute, was approved by Dr. Hansen because SAIF allegedly offered to relocate claimant to the Portland area. However, this relocation never took place and the work release was later terminated by the treating physician when claimant's back condition deteriorated due, in part, to the long daily commute between Salem and Portland. At the time of hearing, claimant was not working as a result of her injury.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Partial Disability

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

Because claimant's condition became medically stationary on November 14, 1988, and her claim was closed by Determination Order on June 21, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

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

Age and Education

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

The appropriate value for claimant's GED is 0. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was as a psychiatric aide (DOT # 355.377-014) which has a SVP of 4. Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

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

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

Adaptability

On review, claimant argues that the Referee erred in rating her adaptability under subsection (3) of former OAR 436-35-310 rather than applying subsection (4) of the rule. We agree.

Even though claimant temporarily returned to a modified job, we conclude that claimant's adaptability is most appropriately evaluated under former OAR 436-35-310(4) rather than former OAR 436-35-310(3). The adaptability value for a claimant who is not working as a result of his or her compensable injury/condition is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

At the time of hearing, claimant was not working as a result of her injury. Even though an offer of employment was made and claimant was released to modified work in May 1989, this release was later terminated by the treating physician when claimant's back condition deteriorated due to the long daily commute between Salem and Portland.

Claimant has restrictions in pursuing work activities that require prolonged postural stances such as sitting and standing. She is also limited to performing activities only at waist level and must be afforded the opportunity to move about as needed to reduce her symptoms and discomfort. (Ex. 16-14). Therefore, the "offer" of employment in Portland, with the extensive commute, was approved by Dr. Hansen because SAIF allegedly also offered to relocate claimant to the Portland area. However, this relocation never took place and Dr. Hansen took claimant off this job in August 1989 because "traveling to Portland was producing an exacerbation to her condition." (Ex. 16-4; Dr. Hansen's Depo. pp 18-19, 27-28; Tr. 40-42).

Claimant's residual physical capacity falls between the light and sedentary categories as defined in former OAR 436-35-310(4). However, she also has restrictions in her ability to sit and stand. In such cases, the value for the sedentary category is averaged with the values for light and restricted sedentary to obtain the appropriate adaptability value. Former OAR 436-35-310(4). The average of 4, the value for light physical capacity, 8, the value for the sedentary category, and 10, the value for restricted sedentary physical capacity (when a worker is unable to perform the full range of activities), is 7.3. Therefore, the appropriate adaptability value is 7.3.

Impairment

The value given by the Referee for claimant's impairment is not in dispute. We essentially concur with the 13 percent rating; however, we arrive at a 12.6 percent value when combining 5 percent for a chronic condition limiting repetitive use with 8 percent for lost ranges of motion. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to her education value, 3, the sum is 4. When that value is multiplied by claimant's adaptability value, 7.3, the product is 29.2. When that value is added to claimant's impairment value, 12.6, the result is 41.8 percent unscheduled permanent partial disability. That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 42 percent.

ORDER

The Referee's order dated February 27, 1990 is modified. In addition to the 25 percent (80 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 17 percent (54.4 degrees) unscheduled permanent disability, giving 0er a total award to date of 42 percent (134.4 degrees) unscheduled permanent disability for a cervical spine injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

December 14, 1990 Cite as 42 Van Natta 2787 (1990)

In the Matter of the Compensation of
NORMA J. BEMROSE, Claimant
WCB Case No. 89-09430
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Lipton's order that: (1) upheld the self-insured employer's partial denial of claimant's low back and left leg conditions; and (2) declined to assess penalties and associated attorney fees for an allegedly untimely denial. Claimant asserts that she was denied due process of law because the Opinion and Order was issued by a Referee other than the Referee before whom she personally appeared and testified. On review, the issues are compensability, penalties and attorney fees and procedural due process.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability of Left Leg and Low Back Conditions

The Referee found that there was no medical evidence to establish that claimant's current left leg and low back complaints were causally related to her compensable shoulder injury and upheld the employer's partial denial of her current conditions. We agree and adopt the Referee's Conclusions of Law and Opinion, as set forth in the "Opinion" portion of the order, with the following comment.

Claimant asserts that she was denied procedural due process because the Referee who issued the Opinion and Order did not have the benefit of making a credibility finding on demeanor. The employer contends that Referee Lipton, the Referee who decided claimant's case, had the benefit of making a credibility finding based on the substantive evidence. The employer further contends, however, that because the causation of her left leg and low back conditions presented a complex medical question, a credibility determination was not essential in this case.

We have previously held that due process does not require that an administrative decision-maker have an opportunity to hear and see the witnesses at hearing. See Roderick A. Mespelt, 42 Van Natta 531 (1990). We continue to hold that there is no such due process right.

Further, we note that claimant presented three possible causes for her left leg and low back conditions: they were inseparable from her January 27, 1989 left shoulder injury; they were the result of a November 1988 fall, for which a claim had not been filed; or, they resulted from a series of traumatic events.

Given the fact that claimant admitted falling in November 1988 and injuring her left leg, and possibly her back, and given the fact that claimant did not have back symptoms until at least 3 weeks after her compensable shoulder injury, we agree with the Referee and find that the causation of claimant's condition was of sufficient medical complexity that it could not be decided without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Since the record is totally devoid of medical evidence to establish a causal relationship between her low back and left leg complaints and her compensable shoulder injury, we find that even a positive demeanor credibility finding would not cure the causation defect. Therefore, we conclude that claimant failed to meet her burden of proving the compensability of her left leg and low back conditions.

Penalty and Attorney Fee - Failure to Timely Accept or Deny Claim

We adopt that portion of the Referee's Conclusions of Law and Opinion, as set forth in the "Opinion" portion of the order, which found insufficient evidence to determine that a claim was filed. Absent a claim, there is no duty to issue an acceptance or a denial.

ORDER

The Referee's order dated December 28, 1989 is affirmed.

December 14, 1990 Cite as 42 Van Natta 2788 (1990)

In the Matter of the Compensation of
JOHN W. CROSS, Claimant
WCB Case Nos. 90-00169 & 89-17857
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portion's of Referee Galton's order which declined to award an assessed attorney fee in conjunction with vacating the Director's order concerning vocational assistance. On review, the issue is attorney fees.

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

The Referee vacated the Director's order in WCB Case No. 90-00169 on the basis that the Director lacked jurisdiction to decide vocational issues resulting from claimant's claim for a respiratory condition. The Referee's decision had no effect on claimant's entitlement to vocational services resulting from the respiratory condition, but rather found that the issue was not properly before the Director. Further, we have previously held that entitlement to vocational services is a question of extent of benefits and, therefore, an assessed attorney fee cannot be awarded even if claimant prevails. See Nyall W. Bacon,

41 Van Natta 2046, 2047 (1989). Accordingly, claimant is not entitled to an assessed attorney fee in this instance.

ORDER

The Referee's order dated January 8, 1990, as amended January 24, 1990, is affirmed.

December 14, 1990 Cite as 42 Van Natta 2789 (1990)

In the Matter of the Compensation of
JAMES E. HUMPHREY, Claimant
WCB Case Nos. 89-16786 & 89-16783
ORDER ON REVIEW (REMANDING)
Rex Q. Smith, Claimant Attorney
David J. Lillig (Saif), Defense Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Thye's orders which: (1) dismissed his request for hearing; and (2) approved a client-paid fee of $1,531.50. On review, the issues are dismissal and attorney fees. We vacate and remand.

FINDINGS OF FACT

In August 1989, claimant requested a hearing challenging the SAIF Corporation's denial of his aggravation claim for his left knee condition. A hearing was scheduled for December 1989. On October 23, 1989, claimant moved the Referee for an order appointing an insurer-paid physician to examine claimant pursuant to OAR 438-07-005(5). In claimant's October 23, 1989 motion he states:

> "In the event that you deny the motion then such order shall be dispositive and I can request Board Review from the motion rather than everybody wasting time showing up for hearing."

On November 17, 1989, the Referee issued an Order of Dismissal in order to "accommodate claimant's expressed desire to not proceed with the hearing in light of an adverse ruling on his motion."

On November 21, 1989 by letter, claimant requested that the Referee withdraw the Order of Dismissal and enter an order denying his motion for an insurer-paid medical examination so that claimant would have a reviewable order. Claimant wrote:

> "...it is settled law that where counsel conceeds [sic] that if a motion is denied, he cannot win the case on the merits, then the appropriate procedural step is to make a final order on the basis that the merits were conceded."

On November 28, 1989, the Referee issued an Order Approving Fee for a client-paid fee not to exceed $1,531.50.

In a November 29, 1989 letter to the Referee, claimant, objecting to the amount authorized, requested that the Referee "reconsider" his order approving the client-paid attorney fee.

The Referee's Order Denying Reconsideration (of the Order of Dismissal) and an Order Abating the Order Approving Fee, issued on December 4, 1989.

On December 6, 1989, claimant requested Board review of the November 17, 1989 Opinion and Order, the November 28, 1989 "denial of reconsideration" [sic], and the December 4, 1989 Denial of Reconsideration. On January 4, 1990, the Referee issued another Order Approving Fee which again approved a client-paid fee of $1,531.50.

CONCLUSIONS OF LAW AND OPINION

Order of Dismissal

The Referee, referring to claimant's intent reflected in his October 23, 1989 motion for an insurer-paid medical examination, stated in his Order of Dismissal that he was dismissing claimant's request for a hearing in order to "accommodate claimant's expressed desire to not proceed with the hearing in light of an adverse ruling on his motion." Although we understand the Referee's reasoning in attempting to give claimant a final, appealable order, we find no basis for a dismissal.

Claimant has conceded that, as the record stands at this time, he cannot prevail on his compensability challenge. Claimant wishes to be examined by a particular physician in order to further develop the record. Claimant argues that where the insurer spends unlimited amounts of money on experts, a claimant, who has limited financial resources, is put to an unconstitutional disadvantage.

Pursuant to OAR 438-06-071, a hearing request may be dismissed when the party requesting the hearing has abandoned the request for hearing or has engaged in conduct that results in an unjustified delay in the hearing of more than 60 days, or has failed to attend the hearing, either personally or through counsel, without extraordinary circumstances justifying postponement or continuance. A request for a hearing may also be dismissed upon a motion to withdraw the request by the requesting party. None of these conditions exist in the present case. Importantly, in his motion for reconsideration, claimant informed the Referee that he did not want his request for a hearing dismissed, but instead wanted an interim order regarding his request for the medical examination.

Claimant apparently believes that such an interim order would be reviewable by the Board. Claimant is not correct. The word "order" in ORS 656.289(1) means a final order which "adjudicates a right or imposes a duty." Beck v. Oregon Steel Mills, 26 Or App 581, 583 (1978). A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Accordingly, the Referee should have first properly issued an interim ruling on claimant's request for an insurer-paid medical examination, then given claimant an opportunity to proceed on the merits. On remand, the Referee should proceed with a determination on the merits of claimant's request for a hearing, either by hearing if claimant desires, or based upon claimant's concession of noncompensability. The Referee shall then issue a final, appealable order on the merits incorporating his interim ruling.

Attorney Fee

Because we vacate the Referee's dismissal order, we do not address the client-paid attorney fee issue raised by claimant.

ORDER

The Referee's order dated November 17, 1989 is vacated. Claimant's request for a hearing is reinstated and this matter is remanded to Referee Thye, who shall conduct further proceedings consistent with this order.

December 14, 1990 Cite as 42 Van Natta 2791 (1990)

In the Matter of the Compensation of
SABETH SOK, Claimant
WCB Case No. 89-03901
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Davis & Bostwick (Saif), Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of those portions of Referee Fink's order that: (1) granted claimant's motion to exclude the employer's exhibits as untimely; (2) found claimant's temporomandibular joint dysfunction claim not barred by res judicata; (3) set aside the employer's denial of claimant's temporomandibular joint syndrome (TMJ); and (4) set aside the employer's denial of current chiropractic treatment as not reasonable and necessary. In her respondent's brief, claimant moves to strike those portions of the employer's brief referencing the employer's exhibits which were not admitted into the record. On review, the issues are admission of evidence, motion to strike, res judicata, compensability and medical services. We deny the motion to strike, affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

Claimant sustained a compensable cervical, left shoulder and left arm injury on September 14, 1989 after slipping on a wet floor and twisting her body and neck. She did not fall to the floor or hit any object during the incident.

Between September 1987 and late March 1988, claimant was treated or evaluated by Drs. Dougan, M.D.; Brown, M.D.; Norris, family practitioner; Malos, neurosurgeon; Ash, neurologist; and Joe, M.D. She underwent independent medical evaluations by the Orthopaedic Consultants and Dr. Klein, psychologist, in February 1988.

On March 29, 1988, claimant began treating with Dr. Dawson, D.C., who initiated weekly chiropractic treatment.

On April 11, 1988, a Determination Order issued closing claimant's claim and awarding temporary disability only.

In June 1988, the employer denied claimant's aggravation claim for the cervical, left shoulder and left arm conditions. Claimant requested a hearing on the Determination Order and on the aggravation denial. By Opinion and Order dated October 19, 1988, Referee Mulder set aside the April 11, 1988 Determination Order as premature and upheld the employer's aggravation denial. That order is final.

Dr. Dawson first noted a bilateral TMJ condition and sought authorization for a TMJ specialist in July 1988. That request was denied. Dawson referred claimant to Dr. Summer, D.D.S.

In November 1988, an MRI was interpreted to reveal marked degenerative changes and deformity relative to claimant's TMJ condition. (Ex. 16).

In December 1988, claimant underwent an independent evaluation by Dr. Jastak, D.D.S.

In January 1989, the employer denied claimant's TMJ condition. In March 1989, the Orthopaedic Consultants performed another independent evaluation.

On April 20, 1989, the employer denied current chiropractic treatment indicating that it was not reasonable or necessary. Claimant requested a hearing on both the TMJ denial and the medical services denial.

At hearing, upon claimant's motion, the Referee excluded the employer's 39 exhibits as untimely. The employer objected and moved for a postponement. The Referee overruled the objection, denied the motion for postponement and excluded the exhibits.

The Referee admitted claimant's Exhibits 1 through 23 into the record and admitted the employer's Exhibits 1 through 39 "under the rule."

ULTIMATE FINDINGS OF FACT

The employer's Exhibits 1 through 39 were timely disclosed.

Claimant's claim for her TMJ condition was not barred by res judicata. Claimant's 1987 compensable injury materially caused her TMJ condition.

Claimant's current chiropractic treatment is neither reasonable nor necessary.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling - Admission of Evidence

The Referee excluded the entirety of the employer's exhibits, Exhibits 1 through 39, as untimely submitted. While we find that the exhibits were submitted untimely, we proceed to admit the exhibits on other grounds.

After our review of the relevant rules, OAR 438-07-015 and OAR 438-07-018, we find that, in this instance, the Referee did not have discretion to exclude the exhibits.

OAR 438-07-015 regulates entitlement to claims information and discovery. Failure to provide timely discovery may be sanctioned. OAR 438-07-015(5) and OAR 438-07-018(4).

OAR 438-07-018, however, pertains to the exchange and admission of exhibits at hearing. OAR 438-07-018(1) requires the insurer to submit its exhibits not later than 20 days before the hearing. No sanctions exist for failure to submit exhibits timely. While OAR 438-07-018(4) does provide for sanctions for untimely discovery under OAR 438-07-015, those sanctions do not pertain to OAR 438-07-018(1)-(3). Therefore, nothing in the rule precludes admission of other documents provided they have been timely disclosed to the other party. See Oliver F. Coon, 42 Van Natta 1845, 1846 (1990). Further, OAR 438-

07-018(4) does not give the Referee discretion to exclude timely-disclosed documents merely because the documents could have been submitted at an earlier time. Coon, supra; T. S. Nacoste, 42 Van Natta 1855 (1990).

Here, there is no evidence that the employer's disclosure of the documents to the other party was untimely. Rather, the evidence establishes only that the employer's submission of exhibits to the Referee was untimely. Therefore, we find that the Referee was without discretion to sanction the employer's untimely submission of documents by excluding the exhibits.

Consequently, we admit the employer's Exhibits into the record, referred to as "Employer's Exhibits (EE) 1-39", and consider them in determining the issues.

Motion to Strike

Because we have found the Referee to be without discretion to exclude the employer's exhibits, and have herein admitted those exhibits into the record, we deny claimant's motion to strike those portions of the employer's respondent's brief referencing those exhibits.

Res Judicata

The Referee found that claimant's claim for TMJ was not barred by the doctrine of res judicata. We agree.

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

"Issue preclusion" precludes future litigation of a subject issue only if that issue was "actually litigated and determined" in a setting where the determination of that issue was essential to the final decision reached. Drews, supra. "Claim preclusion" precludes a plaintiff who has prosecuted one action against a defendant through to a final judgement from prosecuting another action against the same defendant where the claim in the second action is one based on the same factual transaction that was at issue in the first, and where the plaintiff seeks a remedy additional or alternative to the one sought in the first, and is of such a nature as could have been joined in the first action. Drews, supra at 140, citing Rennie v. Freeway Transport, 294 Or 319, 323 (1982).

Under either analysis, we find that claimant is not barred from litigating the compensability of her TMJ condition.

The employer asserts that claimant's TMJ claim should have been considered at the July 25, 1988 hearing because the condition was one which the claimant contended was caused by the compensable cervical, left shoulder and left arm injury. We find, however, that claimant had not yet filed a claim for the TMJ condition at the time of the July 25, 1988 hearing. The July 25, 1988 hearing encompassed only premature closure and aggravation issues, not the compensability of the TMJ condition. Accordingly, we find that the compensability of the TMJ condition had not yet been litigated and determined in a setting where the determination of that issue was essential to the final decision reached. Therefore, the employer has not met the requisites for issue preclusion to bar the claim.

Further, we find that the claim for compensability of the TMJ condition is not one which could have been joined in the first action, thereby forcing the employer's claim preclusion argument to fail. We make this finding based on the fact that the TMJ condition was not diagnosed until July 1988, some eight months after the initial compensable injury. Further, we note that the employer received notice of this condition that same month. Moreover, the employer issued a specific denial of that condition, but not until January 26, 1989, six months after the hearing at which the employer asserts the issue should have been litigated. Therefore, because the compensability of the TMJ condition was not ripe and, as such, could not have been joined with the first action, we conclude that the employer has likewise failed to meet the requisites for claim preclusion.

Based on the above, we conclude that claimant is not barred from litigating the issue of compensability of the TMJ condition.

Compensability of the TMJ Condition

The Referee concluded that claimant met her burden of proving that her compensable cervical, left shoulder and left arm injury materially caused her TMJ condition. We agree.

It is well settled that a carrier is liable for the natural consequences flowing from a compensable injury. Williams v. Gates McDonald & Co., 300 Or 278, 281 (1985); Pattitucci v. Boise Cascade Corp., 8 Or App 503, 507-8 (1972). Therefore, to establish the compensability of claimant's TMJ condition, claimant has the burden of proving by a preponderance of the evidence that her compensable injury is a material cause of her current TMJ condition. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). We find that claimant has met her burden.

Claimant's TMJ condition was treated by Dr. Dawson, chiropractor, Dr. Summer, D.D.S. and Dr. Jastak, oral surgeon. Faced with this complex question, we defer to the opinions of the experts, Drs. Summer and Dr. Jastak. See Abbott v. SAIF, 45 Or App 567, 661 (1980); Warren E. Bechtolt, Sr., 42 Van Natta 2480 (October 31, 1990).

In December 1988, claimant's TMJ condition was evaluated by Dr. Jastak, oral surgeon. After taking claimant's history, noting her current symptoms, and performing a brief examination, Dr. Jastak indicated that claimant suffered from chronic pain behavior secondary to psychologic factors, myofascial pain, degenerative joint disease, and bilateral TMJ. Jastak noted that degenerative changes were relatively common in persons over age 40 and usually are accompanied by a report of pain or disability. Jastak further noted that "regardless of symptoms, such degenerative changes are often a result of long term wear phenomenon or secondary from severe direct joint injury." (EE. 36). Jastak concluded that "there was absolutely no valid evidence that she injured her temperomandibular joints as a result of the work place incident of September 9, 1987." (EE. 36).

In contrast, in May 1989, after an independent examination, Dr. Summer reported that, based on the MRI, claimant suffered from an internal derangement of both her temporomandibular joints, which can be caused by either direct impact or a sudden extension of the head. (Ex. 21). Summer noted that claimant could have had a preexisting strain on her temporomandibular joints, but reasoned that in such a situation, the force required to produce the definitive displacement of the articular disc may not be great. Summer also noted that there was no evidence of a symptomatic TMJ condition before the compensable injury, that claimant reported swelling in the area of her jaw after the accident and that claimant's compensable injury did involve a sudden extension or twisting of the

head. Based on these findings, Summer concluded that it was "very likely that the [compensable injury] was the cause of the symptomatic TMJ condition." Id.

While we note that claimant did consistently complain of facial swelling after the accident, the record does not specifically reflect that it was the jaw area that was swollen. Regardless, we find that the opinion of Dr. Summer is more well-reasoned and based on complete information than the more conclusory opinion of Dr. Jastak. Therefore, we rely on the opinion of Dr. Summer. Somers v. SAIF, 77 Or App 259, 262 (1986); See Hammons v. Perini Corp., 43 Or App 299, 302 (1979); Moe v. Ceiling Systems, 44 Or App 429 (1980).

Consequently, we conclude that claimant has met her burden of proving that her compensable cervical, left shoulder and left arm injury materially caused her TMJ condition.

Medical Services - Chiropractic Treatment

The Referee found that the employer's denial of current chiropractic treatment was both a prospective denial and an improper preclosure denial. On the merits, he found that the chiropractic treatment was reasonable and necessary. We disagree.

Prospective denials are impermissible. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Here, the denial denies current chiropractic treatment because it was not reasonable or necessary. It is not prospective in nature. Therefore, we find that employer's April 20, 1989 denial is not an impermissible prospective denial.

The denial is likewise not an improper preclosure denial. Claimant asserts that the denial is an improper preclosure denial based on Roller v. Weyerhaeuser Company, 67 Or App 583 (1984) and Safstrom v. Riedel International, Inc., 65 Or App 728 (1983). We disagree.

An insurer may not issue a preclosure denial of current treatment for an accepted condition on the grounds that the accepted condition has resolved. See Webb v. SAIF, 83 Or App 386 (1987); Roller, supra; Safstrom; supra. Here, the employer issued a denial of current treatment not on the grounds that the accepted condition had resolved, but on the grounds that it was not reasonable and necessary. See ORS 656.245. Therefore, claimant's reliance upon Roller and Safstrom is misplaced.

Claimant is entitled to all reasonable and necessary curative or palliative medical treatment required for recovery from a compensable injury or for relief of pain. ORS 656.245(1); Wetzel v. Goodwin Bros., 50 Or App 101 (1981). It is claimant's burden to prove that her chiropractic treatments were reasonable and necessary. West v. SAIF, 74 Or App 317 (1985). For example, 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, 74 Or App 317, 320-21 (1985).

After our review of the record, we find that claimant has failed to meet her burden.

In January 1989, Dr. Dawson, chiropractor, reported that claimant continued to need treatment for moderate reduction of her chronic pain. (EE. 37). There is nothing in the record from Dr. Dawson after that date.

In March 1989, however, after noting that claimant admitted that the chiropractic treatment provided only a very brief relief of symptoms, the

Orthopaedic Consultants reported that there was no basis for chiropractic treatment and that the treatment claimant was receiving was palliative only. (EE. 38).

Claimant indicated that the chiropractic treatment reduced her level of pain, but that the pain returned the day following treatment. She further testified that the treatment did not allow her to return to work, nor did it allow her to perform the activities of daily living. (Tr. 22-24).

Claimant's testimony and the Consultants' opinion convince us that the chiropractic treatment did not provide significant palliative benefit. West v. SAIF, 74 Or App 317, 320-21 (1985); See Eusebio O. Juarez, 41 Van Natta 24 (1989); Michael D. Barlow, 38 Van Natta 196, 197-7 (1986). Therefore, we conclude that claimant has failed to establish that the current chiropractic treatment was reasonable or necessary.

Considering our above discussion, it follows that the employer's denial of claimant's current chiropractic treatments on reasonable and necessary grounds was not unreasonable. Furthermore, because the denial has been upheld, there has been no unreasonable resistance to the payment of compensation. Consequently, we reverse the Referee's $250 attorney fee award for an unreasonable chiropractic treatment denial.

Finally, we note that the Referee also awarded a $1,250 carrier-paid fee. Inasmuch as the Referee set aside both the TMJ denial and chiropractic treatments denial, we assume that this award encompassed both denials. Inasmuch as we have reversed the Referee's ruling on the chiropractic treatment denial, we must address the attorney fee award on the TMJ denial.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee for services at hearing concerning the TMJ denial issue is $1,000, to be paid by the employer. In reaching this conclusion, we have considered the complexity of the issue, the time devoted to the case as represented by claimant's counsel's statement of services and the record, and the value of the interest involved.

Finally, after considering the aforementioned rule, we further find that a reasonable fee for claimant's counsel's services on review concerning the TMJ issue is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 7, 1989 is affirmed in part, modified in part, and reversed in part. The self-insured employer's April 20, 1989 medical services denial is reinstated and upheld. The Referee's $250 attorney fee for an allegedly unreasonable chiropractic denial is reversed. In lieu of the Referee's $1,250 attorney fee award, claimant's attorney is awarded $1,000, to be paid by the employer. For services on Board review concerning the TMJ compensability issue, claimant's attorney is awarded a reasonable assessed fee of $1,000, payable by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
JUAN A. GARCIA, Claimant
WCB Case No. 89-08301
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney

Claimant requests reconsideration of our November 23, 1990 Order on Review that: (1) upheld the SAIF Corporation's "de facto" denial of temporary total disability; (2) declined to assess penalties and attorney fees for allegedly unreasonable claims processing; and (3) declined to assess penalties and attorney fees for an alleged unreasonable delay.

On reconsideration, claimant contends that, in effect, the Order on Review has precluded him from obtaining benefits from any employer or insurer. Claimant argues that there was never any contention that he was not entitled to receive benefits for his injury and once SAIF accepted the claim, it was not entitled to unilaterally terminate temporary disability.

Claimant's argument misses the mark. Our Order on Review provided no opinion in regard to the compensability of claimant's claim. Rather, we concluded that, the Referee's order determining that Melvin Ferguson was not the employer on the date of claimant's injury, had become final by operation of law. As a result, SAIF was, at that point, under no obligation to process a claim or pay benefits on behalf of an employer who was not a subject employer. See ORS 656.054.

Furthermore, we conclude that at the subsequent hearings, it was claimant's prerogative to show that he suffered a job-related injury, that he was a subject worker, that the employer was a subject employer and, thus, that SAIF was obligated to process his claim pursuant to ORS 656.054. Any party may request a hearing as to any question concerning a claim. ORS 656.283. Here, claimant did request such a hearing, asserting entitlement to temporary disability compensation. Because it was disputed that he was a subject worker of a subject employer, it was necessary for him to prove those elements of his claim to prevail. ORS 656.005(25) & (26); 656.027; 656.266. Since claimant was not a party to the proceedings involving the Proposed and Final Order, res judicata did not preclude him from asserting that he was a subject worker and the employer was a subject employer at the hearings in which he asserted his right to compensation from SAIF. However, claimant did not meet that burden. Therefore, SAIF was under no legal obligation, either as an insurer or claims processor for a noncomplying employer, to pay claimant temporary disability benefits.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
HENRY M. GRANADO, Claimant
WCB Case No. CO-00332
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al., Claimant Attorneys
David Jorling, Defense Attorney

Reviewed by Board Members Cushing and Myers.

On November 15, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the present payment of $10,000 and future payments of $15,000 in the year 1995, $25,000 in the year 2000 and $40,000 in the year 2005 by the City of Portland, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

A proposed disposition must be set aside if we find that it is unreasonable as a matter of law. ORS 656.236(1)(a). A disposition is unreasonable as a matter of law if a reasonable fact-finder could only conclude that the agreement is unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Here, the claim disposition agreement provides that, as part of the consideration for claimant's release, "claimant will be awarded, by Stipulation pending before the Hearings Division, 60 degrees for 100% scheduled [permanent] disability to claimant's left ear" (page 2, lines 15-17). However, OAR 438-09-030(1) (Temp.) provides that acknowledgment of a claim disposition agreement suspends all other proceedings on the claim. Thus, the processing of a settlement stipulation is suspended and it cannot be reviewed or approved while the claim disposition agreement is pending. Furthermore, once the claim disposition agreement is approved, it finally disposes of claimant's right to permanent disability benefits on the claim, precluding any additional award of those benefits by settlement stipulation. Because the approval of the agreement would effectively preclude claimant from receiving part of the consideration supporting his release, we are persuaded that a reasonable fact-finder could only conclude that the agreement is unreasonable. We find that the agreement is unreasonable as a matter of law and set it aside. Louis R. Anaya, supra.

IT IS SO ORDERED.

In the Matter of the Compensation of
RALPH GYSIN, Claimant
WCB Case Nos. 89-16162 & 89-05407
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Wallace & Klor, Defense Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of those portions of Referee Brown's order that: (1) set aside its denial of claimant's bilateral shoulder condition; and (2) assessed a penalty and attorney fee for its allegedly unreasonable denial. On review, SAIF raises the issue of timeliness of claimant's occupational disease claim for a bilateral shoulder condition. The issues are timeliness, compensability, penalties and related attorney fees.

We affirm and adopt the Referee's order with the following supplemenation concerning the timeliness issue.

SAIF argues that claimant failed to file her claim for a bilateral shoulder condition timely. We disagree. On January 21, 1989, claimant filed a claim for a bilateral shoulder condition, which claimant asserted was the result of excessive lifting on an everyday basis. ORS 656.807 requires that a claimant must file an occupational disease claim within one year from the date the worker first discovered, or in the exercise of reasonable care should have discovered the occupational disease; or one year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease. ORS 656.807(a)(b).

In this case we find that Dr. Gell, rheumatologist, whom claimant was sent to in November 1988 by his treating physician, Dr. McGeary, was the first physician to relate claimant's bilateral shoulder condition to his work exposure. There is no indication that Dr. Gell's November 18, 1988 report was sent to anyone other than claimant's treating physician. However, even assuming that claimant had notice that his bilateral shoulder condition was related to his work exposure at the time of his November 1988 examination with Dr. Gell, we find claimant filed his occupational disease claim within 3 months of this examination. Accordingly, we find that claimant timely filed his claim for an occupational disease.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the timeliness and compensability issues is $200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. In addition, claimant is not entitled to an attorney fee for defending against the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 3, 1990 is affirmed. For services on review, regarding the compensability and timeliness issues, claimant's attorney is awarded an assessed fee of $200, payable by the SAIF Corporation.

December 18, 1990 Cite as 42 Van Natta 2799 (1990)

In the Matter of the Compensation of
ROGER H. DRESCHER, Claimant
WCB Case Nos. 89-17858 & 89-17859
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee McWilliams' order that increased her scheduled permanent disability award for the loss of use or function of her left leg (knee) from 14 percent (21 degrees), as awarded by Determination Order, to 15 percent (22.5 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. Claimant suffers from a chronic condition limiting repetitive use of his left leg (knee).

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

The Referee found that claimant sustained 15 percent permanent loss of use of function of his left leg (knee). After our review of the record, we modify the Referee's award.

Claimant's left leg condition became medically stationary on February 17, 1989. His claim was closed by Determination Order on March 14, 1989. We apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Therefore, former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

Claimant contends entitlement to values of 12 percent for permanent loss of range of motion, 5 percent for a chronic condition limiting repetitive use, 5 percent for left knee surgery and an additional 10 percent based on clear and convincing evidence, for a total scheduled permanent disability award of 29 percent.

The self-insured employer, on the other hand, acknowledges that claimant is entitled to values for lost range of motion and the surgery, but asserts that claimant failed to establish either that he suffers from a chronic condition limiting repetitive use of his left leg and or that his disability exceeds that awarded under the standards.

Claimant's ratable loss of range of motion includes 119 degrees retained flexion in his left leg (knee). The appropriate value for that lost range of motion is 11.3 percent. Former OAR 436-35-220(1).

Claimant contends entitlement to a value for a chronic condition limiting repetitive use. Former OAR 436-35-010(7) provides for a value of 5 percent for a chronic condition limiting repetitive use of a scheduled body part.

Claimant is permanently restricted from performing repetitive crawling, climbing, standing and walking activities due to his leg leg (knee) injury. Claimant's modified job requires him to ride a bicycle for up to six hours daily. This fact, without more, does not prevent claimant from establishing that he is prevented from performing repetitive activities with his left leg. Because it is undisputed that claimant is unable to crawl or climb, and is severely restricted from standing and walking activities, we find that claimant has established that he suffers from a chronic condition which limits repetitive use of his left leg (knee), i.e., crawling and climbing.

Therefore, we find that claimant is entitled to a value of 5 percent for a chronic condition, which limits repetitive use of a scheduled body part, i.e., his left leg (knee). Former OAR 436-35-010(7).

Claimant underwent a limited medial meniscectomy with resection on the posterior horn fragment on the left knee. A partial meniscectomy to either or both menisci is rated as a proportion of 10 percent of the leg for each. Former OAR 436-35-230(4)(d). As the parties do not dispute the 5 percent value assigned by the Referee for claimant's partial meniscectomy, we do not disturb that finding.

After combining claimant's impairment values for his lost range of motion (11.3), his surgery (5) and his chronic condition (5), we find that claimant's total impairment under the "standards" is 19.95 percent. After rounding up to the next whole number, we find that claimant's total impairment due to his compensable left leg injury is 20 percent. Former OAR 436-35-010(6).

Disability Outside the Standards

The Referee found that claimant had not proven by clear and convincing evidence that his disability was greater than that awarded by the "standards." We agree.

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

Claimant contends that he has limitations due to his compensable left knee injury which prevent him from performing certain tasks at work and from doing athletic activities such as water skiing, climbing ladders, and roller skating. However, after our review of his testimony, we find that his responses were merely predictions of what he could and could not do in the way of work and other activities. Therefore, we do not find his testimony to be highly persuasive evidence of entitlement to disability in excess of the "standards."

Based on the aforementioned reasoning, we conclude that claimant has failed to establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by him is more than the entitlement indicated by the "standards." Former ORS 656.283(7); 656.295(5). Therefore, we do not award claimant disability based on clear and convincing evidence.

ORDER

The Referee's order dated January 31, 1990, as amended February 16, 1990, is modified. In addition to the Determination Order and Referee's award, claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability, for a total of 20 percent (30 degrees) scheduled permanent disability for the loss of use or function of his left leg (knee). Claimant's attorney is awarded 25 percent of the increased compensation resulting from this order. However, the total attorney fees awarded by the Referee's order and this order shall not exceed $3,800.

December 18, 1990 Cite as 42 Van Natta 2801 (1990)

In the Matter of the Compensation of
JOHN C. ELMORE, Claimant
WCB Case Nos. 89-09970, 88-17030, 88-18243 & 88-14451
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Sharon Schooley (Saif), Defense Attorney
Wallace & Klor, Defense Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Howell and Speer.

Transamerica Insurance Co., on behalf of HREBEC Properties (HREBEC), requests review of that portion of Referee Leahy's order that found that HREBEC was a subject employer and claimant was its subject worker. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began work putting up siding at the Tanasbourne II apartments in January or February of 1988. At that time, H & H Contractors ran construction. After five or six months, H & H lost its insurance coverage and work stopped on the project. About two weeks later, Gerry Worrell, foreman of the siding applicators (siders) called claimant back to work. Henceforth, HREBEC ran the job. Its employee, Jake Jacobson was superintendent on the site.

Claimant's work remained the same after HREBEC took over. Some workers supplied their own tools. Those who did not have tools were free to use tools supplied by the company. (Tr. 28).

Claimant's method of payment varied over the course of his employment. At the outset, workers kept time sheets and earned hourly wages. (Tr. 16). Workers signed time sheets when they entered and left the job site. (Tr. 17). Later, crews of two or more workers were paid "by the floor." (Exs. 1, 2). Under this arrangement, crew members decided how each bulk payment would be divided. (Tr. 26-7). Although a check-writing company issued payroll checks, HREBEC approved each payroll.

Jacobson required Worrell to sign a "subcontractor" agreement and required claimant and the other siders to sign "independent contractor" agreements before they were allowed to return to work. Worrell's agreement indicated that he would provide workers' compensation coverage for the siders. Worrell informed Jacobson that he did not have such coverage and that he could not provide it. Jacobson told Worrell "not to worry" about the insurance. (Tr. 39).

Worrell answered directly to Jacobson. HREBEC retained the power to unilaterally discharge Worrell and, through Worrell, claimant. Jacobson, HREBEC's employee, controlled the manner of claimant's work through Worrell.

Claimant suffered a compensable injury on June 23, 1988.

FINDINGS OF ULTIMATE FACT

Claimant was a subject worker.

HREBEC, not Worrell, was claimant's employer.

CONCLUSIONS OF LAW AND OPINION

The test for determining who is a subject worker within the meaning of the Workers' Compensation Act is the employer's right to control the performance of the worker's services. Former ORS 656.005(27). The test requires an application of the traditional "right to control" analysis. Woody v. Waibel, 276 Or 189, 196 (1976); Castle Homes, Inc. v. Whaite, 12 Or App 269 (1989).

The factors to be considered under the traditional test of the right to control include: (1) 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 at will without liability. Castle Homes, Inc. v. Whaite, supra.

After HREBEC took over the Tanasbourne project, Jake Jacobson, an HREBEC employee, was superintendent. Jacobson walked the site and directly supervised construction. He informed Worrell when something needed correction and Worrell directed claimant and the other workers to perform the work as Jacobson instructed. Jacobson directed the manner of claimant's work through Worrell. Therefore, we conclude that HREBEC, through Jacobson, retained and exercised direct control over the manner and performance of claimant's work. This is strong evidence of an employer/employee relationship.

The method of payment varied. Sometimes claimant was paid an hourly wage, sometimes he was paid according to work completed. We conclude that, in this case, the method of payment is not a determinative factor in the "right to control" test.

Likewise, insofar as some tools were supplied by workers and some by HREBEC, we conclude that this factor is not determinative.

It is uncontroverted that HREBEC could unilaterally discharge Worrell or claimant at any time; neither individual would have had recourse. (Tr. 11, 49). This is evidence of employment, rather than an independent contract of substance. Bowser v. State Indus. Accident Comm., 182 Or 42, 58 (1947).

We have concluded that the method of payment and the furnishing of tools are neutral factors in the right to control test. We have also found that HREBEC exercised direct control over claimant's work and that HREBEC could fire claimant without liability. Based on the latter factors, we conclude that HREBEC retained and exercised the right to control claimant's work, through its employees, Jacobson and Worrell. Consequently, claimant was a subject worker, and an employee of HREBEC, rather than an independent contractor.

Moreover, even if claimant had been an independent contractor, we find that HREBEC was required to provide workers' compensation coverage, because claimant was not otherwise covered.

Former ORS 656.029(1) provides:

> "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, other than those exempt under ORS 656.027, 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."

HREBEC was in the business of apartment construction. Claimant provided labor for HREBEC. Assuming, for the moment, that HREBEC awarded Worrell an "independent contract," HREBEC was nonetheless statutorily required to provide workers' compensation coverage for those who provided labor under that contract, including claimant.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by Transamerica on behalf of HREBEC. In reaching this conclusion, we have particularly considered the time devoted to the case as represented by claimant's brief and statement of services, the complexity of the issue and the value of the interest to claimant.

ORDER

The Referee's order dated October 18, 1989, as amended October 23, 1989, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by Transamerica Insurance Co., of behalf of HREBEC Properties.

In the Matter of the Compensation of
MICHELLE L. HAMILTON, Claimant
WCB Case Nos. 89-18461 & 89-13835
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Stafford Hazelett, Defense Attorney
Schwabe et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

United Employers Insurance Company requests review of Referee Myzak's order that: (1) set aside its denial of responsibility for claimant's back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of a "new injury" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and make the following additional findings. Claimant's neck pain came on before the December 27, 1988 and March 22, 1989 incidents which she experienced while working for McDonalds, Liberty Northwest's insured.

FINDINGS OF ULTIMATE FACT

Claimant's October 11, 1988 injury with Adobe Motel, United Employers' insured, was a material contributing cause of her disability and need for treatment in March 1989.

Claimant's injuries while working for McDonalds did not independently contribute to the causation of claimant's condition.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion and Conclusion of Law" with the following modification. The Referee, relying on Linda L. Wise, 42 Van Natta 115 (1990), held that where there is an accepted injury followed by additional allegedly injurious incidents at a second employment, the threshold question is whether claimant sustained a new injury at the second employment or an aggravation of the accepted injury. Finding that claimant's underlying condition was not worsened by the incidents at her second employment, the Referee concluded that the first employment is responsible for claimant's disability and need for treatment.

We agree with the Referee's view that the critical factual issue is whether or not the incidents at the second employment contributed to a worsening of the underlying condition. We also agree with her finding that they did not. Consequently, we also find the first employment responsible. Nevertheless, we understand the Wise analysis somewhat differently from the Referee.

Wise holds that in cases such as this, where there is an accepted injury followed by additional allegedly injurious incidents at a second employment, the threshold question is whether the incidents at the second employment were a material contributing cause of the compensable injury--i.e., of the disability or the need for medical services. If so, then the insurer covering the second employment is responsible unless that insurer establishes that the incidents at the second employment did not independently contribute to the worsened condition.

In this case, the incidents at McDonalds did cause additional pain, need for treatment, and disability. Therefore, the burden shifted to its insurer to

establish that the incidents did not cause a worsening of the underlying condition. Liberty Northwest did establish a lack of independent contribution. Consequently, United Employers is responsible.

ORDER

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

December 18, 1990 Cite as 42 Van Natta 2805 (1990)

In the Matter of the Compensation of
DANIEL G. HUFF, Claimant
WCB Case No. 89-11518
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of those portions of Referee Mongrain's order that: (1) increased claimant's unscheduled permanent disability award for a low back injury from 20 percent (64 degrees), as awarded by Determination Order, to 28 percent (89.6 degrees); and (2) assessed a penalty-related attorney fee for the employer's untimely disclosure of claim documents. On review, the issues are extent of unscheduled permanent disability and penalties and attorney fees. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of his finding that claimant's compensable injury produced claimant's L3-4 and L4-5 disc bulges.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See former ORS 656.283(7). Specifically, the Referee applied the version of OAR 436-35-001 et seq, in effect at the time of the June 22, 1989 Determination Order. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. These are the rules which we apply as well.

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

The parties do not dispute the values assigned by the Referee to claimant's age (0), education (3), and adaptability (2.5). We agree and adopt the Referee's findings and analysis as to those values. The parties do, however, disagree with respect to the value assigned to claimant's impairment. We, therefore, address the impairment factor.

The Referee, citing former OAR 436-35-350(2), assigned an 8 percent impairment value for claimant's bulging discs at L3-4 and L4-5. On review, the employer argues that the Referee erred in awarding any value for claimant's bulging discs. The employer argues in this regard that claimant has failed to establish that his bulging discs are due to his compensable injury. In addition, the employer contends that, in order to be entitled to an impairment value, claimant must affirmatively establish permanent impairment resulting from his bulging discs. The employer argues that claimant has failed to carry this burden.

With regard to the employer's latter argument, we do not agree that claimant need establish specific impairment resulting from his disc bulges. Any injury-related unoperated rupture bulge or other disc derangement is entitled to a value of 4 percent. Former OAR 436-35-350(2). In this regard, there is no requirement under the applicable version of former OAR 436-35-350(2) that there be clinically-related symptoms resulting in specific impairment.

However, we agree with the employer that claimant must establish a causal relationship between his disc bulges and his compensable injury. That is, he must show that disability resulting from impairment presumed by the "standards" to result from disc bulges is "due to" the compensable injury. ORS 656.214(5). We agree that claimant has not established the requisite causal relationship. While several post-injury medical reports in the record note the bulging discs, no medical report attributes those bulging discs to the compensable injury. Therefore, we conclude that claimant has failed to establish entitlement to an impairment value for his bulging discs at L3-4 and L4-5.

The parties do not dispute the Referee's remaining impairment values which include a 9 percent value for lost range of motion and a 5 percent value for a chronic condition limiting repetitive use. These values are combined for a total impairment value of 13.6. Former OAR 436-35-360(11).

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to his education value, 3, the sum is 3. Former OAR 436-35-280(4). When that value is multiplied by claimant's adaptability value, 2.5, the product is 7.5. Former OAR 436-35-280(6). When that value is added to claimant's impairment value, 13.6, the result is 21.1 percent. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's unscheduled permanent disability under the "standards" is, therefore, 22 percent.

Penalty-Related Attorney Fees

The Referee assessed a penalty-related attorney fee for the employer's failure to timely provide claims information to claimant's counsel. Claimant contends in this regard that the employer's untimely disclosure prevented claimant from timely requesting a hearing on a denial of medical services. The Referee concluded that claimant failed to establish that the employer's untimely disclosure had, in fact, resulted in claimant's late hearing request. We agree and adopt his discussion of this issue. Because claimant's hearing request was untimely, his challenge of the denial was dismissed. Claimant has not contested that ruling. Consequently, claimant has failed to establish that the employer's conduct amounts to an unreasonable resistance to the payment of compensation. Therefore, no penalty-related attorney fee may be awarded. ORS 656.382(1); Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated October 10, 1989 is affirmed in part, modified in part and reversed in part. In lieu of the Referee's increased award of unscheduled permanent disability, and in addition to the Determination Order award

of 20 percent (64 degrees), claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability for a total award to date of 22 percent (70.4 degrees). Claimant's out-of-compensation attorney fee shall be adjusted accordingly. The Referee's assessment of a $300 penalty-related attorney fee is reversed. The remainder of the Referee's order is affirmed.

December 18, 1990 Cite as 42 Van Natta 2807 (1990)

In the Matter of the Compensation of
YVETTE R. OGLESBY, Claimant
WCB Case Nos. 89-03507, 89-09473 & 89-09474
ORDER ON REVIEW
Ralph M. Yenne, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

The SAIF Corporation requests review of that portion of Referee Brazeau's order which found claimant to be a subject worker of Catholic Community Services. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

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

Claimant served as a proctor parent in the Shelter Evaluation Program. Her home is a certified professional foster home, specifically known as a proctor home. Claimant provided 24-hour care and supervision to boys ages 10 through 18 while these youth offenders were being evaluated by juvenile court. (Ex. 1, 2).

Claimant's job as a shelter care provider was to evaluate the behavior process of each youth for a 28-day period in order to aid juvenile court in making a decision as to where to place these offenders.

Claimant was required to maintain a daily observation log and to submit monthly reports on each youth. (Ex. 2-4). Twenty-four hour supervision was required. (Tr. day one 34). Claimant was allowed 21 days off per fiscal year. If she did not take them, she would lose them. (Ex. 61). Claimant was allowed additional days off on a monthly basis depending on the number of children in her home that month. (Tr. day one 19).

Claimant was on call to receive youth 24 hours per day. Claimant could not refuse to accept a youth into her home. (Tr. day one 8). She was paid approximately $1,200 per month, even when no youth was placed in her home. (Ex. 49, 50). For each youth placed in her home, claimant received an additional $800, from which she was to purchase food, and necessary clothing, and to meet expenses which were not paid by the state. There is no indication that she was required to account for her use of these funds.

If claimant required substitute help, or wanted to take the youths on a long trip or out of the state, she had to obtain prior approval. She also had to notify the agency of changes in her own family composition and of any significant change in the health of her family members. While under contract to the agency, claimant and her husband were told by the agency supervisor who, other than her own children, would be authorized to be in their home, even for a visit. A potential adopted child was not authorized.

The shelter care contract between claimant and Catholic Community Services could be terminated by mutual consent of the parties with 30 days written notice. In addition, if claimant failed to provide care and services in accordance with the contract, the contract could be terminated immediately and payment would stop. Also, if claimant lost her foster home certificate for any reason, the contract would be immediately terminated. (Ex. 3-2). The contract was ongoing as long as all requirements were met.

Prior to becoming a proctor parent in a proctor home, claimant was a foster parent. The objectives of a foster home and proctor home differ greatly. The purpose of the proctor home is to provide a thorough evaluation of a juvenile offender for the court; the purpose of a foster home is to provide a secure, emotionally stable, healthy environment for youth on a temporary basis. (Ex. 1-2, Tr. day one 6-7).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was a subject worker of Catholic Community Services at the time she sustained her industrial injuries. We agree.

ORS 656.005(13) provides that an "employer" is any person who contracts to pay a remuneration for and secures the right to direct and control the services of any person. ORS 656.005(27) provides that a "worker" is any person who engages to furnish services for a remuneration, subject to the direction and control of an employer. Thus, the right of the employer to direct and control the activities of the worker is an essential ingredient of the test for an employer/employee relationship. The test requires an application of the traditional "right to control" analysis. See Woody v. Waibel, 276 Or 189, 196 (1976); Castle Homes, Inc. v. Whaite, 95 Or App 269, 271 (1989).

Under the traditional test of the right to control, the factors to be considered include: (1) evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment by the employee; and (4) the right to fire at will, without liability. Castle Homes, Inc. v. Whaite, supra.

Right to Control

With reference to the element of control, we find that Catholic Community Services did exercise significant control over claimant. She was to be available 24 hours a day in order to receive youth into her home. She had to obtain prior approval for substitute or relief help for herself, and prior approval if she wanted to take the youths out-of-state or on long trips.

Claimant was required to maintain a daily log and submit monthly reports on each youth in her home. Her home was periodically inspected for compliance with shelter home guidelines. Claimant was required to supervise the youth, or make sure there was adult supervision, 24 hours per day. Claimant was also required to notify Catholic Community Services of any changes in the composition or health of her own family members.

Aspects of the relationship between claimant and Catholic Community Services which point to a lack of control over claimant include the fact that the agency did not control specific details of claimant's work, such as the types of food and recreational activities she provided, and that claimant set and utilized the same set of house rules for her own children as she did the shelter care youth. However, the house rules enforced by claimant were subject to agency approval.

Considering the abovementioned elements of control, we conclude that Catholic Community Services had the right to, and did, exercise considerable control over claimant's work.

Method of Payment

SAIF argues that claimant was not paid remuneration for her services. See ORS 656.005(27). We disagree. Claimant was paid a set monthly amount of approximately $1,200, whether or not she had youth in her home. When there were youth in the home, she received an additional $800 per month for each. This method of remuneration indicates that claimant is an employee of Catholic Community Services.

Furnishing Equipment

Considering the nature of this employment, the main "equipment" necessary is a home, which was furnished by claimant. She also furnished transportation and the food and clothing for the youth. The state did, however, provide for some of the youth's expenses. We conclude that claimant's furnishing of particular equipment indicates that she had the status of non-employee.

Right to Fire at Will

The evidence here shows that claimant could be immediately terminated and payment would cease if she failed to provide the required care and services set forth in the shelter care contract or if her foster home certificate of approval was terminated for any reason. We conclude that the agency's right to immediately terminate claimant's contract indicates that she was an employee of the agency.

Although Catholic Community Services did not control the fine details of claimant's daily work, it had the right to control very substantial elements of her work. It controlled who was to live in claimant's home, including other foster children and adopted children, when claimant was to have time off and the content of her house rules. It required strict supervision and monthly written reports on each youth in her home, and it required continuous availability to accept placements. We conclude that under the "right to control" test, the abovementioned facts prove an employer/employee relationship between Catholic Community Services and this proctor parent serving in the Shelter Evaluation Program.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the issue of subjectivity is $1,200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value, to claimant, of the interest involved.

ORDER

The Referee's order dated October 23, 1989 is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $1,200, payable by the SAIF Corporation.

In the Matter of the Compensation of
ROY H. ROBERTSON, Claimant
WCB Case No. 89-23703
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Mongrain's order that held that claimant is not entitled to temporary total disability compensation. On review, the issue is entitlement to temporary total disability compensation.

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

If an injured worker is discharged from his modified work because of a "violation of a normal employment standard," he is not entitled to a resumption of temporary total disability. Rayle R. Jensen, 38 Van Natta 1027 (1986); Thomas C. Harrell, 34 Van Natta 589 (1982). Here, claimant was fired because of the frequency of tallying errors. His compensable impairment was not a material or significant factor in the errors that led to his discharge. Because claimant left work for reasons not associated with his compensable injury, he is not entitled to resumption of temporary total disability benefits. Rather, he is entitled only to the amount of temporary partial disability that he would have received had he not been fired. In this case, that is nothing. See Safeway Stores v. Owsley, 91 Or App 475 (1988).

ORDER

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

In the Matter of the Compensation of
LEOVIGLIDO RUEDA (MENDOZA), Claimant
WCB Case No. 89-18549
ORDER ON REVIEW
Constance Crooker, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Knapp's order that upheld the SAIF Corporation's denial of his claim for a left arm injury. On review, the issue is compensability. 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 Conclusions of Law and Opinion, with the following supplementation.

Claimant contends that the purpose of the ranch was to provide a residence for employees who would then be accessible to harvest the owner's crops.

Claimant argues that the "bunkhouse rule" should be applicable in this case, because it concerns employees who are in residence, but who are not "on-call." Under the "bunkhouse rule," an injury occurring to an employee who is required to live on the employment premises is compensable.

SAIF argues that the "bunkhouse rule" should not apply in this case, as claimant was not required to live on the premises. See SAIF v. Reel, 303 Or 210 (1987). In Reel, the Court held that when residence on the premises is merely permitted, injuries resulting from such residence are not compensable under the broad doctrine built up around employees required to reside on the premises. Id.

SAIF argues that, in this case, only 20 percent of the workers lived on the ranch. In addition, there was alternative housing available three miles away in the closest town. Claimant decided to live on the ranch, and was also free to work for other employers while he stayed there.

We agree with SAIF's argument and we conclude that the "bunkhouse rule" is not applicable in this case, as claimant was not required to live on the employer's premises. Accordingly, we conclude that claimant's injury claim is not compensable.

ORDER

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

December 18, 1990 Cite as 42 Van Natta 2811 (1990)

In the Matter of the Compensation of
ALBERT W. VANSLYKE, Claimant
WCB Case No. 89-24556
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Emerson's order that found that the Hearings Division lacked jurisdiction to correct or clarify an alleged error in a final and unappealed Board order concerning claimant's entitlement to an attorney fee. The self-insured employer seeks supplementation of the record through the inclusion of a transcript of the closing argument, provided that the transcription costs are borne by the Board. On review, the issues are jurisdiction and transcription costs.

We affirm and adopt the Referee's order with the following comments concerning the employer's request.

The employer requested that we have the closing arguments transcribed. There is no requirement that closing arguments at hearing be recorded and/or transcribed. As a policy matter, we do so when a Referee makes such a request. Otherwise, we are willing to accept transcripts of arguments obtained at a party's expense.

The employer reads our order in Charles T. Brence, 39 Van Natta 422 (1987), as announcing some other policy. It does not. Because the Referee did not request that the closing arguments be transcribed, the party requesting submission of the arguments must bear the costs of obtaining such a transcript.

Since the employer does not wish to have the arguments submitted under those circumstances, we have proceeded with our review without them.

ORDER

The Referee's order dated March 30, 1990 is affirmed.

December 19, 1990 Cite as 42 Van Natta 2812 (1990)

In the Matter of the Compensation of
CAROLYN D. FOUT, Claimant
WCB Case No. 89-07355
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Speer and Howell.

Roseburg Lumber Company, a self-insured employer, requests review of Referee Gruber's order which: (1) remanded claimant's claim for closure by the self-insured employer; (2) found that the issue of claimant's aggravation claim was premature; and (3) declined to award a penalty and associated attorney fee for unreasonable claim processing. On review, the issues are jurisdiction, aggravation and penalties and attorney fees. We reverse.

FINDINGS OF FACT

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

The self-insured employer accepted claimant's claim on June 5, 1984.

At her doctor's suggestion, claimant changed her job to lighter work in August 1987.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that, because claimant's claim was not properly closed, it was premature to consider the aggravation issue.

Claimant was injured on May 9, 1984. She initially lost no time from work due to her injuries. On June 5, 1984, the employer accepted the claim for cervical, thoracic and lumbar strain as nondisabling.

At the time of claimant's injury, former ORS 656.268(3) provided that claims for nondisabling injuries could be closed either through a Notice of Closure or by Determination Order. In any event, closure of a claim was required, whether disabling or nondisabling. See Webb v. SAIF, 83 Or App 386, 390 (1987). As the Referee noted, the employer did not close this claim with a Notice of Closure, and a Determination Order was not issued.

Nevertheless, the employer/insurer's failure to close a nondisabling claim has no effect on claimant's aggravation rights. If the claim that a nondisabling injury has become disabling is made more than one year after the date of injury, the claim is to be treated as an aggravation claim pursuant to ORS 656.273. Former ORS 656.262(11). If the injury was nondisabling and no determination has been made, a claim for aggravation has to be filed within five years after the date of injury, not the date of closure. Former ORS 656.273 (4)(b).

The self-insured employer initially accepted this claim as nondisabling. Claimant has not shown that the claim was misclassified or that she was not notified of her right to challenge the classification of her claim. Compare Davison v. SAIF, 80 Or App 541, modified on recon, 82 Or App 546 (1986); Richard N. Egli, 41 Van Natta 149 (1989). Claimant did not seek reclassification of her injury from nondisabling to disabling within one year of her injury. See former ORS 656.262(11) (renumbered ORS 656.262(12)). Claimant's claim that her injury has become disabling must be treated as an aggravation claim under ORS 656.273, because it is made on the basis that her previously nondisabling injury has become disabling and the claim was first made more than one year after the date of injury. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Smith v. Ridgepine, Inc., 88 Or App 147, 149 (1987); Darold W. Miller, 42 Van Natta 2296 (1990); Denise A. Robinson, 42 Van Natta 2514 (1990).

Aggravation

To establish a compensable aggravation under ORS 656.273(1), claimant must prove: (1) her back condition has worsened, by increased symptoms or a worsened underlying condition, rendering her more disabled, either temporarily or permanently; and (2) a causal connection between the worsened back condition and the compensable injury. See Smith v. SAIF, 302 Or 396, 399 (1986); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Stepp v. SAIF, 78 Or App 438 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989). Because an unscheduled body part is involved, "more disabled" means increased loss of earning capacity. See Smith v. SAIF, supra. Claimant does not have to show she is less able to work in her last employment experience; but rather, less able to be employed in the broad field of general occupations. Smith, supra at 401-402. Claimant's testimony may itself be sufficient to establish a compensable worsening. See Garbutt v. SAIF, 297 Or 148 (1984). A medical report will serve as a claim for aggravation if it puts the insurer on notice of the need for additional medical services for a worsened condition. Krajacic v. Blazing Orchards, 84 Or App 127 (1987).

Here, claimant's prior accepted claim had been for medical services only. Because claimant was not awarded any permanent disability, we find that future exacerbations resulting in a loss of earning capacity were not contemplated. See Louis A. Duchene, 41 Van Natta 2399, 2400 (1989). Consequently, any subsequent change in claimant's condition resulting in temporary or permanent loss of earning capacity would be sufficient to prove increased disability.

Claimant was injured in May 1984. In September 1985, she returned to Dr. Resner, D.C.'s, office complaining of symptoms identical to those reported in May 1984. Dr. Resner stated that claimant's symptoms were progressive. (Ex. 3).

In October 1985, claimant was examined by Dr. Freeman, M.D. She reported neck pain that works down her back and both arms, and stated that her symptoms were increasing in frequency and severity. (Ex. 4-1).

Dr. Peterson, neurologist, diagnosed cervical dorsal syndrome with increased muscle tension of the cervical and scapular muscles in February 1986. (Ex. 5B-1). He continued to follow claimant, prescribing physical therapy one to three times per week, until early 1988. He noted that after claimant changed to a lighter job with the employer, her symptoms decreased significantly. (Exs. 7, 8).

We find that claimant has successfully established that she suffers increased disability and that the disability is causally related to her May 1984 injury. Drs. Resner, Freeman and Peterson all documented an increased level of

symptoms in claimant's neck, upper back and arms in late 1985 and early 1986. SAIF did not accept or deny an aggravation claim.

Additionally, because claimant was required to change her job duties to those that were lighter and did not require fast, repetitive movements or require claimant to lift her arms above her head, we conclude that claimant is less able to be employed in the broad field of general occupations. Accordingly, we find that claimant had proven by a preponderance of the evidence that she suffered an aggravation of her May 1984 injury.

Penalty and Attorney Fee

We agree with the Referee that, given the fact that the employer attempted to obtain closure of this claim through the Evaluation Division and the Division would not issue a Determination Order, the employer's processing of the claim was not unreasonable. Accordingly, claimant is not entitled to a penalty or associated attorney fee.

ORDER

The Referee's order dated December 4, 1989 is reversed. This case is remanded to the self-insured employer for acceptance and processing of claimant's aggravation claim according to law. For services at hearing and on Board review, claimant's attorney is awarded a reasonable assessed fee of $2,300, payable by the self-insured employer.

In the Matter of the Compensation of
DANIEL MERCADO-NUNO, Claimant
WCB Case No. 89-17814
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Bethlahmy's order that awarded 10 percent (32 degrees) unscheduled permanent disability for injury to the low back in addition to the 24 percent (76.8 degrees) awarded by Determination Order. On review, the issue is extent of permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and make the following additional findings. Claimant is able to do light-medium work with restrictions on prolonged stooping or lifting involving twisting. He cannot return to his prior work without modification. Prior to claimant's injury, he was capable of performing 14 percent of the jobs in Oregon, considering his physical capacity together with his education and other vocational and social factors. The array of jobs that claimant is physically and otherwise capable of performing has been significantly reduced because he can no longer do heavy or medium work.

FINDING OF ULTIMATE FACT

Claimant has suffered a 50 percent loss of earning capacity due to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Claimant was medically stationary after January 1, 1988, and his claim was closed by Determination Order after July 1, 1988. Consequently, for purposes of determining injury-related permanent partial disability, former ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A).

Nevertheless, the statute also provides that either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards". Former ORS 656.283(7) and former 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 302 (1987).

The Referee calculated claimant's entitlement under the applicable "standards" to entitle him to an award of 24 percent unscheduled permanent partial disability, precisely the amount awarded by Determination Order. Neither party challenges that calculation on review. The Referee, however, awarded claimant 34 percent in lieu of the 24 percent awarded by Determination Order, concluding that there was clear and convincing evidence in the record as a whole to establish that claimant's loss of earning capacity exceeded that allowable under the standards. Claimant contends that his loss was greater then 34 percent. We agree.

Vocational expert Aaron Hughes has evaluated claimant's language ability and persuasively opined that claimant is unable to read or write a simple message such as instructions or an inventory list. He further noted that claimant has a work history that is confined to unskilled work. He concluded that, in view of his physical impairment due to the compensable injury, his employment options are few. Assuming that claimant was limited to light work as the treating physician had opined, rather than to light-medium work as found by the Referee, he concluded that the share of the labor market available to claimant was reduced from 14 percent to 5 percent. He concluded that claimant had lost 66 percent of his earning capacity. Although we are persuaded that claimant's lifting capacity is not quite as drastically reduced as Hughes assumed, we are nonetheless persuaded that claimant can no longer do a great many jobs that he could previously do--including, it would appear, all of the jobs that he has performed in the past.

The Board has declined to make permanent disability awards reflective of loss in access to the labor market alone. Thus, we do not award 60 percent unscheduled permanent disability to all individuals who have lost access of 60 percent of that share of the labor market available to them preinjury. See Goldie M. Ames, 42 Van Natta 1657 (1990). We must consider also such factors as the absolute number of jobs that claimant remains capable of performing, the wages obtainable in those jobs, and the like. Richard A. Gonsalves, 42 Van Natta 1787 (1990).

In this case, claimant has significant physical impairment precluding return to his prior work without modification. He does not possess the skills to do anything but entry level work. His language handicap was such that he was never qualified to perform many jobs. His access is now substantially reduced. For these reasons, we are persuaded that claimant has lost 50 percent of his earning capacity.

ORDER

The Referee's order dated February 1, 1990 is modified. In addition to the Determination Order and Referee awards claimant is awarded 16 percent (51.2 degrees) unscheduled permanent disability, giving him a total award to date of 50 percent (160 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created

by this order. However, the total out of compensation fee awarded under the Referee and Board orders shall not exceed $3,800.

December 19, 1990 Cite as 42 Van Natta 2816 (1990)

In the Matter of the Compensation of
JOHN L. RIGGS, III, Claimant
WCB Case Nos. 89-16028, 89-15744, 89-16027 & 89-10021
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Pamela Schultz, Defense Attorney
Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Crider, Nichols and Brittingham.

The SAIF Corporation requests review of those portions of Referee/ Arbitrator Tenenbaum's order that: (1) set aside SAIF's denial of an aggravation claim for right elbow epicondylitis; (2) upheld Liberty Northwest Insurance Corporation's denial of a new injury claim for the same condition; and (3) required SAIF to pay the cost of transporting claimant to hearing. On review, the issues are responsibility and witness transportation costs. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's recitation of the Stipulations of the parties as well as the Referee's Findings.[1]

CONCLUSIONS OF LAW AND OPINION

The Referee assigned responsibility to SAIF and, in addition, required SAIF to pay for claimant's transportation to hearing. SAIF has requested review.

Responsibility

We review the Referee's order as it relates to the responsibility issue only for errors of law. The hearing was conducted pursuant to referral from the

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1) We note that the fourth page of the opinion states that claimant worked as a sorter rather than a grader at Lazy S. It goes on to say that grading is easier, lighter worker. And that, as a grader, claimant pulled pieces off the line and did not have to grip and twist each piece as it went by. We conclude, based on a reading of the order as a whole, that the Referee intended to say that sorting is easier, lighter work and that, as a sorter, claimant pulled pieces off the line and did not have to grip and twist each piece as it went by. We so conclude for three reasons: First, in the first paragraph of page four, the Referee had already described the grading job as involving constant repetitious twisting of pieces of lumber and as requiring the turning of every board. Paragraph four is not consistent with paragraph one unless we assume a clerical-type error in paragraph four. Second, our understanding of the Referee's intentions is consistent with claimant's testimony, which the Referee found credible. Third, our understanding is also consistent with the history upon which Dr. Kaesche relied at deposition when he rendered the opinion upon which the Referee relied. For these reasons, in reviewing this order, we assume that the Referee found that sorting was easier work and that paragraph four describes claimant's work as a sorter at Lazy S.

Director upon issuance of a .307 order. The .307 order referring the case for hearing was received by the Board on August 16, 1989. Consequently, ORS 656.307(2) applies. Timothy R. Schroeder, 41 Van Natta 568 (1989). Inasmuch as SAIF, and not claimant, challenges the Referee's order, we review for questions of law.

ORS 656.307(2) provides that we review decisions rendered by an arbitrator on referral from the Director for question of law except in one circumstance: "[If] the claimant can establish, on the arbitration record, that the determination [of the responsibility issue] resolves a matter concerning a claim as defined in ORS 656.704(3), review of the determination of the arbitrator by the board and the Court of Appeals shall be as provided for matters concerning a claim." We conclude that the Legislature intended, by the exception, to give a claimant the benefit of de novo review when the claimant contends that the arbitrator erred and a different assignment of responsibility will affect his rate of temporary disability compensation. Jon E. Robinson, 42 Van Natta 512 (1990). See Minutes, Senate Committee on Labor, June 9, 1987. We do not believe that the mere fact that the record indicates that the temporary disability rate will vary depending on the assignment of responsibility entitles an insurer or self-insured employer to de novo review of an arbitration order. We recognize that claimant's temporary total disability rate will be affected by the assignment of responsibility in this case. Nevertheless, for the reasons stated above, because claimant has neither requested nor cross-requested review of the arbitrator's decision, and in fact seeks its affirmance, we address questions of law only. Insofar as our decision in Susan Alley, 42 Van Natta 1131 (1990), is to the contrary, we disavow it.

We adopt that portion of the Referee's order addressing the issue of responsibility. The Referee found that claimant's work activity while employed at SAIF's insured did not independently contribute to his worsened condition. It follows that Liberty Northwest is responsible for claimant's worsened condition.

Transportation costs

We review de novo that portion of the Referee's order that deals with the dispute between the insurers regarding who must pay the cost of claimant's travel from California to appear as a witness at hearing.

The record discloses nothing relevant to the dispute over responsibility for payment of claimant's travel cost. Based on the parties' representations on review, however, it appears that both SAIF and Liberty Northwest wished to procure claimant's testimony for introduction at hearing. Inasmuch as claimant was not required to appear personally at hearing, the insurers sought to procure that testimony. Liberty Northwest suggested that claimant's testimony be obtained by telephone. SAIF was unwilling to agree to anything except personal appearance at hearing because it regarded his credibility as an important factor in the outcome of the case. Because SAIF would not agree to telephone testimony, claimant planned to attend in person. Prior to hearing, the Referee directed the insurers to split claimant's travel cost. After hearing, she concluded that SAIF's contention that claimant was not a credible witness was without foundation. Consequently, she concluded that SAIF was not justified in demanding claimant's attendance to testify in person at hearing and, therefore, ordered SAIF to bear the entire cost of claimant's travel.

We approach the question differently. OAR 438-07-022 controls the presentation of lay testimony. It reads as follows:

> "Testimony of lay witnesses shall be taken by personal appearance of the witness before the referee at the hearing unless the witness is unable to attend the hearing due to extraordinary circumstances beyond the control of the party offering the testimony and all parties and the referee agree, or the referee finds, that the testimony should be taken other than by personal appearance of the witness at the hearing and that the testimony of the witness cannot be taken by a telephone deposition or in-person deposition. In such cases, the referee may allow testimony to be taken in any manner that will afford substantial justice and insure a complete and accurate record of all examination and testimony."

The rule provides that lay testimony shall be taken in person at hearing except where extraordinary circumstances preclude attendance in person. Only if extraordinary circumstances preclude attendance at hearing is telephone testimony even permissible. There is no indication that claimant was unable to attend; in fact, he did attend. Consequently, even if SAIF had been willing to agree to take claimant's testimony by telephone, such testimony would have been inadmissible. For this reason, SAIF's reason for objecting to telephone testimony and the persuasiveness of that reason are immaterial.

Inasmuch as both insurers sought claimant's testimony, the travel cost associated with his appearance at hearing shall be equally divided between the insurers.

ORDER

The Referee's order dated November 7, 1989, is affirmed in part and reversed in part. That portion of the order that required the SAIF Corporation to pay claimant's travel cost associated with attendance at hearing is reversed. The travel cost shall be equally divided between SAIF and Liberty Northwest Insurance Corporation. The remainder of the order is affirmed.

December 20, 1990 Cite as 42 Van Natta 2818 (1990)

In the Matter of the Compensation of
TANYA L. BAKER, Claimant
WCB Case Nos. 88-18028 & 88-19615
ORDER ON RECONSIDERATION
Black, Chapman & Webber, Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Roberts, et al., Defense Attorneys

Claimant has requested reconsideration of those portions of our August 31, 1990 Order on Review that did not award claimant an assessed attorney fee for her counsel's services either at hearing or on Board review. In order to allow the insurers sufficient time to respond to claimant's motion, we abated our order. Having now received the insurers' responses, we proceed to our review.

At hearing, the Referee set aside Royal Insurance Company of America's denial of claimant's "new injury" claim for a low back condition and upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition. The Referee also awarded claimant an assessed attorney

fee of $2,300, to be paid by Royal. On review, we reversed the Referee's responsibility determination. We reinstated Royal's denial and set aside Liberty Northwest's denial. Our order did not address the effect of our decision on the Referee's attorney fee award.

On reconsideration, claimant requests that we order Liberty Northwest to pay the assessed fee awarded by the Referee. Neither insurer contests claimant's entitlement to a fee for services at hearing; however, each insurer argues that the other is responsible for payment of that fee. Royal contends that Liberty Northwest should be responsible for the fee because Liberty has been found to be the responsible insurer for claimant's condition. Liberty Northwest, on the other hand, argues that Royal should be responsible for payment of the attorney fee because only Royal denied compensability of the claim.

In this regard, Liberty's November 2, 1988 denial alleged insufficient evidence relating claimant's current complaints to her injury with its insured. Liberty did not contend in its denial that claimant's condition was the responsibility of Royal. In addition, Liberty expressly noted that it was not waiving "further questions of compensability or responsibility." Moreover, at hearing, Liberty's counsel stated the denial was of the aggravation claim and "in the event that the condition was, in fact, aggravated" then responsibility was also an issue. (Tr. 6). We conclude, contrary to Liberty Northwest's assertion in its brief on review and on reconsideration, that both Royal and Liberty raised compensability as an issue at hearing. Therefore, because we have concluded that Liberty is the responsible insurer for claimant's condition, we further conclude that Liberty is responsible for payment of the assessed attorney fee awarded at hearing.

Claimant also alleges entitlement to an assessed attorney fee for her counsel's services on Board review. Claimant's entitlement to such a fee could follow from either of two statutes: ORS 656.386(1) or 656.382(2). ORS 656.386(1) authorizes a carrier-paid fee where the claimant has initiated the review or appeal from an order denying the claim. Short v. SAIF, 305 Or 541, 545 (1988). Such is not the case here. Accordingly, no fee is assessable under ORS 656.386(1).

The second basis for a fee is ORS 656.382(2). That statute provides for attorney fees where the review or appeal is initiated by the employer or insurer, and the referee, Board or court finds that the compensation awarded to a claimant should not be disallowed or reduced. Citing Howard v. Willamette Poultry, 101 Or App 584 (1990), Royal argues that responsibility was the only issue on review and, therefore, that claimant is not entitled to an assessed fee. In Howard, responsibility was the only issue because claimant's right to compensation was protected by prior issuance of an order issued pursuant to ORS 656.307 (.307 order). Because claimant's right to compensation was never at risk, the court held that ORS 656.382(2) did not provide a basis for an award of carrier-paid attorney fees.

By contrast, in this case, both insurers denied compensability. Moreover, no .307 order issued. Thus, claimant's right to compensation was at risk at hearing. Both compensability and responsibility were decided in the Referee's order. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. Destael v. Nicolai Co., 80 Or App 596 (1986). See Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Because Royal initiated review and claimant's compensation was not reduced or disallowed, claimant is entitled to an assessed fee under ORS 656.382(2). See Joel D. Turpin, 41 Van Natta 1736 (1989). Because Royal sought Board review, Royal shall be responsible for the assessed attorney fee for claimant's counsel's services on Board review. Cigna Insurance Companies v. Crawford & Co., 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $200, to be paid by Royal. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Accordingly, claimant's request for reconsideration is granted. On reconsideration, Liberty Northwest Insurance Corporation is ordered to pay the $2,300 assessed attorney fee awarded by the Referee at hearing. Royal Insurance Company is ordered to pay claimant's counsel a reasonable assessed fee of $200 for services on Board review concerning the compensability issue. As modified, we adhere to and republish our August 31, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

December 20, 1990 Cite as 42 Van Natta 2820 (1990)

In the Matter of the Compensation of
CYNTHIA L. MCHENRY, Claimant
WCB Case No. 89-11304
CORRECTED ORDER ON REVIEW (REMANDING)
Willard Bodtker, Claimant Attorney
Sandra Haynes, Attorney
Bonnie Laux (Saif), Defense Attorney

The Board issued its Order on Review (Remanding) in this matter on December 5, 1990. The last sentence of the "Conclusions and Opinion" section of that order instructs the Referee to determine, in light of our order in Kristi L. Chase, 42 Van Natta 1247 (1990), whether claimant's request for review is timely and, if so, whether the claim is compensable. The sentence should have instructed the Referee to determine whether claimant's request for hearing is timely, not the request for review.

Accordingly, our December 5, 1990 order is abated and withdrawn. As corrected herein, we adhere to and republish our December 5, 1990 order in its entirety.

IT IS SO ORDERED.

December 20, 1990 Cite as 42 Van Natta 2820 (1990)

In the Matter of the Compensation of
ARTHUR R. MORRIS, Claimant
WCB Case No. 89-0063M
OWN MOTION ORDER ON REMAND
Douglas L. Minson, Claimant Attorney
David O. Horne, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Wausau Insurance Companies v. Morris, 103 Or App 270 (1990). The court has reversed our Own Motion order that reopened claimant's claim for the payment of temporary disability benefits. In so doing, we found that claimant was willing to work and in the work force at the time his condition worsened. Concluding that we had not adequately explained how we reached a finding that was directly contrary to our previous determinations that claimant had been unwilling to return to the work force, the court has remanded for reconsideration.

The insurer has submitted claimant's claim for an alleged worsening of his March 1977 compensable back injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for claimant's proposed May 1989 surgery. However, contending that claimant has withdrawn from the work force, the insurer opposes payment of temporary disability benefits.

We may exercise our "Own Motion" authority to reopen a claim for additional 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. ORS 656.278(1)(a). In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

After review of the record, we conclude that claimant's compensable condition has worsened requiring surgery. Notwithstanding such a finding, to receive temporary disability benefits for such a worsening, claimant must be in the work force at the time of the worsening, or if not in the work force, willing to work and making reasonable efforts to obtain employment (unless such efforts would be futile because of the work-related injury). Wausau Ins. Companies v. Morris, 103 Or App 270 (1990).

Here, claimant has not worked since at least 1983. His compensable condition was evaluated at a December 1983 hearing concerning his appeal from a Determination Order. At that hearing, claimant, then 54 years of age, sought permanent total disability. In declining to grant claimant's request, the Referee found claimant's testimony to be unreliable and to lack credibility. The Referee concluded as follows:

> "As has been observed by most of the physicians who have examined claimant over the past several years, he clearly lacks any motivation to return to work. Not only does he lack motivation to return to work, but he is strongly motivated to preserve his disability status and to convince others that he is unable to work. It appears that claimant determined several years ago that he would never return to work and he has proceeded to insure that that decision becomes a self-fulfilling prophecy. That is unfortunate, because claimant is undoubtedly quite disabled. His unwillingness to consider a return to work, however, makes any rehabilitation efforts futile and hampers a determination of the extent to which he is precluded from the general labor market."

The Referee increased the Determination Order award from 55 percent to 80 percent unscheduled permanent disability. This award was affirmed by the Board and, subsequently, by the Court of Appeals. In September 1986 claimant requested Own Motion relief. Contending that his compensable condition had further deteriorated, claimant renewed his request for permanent total disability. Unpersuaded that claimant was so severely disabled as to relieve himself of the responsibility to seek work, the Board concluded that he had demonstrated no motivation to change his employment status. Accordingly, claimant's request for own motion relief in the form of permanent total disability benefits was denied.

Such prior findings do not irrevocably commit claimant to retirement for purposes of workers' compensation benefits. Wausau Ins. Companies v. Morris, supra. If he is willing to seek work at the time of the worsening, he is considered to be a member of the work force at that time. Id.

Here, claimant contends, through his counsel, that he has never voluntarily removed himself from the work force. Rather, he adamantly asserts that he has always wanted to work within his physical and educational capacities. Moreover, he notes that Dr. Nash, the surgeon who proposed the surgery, has reported that claimant has been totally unemployable since a May 1986 examination.

We do not find this evidence persuasive. To begin, claimant's bare assertion that he has always been willing to return to the work force is directly contrary to express findings made and conclusions reached by the Referee's 1983 order. Those findings and conclusions have also been affirmed by the Board and court. Furthermore, similar conclusions concerning claimant's motivation to seek work were rendered in the Board's September 1986 Own Motion order. Thus, lacking corroborative evidence to demonstrate that his attitude toward returning to the labor market has changed since the Board's September 1986 finding, we consider claimant's statements inadequate to satisfy the requisite burden of proof for entitlement to temporary disability benefits.

Dr. Nash's November 1988 report does not provide the needed corroboration. In a conclusory manner, Nash states that claimant has been "totally unemployable" since his last examination in May 1986. We interpret such a statement as an assertion that, prior to the November 1988 examination, it would have been futile for claimant to make reasonable efforts to obtain employment because of his compensable condition.

Nash describes in some detail the severity of claimant's condition and provides recommendations for further invasive procedures. Yet, Nash does not explain why it is now futile for claimant to make reasonable efforts to seek work, when in September 1986, the Board had reached a finding that it would not be futile for claimant to make such efforts. Moreover, Nash's opinion that claimant has been "totally unemployable" since May 1986 is in direct contravention of the Board's September 1986 findings reached in determining that claimant was not entitled to permanent total disability benefits. Under such circumstances, we find no persuasive reason to depart from our prior determinations that claimant's compensable condition did not make it futile for him to make reasonable efforts to obtain employment.

Finally, claimant asks that this matter be referred to a Referee for the taking of further evidence. In submitting his request, claimant provides no explanation as to why such a referral was not sought during our initial review of this case. Instead, noting that additional surgery is being contemplated, he suggests that testimony be taken on that issue as well as the temporary disability issue.

As noted by the court, we have authority pursuant to OAR 438-12-040 to refer Own Motion petitions to a Referee to hold a hearing. Wausau Ins. Companies v. Morris, supra, at page 274. However, this case concerns a petition for claim reopening arising from a surgery request in approximately May 1989. Thus, any evidence regarding subsequent surgeries or claim reopening requests is irrelevant to the issue at hand. Furthermore, considering the dilatory nature of claimant's request for further evidence on his entitlement to temporary disability, we are not inclined to look favorably on the motion. In any event, we consider the record concerning this issue to be adequately and sufficiently developed to reach a decision that achieves substantial justice to all parties. Consequently, the motion to refer this matter to a Referee for hearing is denied.

In conclusion, based on the aforementioned reasoning, we are not persuaded that, at the time of the worsening of his compensable back condition, claimant had made reasonable efforts to obtain employment or that those efforts would have been futile as a result of his compensable condition. Therefore, we hold that, at the time of the worsening of his compensable condition, claimant had withdrawn from the work force. Accordingly, the request for own motion relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWIN A. STEINBORN, Claimant
WCB Case No. 87-03249
ORDER OF ABATEMENT
Emmons, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

The Board has received the self-insured employer's motion for reconsideration of our Order on Review in the above-captioned matter, dated December 12, 1990.

In order to allow sufficient time to consider the motion, the Board's December 12, 1990 order is abated and withdrawn. Claimant is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ETHEL M. TURNER, Claimant
WCB Case No. 89-09078
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Bennett's order that found that claimant's back injury claim was not prematurely closed. On review, the issue is premature closure. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Claimant inexplicably missed a mandatory independent medical examination scheduled on January 25, 1989 with Dr. Duff, M.D. Claimant did not respond to the claims administrator's letter dated April 7, 1989 which requested information as to whether claimant felt that further medical treatment was necessary. Claimant has received unemployment benefits from late February 1989 through the hearing date.

ULTIMATE FINDING OF FACT

At the time of the June 27, 1989 Determination Order, no further material improvement would reasonably be expected from medical treatment or the passage of time.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the June 27, 1989, Determination Order had not prematurely closed the claim. We agree.

Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary. ORS 656.268(1). An injured worker is considered medically stationary when no further material improvement of the compensable condition would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The term "medically stationary," however, does not mean that there is no longer a need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984).

It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981); Dale R. Bennett, 40 Van Natta 843 (1988). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981). We evaluate claimant's condition and the reasonable expectation of improvement as of the date of closure. Alvarez v. GAB Business Services, 72 Or App 524 (1985).

The Referee assumed that claim closure occurred on January 25, 1989, the date the Determination Order found claimant medically stationary. However, the correct date of claim closure was June 27, 1989, the date the Determination Order issued. Harmon v. SAIF, supra; Aldrich v. SAIF, 71 Or App 168, 172 (1984). We find that claimant was medically stationary on January 25, 1989 and continued to be so through claim closure on June 27, 1989.

Claimant sustained a compensable low back injury on September 27, 1988. She began treating with Dr. Stewart, orthopedist, who provided treatments until January 20, 1989. At that time, Dr. Stewart declared her medically stationary, and stated that she would occasionally experience discomfort but that any impairment would be minimal based on subjective symptoms only. (Ex. 3-5). Claimant received no further treatment until she changed her attending physician to Dr. Long, M.D., on June 7, 1989, who prescribed physical therapy.

Claimant testified that her condition worsened in May 1989, but that it was starting to improve under Dr. Long's care when her physical therapy was discontinued by the employer. (Tr. 15). She stated that at the time of the hearing her condition had returned to its May post-worsening level. Claimant relies on Dr. Long's prescription of physical therapy and exercise to support her argument that her claim was prematurely closed. However, this reliance is misplaced because, although Dr. Long's opinions are closest in time to claim closure, he did not state that claimant was not medically stationary. He stated that claimant "should be able, with some formal physical therapy and a supervised exercise program, to get relief of her persisting symptoms and return to normal activity tolerance." (Ex. 5D-3)

Furthermore, Dr. Long stated that claimant's therapy should be directed toward management of myofascial pain. (Ex. 5D-3). We interpret this to be treatment for palliative rather than curative purposes which supports Dr. Stewart's diagnosis that claimant would have occasional periods of discomfort. A need for continuing palliative treatment does not preclude a medically stationary status. Kenneth W. Meyers, 41 Van Natta 1375 (1989). Thus, contrary to claimant's contention, Dr. Long's opinion supports the persuasive conclusions of Dr. Stewart in that Dr. Long did not deny that claimant was medically stationary and he prescribed only palliative treatment.

In conclusion, based on the aforementioned reasoning, we are persuaded that claimant was medically stationary in January 1989 and remained medically stationary through the date of claim closure. Accordingly, we find that claimant has failed to prove that she was not medically stationary as of June 27, 1989, the date of closure.

ORDER

The Referee's order dated September 6, 1989 is affirmed.

Board Member Crider, dissenting.

The panel finds that the claim was not prematurely closed because Dr. Long did not state that the claim was prematurely closed and because he specified

that the purpose of the prescribed physical therapy was to accomplish pain relief.

In Austin v. SAIF, 48 Or App 7 (1980), the court held a claimant may carry the burden of proof without submission of any expert medical opinion stating that he or she was not medically stationary at the time of claim closure. It is sufficient to show that, at the time of claim closure, a physician had recommended physical therapy which, in the court's words, was "arguably aimed at improving claimant's condition." Id. at 13.

In this case, we need not infer that the therapy recommended by Dr. Long was aimed at improving her condition for Dr. Long specifically stated that the purpose of the therapy was to reduce pain and thereby to "return [claimant] to normal activity tolerance." Thus, the therapy was not recommended for pure palliative purposes but to reduce physical disability. Consequently, the claim was prematurely closed.

I would reverse.

In the Matter of the Compensation of
JOHN M. VERING, Claimant
WCB Case No. 89-10291
ORDER ON REVIEW
Jeff Carter, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Michael Johnson's order which: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 27 percent (86.4 degrees), as awarded by a Determination Order, to 31 percent (99.2 degrees). On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact." In addition, we supplement with the following findings of fact. Claimant has preexisting borderline and passive-aggressive personality disorders with long-standing maladaptive behavior and personality characteristics. Additionally, as a consequence of a prior compensable skull injury, claimant has mildly impaired concentration and auditory memory abilities.

Claimant is able to lift up to 20 pounds as required to perform light level work activity as long as he has the opportunity to move about several times during the day.

Prior to his compensable injury, claimant performed semi-skilled, medium level work as a surveyor's assistant. He has an Associate of Arts degree in Forestry, high school or above reading level capabilities and good mathematics skills and is currently functioning in the average range of intelligence.

Claimant was not employed when the most recent aggravation occurred. He has not worked or looked for work since 1985.

Claimant became medically stationary March 8, 1989.

FINDINGS OF ULTIMATE FACT

Claimant is not totally incapacitated from regularly performing gainful and suitable employment from a medical standpoint alone.

Claimant's compensable injury did not worsen his preexisting psychological conditions.

Claimant is not foreclosed from gainful employment due to a combination of medical and nonmedical factors.

Claimant has not made reasonable efforts to secure employment at a suitable, gainful occupation.

It would not be futile for claimant to seek regular, gainful employment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not totally unemployable and, therefore, he declined to award permanent total disability. However, he did increase claimant's permanent partial disability award to 31 percent. On review, claimant alleges that he is permanently and totally disabled based on a combination of his preexisting mental condition and low back injury. 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). Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Permanent total disability may be established through evidence of complete physical incapacity, or by establishing that the physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd-lot doctrine." Welch v. Bannister Pipeline, 70 Or App 699 (1984), rev den 298 Or 470 (1985). Additionally, in evaluating permanent total disability, we consider preexisting disabilities and their impact on performing work at a gainful and suitable occupation, as those conditions existed at the time of claimant's compensable injury, or to the extent that claimant's compensable injury worsened the preexisting condition. ORS 656.206(1)(a); Searles v. Johnston Cement, 101 Or App 589 (1990); Fowler v. SAIF, 82 Or App 604 (1986).

Claimant asserts that he cannot work in any capacity because of the pain level associated with his back condition and because Dr. Fortner, his current treating physician, has not released him to return to work. Dr. Fortner resumed treating claimant after Dr. Buza, claimant's treating neurosurgeon, declared him to be medically stationary and released him to return to light duty work. We are unable to evaluate the basis for Dr. Fortner's opinion as she has submitted no post-operative reports on this claimant. Her opinions are contained in forms submitted to claimant's vocational rehabilitation counselor consisting of a "checked-box" on a questionnaire indicating that claimant is unable to participate in vocational services, and in a physical capacities evaluation form that is otherwise blank except for a notation that claimant "is unable to work." Although the Board generally gives greater weight to the conclusions of a treating physician, it will not do so when there are persuasive reasons to do otherwise. Given the lack of discussion of claimant's current condition which accompanies her opinion, we find that there are persuasive reasons not to defer to Dr. Fortner's opinion.

On the other hand, we find the medical reports of claimant's neurosurgeon, Dr. Buza, and of Dr. Chester, an industrial medicine specialist, to be well-reasoned and based on complete information. Dr. Buza examined claimant in

January 1989; he noted that claimant's post-operative orthopedic and neurological examinations were nearly normal and declared him medically stationary. He restricted claimant to lifting up to 20 pounds maximum and recommended that he be given the opportunity to alternately sit, stand, and walk during the day.

Claimant was evaluated at the Salem Hospital Industrial Medicine Program in March 1989. Dr. Chester examined claimant and similarly noted that the residuals of claimant's prior low back and leg problems were "very meager." Chester recommended that claimant participate in a "work hardening" exercise program to help restore him to an appropriate level of physical functioning. Claimant declined to participate, stating that he was totally disabled and would never work again.

In addition to his physical impairment, claimant has a preexisting psychological condition that interferes with his ability to relate to people and to perform complex work activity. Claimant has no psychological/emotional disability as a consequence of this compensable injury, and the parties agree that claimant's compensable injury did not worsen his preexisting mental/emotional condition. Psychological evaluation performed during the March 1989 industrial medicine examination revealed that claimant has persistent mild auditory memory difficulties and maladaptive behavior and personality characteristics. Nevertheless, claimant's psychological/emotional conditions have been present for many years and he was able to work successfully with them prior to his compensable 1983 injury. Consequently, we do not consider claimant's psychological condition in our permanent total disability analysis.

Accordingly, we conclude that claimant is not completely physically disabled nor totally precluded from employment on medical grounds alone. We must, therefore, address claimant's assertion that he is permanently and totally disabled under the "odd-lot" doctrine.

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, work experiences, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Clark v. Boise Cascade Company, 72 Or App 397 (1985); Welch v. Bannister Pipeline, supra at 701. Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to make reasonable efforts to find work, unless such efforts would be futile. Welch v. Banister Pipeline, supra. Moreover, at least where, as here, claimant was not employed or seeking work at the time of the aggravation, claimant must prove that, but for the compensable injury, he is or would be willing to seek regular gainful employment. SAIF v. Stephen, 308 Or 41 (1989); SAIF v. Orr, 101 Or App 612 (1990).

In making the assertion that he is permanently and totally disabled under the "odd-lot" doctrine, claimant relies on the opinion of vocational counselor Hughes, and that of Mr. McFetridge, his mental health worker. In August 1989, Mr. McFetridge opined that claimant is not able to function "well" in competitive employment. However, he did not indicate that claimant was foreclosed from all competitive employment and provided no psychological data to support his conclusion.

Moreover, the uncontroverted expert vocational opinion is that claimant can return to some work. Based primarily on claimant's perception of his limitations, Mr. Hughes initially testified that claimant cannot work. However, he later clarified his testimony and stated that given claimant's short-term memory problem, he could perform only fairly routine, unskilled work. Similarly, Mr. McNaughton, SAIF's vocational expert, testified that claimant is capable of performing at least unskilled, and possibly semi-skilled, repetitive work tasks at

a light level of physical exertion. He specifically identified eight jobs that claimant could perform that would use claimant's current skills and/or aptitudes and would produce a wage close to his at-injury wage. In addition, Mr. McNaughton explained that there were numerous entry-level "every man" jobs that exist in the competitive labor market that are within claimant's physical and psychological capabilities. We find that these opinions are consistent with the persuasive medical evidence -- both physical and psychological.

Claimant testified that he would try to find a job if he were released to return to work. However, he has made no attempts to seek work since his treating neurosurgeon released him to perform light level work. Similarly, although claimant has been offered physical reconditioning services, he has declined because he insists that he is too disabled to return to work. Claimant's situation is not as extreme as he presents it. He was 40 years old as of the date of the hearing. He is able to perform light level work activity. Claimant has an Associate of Arts degree in Forestry, high school or above reading level capabilities, good mathematics skills and is currently functioning in the average range of intelligence. Claimant is able to compensate for his difficulty with verbal learning by appropriately keeping notes.

At the very least, the record establishes that it would not have been futile for claimant to make reasonable efforts to obtain employment. We find that claimant has not demonstrated that he is willing to work. Claimant refused to even attempt to participate in a work-hardening program that would help restore his level of physical conditioning. In sum, claimant retains the ability to perform at least unskilled, light level work requiring minimal personal interaction. Consequently, claimant's medical and nonmedical factors in combination are not sufficient to support an "odd-lot" award of permanent total disability.

ORDER

The Referee's order of September 29, 1989, as republished on reconsideration November 16, 1989, is affirmed.

In the Matter of the Compensation of
JAMES H. FORD, Claimant
WCB Case No. 89-15586
ORDER ON REVIEW
Philip Schuster, II, Claimant Attorney
Roderick D. Peters (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Bennett's order which set aside its partial denial of claimant's cervical condition and psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's cervical condition and psychological condition were compensable as natural consequences flowing from his compensable injury. We agree.

As a general rule, a carrier is responsible for harmful effects of medical treatment if there is a material causal connection between the treatment and a compensable condition. Williams v. Gates McDonald & Co., 300 Or 278, 281-82 (1985); see 1 A. Larson, The Law of Workmen's Compensation 13.21 (1985). Treatment may be unreasonable, unnecessary or excessive from a medical standpoint or may be negligently or otherwise tortiously performed and still be causally related to a compensable condition. In such cases, the causal connection between the compensable condition, the improper or tortious treatment and the harmful effect of the treatment remains intact. When this occurs, the harmful effect is compensable even if the treatment which caused it is not. See 1 A Larson, supra 1321. at 3-415 & n. 84 (1985 & Supp 1988); Barbara D. Olinghouse, 41 Van Natta 303, 308 (1989). When the treatment is not causally related to a compensable injury or the causal relation is broken by the deliberate intention of the claimant to produce an injury, harm resulting from the treatment is not compensable. See ORS 656.156(1); 656.245; 1 A Larson, supra 13.21 at 3-419 to 3-425.

In this case, claimant sought treatment from Dr. Huryk, D.C., for a compensable low back injury, and treatment from Dr. Huryk caused a worsening of a preexisting cervical condition and associated psychological condition.

Dr. Fechtel, D.C., testified at hearing, conceding that, because of certain symptomology that claimant mentioned to Dr. Huryk, his manipulation could have been a reasonable diagnostic procedure. (Tr. 41-44). That testimony is uncontroverted. Further, claimant's cervical injury was suffered while seeking treatment for his compensable low back injury. Claimant had no intention to produce the injury. Accordingly, we find that claimant has met his burden of proving that there is a material causal connection between Dr. Huryk's treatment and his compensable condition so as to make the results of the harmful treatment compensable.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $810, to be paid by SAIF. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case as represented by claimant's statement of services, and the value of the interest involved.

ORDER

The Referee's order dated January 26, 1990 is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $810, payable by the SAIF Corporation.

December 21, 1990 Cite as 42 Van Natta 2829 (1990)

In the Matter of the Compensation of
EUGENE R. INKS, Claimant
WCB Case No. 89-03957
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Quillian's order that: (1) set aside its denial of claimant's aggravation claim for cervical spondylosis; (2) awarded claimant interim compensation commencing January 4, 1989; and

(3) assessed penalties and related attorney fees for unreasonable delay in paying interim compensation. The issues on review are aggravation, interim compensation, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable chest wall injury on August 10, 1987. He had no time loss due to this original incident and the claim was accepted as nondisabling in September 1987. He returned to work the same day. Claimant has a preexisting cervical spondylosis, which was not diagnosed at the time of injury.

After the industrial accident in August 1987, claimant began to have daily headaches, as well as neck and shoulder pain. These symptoms worsened even more after a second work incident that occurred in September 1987. Claimant reported this second incident to his supervisor, however, no claim was filed. Claimant self-treated with aspirin for approximately three months and then sought treatment from orthopedist, Dr. Kitchel, in late 1987. After a treatment regime of physical therapy, traction, and ultrasound, claimant did not improve.

Ultimately, claimant developed a perforated ulcer due to the anti-inflammatories prescribed by Dr. Kitchel. He was hospitalized for 10 days in March 1988 for the bleeding ulcer. During this hospitalization claimant underwent an orthopedic consultation with Dr. Bert for his ongoing complaints involving the head, neck and shoulders. Claimant made no claim within one year of the injury that his nondisabling injury had become disabling.

Claimant returned to work after the hospitalization and was followed by Dr. Bert, for his cervical spine complaints, until October 1988 when the doctor restricted claimant to light duty work. Thereafter, claimant was laid off from work due to the unavailability of light duty positions. MRI studies performed in January 1989 revealed cervical spondylosis with nerve impingment and hypertrophic spurring at C6-7.

The medical experts and treating physician uniformly agree that the August 1987 industrial accident materially contributed to a worsening of claimant's underlying cervical spondylosis.

Claimant sought interim compensation from January 4, 1989, the date Dr. Bert ordered further diagnostic tests. Interim compensation was not paid within 14 days of January 4, 1989. In April 1989, SAIF denied both an aggravation claim and the compensability of claimant's cervical spondylosis.

CONCLUSIONS OF LAW AND OPINION

Nondisabling Injury

A threshold issue is whether claimant's compensable injury was either misclassified as "nondisabling" from the outset, or whether, within one year of the injury, he had asserted a claim that his nondisabling injury had become disabling. Pursuant to former ORS 656.262(12), a claim that a nondisabling injury has become disabling, if made more than one year after injury, is to be treated as an aggravation claim. However, if the claim was misclassified from the outset, there is no need to prove an aggravation. See Davison v. SAIF, 80 Or App 541, modified on recon 82 Or App 546 (1986). Here, claimant makes no argument that he had, within one year of the date of injury, made a claim that his nondisabling injury had become "disabling," and we conclude that the injury was not misclassified from the outset.

Claimant was injured on August 10, 1987 and he initially lost no time from work due to his injuries. In March 1988, claimant was hospitalized for 10 days

due to a bleeding ulcer that was caused by medications he was taking for head, neck, and shoulder pain. The neck and shoulder symptoms have since been diagnosed as cervical spondylosis and are attributed to the August 1987 accepted injury. However, claimant was performing his regular work without restrictions from August 1987 to October 1988 when his treating orthopedist finally restricted him to light duty jobs. He was subsequently laid off because there was no light duty work available. Claimant made no claim within one year of the injury that his nondisabling injury had become disabling. Former ORS 656.262(12).

Under these circumstances, because claimant first claimed that his nondisabling injury became disabling more than one year after the date of injury, the claim is to be treated as an aggravation claim pursuant to ORS 656.273. Former ORS 656.262(12). See Smith v. Ridgepine, Inc., 88 Or App 147, 149 (1987); Darold W. Miller, 42 Van Natta 2296 (1990).

Aggravation

To establish an aggravation, claimant must show a worsening of his accepted nondisabling injury since the last arrangement of compensation. Smith v. SAIF, 302 Or 296 (1986). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id. In this case there is no award or arrangement of compensation since the original industrial injury was accepted as nondisabling. Under these circumstances, claimant need only show that his compensable injury became disabling and resulted in a diminished earning capacity.

On reconsideration, the Referee concluded that: (1) claimant's cervical spondylosis is compensably related to the accepted August 1987 injury; and (2) claimant has shown that as a result of a worsened condition he is more disabled than he was at the time of the original injury. We agree that claimant has established an aggravation.

Dr. Bert, the treating orthopedist, states that the August 1987 industrial accident materially contributed to a worsening of claimant's cervical spondylosis. Similarly, the Western Medical Consultants opine that the August 1987 work accident contributed to claimant's headaches and neck pains. They conclude claimant would not have developed these symptoms "but for" the accident. Likewise, Dr. Woolpert says the August 1987 injury independently contributed to claimant's head and neck symptoms. There is no evidence to the contrary. The medical record as a whole also establishes that claimant's condition gradually worsened between August 1987 and October 1988 when claimant was finally restricted from performing his regular job duties.

Accordingly, we conclude that claimant has shown by a preponderance of the medical evidence both a worsening since the original compensable injury, and a causal relationship between that worsening and the original injury in August 1987.

Interim Compensation

With regard to an aggravation claim, interim compensation is payable from the date of medically verifiable inability to work or need for further medical care due to worsened conditions. Former ORS 656.273(6). Claimant is eligible for interim compensation if he left work or suffered a loss of wages due to the disability. Bono v. SAIF, 298 Or 405 (1984).

Here, in October 1988, claimant was medically restricted from performing his regular work and he was laid off because no light duty work was available. However, claimant did not seek interim compensation until January 4, 1989, the

date his treating physician ordered more tests. At that time, claimant still did not have a full release to his regular job, he was not medically stationary and there was need for further testing. In addition, the employer knew claimant had sustained an earlier work injury and that he was not working because there was no work available within his light duty restrictions. This was sufficient notice to trigger the obligation to pay interim compensation. Merlyn E. Langley, 42 Van Natta 2745 (1990); Melton J. Jackson, 42 Van Natta 264 (1990). Therefore, interim compensation should have been paid within 14 days of January 4, 1989. ORS 656.262(4). The Referee's award of interim compensation and the penalties and attorney fees for unreasonable delay in paying interim compensation are, accordingly, affirmed.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the aggravation and interim compensation issues is $250, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved. While claimant has submitted no brief, the record otherwise documents services rendered on claimant's behalf on review. See Lloyd A. Douglass, 42 Van Natta 838 (1990); Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated August 18, 1989 is affirmed. For services on Board review concerning the aggravation and interim compensation issues, claimant's attorney is awarded an assessed fee of $250, to be paid by the SAIF Corporation.

December 21, 1990 Cite as 42 Van Natta 2832 (1990)

In the Matter of the Compensation of
TOBERT L. WHITE, Claimant
WCB Case Nos. 89-03341, 89-08674 & 89-09561
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
Steven D. Hallock, Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Aetna Life and Casualty (Aetna) requests review of those portions of Referee Thye's order which: (1) set aside its denial, on behalf of Stanley Tools, of claimant's chiropractic treatments; and (2) upheld Cigna Insurance Company's (Cigna) denial, also on behalf of Stanley Tools, and Royal Insurance of America's (Royal) denial, on behalf of Premier Gear Company, of the same treatments. In his brief, claimant, as an alternative to the Referee's order, contends that he has established a compensable occupational disease for which Cigna is responsible. On review, the issues are responsibility for chiropractic treatments and, alternatively, compensability of an occupational disease claim. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant worked for Premier Gear, insured by Royal, at the time of his December 7, 1981 injury. He began working for Stanley Hydraulic Tools on

January 28, 1986. Stanley Tools was insured by Aetna through June 30, 1987. Cigna began insuring Stanley Tools on July 1, 1987.

Claimant has not experienced a work injury since July 1, 1987. His work activities at Stanley Tools contributed only to an exacerbation of symptoms.

Claimant treated with Dr. Bolera, D.C., after his 1981 accepted injury, until March 1988. Dr. Skelton worked with Dr. Bolera between the fall of 1987 until he took over the practice in March 1988.

CONCLUSIONS OF LAW AND OPINION

Responsibility

In successive injury cases, where there are successive compensable injuries to the same part of the body, there is a "rebuttable presumption" that the carrier on the risk at the time of the most recent injury is responsible for the condition. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). To rebut the presumption, it must be shown that the most recent injury no longer contributed to the claim for compensation. In the alternative, the carrier on the risk at the time of the most recent injury may prove that subsequent employment independently contributed to a worsening of claimant's underlying condition. Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986).

In this case, Aetna was on the risk at the time of the most recent compensable injury. Thus, it has the burden of proving that its injury no longer contributed to claimant's need for chiropractic treatments, or that claimant's employment while Cigna was on the risk independently worsened claimant's underlying injury condition. These issues of medical causation are complex, requiring us to rely heavily on expert opinion. We find that Aetna has met its burden.

Claimant treated with Dr. Bolera, D.C., after his 1981 accepted injury with Royal's insured, until March 1988. In April 1986, in a letter to Royal, Bolera noted that claimant suffered periodic exacerbations of his chronic back condition requiring ongoing chiropractic treatment. (Ex. 23). He reiterated the occurrence of exacerbations and need for treatment in August 1986. (Ex. 26).

Claimant testified that he felt the November 1986 injury with Aetna's insured resolved after approximately 30 to 60 days, and that his back returned to its pre-1986 injury status. He also stated that he suffered recurrent exacerbations of his 1981 injury periodically after 1981. In his mind, the treatments being given by Drs. Bolera and Skelton were related to his 1981 injury. (Tr. 35-36).

In April 1989, and again in August 1989, Dr. Skelton related claimant's current treatment to his 1981 injury. He noted that he had worked with Dr. Bolera in treating claimant for six months before Dr. Bolera left the practice, and he also reviewed claimant's treatment history from the time Dr. Bolera first began treating claimant. He again noted the occurrence of exacerbations since the 1981 injury. Moreover, even though Dr. Skelton did not treat claimant immediately after his 1986 injury, he stated that, while discussing claimant's condition with Dr. Bolera, he did not recall Dr. Bolera "making comments as to [claimant's] 1986 claim contributing independently to his 1981 injury." By August 7, 1989, it was his opinion that the 1986 injury no longer contributed to claimant's condition. (Ex. 62). That opinion is unrebutted.

Accordingly, we conclude that Aetna has successfully established that claimant's 1986 compensable injury, while it was on the risk, no longer contributes to claimant's claim for compensation. Therefore, responsibility rests

with Royal as the insurer on the risk at the time of claimant's 1981 accepted injury unless it is shown that claimant's work activity subsequent to July 1, 1987 independently contributed to a worsening of his condition. Hensel Phelps, supra. Dr. Skelton has specifically stated that claimant's work activities at Stanley Tool Co. have not contributed to his disability. Additionally, claimant suffered no injury working at Stanley Tool Co. while Cigna was on the risk, although he did suffer periodic exacerbations of his symptoms. Accordingly, there is insufficient evidence to shift responsibility for claimant's chiropractic treatments to Cigna. Royal remains responsible for claimant's current condition requiring treatment.

Occupational Disease Claim

On review, claimant alternatively contends for the first time that he has established a compensable occupational disease for which Cigna is responsible. When an issue is not raised at hearing and the record is closed, that issue will not subsequently be considered. Mavis v. SAIF, 45 Or App 1059 (1980); Richard C. Centeno, 41 Van Natta 617 (1989); Randy D. Johnson, 39 Van Natta 463 (1987). We have reasoned that to address an issue that was not raised at hearing would be fundamentally unfair. Gunther H. Jacobi, 41 Van Natta 1031 (1989). We decline to consider this issue on review.

Because no order issued designating a paying agent pursuant to ORS 656.307, compensability was an issue at hearing, and remained at risk on review as well by virtue of the Board's de novo review authority. Destael v. Nicolai Co., 80 Or App 596 (1986); see Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Because Aetna initiated review and claimant's compensation was not reduced or disallowed, claimant is entitled to an assessed fee under ORS 656.382(2). Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the potential compensability issue is $200, to be paid by Aetna. In reaching this conclusion, we have particularly considered the time devoted to that portion of the case related to compensability (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated September 11, 1989, as amended September 26, 1989, is reversed in part and affirmed in part. That portion finding Aetna Life and Casualty Insurance responsible for payments of chiropractic treatments on and after March 21, 1989 is reversed. Royal Insurance of America is responsible for those treatments. That portion holding Aetna responsible for claimant's assessed attorney fee at hearing is reversed. Royal shall pay claimant's attorney fee at hearing of $1,500. The remainder of the Referee's order is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed fee of $200, payable by Aetna.

In the Matter of the Compensation of
CHRIS A. MEIRNDORF, Claimant
WCB Case No. TP-90060
THIRD PARTY DISTRIBUTION ORDER
Kelly L. Anderson, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Claimant has petitioned the Board to resolve a dispute concerning a just and proper distribution of proceeds from a third party settlement. ORS 656.593(3). Specifically, claimant asserts that the acceptance by the SAIF Corporation, as paying agency, of claimant's counsel's check in a lesser amount than that ordered payable by a previous Board third party distribution order, completely satisfies his obligation under the Board order. We conclude that SAIF accepted the check as a partial payment of claimant's obligation and that SAIF is entitled to recover the unpaid portion of its share of the settlement proceeds.

FINDINGS OF FACT

In September 1985 claimant sustained a compensable injury to his right eye and face. He instituted a cause of action against several third parties for his injuries. With SAIF's approval, claimant and the third parties settled the action for $86,000.

A dispute ensued over the "just and proper" distribution of proceeds from the settlement. Claimant objected to SAIF's contention that it was entitled to its statutory share of the proceeds following the distribution of attorney fees, litigation costs, and claimant's statutory 1/3 share. Claimant argued that SAIF's share should be reduced because it had "not participated in the tremendous risks" in prosecuting the third party action.

On June 8, 1989, we concluded that SAIF was entitled to its statutory share of the settlement proceeds. Chris A. Meirndorf, 41 Van Natta 962 (1989). We held that SAIF should recover $20,394.03 as its just and proper share of the settlement. Claimant's counsel was directed to distribute the aforementioned sum to SAIF, which, assuming that the proceeds had been distributed in accordance with the statutory scheme, would not exceed the remaining balance of proceeds from the settlement.

By letter dated June 12, 1989, claimant's counsel advised SAIF that only $18,295.08 of the third party settlement proceeds remained in trust. Counsel's explanation for this reduced sum was that claimant would not have settled his third party lawsuit unless he received at least $30,000. Consequently, upon settling the case, counsel stated that $30,000 had been advanced to claimant and the remainder placed in a trust account.

With the June 12, 1989 letter, claimant's counsel enclosed a June 16, 1989 check in the amount of $18,295.08. Counsel acknowledged that the amount of the check was "just under the amount ordered to be paid by the Board." However, counsel offered as follows:

> "[W]e are willing to forego any further appeals in this matter in exchange for your acceptance of the enclosed money as payment in full."

Upon receipt of the letter and check, SAIF's claims examiner sought legal advice from its trial counsel. SAIF's counsel noted that the letter did not provide that acceptance of the draft was satisfaction in full. Rather, SAIF's counsel stated that the letter offered to forego appeals if the draft was accepted as payment in full. Inasmuch as SAIF would not accept such an offer, SAIF's trial

counsel recommended that the check be accepted as partial payment and leave claimant to pursue his "further appeals." SAIF's counsel further advised that he would send a letter responding to claimant's counsel's June 12, 1989 letter.

On June 22, 1989, SAIF cashed the check, which was drawn on claimant's counsel's client's trust account. The memo portion of the check stated that the check was "For Meirndorf." Also on June 22, 1989, SAIF's trial counsel sent claimant's counsel a letter. Claimant's counsel was advised that the terms of the June 12, 1989 letter were "unacceptable." Stating that SAIF would "not accept anything less than the entire $20,394.03 ordered by the Board," claimant's counsel was warned that unless the remaining balance of $2,098.95 was forwarded to SAIF within 7 days of the letter SAIF would initiate further legal action to collect that sum.

On July 10, 1989, claimant timely petitioned the Court of Appeals for judicial review of the Board's order. By letter dated July 12, 1989, claimant's counsel notified SAIF that since the letter accompanying the June 16, 1989 check "clearly stated that the check was intended as payment in full, SAIF's cashing of the check constitutes an accord and satisfaction, thereby discharging the debt." Counsel requested SAIF's prompt reply "regarding your agreement that the debt has been discharged by SAIF's cashing of the check." In addition to the July 12, 1989 letter, claimant's counsel also had a telephone conversation with SAIF's trial counsel on that date.

On July 14, 1989, SAIF's trial counsel advised SAIF's appellate counsel of claimant's contentions that the dispute had been satisfied. SAIF's trial counsel also reiterated his prior advice to SAIF's claim examiner, as well as his July 12, 1989 phone conversation with claimant's counsel. In that conversation, SAIF's trial counsel noted that he had explained to claimant's counsel that because SAIF had not accepted the check in full payment, the offer extended by claimant had not been accepted and claimant was free to pursue his appeal of the Board's order.

On October 30, 1989, the court dismissed claimant's appeal of the Board's order. In so doing, the court did not address a motion for satisfaction of judgment which claimant had filed. On August 2, 1990, at claimant's request, the court vacated its dismissal order and reinstated claimant's petition for judicial review. However, reasoning that the Board was the appropriate forum to determine the motion for satisfaction of judgment, the court denied claimant's motion. Thereafter, claimant petitioned the Board for resolution of this dispute.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, 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. ORS 656.593(1).

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd Estate of Troy Vance v. Williams, 84 Or App 616 (1987).

ORS 656.593(1) provides in exact detail how, and in what order, the damages shall be distributed. After the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, the paying agency is entitled to retain the

balance of the third party 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 claims under ORS 656.001 to 656.794. See ORS 656.593(1)(a), (b), & (c). The balance of any recovery shall be paid to the worker. ORS 656.593(1)(d).

Here, in our June 8, 1989 order, we resolved the parties' dispute concerning SAIF's share of the third party settlement proceeds. Chris A. Meirndorf, supra. Pursuant to that order, claimant's counsel was expressly directed to distribute to SAIF $20,394.03 from the remaining balance of proceeds. In reaching this conclusion, we were under the impression that the remaining balance was in excess of SAIF's asserted lien. This conclusion was based on the understanding that claimant's attorney fee, litigation costs, and statutory 1/3 share had been apportioned in accordance with statutory prerequisites.

Yet, as acknowledged in claimant's counsel's June 12, 1989 letter, our understanding was inaccurate. Contrary to statutory requirements, as well as the clear directive in our subsequent order, claimant's counsel had previously forwarded to claimant $30,000 of the settlement proceeds. This sum exceeded claimant's statutory 1/3 share of the balance which would remain after deductions for claimant's counsel's 1/3 attorney fee and litigation expenses. Thus, in effect, SAIF's recovery had been unilaterally and invalidly reduced from $20,394.03 to $18,295.08. See Steven B. Lubitz, 40 Van Natta 450 (1988). (Claimant's attorney's disbursement of proceeds from a third party settlement directly to a physician was in direct contravention of statutory distribution scheme and a Board order, thereby entitling paying agency to recover unpaid portion of Board ordered lien from claimant's attorney).

Claimant seeks to distinguish Lubitz. Specifically, he contends that, in the June 12, 1989 letter to SAIF, his counsel clearly expressed his intention to appeal the Board's order, as well as his offer to forego that appeal in exchange for SAIF's acceptance of the $18,295.08 check as payment in full of claimant's obligation. In support of this contention, claimant cites Kilander v. Blickle, 280 Or 425, 429 (1977), which held that ". . . when a debtor tenders payment upon condition that it is accepted as discharging a disputed or unliquidated debt, and the creditor accepts the payment upon this condition, the debtor is entitled to regard the matter as settled."

We do not share claimant's interpretation of either his offer or the effect of SAIF's acceptance of the check. We consider the operative phrase in claimant's counsel's letter to be "we are willing to forego any further appeals in this matter in exchange for your acceptance of the enclosed money as payment in full." We do not interpret the aforementioned phrase to provide that acceptance of the check automatically meant that claimant's obligation was satisfied. Such an action by SAIF could mean full satisfaction of the obligation. However, such a conclusion would only be reached if SAIF accepted the check as payment in full.

As expressly confirmed in its trial counsel's June 22, 1989 letter to claimant's counsel, SAIF did not accept the check as full payment. Instead, in notifying claimant's counsel that the June 12, 1989 offer was "unacceptable", SAIF advised that it was demanding payment of the remainder of the unpaid portion of the $20,394.03 ordered payable under the Board's order.

In conclusion, we find that claimant's offer was conditioned upon the manner in which SAIF accepted the check. Since SAIF did not accept the $18,295.08 as "payment in full," claimant was not required to forego his appeal and his obligation under the Board's order was not satisfied. Moreover, even if we interpreted the conditional phrase in the manner claimant is advancing, SAIF's

counsel's June 22, 1989 letter persuasively establishes that SAIF did not accept the $18,295.08 payment upon that condition. In other words, there was no "meeting of the minds." Thus, under either approach, we conclude that SAIF's acceptance of the $18,295.08 did not absolve claimant of his liability for the entire $20,394.03 as ordered payable under the Board's order.

Consequently, in accordance with the reasoning discussed above and the rationale articulated in the Lubitz holding, we conclude that it is claimant's attorney's responsibility to remedy this matter. Accordingly, claimant's attorney is directed to pay SAIF the unpaid portion of its rightful share of the settlement proceeds. i.e., $2,098.95.

IT IS SO ORDERED.

December 21, 1990 Cite as 42 Van Natta 2838 (1990)

In the Matter of the Compensation of
KURT KRAAL, Claimant
WCB Case No. 89-09254
ORDER OF ABATEMENT
David Hollander, Claimant Attorney
Williams, et al., Defense Attorneys

The Board has received the insurer's motion for abatement and reconsideration of our Order on Review dated November 23, 1990.

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 10 days from the date of this order. Thereafter the Board shall take this matter under advisement.

IT IS SO ORDERED.

December 26, 1990 Cite as 42 Van Natta 2838 (1990)

In the Matter of the Compensation of
IRENE JENSEN, Claimant
WCB Case No. 89-00938
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Foster's order that: (1) declined to find that claimant's occupational disease claim for fibromyalgia was barred by the doctrine of res judicata; and (2) set aside its denial of the aforementioned claim. SAIF also requests review of Referee Davis' order on reconsideration (issued in the absence of Referee Foster due to his retirement) that found that claimant had timely filed her occupational disease claim. The issues on review are res judicata, timeliness of claim filing, and compensability. We reverse.

FINDINGS OF FACT

Claimant resigned her position with SAIF's insured, Oregon Employment Division, on August 1, 1984. In December 1985, more than a year after her

resignation, claimant filed an occupational disease claim. Claimant worked as a job service representative in a State employment office. She alleged a gradual onset of neck and back problems due to the emotional and physical demands of the hostile work environment. Claimant was diagnosed as having a preexisting degenerative disc disease of the cervical and lumbar spine. She claimed that muscle tension, caused by work stress, aggravated her arthritic spine and that the resulting back strain or mechanical difficulty was disabling.

In a prior proceeding, Referee Galton found the condition compensable. The Board reversed on April 7, 1987, and this decision was affirmed by the Court of Appeals on November 2, 1988. Jensen v. Employment Division, 93 Or App 635, 637 (1988) (Strain was merely a symptom of the degenerative disease and not a separate condition that was work-caused).

Between the time of the Board's determination that claimant had failed to prove an occupational disease claim and the court's affirmation of that decision, claimant began medical treatments with Dr. Sultany who diagnosed claimant's condition as fibromyalgia. This diagnosis was based on the identical symptomatology present in the initial occupational disease claim. Claimant now presents a new claim under the more recent diagnosis of fibromyalgia. Claimant acknowledges that she is claiming an occupational disease for the same period of time as the previous claim, and using the same medical evidence (as updated by the new diagnosis and treatments with Dr. Sultany). Claimant has not worked since August 1984.

Claimant gave notice of her claim to the SAIF Corporation on December 15, 1988. She first learned of her newly diagnosed fibromyalgia condition sometime in October-November of 1987. Written notice of claimant's new diagnosis was given to claimant's attorney on December 24, 1987; however, actual medical verification that the fibromyalgia was potentially an occupational disease was not known by claimant until May 1989.

UTLIMATE FINDINGS OF FACT

Claimant's occupational disease claim was filed within one year from the date her treating physician informed her that the fibromyalgia condition was related to her work-exposure.

Fibromyalgia and pain syndrome are different diagnoses of the disease previously claimed by claimant and found not compensable

CONCLUSIONS OF LAW AND OPINION

Timeliness of Claim Filing

As a threshold matter we address the question of whether claimant filed a timely claim. On reconsideration of Referee Foster's June 1, 1989 order, Referee Davis declined to dismiss the claim for an alleged untimely filing. We concur, and affirm and adopt the Referee's "Order on Reconsideration" with the following comments.

Pursuant to ORS 656.807(1), a claim for an occupational disease must be filed with the insurer one year from the date the worker discovered (or should have discovered) the disease or one year from the date the claimant became disabled or is informed by a physician that she is suffering from an occupational disease, whichever is later.

Here, claimant gave notice of her claim to SAIF on December 15, 1988, which was over four years after she resigned her job with the Employment Division due to a back condition. Claimant first learned of the new diagnosis of a fibromyalgia condition sometime in October-November of 1987. Written notice of

claimant's new diagnosis was given to claimant's attorney on December 24, 1987; although actual medical verification that the fibromyalgia was potentially an occupational disease was not received until May 1989. Her claim was, therefore, filed in a timely manner because claimant had not been clearly told she was suffering from an occupational disease prior to actually filing her claim. See Templeton v. Pope & Talbot, Inc., 7 Or App 119 (1971); Victor L. Southwell, 41 Van Natta 234 (1989). Accordingly, we affirm the Referee's determination on the timeliness of claim filing.

Res Judicata

Referee Foster determined that because the fibromyalgia diagnosis had not been made at the time of claimant's first hearing, her new claim was not barred by principles of res judicata. We disagree.

Claimant's pain syndrome or fibromyalgia is merely calling claimant's back condition by a different name. In order for claimant to establish that her fibromyalgia is compensable, her current condition must be different,or changed, from her condition at the time of the earlier final adjudication. See Proctor v. SAIF, 68 Or App 333 (1984). The record indicates the contrary. Claimant merely contends that her current symptoms are the result of "fibromyalgia," not "back strain," as was the alleged cause in her previous claim. The facts persuade us that claimant's current condition, despite the new diagnosis, is the same as the condition previously claimed as an occupational disease.

Therefore, regardless of Dr. Sultany's new diagnosis, claimant's claim for relief arises out of the same set of operative facts which have been previously fully litigated and determined by Final Order. Thus, as between claimant and this employer, her claim is barred by claim preclusion. Drews v. EBI Companies, 310 Or 134, 146 (1989). The fact that claimant now asserts her claim by another name does not alter the preclusive effect of the prior adjudication. Million v. SAIF, 45 Or App 1097, 1102 rev den 289 Or 337 (1980) (Res judicata applies not only to every claim included in the pleadings but every claim which could have been alleged under the same aggregate of operative facts).

ORDER

The Referee's order dated June 1, 1989, as reconsidered September 29, 1989, is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's assessed attorney fee award of $1,500 is reversed.

December 26, 1990 Cite as 42 Van Natta 2840 (1990)

In the Matter of the Compensation of
TIMOTHY W. O'BRIEN, Claimant
WCB Case No. 89-16000
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of that portion of Referee Peterson's order that found that claimant was entitled to vocational assistance. On review, the issue is vocational assistance. We reverse.

BACKGROUND

Claimant was injured in November 1984, while working as a clipper operator for the employer's lumber company. He returned to work for the employer until

September 1985, at which time he was laid off. At the time of his injury, claimant earned $10.55 per hour. His claim was closed November 1, 1985 and he was awarded unscheduled permanent disability for his low back injury.

Claimant was unemployed for approximately a year following his layoff with the employer. He then worked for several months in 1986 and 1987 as a loader operator for a subsequent employer. Claimant earned a total of $9,791, on a piece-work basis as a loader operator.

Claimant next worked for Smith's Frozen Foods as a seed plant warehouse worker, from July 1987 to January 1988. He reinjured his back in July 1988, while working at home on a family car. Claimant's aggravation claim was accepted.

In February 1989, claimant's vocational counselor found that, based upon the wages earned at Smith's, claimant was not eligible for vocational assistance. She reported that claimant was not eligible because there were sedentary jobs which he could perform, that paid wages within 20 percent of the wages earned at Smith's.

Claimant requested that the Director review SAIF's eligibility decision. On September 15, 1989, the Director issued an order which concluded that claimant was not eligible for vocational assistance. The Director concluded that it was reasonable to assume that the most recent employer, Smith's, provided claimant with work which could be considered his regular employment. The Director further concluded that claimant worked for Smith's for a period of more than 60 days and the wages available for alternative employment were within 20 percent of the wage at Smith's.

Claimant requested review by a Referee, pursuant to ORS 656.283(1). The Referee held an evidentiary hearing and found claimant eligible for vocational assistance.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's work at Smith's for several months at $4.50 per hour was not suitable employment and was, therefore, not sufficient to end his eligibility for vocational assistance. The Referee concluded that the Director's order was contrary to the facts of the case and should be modified to find claimant eligible for vocational assistance. We disagree.

SAIF argues that the Referee should not have modified the Director's decision because he did not conclude that it violated a rule, exceeded authority, was made upon unlawful procedure or was an abuse of discretion, as provided in ORS 656.283(2). SAIF contends that the following rules apply in this case. OAR 436-120-004 provides that:

> "The objective of vocational assistance is 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."

In addition, OAR 436-120-005(6)(b) defines regular employment as:

> "Employment of the kind the worker held at the time of the injury or the claim for aggravation, whichever gave rise to the eligibility for vocational assistance...."

OAR 436-120-050 provides that the eligibility of a worker for vocational assistance ends when any of the following conditions have occurred:

> "(2) The worker has been employed in suitable employment after the injury or claim for aggravation for 60 days. This provision shall not apply if the worker is not medically stationary and further vocational assistance is required to overcome obstacles to the worker's continued employment."

SAIF contends that claimant's job at Smith's was his regular employment at the time of the aggravation claim. He had worked at Smith's approximately six months prior to his aggravation claim. SAIF also argues that jobs have been identified that claimant could perform which have wages within the definition of suitable employment (20 percent of the wage paid to claimant at Smith's).

At the outset, we agree with SAIF's contention that, before the Referee may modify the Director's order, he is required to make a finding that one of the circumstances listed in ORS 656.283(2) has been met. See Richard A. Colclasure, 42 Van Natta 2454 (1990). Here, the Referee made no findings on any of the four bases for modifying the Director's order. In addition, on review, claimant has not alleged grounds upon which the Director's order may be modified.

In the present case, we are unable to find that the Director's decision either violated a statute or rule. However, claimant contends that his wage as a logger, rather than his wage working at Smith's should be used to determine whether the jobs of security guard and parking lot attendant are suitable. We disagree.

We conclude that claimant's July 1988 aggravation claim was the claim which gave rise to his eligibility for vocational assistance. Claimant had returned to work for three different employers since his original date of injury. Because claimant was unemployed on the date of his aggravation, the Director correctly used the last previous employment to establish a suitable pay range. OAR 436-120-005(6)(6). We do not find the Director's conclusion in this regard to be either a violation of a rule or an abuse of discretion.

In addition to our conclusion that the Director's order neither violated a rule nor constituted an abuse of discretion, we are unable to find any other grounds for modification of the order, as required by ORS 656.283(2). Therefore, we may not alter the Director's order, holding that claimant is not entitled to vocational assistance.

ORDER

The Referee's order dated December 12, 1989 is reversed. The Director's order is reinstated in its entirety.

December 26, 1990 Cite as 42 Van Natta 2842 (1990)

In the Matter of the Compensation of
MICKEY D. SIMPSON, Claimant
WCB Case No. 89-17573
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Garaventa's order that declined to assess an attorney fee for his counsel's services in obtaining a Director's

order directing the insurer to provide vocational assistance. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's right to vocational assistance was a question of the amount of compensation due from a compensable claim. She, therefore, found that an attorney fee must come out of the increased compensation, which, in effect, denied claimant's counsel an attorney fee for efforts in gaining vocational assistance.

On review, claimant contends that the present case can be distinguished from Nyall W. Bacon, 41 Van Natta 2046 (1989), upon which the Referee relied. In Bacon, the issue was whether an attorney is entitled to a carrier-paid fee when the attorney is instrumental in reinstating vocational rehabilitation without a hearing. Nyall W. Bacon, 41 Van Natta 2046 (1989). In Bacon, the Board concluded that 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. The Board reasoned that the question of entitlement to further vocational services is a question of extent of benefits. (Emphasis added). Therefore, claimant's counsel was not entitled to a carrier-paid fee, but was awarded a fee under ORS 656.386(2) (out of compensation). Bacon, supra.

Claimant argues that his case is different from Bacon because the issue was not whether he was entitled to further vocational services, but whether he was entitled to any vocational assistance. Here, claimant was found ineligible for vocational assistance because the insurer concluded that his lack of suitable employment was no longer due to the disability caused by the injury. Claimant contends, therefore, that causation is in issue in the present case. Claimant also argues that the "Notice of Ineligibility" was a denial of compensation, which was reversed by the Director's order. We disagree.

We are not persuaded by claimant's argument that this case is distinguishable from the Bacon case. We conclude that, in both cases, the claimants were similarly not receiving vocational services and were required to go before the Director in order to establish an entitlement to benefits. We, therefore, proceed to consider whether claimant's counsel may be awarded an attorney fee under the following statutory provisions.

Bases for attorney fees

ORS 656.386(1)

We do not agree with claimant's argument that he is entitled to an attorney fee under ORS 656.386(1). We have previously held that ORS 656.386(1) does not authorize an assessed fee for prevailing before the Director. See Gloria A. Severson, 41 Van Natta 2109 (1989). ORS 656.386(1) requires claimant to "prevail finally" in a hearing before a Referee or before the Board. In the present case, as in Severson, claimant has prevailed before the Director, not before the Referee.

In addition, we conclude that attorney fees are not "benefits" or "compensation" within the meaning of the Workers' Compensation Law. See Dotson v. Bohemia, Inc., 80 Or App 233, 236, rev den 302 Or 35 (1986). The assessment of

an attorney fee, therefore, does not present an issue of compensation and claimant did not "prevail finally" before the Referee for purposes of ORS 656.386(1). Finally, as noted above, claimant did not prevail against a denial of the compensability of a claim. Accordingly, an attorney fee under ORS 656.386(1) is not warranted.

ORS 656.382(1)

Claimant has not argued that the insurer has unreasonably resisted payment of compensation. Because the issue has not been raised, we decline to consider whether claimant's counsel is entitled to an assessed fee under this statute. See Mavis v. SAIF, 45 Or App 1059 (1980).

ORS 656.386(2)

The Board adopts the Referee's "Conclusions and Opinion" pertaining to an attorney fee out of increased compensation under ORS 656.386(2).

ORDER

The Referee's order dated January 22, 1990 is affirmed.

December 26, 1990 Cite as 42 Van Natta 2844 (1990)

In the Matter of the Compensation of
JEFF STEINKELLNER, Claimant
WCB Case No. TP-90057
THIRD PARTY DISTRIBUTION ORDER
Peter E. Baer, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Claimant has petitioned the Board for resolution of a dispute concerning a proposed settlement of a third party action. See ORS 656.587. The SAIF Corporation, as paying agency, objects to the settlement. However, should we order approval, SAIF alternatively seeks recognition that it retains its rights to share in any recovery from any subsequent attorney negligence action. We approve the settlement and acknowledge SAIF's lien rights.

FINDINGS OF FACT

In approximately June 1987, claimant, an automotive spray painter, filed an occupational disease claim for "allergic rhinosinusitis." The SAIF Corporation, as insurer for claimant's employer, denied the claim. Thereafter, claimant filed another occupational disease claim, this time for "temporary exacerbation of underlying reactive airways disease." SAIF also denied this claim.

Pursuant to a March 1988 stipulated order, SAIF and claimant agreed that SAIF would rescind its denials and process the claims as one claim bearing an "injury date" of June 1, 1987. Thereafter, SAIF has provided compensation under the claim. To date, it has incurred $60,384.08 in claim costs, consisting of medical expenses, vocational rehabilitation costs, temporary disability benefits, and a permanent disability award.

Claimant engaged legal representation to pursue a cause of action against his employer and several third parties (chemical and air compressor manufacturers). On May 31, 1989, a complaint was filed in Federal District Court, seeking damages for negligence, strict liability/product liability, loss of consortium, and violation of the Employer's Liability Law.

Shortly thereafter, claimant notified SAIF of his election to bring a civil action against his employer and the third party manufacturers. Claimant asserted that his respiratory condition had been caused by a defective fresh air supply system, which allowed toxic isocynates to enter his respiratory system.

Following the discovery process, the third party defendants joined in a motion for summary judgment. They alleged that claimant had begun suffering respiratory symptoms before May 31, 1987. Since the statute of limitations for products liability claims is two years, the defendants contended that claimant's complaint was barred as untimely. In addition, claimant's employer moved for summary judgment, asserting that claimant's complaint failed to allege facts which would permit him to seek damages outside of the workers' compensation system.

The third party defendants' motions for summary judgment were granted. Consequently, the defendants' counsels were directed to prepare appropriate judgment orders for the court's signature.

Thereafter, the third parties (except the employer and its president) and claimant agreed to settle the actions for a total sum of $7,500. SAIF has declined to approve the settlement, contending that such an offer represents only "nuisance value." SAIF also wishes to preserve its right to share in any further recovery should a subsequent attorney negligence action for the untimely filing of the complaint be instituted. Thus, concerned that its approval of this settlement could be interpreted as a waiver of its future recovery rights, SAIF refuses to provide its approval.

In bringing his cause of action against the third parties, claimant has expended $266.35 in litigation costs. These expenses are composed of filing and service fees, as well as discovery charges.

FINDINGS OF ULTIMATE FACT

The third party settlement offer of $7,500 is reasonable.

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Dorotha M. Clarke, 40 Van Natta 1125 (1988); Kathryn I. Looney, 39 Van Natta 1140 (1987).

After reviewing the parties' respective positions, as well as the procedural posture of claimant's cause of action against the third parties, and considering the aforementioned standard, we conclude that a settlement offer of $7,500 is reasonable. Consequently, we approve the settlement.

In reaching this conclusion, we wish to emphasize that our approval extends only to the present third party settlement. In other words, our decision does not effect SAIF's rights to share in any future recoveries stemming from claimant's compensable injury and/or her third party lawsuit. As a paying agency, SAIF's lien for any previously unrecovered costs would continue to extend to any subsequent recovery attributable to attorney negligence. See Victor S. Lloyd, 41 Van Natta 1444 (1989); Charlene Toole, 41 Van Natta 1392 (1989).

Finally, we turn to a just and proper distribution of the third party settlement proceeds. ORS 656.593(3). The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). 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).

We find no persuasive reason to depart from the aforementioned approach. Therefore, after the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, SAIF is entitled to retain the balance of the third party 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 claims under ORS 656.001 to 656.794. See ORS 656.593(1)(a), (b), & (c).

Accordingly, we conclude that a distribution of proceeds from the third party settlement in accordance with ORS 656.593(1) would be "just and proper." Furthermore, since SAIF's uncontested actual claim costs exceed the balance of settlement proceeds remaining after deduction of claimant's attorney fee, litigation costs, and statutory 1/3 share, we hold that SAIF is entitled to that remainder.

Consequently, claimant's counsel is directed to distribute the settlement proceeds in the following manner:

Settlement	$7,500.00
1/3 Attorney Fee	- 2,500.00
Sub-Total	$5,000.00
Litigation Costs	- 266.35
Sub-Total	$4,733.65
Claimant's 1/3	1,577.88
Remaining Balance (SAIF's Share)	$3,155.77

IT IS SO ORDERED.

December 26, 1990 Cite as 42 Van Natta 2846 (1990)

In the Matter of the Compensation of
MARY A. VOGELAAR, Claimant
WCB Case No. 89-06466
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Brazeau's order that affirmed a Determination Order which declined to grant an unscheduled permanent disability award for a cervical spine and shoulder injury. The issue on review is extent of unscheduled permanent disability, if any. We reverse.

FINDINGS OF FACT

Claimant, 52 years old at hearing, worked as a custodian for the State of Oregon for over fifteen years. Claimant sustained a compensable injury to her low back in 1978. For this initial injury she received a total award of 10 percent unscheduled permanent disability. Claimant's low back condition persisted

with periodic exacerbations and time loss. In November 1986 she compensably reinjured her low back. Her 1986 injury claim was closed by Determination Order in December 1987 awarding 15 percent unscheduled permanent disability. An additional 10 percent was awarded by stipulation in June 1988. Claimant's unscheduled permanent disability awards for the 1978 injury and the 1986 injuries total 35 percent.

Claimant was placed under "heavy" lifting restrictions (50 pounds) and she returned to job duties descriptive of medium-heavy work.

Claimant has been compensated for the loss of earning capacity resulting from her various low back injuries. Claimant has not regained any of the loss of earning capacity suffered and compensated for prior to August 1988.

On August 30, 1988, claimant sustained her most recent injury. This time the mid-back, neck, and shoulders were involved -- not the low back. Due to this injury, claimant was permanently restricted from working in stairwells, doing heavy lifting, and mopping. Also, certain jobs were to be done only with assistance. She was restricted to modified jobs in the medium range, whereas prior to the current injury, claimant was performing medium-heavy work.

The claim for mid-back, neck, and shoulder injuries was closed by Determination Order on February 1, 1989 with a temporary total disability award but no permanent disability award.

CONCLUSIONS OF LAW AND OPINION

No briefs were filed in this matter; however, at hearing claimant argued that the 35 percent unscheduled permanent disability award for her prior low back injuries was the law of the case and that she was entitled to an additional award because her last injury resulted in additional impairment. The Referee concluded that claimant failed to prove her loss of earning capacity exceeds the 35 percent previously awarded. After our de novo review of the record, we disagree.

Claimant's current claim was closed by a February 1, 1989 Determination Order. Accordingly, in determining the extent of claimant's permanent disability due to the most recent injury, we apply the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, we apply the version of OAR 436-35-001 et seq in force from January 1, 1989 to October 1, 1990.

Generally, the criterion for rating unscheduled permanent disability is the loss of earning capacity due to the injury in issue, which is "determined by the extent of disability compared to the worker before such injury and without such disability." See former ORS 656.214(5). Similarly, ORS 656.222 provides in pertinent part that:

> "Should a further accident occur . . . the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities."

There is some confusion over whether former ORS 656.222 is applicable to unscheduled permanent disabilities. See, Green v. S.I.A.C., 197 Or 160 (1953); Cain v. S.I.A.C., 149 Or 29 (1934) (Holding that ORS 656.222 does not apply to unscheduled permanent disabilities). See also American Bldg. Maint. v. McLees, 296 Or 772, 774-75 (1984); Nesselrodt v. Compensation Dept., 248 Or 452, 455 (1967). But see, Thomason v. SAIF, 73 Or App 319 (1985); Cascade Steel Rolling Mills v. Madril, 57 Or App 398 (1982); Hannan v. Good Samaritan Hosp., 4 Or App

178 (1970) (applying ORS 656.222 to unscheduled permanent disability evaluations). See also, Norby v. SAIF, 303 Or 536 (1987). The Court of Appeals most recently held that ORS 656.222 "... is limited to subsequent awards for scheduled disability." City of Portland v. Duckett, 104 Or App 318 (1990) (Emphasis in original).

Nevertheless, former ORS 656.214(5) requires that unscheduled permanent disability due to a compensable injury be determined by comparing the worker before such injury and without such disability. Thus, we conclude that under former ORS 656.214(5) an injured worker is entitled to that unscheduled permanent disability which results from the injury in question, but the worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question but which had already been produced by an earlier accident and compensated by a prior award. See Thomason v. SAIF, supra at 322; Cascade Steel Rolling Mills v. Madril, supra at N. 2; Lawrence W. Scott, 40 Van Natta 1721 (1988).

The principle established by former ORS 656.214(5) applies equally whether a series of accidents involves injury to the same or different unscheduled parts of the body. See e.g. Jerry R. Miller, 42 Van Natta 571 (1990). For example, a low back injury may result in permanent limitation to a worker, precluding heavy lifting, pushing and pulling. That limitation would result in a certain loss of earning capacity in the general labor market. A subsequent accident to the same worker which permanently injured the neck could produce similar permanent restrictions and a similar loss of earning capacity. However, where the worker received an unscheduled permanent disability award for loss of earning capacity due to the low back injury, the worker is not entitled to a permanent disability award for the subsequent neck injury to the extent that the neck injury independently produced the same limitations and a loss of earning capacity in the same form and degree as was considered in the award for the low back injury.

The issue presented in this case is how to apply former ORS 656.214(5) where present disability must be rated in accordance with "standards" which are intended to rate total, present permanent disability without consideration of any permanent disability in existence before the injury in question. We conclude that, after first rating all permanent disability (considering only permanent impairment due to the injury in question) under the "standards," we next determine whether disability, without regard to prior awards, is, by clear and convincing evidence, less than or greater than disability determined by application of the "standards."

Once an unscheduled permanent disability figure is arrived at, either by application of the "standards" or by clear and convincing evidence, we must determine whether, and to what extent, such disability figure includes unscheduled permanent disability (loss of earning capacity) present before the injury in question.

Obviously, this process cannot always be performed with mathematical precision. The best we can do is to attempt to determine and consider to what extent a prior loss of earning capacity resulted from the same permanent limitations and vocational factors as are relied upon in the subsequent evaluation of permanent disability. To the extent that the subsequent award would compensate permanent disability previously present, we will reduce the award by the amount which represents previously compensated loss of earning capacity. Norby v. SAIF, supra.

Unscheduled Permanent Disability

We first calculate claimant's current disability under the "standards."

Age and Education

The appropriate value for claimant's age of 52 years is 1. Former OAR 436-35-290(3).

Claimant has a high school education. Therefore, the appropriate formal education value is 0. Former OAR 436-35-300(3). The highest SVP level demonstrated by claimant during the ten years prior to date of determination is a 3, as a custodian. Thus, the appropriate value for skills is 3. Former OAR 436-35-300(4). Claimant has competence in a specific vocational pursuit beyond the entry level and accordingly no value is allowed for training. Former OAR 436-35-300(5)(b).

Claimant's total education value is, therefore, 3.

Adaptability

Prior to the injury, claimant was performing work activities classified in the medium-to-heavy category. After the injury, she returned to her job as a custodian; however, claimant's permanent on-the-job restrictions place her in the limited medium category. Therefore, claimant's adaptability value is 1.5. Former OAR 436-35-310(3).

Impairment

Claimant contends entitlement to disability for her right shoulder, left shoulder, and cervical spine conditions.

We concur with the Referee's analysis of claimant's impairment and claimant does not contest the impairment rating. Based on loss of range of motion in both the right and left shoulders we rate claimant's impairment as 2 percent on the left and 5 percent on the right. Former OAR 436-35-330. Claimant's total impairment due to loss of motion in the cervical spine is 6 percent. Former OAR 436-35-360(1-5). Finally, claimant has a chronic condition limiting the repetitive use of her cervicothoracic spine and accordingly is entitled to 5 percent impairment under former OAR 436-35-320(4).

The 6 percent and 5 percent impairment values for the cervical spine are combined to obtain a single cervical impairment value. Former OAR 436-35-360(11). That value is 10.7 percent. Pursuant to former OAR 436-35-320(2), we combine the 2 percent impairment of the left shoulder with the 5 percent impairment of the right shoulder for a subtotal of 6.9 percent. We then combine the 6.9 percent for the shoulders with the 10.7 percent for the cervical spine and get a 16.9 percent overall impairment rating.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to her education value, 3, the sum is 4. When that value is multiplied by claimant's adaptability value, 1.5, the product is 6. When that value is added to claimant's impairment value, 16.9, the result is 22.9 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That value is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability for her cervical spine and shoulder injuries under the "standards" is, therefore, 23 percent.

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards."

Former ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987). The record fails to establish that claimant suffers injury-related permanent disability in excess of that awarded under the standards. Therefore, we do not find clear and convincing evidence that claimant suffers more than 23 percent unscheduled permanent disability.

Application of Former ORS 656.214(5)

As stated earlier, once we have determined the extent of disability under the "standards" or by clear and convincing evidence, we must determine whether, and to what extent, that determination includes unscheduled permanent disability which already existed before the present injury.

Here, we have found that claimant is entitled to 23 percent unscheduled permanent disability under an application of the "standards" to her current neck and shoulder condition. Further, we have found that there is no clear and convincing evidence that claimant suffers more than that amount.

After claimant's compensable low back injuries in 1978 and 1986, claimant returned to medium/heavy work activities. Her current neck and shoulder injuries increased claimant's working restrictions, i.e., claimant is now limited to work in the medium range with further restrictions on the activities she can perform within that range. We take this into account in determining whether and to what extent the prior unscheduled permanent disability resulted from the same permanent limitations, vocational factors, etc., as claimant's present permanent disability determined by application of the "standards." We conclude that 10 percent of the current award, determined by the "standards," represents permanent disability which was not present prior to the 1988 injury.

Therefore, claimant is entitled to an award of 10 percent permanent disability as "due to" the 1988 injury.

ORDER

The Referee's order dated July 18, 1989 is reversed. In addition to the February 1, 1989 Determination Order award of temporary total disability, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney by the SAIF Corporation.

December 27, 1990 Cite as 42 Van Natta 2850 (1990)

In the Matter of the Compensation of
STEVEN A. ERWERT, Claimant
WCB Case Nos. 88-08897, 88-06172, 88-08896 & 88-07303
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Norman Cole (Saif), Defense Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Howell, Speer, and Crider.

Liberty Northwest Insurance Corporation (Liberty) requests review of Arbitrator/Referee Tenenbaum's order that: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; (2) upheld the SAIF

Corporation's denial of claimant's "new injury" claim for the same condition; (3) awarded claimant 19 percent (60.8 degrees) unscheduled permanent disability for the right shoulder, whereas a Determination Order awarded 8 percent (25.6 degrees) unscheduled permanent disability; and (4) awarded claimant a carrier-paid attorney fee for services rendered on the responsibility claim. Claimant cross-requests review, seeking an increase in the unscheduled permanent disability award. On review, the issues are responsibility, extent of permanent disability, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

ULTIMATE FINDINGS OF FACT

Claimant has sustained a 21 percent permanent loss of earning capacity as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

We adopt the Arbitrator/Referee's "Opinion and Conclusions" with the following comments and modifications.

Responsibility

The Arbitrator found that claimant developed a compensable right shoulder occupational disease while employed with the first employer (Liberty's insured), and that this underlying condition did not independently worsen during claimant's work with the second employer (SAIF's insured). We do not review these factual findings as Board review of the Arbitrator's decision is limited to questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989).

Notwithstanding the foregoing, Liberty argues that the scope of our review is de novo. In support of this contention, Liberty notes that extent of permanent disability was also an issue at hearing, and that resolution of the responsibility issue would also determine who is responsible for the payment of the permanent partial disability award. Consequently, Liberty argues, the Arbitrator's decision resolves a matter concerning a claim, thereby giving rise to de novo review. See ORS 656.307(2).

We do not agree with Liberty's interpretation of ORS 656.307(2). That provision allows for de novo review where the claimant contends that the arbitrator erred and a different assignment of responsibility will resolve a matter concerning a claim. Here, claimant has neither requested nor cross-requested review of the Arbitrator's responsibility determination and, in fact, seeks its affirmance. Therefore, we review the Arbitrator's responsibility determination for questions of law only. John L. Riggs III, 42 Van Natta 2816 (1990). Moreover, the fact that an independent issue (extent of permanent disability) was considered with an ORS 656.307 arbitration proceeding, does not change that proceeding or the scope of our review of it.

Claimant's condition was properly characterized by the arbitrator as an occupational disease. In Linda L. Wise, 42 Van Natta 115 (1990), we recently noted that with an occupational disease the critical event for assigning responsibility is the "onset of disability." However, in the occupational disease context the triggering event for fixing responsibility is not always apparent. We assign responsibility, where it can be determined, to the last employment prior to time loss which actually contributed to the cause or worsening of the

underlying disease. See United Pacific Ins. v. Harris, 63 Or App 256 (1983); SAIF v. Gupton, 63 Or App 270 (1983); Inez Horsey, 42 Van Natta 331 (1990).

In the present case, the arbitrator found that claimant worked for Liberty's insured for about nineteen months before developing a right shoulder problem, described as an impingement syndrome. On November 10, 1987, claimant received a steroid shot that relieved his pain for one month. Claimant was laid off for unrelated reasons on November 13, 1987, and there is no finding of time loss prior to this date.

As further found by the Referee, on November 18, 1987, claimant began working for SAIF's insured doing essentially the same type of work. By mid-December, claimant's shoulder was once again symptomatic and he had two more steroid injections -- one in January 1988 and one in February 1988. The steroid shots were less and less beneficial and, in June 1988, claimant had a partial right shoulder acrominoplasty and an excision of bony protuberances from the clavicle and the acromioclavicular junction. The first reported time loss was with the second employer and this began in March 1988 (Ex. 22; Tr. 55). After the surgical procedure, which relieved the impingement of the rotator cuff, claimant returned to work in the same occupation working for a third employer who is not a party.

Based on the Arbitrator's finding that claimant's second employment with SAIF's insured did not materially worsen claimant's shoulder condition, we conclude that the last employment prior to time loss, which actually contributed to the cause or worsening of claimant's underlying disease, was with the first employer. See Inez Horsey, supra at 332. Accordingly, the Arbitrator properly assigned responsibility to Liberty.

Liberty argues on review that SAIF must show that working conditions with its insured did not independently contribute to a worsening of claimant's underlying condition. The burden is on the second employer, according to Liberty, under the "last injurious exposure rule." Champion International v. Castilleja, 91 Or App 556 (1988); Kenneth R. Nisbet, 41 Van Natta 1016, 1018 (1989); Donald D. Davis, 40 Van Natta 2000, 2002 (1988).

However, these cases are only applicable when the trier of fact is unsure which employer caused the condition. The Arbitrator here was convinced that the second employment did not independently contribute to a pathological worsening of claimant's accepted condition and that the evidence regarding causation was not in equipoise. However, even if the burden of persuasion was on SAIF, the Arbitrator's findings make clear that that burden was met.

Attorney Fees

The final issue presented is whether the Arbitrator properly awarded a carrier-paid attorney fee to claimant for services rendered in this responsibility case.

Contrary to the Arbitrator's statement that claimant's entitlement to compensation was in jeopardy until Liberty's concession during closing argument, we observe that once the previous ".307" order was entered, compensability was not at issue. See ORS 656.307(1).

In her amended order, the Arbitrator, after reviewing the complete files of two hearings, including the correspondence, granted a carrier-paid attorney fee. We concur.

Claimant's attorney provided active and meaningful services by his participation in pre-hearing matters and in resolving the "responsibility" question at hearing. See Jean Novotny, 42 Van Natta 1060 (1990). Claimant obtained the assistance of counsel several months before the ".307" order issued on May 10,

1988. There were two hearings, several depositions, and extensive correspondence involved in this matter -- all of which required counsel's involvement to protect claimant's interests. Moreover, claimant has actively asserted the prevailing view on the responsibility issue, i.e., that Liberty is responsible. See Allen V. Moore, 42 Van Natta 2023 (1990). Accordingly, we affirm the Arbitrator's award of a reasonable fee for claimant's attorney to be paid by Liberty.

Extent of Permanent Disability

We note preliminarily that the Referee and Board apply the standards de novo based on the hearing record. The Evaluation Section may have applied the "standards" entirely correctly based on the evidence before it, yet claimant could still prove a greater permanent disability under the standards, based on evidence presented at hearing. In other words, claimant need not demonstrate that the standards were incorrectly applied by the Evaluation Section.

Liberty argued that shoulder surgery in and of itself does not constitute a basis for a disability award where the surgical procedure resolves the disabling condition. We agree with the Referee that the "standards" for rating disability provide values for surgical procedures, reduced strength and endurance, and impairment due to loss of repetitive use. The Referee may consider lay evidence, as well as medical evidence, in determining whether a claimant has permanent impairment. See Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, the combination of medical evidence and claimant's testimony supports a permanent impairment rating of 5 percent for a chronic condition limiting repetitive use of the right shoulder. Former OAR 436-35-320(4). In addition, claimant is entitled to a 5 percent rating for a resection of his clavicle and 5 percent for the resection of the acromion. Former OAR 436-35-330(13 & 14). Finally, claimant has demonstrated a 7.5 percent loss of strength in the right shoulder under former OAR 436-35-330(19). These impairment values are combined to obtain a total impairment value. In this case the total impairment value is 20.7.

On review claimant argues that he is entitled to an increase of his permanent disability due to disabling pain. Under the standards, as amended effective January 1, 1989, pain is considered to the extent it results in "measurable impairment." Former OAR 436-35-320(1). Thus, no separate award is given for pain under the standards. To the extent that pain results in disability greater than that evidenced by the measurable impairment, the loss of earning capacity is included under the adaptability factor. Id.

No values are assigned for claimant's age, education or adaptability under former OAR 436-35-290(2)(b), 436-35-300(2)(b) and 436-35-310(2)(b). The validity and application of those rules is not challenged. Therefore, under the standards claimant's permanent disability is 21 percent. Former OAR 436-35-280. We do not find clear and convincing evidence that the degree of permanent disability suffered by claimant is more or less than that allowed by the standards. See former ORS 656.295(5).

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

ORDER

The Arbitrator/Referee's order dated June 21, 1989, as amended July 19, 1989, is affirmed in part and modified in part. In lieu of the Referee's award and in addition to the 8 percent (25.6 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 13 percent (41.6 degrees) unscheduled permanent disability, giving him a total award to date of 21 percent (67.2 degrees) unscheduled permanent disability for a right shoulder condition. Claimant's attorney is awarded an approved fee of 25 percent of the increased compensation created by this order. However, the total approved attorney fees granted by the Referee and Board orders shall not exceed $3,800. In addition, for prevailing on Liberty's request for review on the extent issue, claimant is awarded a reasonable assessed fee of $600. The remainder of the order is affirmed.

In the Matter of the Compensation of
NANCY C. EVENHUS, Claimant
Own Motion No. 90-0625M
OWN MOTION ORDER
Whitehead & Klosterman, Claimant Attorneys
Industrial Indemnity, Insurance Carrier

Industrial Indemnity has submitted its request for authorization for reimbursement from the Reopened Claims Reserve for the above captioned claim. Claimant's aggravation rights expired January 9, 1986. Industrial Indemnity contends that it is entitled to reimbursement for payment of claimant's temporary disability benefits since it has recently been found responsible for claimant's December 1, 1986 surgery. Nancy C. Evenhus, 42 Van Natta 2615 (1990). We grant the request, subject to the following qualifications.

The relevant facts are as follows. Industrial Indemnity denied responsibility for claimant's December 1, 1986 surgery claim. Thereafter, Liberty Northwest accepted the claim as a "new injury" and provided temporary disability benefits for her left knee surgery. In February 1987, Liberty Northwest rescinded its denial, contending that it did not provide coverage during the time in question. A hearing was convened, which, in addition to another denial from another carrier, concerned the aforementioned denials. A Referee held that Liberty Northwest was precluded from issuing its denial and, therefore, remained responsible for the claim. We affirmed. Nancy C. Evenhus, 41 Van Natta 1023 (1989).

In accordance with the Referee and Board order, Liberty Northwest processed the claim to closure. A November 11, 1988 Determination Order awarded temporary total disability between December 1, 1986 and February 1, 1987, as well as 5 percent scheduled permanent partial disability. The Court of Appeals subsequently reversed the Board order and remanded for further consideration. Camlu Retirement Center v. Evenhus, 102 Or App 603 (1990). On remand, we upheld Liberty Northwest's denial and found Industrial Indemnity responsible for claimant's December 1, 1986 surgery claim. Nancy C. Evenhus,42 Van Natta 2615 (1990).

Industrial Indemnity has now submitted the "own motion" portion of claimant's surgery claim to us. It does not oppose reopening of the claim for the payment of temporary total disability benefits effective upon claimant's December 1, 1986 surgery and terminating as of her February 2, 1987 return to work, as found by the November 11, 1988 Determination Order. In addition,

Industrial Indemnity seeks authorization to recover reimbursement for this temporary disability compensation from the Reopened Claims Reserve.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find a worsening of claimant's compensable 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.

Here, we find that claimant's compensable left knee condition worsened, resulting in the December 1, 1986 surgery. Such circumstances would generally entitle a claimant to the reopening of her claim for the payment of temporary disability. However, as previously discussed, claimant has already received temporary disability benefits from Liberty Northwest for the period of his disability resulting from the December 1, 1986 surgery. Under such circumstances, we conclude that claimant is not entitled to a double recovery for the same disability.

Thus, claimant's claim is reopened for the payment of temporary disability compensation, subject to the following conditions. If claimant's temporary disability rate under the Liberty Northwest claim exceeds her temporary disability rate under the Industrial Indemnity claim, she shall not be entitled to receive additional temporary disability benefits for the period of her disability which coincides with the period in which she received benefits under the Liberty Northwest claim. If claimant's temporary disability rate under the Liberty Northwest claim is less than her rate under the Industrial Indemnity claim, she shall receive from Industrial Indemnity the difference between the two rates for the period of her disability which coincides with the period in which she received benefits under the Liberty Northwest claim. Finally, If claimant is entitled to temporary disability benefits beyond the period in which Liberty Northwest provided such benefits, she shall receive full temporary benefits under the Industrial Indemnity claim for that additional period until such compensation can be lawfully terminated.

In the event that Industrial Indemnity is required to provide temporary disability benefits as a result of this order, reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436 Division 45.

Finally, although the record suggests that claimant has long since returned to work and become medically stationary as a result of her December 1, 1986 surgery, it would not be appropriate for us to close the claim. Rather, the claim should be closed by Industrial Indemnity pursuant to OAR 438-12-055.

IT IS SO ORDERED.

December 27, 1990 Cite as 42 Van Natta 2855 (1990)

In the Matter of the Compensation of
LILIA D. PAREL, Claimant
WCB Case No. 89-13789
ORDER ON REVIEW
Cynthia Cumfer, Claimant Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Neal's order that upheld the insurer's denial of her neck, head and shoulder injury claim. In her brief, claimant asserts that the Referee erred in excluding the content of speeches delivered at the party where claimant sustained her injury. On review, the issues are evidence and compensability.

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

Evidence

The Referee excluded claimant's testimony regarding the content of speeches delivered at the employer's party honoring a "Super Star" employee. Inasmuch as the speeches in question were not offered for the truth of their contents, the evidence was not hearsay and should have been admitted.

However, we conclude that, even if the speeches were work-related, consideration of their content would not change the outcome of this case. Because the case has not been improperly, incompletely, or otherwise insufficiently developed, it does not merit remand. See former ORS 656.295(5).

Compensability

We adopt the Referee's opinion, except for her first "Ultimate Finding of Fact." In this regard, we do not decide that claimant attended the party solely for her own pleasure. See former ORS 656.005(7)(b).

However, we agree with the Referee's conclusion that claimant has not proven a sufficient relationship between her injury and her employment to establish compensability. We conclude, as did the Referee, that the employer did not derive substantial direct benefit from the party "beyond the intangible value of improvement in employee health and morale that is common to all kinds of recreational and social life." See Colvin v. Industrial Indemnity, 83 Or App 73 (1986).

ORDER

The Referee's order dated November 20, 1989, as amended November 27, 1989, is affirmed.

December 27, 1990 Cite as 42 Van Natta 2856 (1990)

In the Matter of the Compensation of
RON M. ROGERS, Claimant
WCB Case No. 88-11310
ORDER ON REVIEW
Gary K. Jensen, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Myers and Cushing.

The insurer requests review of those portions of Referee Michael Johnson's order which: (1) found that it had incorrectly calculated claimant's rate of temporary disability benefits; and (2) assessed a penalty and related attorney fee for an allegedly unreasonable calculation of temporary disability benefits. On review, the issues are calculation of temporary disability benefits and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant was hired by the employer as a truck driver in March 1988. He had driven approximately three days for the employer when he sustained compensable injuries in a motor vehicle accident.

At the time he was hired, it was agreed that claimant would be paid eighteen cents per mile. Claimant had expectations with regard to how many

miles he would be driving per month, but no representations were made by the employer. The eighteen cents per miles included a six cents per diem which was used for maintenance expenses such as motel bills and food.

The employer paid claimant based on a chart showing the mileage between given locations. The employer paid all of its drivers in this manner. Claimant was not paid for actual mileage incurred which was measured by a hub odometer installed on the truck. Claimant's rate of temporary total disability was calculated using the mileage chart and not on actual or "hub" mileage.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's rate of temporary total disability should have been calculated using "hub" mileage. He further found that calculation based on a mileage chart was unreasonable. We disagree.

OAR 436-60-020 provides for methods of calculation and payment of temporary total disability compensation. OAR 436-60-020(7)(a)(b) & (c) provide for calculation of temporary total disability workers who are on call, do piecework or have varying hours, wages or salary. When a claimant's work falls within these three subsections, and he has worked less than four weeks, his rate of temporary total disability is based upon the intent of hire as confirmed by the employer and worker. See OAR 436-60-020(7)(a).

Here, Ms. Owens, the co-owner who hired claimant, testified that there had been no agreement to pay claimant based on "hub" mileage. She further testified that all other drivers employed by the employer were paid based upon chart mileage rather than "hub" mileage.

Claimant testified that the employer had a "standard computer mileage from point A to point B and that they paid mileage on that," but indicated that he disagreed with that type of calculation. (Tr. 41). He further testified that other employers had paid him based on "hub" mileage.

Although claimant may have disagreed with the employer's method of payment, there is no persuasive evidence of an intent by the employer to base claimant's wages on "hub" mileage. Further, there is no evidence which indicates that the employer told claimant that he would be paid based on "hub" mileage. Finally, the fact that the employer paid all other drivers based on chart mileage rather than "hub" mileage leads us to conclude that there was no intent to base claimant's wages on "hub" mileage. Accordingly, we find that basing claimant's rate of temporary total disability on chart mileage was appropriate.

Inasmuch as we have concluded that there was no intent to pay claimant based on "hub" mileage, we do not find the insurer's calculation of temporary total disability, based on chart mileage, was unreasonable. Therefore, neither a penalty nor an associated attorney fee is warranted.

ORDER

The Referee's order dated February 13, 1989, as reconsidered January 10, 1990, is reversed. That portion which ordered claimant's temporary total disability to be recomputed based on "hub miles" is reversed. The insurer's calculation of temporary total disability benefits, based on chart miles, is reinstated and affirmed. That portion which awarded a 25 percent penalty and a $200 associated attorney fee is reversed.

In the Matter of the Compensation of
VALREE BLOCKER, Claimant
WCB Case No. 89-20786
ORDER ON REVIEW (REMANDING)
Gatti, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Baker's order that dismissed her request for hearing. On review, the issue is dismissal. We remand.

FINDINGS OF FACT

Claimant requested a hearing on October 26, 1989. A Notice of Hearing set the hearing for February 13, 1990. Claimant failed to appear. Claimant's attorney appeared, but chose not to proceed in claimant's absence. No proceedings of record were held.

Thereafter, claimant indicated by letter that she had missed the hearing due to an incorrect note on her calendar. She explained: "Somewhere along the line, I understood that the hearing was going to be on February 19, 1990." With the letter, her attorney requested that the Referee find good cause for her failure to appear and to reset the matter for hearing. The insurer subsequently moved for a dismissal of claimant's request for hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee entered an Order of Dismissal, finding that claimant failed to appear at the February 13, 1990 hearing and concluding that claimant had not establish good cause that would have justified postponement. We remand.

Former OAR 438-06-071 authorizes a Referee to dismiss a request for hearing for "failure of a party, or the party's representative to appear at the time and place scheduled for hearing." In this case, claimant personally failed to appear. However, she did appear by counsel. In Williams v. SAIF, 99 Or App 367 (1989), the Court of Appeals held that former OAR 438-06-071 does not allow a Referee to dismiss a request for hearing when a claimant, while not personally present, was represented by her attorney at the hearing. On review, the Supreme Court reversed, concluding that the Referee and the Board had relied on another rule in dismissing claimant's hearing request. SAIF v. Williams, 310 Or 320 (1990). The Court, however, noted that it expressed no opinion regarding the Court of Appeals' interpretation of former OAR 438-06-071, because it was dicta. 310 Or at 327.

Notwithstanding, we are persuaded that the Court of Appeals' dicta regarding the application of former OAR 438-06-071 is correct and we continue to apply that interpretation to cases involving the rule. See Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990). Accordingly, we conclude that the Referee was without authority to dismiss.

We, therefore, proceed to consider claimant's request for postponement. In order to obtain a postponement, claimant must demonstrate that extraordinary circumstances beyond her control existed that prevented her appearance at hearing. Former OAR 438-06-081. Claimant contends that she marked the incorrect hearing date on her calendar. That mistake, however, was within her control. Accordingly, we do not consider it to be an extraordinary circumstance that prevented her appearance at the hearing. Claimant's request for postponement is

denied. Because claimant failed to appear at the hearing, she has waived her right to appear at a subsequent hearing. Jose Arisqueta-Martinez, supra.

We remand this matter to Referee Baker for a hearing on the merits. At hearing, the Referee shall determine what evidence may be received; however, no exhibits shall be received that were not submitted in connection to the prior hearing, nor shall any witness, including claimant, be permitted to testify who was not available to and planned to testify at the prior hearing or was under subpoena to testify at that hearing. Mario Miranda, 42 Van Natta 405 (1990).

ORDER

The Referee's order dated April 18, 1990 is vacated and the case is remanded to Referee Baker for further proceedings consistent with this order.

December 28, 1990 Cite as 42 Van Natta 2859 (1990)

In the Matter of the Compensation of
AGATHA K. BOHM, Claimant
WCB Case No. 89-14867
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Pamela Schultz, Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of those portions of Referee Thye's order that: (1) found claimant had failed to establish good cause for an untimely filing of a hearing request; and (2) affirmed a Determination Order award of no permanent disability. In its brief, the insurer has moved to strike three documents that were attached and submitted with claimant's appellant brief. On review, the issues are remand, timeliness and extent of permanent disability. We deny remand and affirm.

FINDINGS OF FACT

Claimant, who was 50 years old at the time of hearing, was employed as a seamstress for a foam rubber mattress manufacturer. She first developed symptoms of asthma in 1980 and was first hospitalized for breathing problems in 1983. Her condition worsened with continued waxing and waning of symptoms that, on occasion, required hospitalization and time off from work. She began treatment with Prednisone, a steroid that often causes weight gain and, in February 1987, quit smoking cigarettes, a habit she had started when she was 13 years old.

On October 27, 1987, claimant was exposed to fumes of an isocyanate known as Toluene Diisocyanate (TDI), which is used in the process of curing foam rubber. She suffered a severe asthmatic seizure and was taken to the hospital for treatment.

Dr. Keppel, a pulmonary specialist, examined claimant on November 4, 1987. He found a severe obstruction of her pulmonary functions and recommended that she avoid further exposure to the isocyanate. On November 19, 1987, Dr. Ritzenthaler, who had treated claimant since 1985, found that her condition had stabilized since the exposure and also recommended that she avoid further exposure to TDI. Claimant has not worked since October 27, 1987.

Shortly after the October 27, 1987 exposure, claimant filed a claim seeking benefits for occupationally induced asthma. In February 1988, the insurer denied compensability of claimant's asthma condition on the basis that it did not arise out of and in the course and scope of her employment. It also denied that claimant's underlying asthma condition had worsened as a result of her work exposure. Claimant subsequently filed a request for hearing.

On June 8, 1988, a Stipulation and Order was approved, in which the parties agreed that: (1) the insurer would modify its denial and accept the effects of a temporary symptomatic increase in claimant's underlying asthma condition caused by the October 27, 1987 exposure; (2) the insurer was not accepting a worsening of claimant's underlying asthma condition by its action in the matter; and (3) claimant's request for hearing and all issues raised or raisable at that time would be dismissed with prejudice. (Ex. 23).

Pursuant to the stipulation, the insurer processed the claim according to law. A March 15, 1989 Determination Order found claimant medically stationary as of January 25, 1989, and awarded temporary total disability benefits with no permanent disability.

Meanwhile, claimant had returned to Dr. Keppel, who found that claimant had gained 20 pounds and that her night breathing problems had increased. A sleep study revealed severe obstructive sleep apnea. The insurer received billings for the sleep study and, on May 4, 1989, issued a denial of claimant's sleep apnea condition.

On August 1, 1989, claimant's original attorney timely filed a request for hearing on the Determination Order, asserting that claimant is totally and permanently disabled. That attorney had received a copy of the May 4, 1989 denial of the sleep apnea condition, but did not request a hearing on it because he felt that it was issued by mistake. Shortly thereafter, claimant hired a new attorney, who filed a supplemental request for hearing on that denial. The Board received the request on August 22, 1989, more than 60 days after claimant received notice of the denial.

CONCLUSIONS OF LAW AND OPINION

Admissibility of Evidence

With her brief, claimant has submitted three documents that were not submitted or admitted in the evidentiary record. Those documents include a worksheet on permanent partial disability and data from the Dictionary of Occupational Titles.

The Board's review is limited to the record developed by the Referee. We may remand to the Referee for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand, however, it must be shown that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Because claimant has made no such showing, remand is not warranted. Accordingly, we exclude the three documents contained in claimant's brief and do not consider them on review.

Timeliness

The Referee found that claimant had failed to establish good cause for failing to timely request a hearing on the denial of her sleep apnea condition. We agree.

ORS 656.319(1)(a) requires a claimant to request a hearing of a denial within 60 days of notification. However, a hearing request filed after 60 days, but within 180 days of a denial, may be excused only if claimant establishes that she had good cause for the late filing. ORS 656.319(1)(b). The test for determining whether good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986).

Claimant contends that her reliance on her first attorney, who failed to file the necessary request for a hearing, constitutes good cause. We disagree.

The ordinary negligence of an attorney is not excusable neglect within the meaning of ORS 18.160 unless the attorney's reason for failure to file would be excusable if attributed to claimant. Sekermestrovich v. SAIF, 280 Or 723, 727 (1977). In this case, the attorney failed to file the request for hearing because he thought the denial was issued by mistake and was invalid. We conclude that nothing in the attorney's actions could be held to be excusable neglect if it were done by claimant herself.

Consequently, we affirm the Referee's determination that claimant has failed to established good cause for her failure to file a timely hearing request on the May 4, 1989 denial.

Permanent Disability

Claimant contends that she is entitled to an award of permanent total disability or, in the alternative, unscheduled permanent partial disability. We disagree.

At the outset, we note that, per stipulation, the accepted condition is a "temporary symptomatic increase in claimant's underlying asthma condition." Claimant's underlying condition itself is not compensable. Moreover, claimant's sleep apnea is not compensable because, as previously discussed, the May 4, 1989 denial is final. Therefore, in order to prove entitlement to permanent disability, claimant must prove by a preponderance of the evidence that the alleged permanent disability is caused by the temporary exacerbation of her symptoms related to the October 27, 1987 incident, and not caused by her preexisting asthmatic condition. See Harris v. Albertson's Inc., 65 Or App 254 (1983).

Of the numerous expert opinions introduced in this matter, only Dr. Keppel, the treating physician since November 1988, believed that claimant's current disability was caused by the October 27, 1987 exposure. Dr. Ritzenthaler, the treating physician from 1985 until November 1988, found that claimant's condition had stabilized three weeks after the exposure and felt that she was capable of returning to work in a clean environment. In fact, during his April 1988 deposition, he described claimant's condition as slightly better that it was prior to the October 1987 exposure.

Dr. Montanaro, who had examined claimant on several occasions since 1984, reported that there was no direct evidence that the exposure caused anything more than a temporary worsening of her underlying condition. Dr. Zbinden, a pulmonary disease specialist who examined claimant in December 1988, noted that the medical record indicated that claimant had significant airways disease both before and after the October 27, 1987 incident and concluded that "there was no way to determine any permanent aggravation of her airway process from that isolated exposure." (Ex. 46-4).

In light of this substantial contrary evidence, we do not find Dr. Keppel's opinion persuasive. Rather, we find that the preponderance of the medical evidence indicates that claimant's compensable condition, the "temporary worsening," resolved with no permanent residuals. After our review of the record, we conclude that claimant's current disability is caused by her preexisting, noncompensable asthmatic condition. Accordingly, claimant is not entitled an award of permanent disability.

ORDER

The Referee's order dated February 23, 1990, as amended March 6, 1990, is affirmed.

In the Matter of the Compensation of
WCB Case No. 87-16765
KENNETH DAVIES, JR., Claimant
ORDER ON REMAND
Skalak & Associates, Claimant Attorneys
Terrall & Miller, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Diamond Fruit Growers v. Davies, 103 Or App 280 (1990). The court has concluded that our prior order, which awarded claimant a $600 attorney fee for services on review pursuant to ORS 656.382(2), provided no explanation from which the court could determine whether there was a reasonable basis for the amount awarded. Consequently, the court has remanded for reconsideration of the attorney fee award. We proceed with our reconsideration.

The self-insured employer requested Board review of that portion of the Referee's order which set aside its denial of claimant's injury claim for his neck, back, and right shoulder conditions. In response to the employer's brief, claimant's counsel submitted an 8 1/2 page respondent's brief defending the Referee's order. Approximately 7 pages of the brief pertained to his arguments rebutting the employer's contentions concerning the incident in question, the medical evidence, and claimant's credibility. Enclosing a statement of services noting 11.5 hours of actual time, claimant's counsel sought a carrier-paid fee for services on Board review of $1,562.50.

We affirmed and adopted the Referee's order. Without discussing the basis for our decision, we also summarily awarded claimant's counsel a $600 carrier-paid attorney fee. In accordance with the court's instructions, we now provide an explanation for our award.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $1,150, to be paid by the employer. This conclusion is based on the following reasoning.

Counsel's efforts have been of value to claimant in that his right to compensation has remained secure. See OAR 438-15-010(4)(c), and (f). The compensability issue raises a general question of normal factual and medical complexity. See OAR 438-15-010(4)(b). Claimant's counsel, an attorney with 10 years of experience in the workers' compensation field, has expended 11.5 hours of research and preparation in producing a reasoned response to the employer's arguments. See OAR 438-15-010(4)(a), (d), and (e). The issue raised by the employer on review was not of a frivolous nature. See OAR 438-15-010(4)(h). Considering all of these factors, as well as the risk that claimant's attorney's efforts may go uncompensated (See OAR 438-15-010(4)(g)), we conclude that a reasonable fee for services on Board review is $1,150.

Consequently, on reconsideration, after considering the factors recited in the aforementioned administrative rule, we find that a reasonable attorney fee for claimant's counsel's services on Board review is $1,150. Accordingly, in lieu of our prior attorney fee award, claimant's counsel is awarded $1,150, to be paid by the self-insured employer.

IT IS SO ORDERED.

In the Matter of the Compensation of
PEGGY A. DAWES, Claimant
WCB Case No. 89-14499
ORDER ON REVIEW
Olson, Rowell & Walsh, Claimant Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of those portions of Referee Irving's order which: (1) allowed the insurer to offset temporary disability benefits paid between April 5, 1987 and May 16, 1989; and (2) found claimant medically stationary as of May 16, 1989. The insurer cross-requests review of that portion of the Referee's order which: (1) found that claimant was procedurally entitled to temporary disability benefits between April 5, 1987 and May 16, 1989; and (2) assessed a penalty and attorney fee for an allegedly unreasonable failure to pay temporary disability benefits between April 5, 1987 and May 16, 1989. On review, the issues are offset, medically stationary date, temporary disability benefits and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant returned to modified work on April 1,1987, but was terminated on April 5, 1987, for reasons unrelated to her compensable injury. The June 28, 1989 Determination Order provided that, "The Department orders [claimant] entitled to additional compensation for temporary disability, less time worked, as follows. . ." The Determination Order then awarded claimant temporary total disability from May 8, 1986 through May 16, 1989, among other things.

FINDINGS OF ULTIMATE FACT

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

CONCLUSIONS OF LAW AND OPINION

Offset

We adopt the conclusions and reasoning concerning the offset of temporary disability benefits paid between April 5, 1987 and May 16, 1989, as set forth in the Referee's order.

Medically Stationary Date

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

Temporary Total Disability

We adopt the conclusions and reasoning concerning claimant's entitlement to temporary total disability benefits pursuant to the June 28, 1989 Determination Order as set forth in the Referee's Order on Reconsideration.

Penalties and Attorney Fees

In her Order on Reconsideration, the Referee found the insurer's failure to pay temporary total disability benefits, pursuant to the June 28, 1989 Determination Order, to be unreasonable. Therefore, the Referee assessed 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 action must be gauged on the information available to it at the time of its action. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988); Mt. Mazama Plywood Co. v. Beattie, 62 Or App 355 (1983).

Here, the insurer knew that claimant had left her modified work for reasons unrelated to her injury. Further, the Determination Order language indicated entitlement to temporary disability benefits "less time worked." Inasmuch as the insurer knew that claimant had left her modified work for reasons unrelated to her injury, we consider the language of the Determination Order, insofar as it pertains to claimant's temporary disability award, to be ambiguous.

Under these circumstances, we conclude that the insurer had a legitimate doubt in regards to its duty to pay temporary total disability pursuant to the Determination Order. See Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). Therefore, we do not find the insurer's failure to pay temporary total disablity benefits unreasonble. Accordingly, a penalty or related attorney fee is not warranted.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the entitlement to temporary total disability pursuant to the June 28, 1989 Determination Order is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 13, 1989, as reconsidered February 2, 1990, is reversed in part and affirmed in part. That portion which awarded a 25 percent penalty based on temporary total disability benefits payable between April 5, 1987 and May 16, 1989, is reversed. That portion which awarded a $400 assessed attorney fee in association with the penalty is reversed. The remainder of the order is affirmed. For services on review concerning the issue of entitlement to temporary total disability benefits payable pursuant to the June 28, 1989 Determination Order, claimant's counsel is awarded an assessed attorney fee of $500, payable by the insurer.

In the Matter of the Compensation of
MILFORD W. HAYES, Claimant
WCB Case No. 89-06039
ORDER ON REVIEW
Marilyn K. Odell, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of those portions of Referee Miller's order that: (1) affirmed a Determination Order medically stationary date of August 18, 1988; and (2) assessed an attorney fee for claimant prevailing on the employer's cross-request for hearing. On review, the issues are the date claimant became medically stationary and attorney fees. We reverse.

FINDINGS OF FACT

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

ULTIMATE FINDINGS OF FACT

Claimant has been medically stationary since December 30, 1987.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

The employer contends that claimant was medically stationary on December 30, 1987, rather than August 18, 1988, the date used in the Determination Order. The employer has the burden of proving by a preponderance of the evidence that claimant was medically stationary at an earlier date than that contained in the Determination Order. Norton v. SAIF, 86 Or App 447 (1987).

Notwithstanding her finding of ultimate fact that claimant had been medically stationary since December 30, 1987, the Referee concluded that the proper medically stationary date was August 18, 1988. She relied on the fact that, although Dr. Lafrance believed that claimant was medically stationary as of December 30, 1987, he continued to treat claimant in a curative fashion. She also noted that Dr. Lafrance had placed claimant on restrictive work duty and was seeking effective vocational assistance. We disagree.

While Dr. Lafrance continued to treat claimant after he declared him medically stationary, the evidence indicates that his treatment was limited to the prescription of pain medicine. Moreover, his placing of claimant on restricted duty and his seeking vocational assistance does not indicate that he expected claimant to get better. As explained by Dr. Lafrance in his deposition:

> "So it's always been my thought that [a belief that claimant is medically stationary and an assessment that he is not able to work in a job] are two different things. Somebody may be quite stationary but still not able to work or work at their previous job, and I think that's what we found." (Ex. 106C-35).

Furthermore, we do not agree with claimant that he was not medically stationary on December 30, 1987, because his condition subsequently worsened. The Workers' Compensation Act does not require that an injured worker progress to the

lowest level of physical deterioration before his claim may be closed. See Pratt v. SAIF, 29 Or App 255 (1977).

After our de novo review of the record, we conclude that the employer has established that a date earlier than the one used by the Determination Order is the correct medically stationary date. Accordingly, we find that claimant became medically stationary as of December 30, 1987.

Attorney Fees

Pursuant to ORS 656.382(2), the Referee assessed an attorney fee for claimant's prevailing on the employer's cross-request for hearing regarding the medically stationary date and termination of temporary total disability. Given the fact that the employer has ultimately prevailed on those issues, the Referee's assessed fee is reversed.

ORDER

The Referee's order dated February 16, 1990 is affirmed in part and reversed in part. That portion that affirmed the Determination Order medically stationary date of August 18, 1988 is reversed. Claimant is entitled to temporary disability through the date of December 30, 1987, rather than the August 18, 1988 date found by the Determination Order. The employer is authorized to recover the overpaid temporary disability paid after December 30, 1987 against claimant's future permanent disability awards in this claim, if any. The Referee's assessed attorney fee of $150 awarded to claimant for prevailing on the employer's cross-appeal is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
VINCENT G. JACOBAN, Claimant
WCB Case No. 89-18043
ORDER ON REVIEW (REMANDING)
Donald L. Dickerson, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Schultz' order that dismissed his request for hearing on the grounds that neither he nor his attorney appeared at the hearing. Claimant contends that he had good cause for his failure to appear and he moves for remand to the Referee. We remand the case to the Referee for further evidence taking and reconsideration.

FINDINGS OF FACT

On September 11, 1989, claimant requested a hearing. The case was set for a hearing to take place on January 5, 1990. On that date, the self-insured employer's counsel appeared at the hearing, but neither claimant nor his attorney appeared at that time. The Referee granted the employer's motion to dismiss claimant's request for hearing.

After the Referee's Order of Dismissal issued, claimant's counsel wrote to the Referee to request that he reschedule the matter. There is no response to this request in the record.

In the Matter of the Compensation of
MILFORD W. HAYES, Claimant
WCB Case No. 89-06039
ORDER ON REVIEW
Marilyn K. Odell, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of those portions of Referee Miller's order that: (1) affirmed a Determination Order medically stationary date of August 18, 1988; and (2) assessed an attorney fee for claimant prevailing on the employer's cross-request for hearing. On review, the issues are the date claimant became medically stationary and attorney fees. We reverse.

FINDINGS OF FACT

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

ULTIMATE FINDINGS OF FACT

Claimant has been medically stationary since December 30, 1987.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

The employer contends that claimant was medically stationary on December 30, 1987, rather than August 18, 1988, the date used in the Determination Order. The employer has the burden of proving by a preponderance of the evidence that claimant was medically stationary at an earlier date than that contained in the Determination Order. Norton v. SAIF, 86 Or App 447 (1987).

Notwithstanding her finding of ultimate fact that claimant had been medically stationary since December 30, 1987, the Referee concluded that the proper medically stationary date was August 18, 1988. She relied on the fact that, although Dr. Lafrance believed that claimant was medically stationary as of December 30, 1987, he continued to treat claimant in a curative fashion. She also noted that Dr. Lafrance had placed claimant on restrictive work duty and was seeking effective vocational assistance. We disagree.

While Dr. Lafrance continued to treat claimant after he declared him medically stationary, the evidence indicates that his treatment was limited to the prescription of pain medicine. Moreover, his placing of claimant on restricted duty and his seeking vocational assistance does not indicate that he expected claimant to get better. As explained by Dr. Lafrance in his deposition:

> "So it's always been my thought that [a belief that claimant is medically stationary and an assessment that he is not able to work in a job] are two different things. Somebody may be quite stationary but still not able to work or work at their previous job, and I think that's what we found." (Ex. 106C-35).

Furthermore, we do not agree with claimant that he was not medically stationary on December 30, 1987, because his condition subsequently worsened. The Workers' Compensation Act does not require that an injured worker progress to the

lowest level of physical deterioration before his claim may be closed. See Pratt v. SAIF, 29 Or App 255 (1977).

After our de novo review of the record, we conclude that the employer has established that a date earlier than the one used by the Determination Order is the correct medically stationary date. Accordingly, we find that claimant became medically stationary as of December 30, 1987.

Attorney Fees

Pursuant to ORS 656.382(2), the Referee assessed an attorney fee for claimant's prevailing on the employer's cross-request for hearing regarding the medically stationary date and termination of temporary total disability. Given the fact that the employer has ultimately prevailed on those issues, the Referee's assessed fee is reversed.

ORDER

The Referee's order dated February 16, 1990 is affirmed in part and reversed in part. That portion that affirmed the Determination Order medically stationary date of August 18, 1988 is reversed. Claimant is entitled to temporary disability through the date of December 30, 1987, rather than the August 18, 1988 date found by the Determination Order. The employer is authorized to recover the overpaid temporary disability paid after December 30, 1987 against claimant's future permanent disability awards in this claim, if any. The Referee's assessed attorney fee of $150 awarded to claimant for prevailing on the employer's cross-appeal is reversed. The remainder of the Referee's order is affirmed.

December 28, 1990 Cite as 42 Van Natta 2866 (1990)

In the Matter of the Compensation of
VINCENT G. JACOBAN, Claimant
WCB Case No. 89-18043
ORDER ON REVIEW (REMANDING)
Donald L. Dickerson, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Schultz' order that dismissed his request for hearing on the grounds that neither he nor his attorney appeared at the hearing. Claimant contends that he had good cause for his failure to appear and he moves for remand to the Referee. We remand the case to the Referee for further evidence taking and reconsideration.

FINDINGS OF FACT

On September 11, 1989, claimant requested a hearing. The case was set for a hearing to take place on January 5, 1990. On that date, the self-insured employer's counsel appeared at the hearing, but neither claimant nor his attorney appeared at that time. The Referee granted the employer's motion to dismiss claimant's request for hearing.

After the Referee's Order of Dismissal issued, claimant's counsel wrote to 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 January 5, 1990 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. See Mark R. Luthy, 41 Van Natta 2132 (1989). In the present 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 why there was no request for a postponement before the hearing, or the reason for claimant's counsel's failure to appear at hearing. Accordingly, we find that the record has been incompletely developed.

ORDER

The Referee's order dated January 17, 1990 is vacated and the case is remanded to Referee Schultz for reconsideration. If the Referee determines that a postponement of the January 5, 1990 hearing should be granted, the Referee shall proceed with a hearing concerning the merits of the claim.

December 28, 1990 Cite as 42 Van Natta 2867 (1990)

In the Matter of the Compensation of
FRANKLIN H. KING, Claimant
WCB Case Nos. 88-12747, 88-11016 & 88-12746
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Gruber's order that: (1) upheld the SAIF Corporation's denial of claimant's injury claim for an electrical shock; (2) upheld SAIF's denial of claimant's right eye injury claim; (3) upheld SAIF's denial of claimant's head injury claim; (4) upheld SAIF's denial of claimant's aggravation claim for a preexisting psychiatric condition; and (5) declined to assess penalties and related attorney fees for allegedly unreasonable denials. On review, the issues are compensability, aggravation and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Ultimate Findings of Fact" as our own, with the following supplementation.

SAIF's denials of compensability and aggravation were reasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability and Aggravation

We adopt the Referee's "Conclusions and Reasoning" as our own. Claimant failed to establish the compensability of his electric shock, eye and head injury claims and he also failed to establish either a symptomatic or pathological worsening of his preexisting psychiatric condition.

The Referee did not address claimant's contention that each of SAIF's denials were unreasonable. We now address those issues.

Penalties and Related Attorney Fees - Compensability Denials

Where the insurer has a legitimate doubt as to its liability and issues a denial based on that doubt, its denial is not unreasonable. Brown v. Argonaut Insurance Co., 93 Or 588 (1988).

Here, SAIF issued three denials on July 22, 1988: one regarding an October 1987 incident, one regarding a January 1988 incident, and one regarding a March 1988 incident. Each of the denials stated that no injuries requiring medical treatment and/or disability resulted from the alleged incidents.

We have already found that claimant failed to meet his burden of proving the compensability of each of the three incidents. Further, the medical evidence establishes that the only alleged treatment claimant received for these alleged incidents was spiritual in nature. While such treatment may be compensable under ORS 656.010, we find that there was insufficient evidence to establish the compensability of such treatment. Because SAIF was without any evidence of medical treatment for the alleged incidents, we find that SAIF had a legitimate doubt as to its liability for such alleged incidents. Consequently, we conclude that SAIF acted reasonably in issuing its denials.

Penalties and Related Attorney Fees - Denial of Aggravation

As stated earlier, where the insurer has a legitimate doubt as to its liability and issues a denial based on that doubt, its denial is not unreasonable. Brown v. Argonaut Insurance Co., supra.

SAIF issued its denial of claimant's aggravation claim based upon receipt of two inconsistent psychiatric reports. Given the fact that one report supported a worsening and the other did not support a worsening, we find that SAIF had a legitimate doubt as to the compensability of claimant's aggravation claim. Therefore, we find that SAIF's denial of claimant's aggravation claim was likewise reasonable.

ORDER

The Referee's order dated March 1, 1990 is affirmed.

In the Matter of the Compensation of
TERRANCE C. MANN, Claimant
WCB Case No. 89-21802
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of Referee Crumme's order that: (1) awarded 19 percent (28.5 degrees) scheduled permanent disability for a loss of use or function of the right forearm, whereas a Determination Order had awarded no permanent disability; and (2) assessed a penalty and related attorney fee for an allegedly unreasonable denial. On review, the issues are extent of scheduled permanent disability and penalties and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured his right arm on May 26, 1988, while working as a gauge mechanic. Dr. Utterback, M.D., diagnosed a small flake fracture in claimant's right wrist and recommended that claimant work light duty. (Ex. 2). Claimant remained on light duty for about six weeks and thereafter returned to his regular duties as a gauge mechanic. (Tr. 23-24). He continued treatment with Dr. Utterback until he was declared medically stationary on August 30, 1988, with no permanent impairment.

In October 1988, claimant returned to Dr. Utterback with complaints of increased pain. He continued treatment until he was declared medically stationary on May 22, 1989. At that time, Dr. Utterback suggested that claimant undergo an independent medical examination to determine whether he had any permanent impairment attributable to his injury. (Ex. 8).

On June 6, 1989, claimant began work as a shift electrician. He had requested to work as shift electrician before his injury and the position change was unrelated to his injury. (Tr. 55).

In response to Dr. Utterback's suggestion, Dr. Button, M.D., examined claimant on August 23, 1989, October 2, 1989, and December 18, 1989. Dr. Button performed grip strength exams on claimant and reported:

	August 23rd	October 2nd	December 18th
Right grip (injured)	24 kg	31 kg	22 kg
Left grip (uninjured)	49 kg	68 kg	59 kg

Dr. Button declared claimant medically stationary on December 18, 1989, with no objective evidence of grip strength loss. (Ex. 11).

A Determination Order issued on February 23, 1990, awarding no temporary or permanent disability. (Ex. 13).

As a result of his compensable injury, claimant has chronic pain in his right hand, wrist and forearm that limits his ability to engage in repetitive activities.

CONCLUSIONS OF LAW AND OPINION

Permanent Disability

The Referee awarded claimant permanent disability for diminished grip strength in his right hand and for a chronic condition that limits the repetitive use of his right hand and forearm. We adopt the Referee's reasoning and conclusion concerning an award of 5 percent for claimant's condition limiting the repetitive use of his hand and forearm. We disagree, however, that claimant has suffered a loss of function due to a loss of grip strength.

Claimant relies on the grip strength tests performed by Dr. Button. We do not consider the grip stength measurements evidence that claimant has sustained permanent impairment as a result of his compensable injury. While those measurements suggested that claimant retained only 70 percent grip strength, Dr. Button did not conclude that they indicated permanent impairment. Rather, he specifically concluded that the measurements lacked objective validity due to a lack of full effort on claimant's part during testing. He based his conclusion on the wild fluctuations in the grip strength measurements in both hands, the lack of right arm atrophy and the equal wear pattern of claimant's hands.

Consequently, we conclude that claimant has failed to prove by a preponderance of the evidence that he has suffered a loss of function due to a loss of grip strength. Accordingly, grip strength will not be considered in rating claimant's permanent disability.

Penalties and Attorney Fees

A penalty and related attorney fee 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 delay and resistance to the payment of compensation must be considered in the light of all the information available to the insurer. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

The Referee found that the employer's processing of the claim as nondisabling was unreasonable and assessed a penalty and an insurer-paid attorney fee. He relied on the fact that, because the employer kept claimant on light duty until June 6, 1989, it tacitly recognized that claimant had a continuing impairment. He, therefore, concluded that processing the claim as nondisabling unreasonably delayed closure and rating of permanent disability.

We do not consider the employer's actions unreasonable. Claimant remained on light duty only until early July 1988, at which time he returned to his regular duties as a gauge mechanic. (Tr. 23-24). The date relied upon by the Referee, June 6, 1989, is the date claimant began work as a shift electrician. Claimant lost no wages because of his injury and did not request time loss. Moreover, Dr. Utterback declared claimant medically stationary on August 30, 1988, with no permanent impairment.

Under those circumstances, we do not find the employer's processing the claim as nondisabling to have been unreasonable. Accordingly, the award of a penalty and attorney fee is not warranted.

ORDER

The Referee's order dated March 23, 1990 is modified in part and reversed in part. In lieu of the Referee's award and in addition to the Determination Order award of scheduled permanent disability, claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for a loss of use or function of the right forearm. The Referee's assessed 15 percent penalty and related attorney fee of $600 is reversed.

In the Matter of the Compensation of
JAY D. MARRINGTON, Claimant
WCB Case No. 89-15308
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Foss, Whitty, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee Mongrain's order which increased claimant's scheduled disability for the loss of use and function of his right arm from 4 percent (7.68 degrees), as awarded by a Determination Order, to 19 percent (36.48 degrees). On review, the issue is extent of scheduled disability. We modify.

FINDINGS OF FACT

Claimant experienced a compensable right arm injury on June 5, 1988. (Ex. 1). He underwent surgery on November 30, 1988 to relieve compression neuropathy of the median nerve beneath the pronator interest muscle. (Ex. 15).

Claimant was medically stationary on May 22, 1989. (Ex. 21). A June 22, 1989 Determination Order awarded claimant 4 percent scheduled permanent partial disability for the right arm.

Claimant has a chronic right arm condition that limits repetitive use of his right arm.

He experiences loss of right elbow extension equal to 4 percent disability of the right arm.

Claimant has not established the extent of any loss of grip strength.

CONCLUSIONS OF LAW AND OPINION

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

Because claimant's condition became medically stationary on May 22, 1989, and his claim was closed by Determination Order on June 22, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

The Referee awarded claimant an additional 15 percent scheduled disability for his right arm condition. We modify.

The Referee found that claimant suffered 4 percent disability for right arm impairment. See former OAR 436-35-100(2). The parties do not dispute this finding.

Grip Strength

The Referee found it was reasonable to conclude that claimant's loss of grip strength was due to median nerve damage. Consequently, grip strength was ratable pursuant to former OAR 436-35-110(3)(d). We disagree.

In this case there is no medical evidence of nerve impairment following the November 1988 surgery. On January 16, 1989, claimant's operating surgeon, Dr. Workland released claimant to work, free of restrictions. (Ex. 18). Moreover, on April 12, 1989, Dr. Samuel, chiropractor, noted that claimant's hand was free of numbness. (Ex. 19). There is no contrary medical evidence. Accordingly, because there is no evidence of permanent nerve damage, claimant's grip strength cannot be rated in accordance with former OAR 436-35-110(3)(d).

We also note that although Dr. Samuel found that claimant could generate a total of 64 kg of force with three squeezes with the right hand, he failed to indicate what is normal for grip strength, and we can find no standard in the AMA Guidelines for Rating Permanent Impairment. See former OAR 436-35-005(1); Gary L. Waldrupe, 42 Van Natta 2623 (1990). Accordingly, we are not able to rate grip strength.

Chronic Condition Limiting Repetitive Use

After our review of the record, we find that claimant does suffer from a chronic condition which limits the repetitive use of his right arm.

Former OAR 436-35-010(7) provides for a 5 percent disability award for chronic conditions which limit repetitive use of a scheduled body part.

Claimant experiences pain after repetitive gripping. (Tr. 9). He is forced to release items held with his right hand because of the pain. Moreover, Dr. Samuel reported that gripping, pulling, and pushing increases claimant's right arm pain. (Ex. 20-1). Accordingly, we find that claimant is entitled to an additional 5 percent impairment for his chronic right arm condition limiting repetitive use. Former OAR 436-35-010(7).

Computation of Scheduled Permanent Disability

To arrive at claimant's total impairment, we combine the value assigned for loss of repetitive use of the right arm (5) with the value assigned for loss of range of motion of the right arm (4) to arrive at a total impairment value of 8.8 percent. Former OAR 436-35-100(8). That disability is rounded to the next higher percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore 9 percent (17.28 degrees) for the right arm condition.

ORDER

The Referee's order dated December 18, 1989 is modified. In lieu of the Referee's award and in addition to the Determination Order, claimant is awarded 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the right arm, for a total award to date of 9 percent (17.28 degrees).

In the Matter of the Compensation of
MARK A. OSTERMILLER, Claimant
WCB Case Nos. 89-13019 & 89-08127
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of Referee McWilliams' order that: (1) set aside its denial of claimant's injury claim for a left leg bruise; and (2) set aside its denial of claimant's occupational disease claim for a psychological condition. Claimant moves to remand for the taking of additional evidence. On review, the issues are remand and compensability. We deny the motion and reverse.

FINDINGS OF FACT

Claimant has suffered chronic headaches, fatigue, disorientation, imbalance, and insomnia since 1981 and continuing until the date of hearing. The severity of those complaints varied during the years. In 1981, claimant was diagnosed with chronic anxiety with tension headaches. Claimant also suffers from hypertension since 1986, hypercholesterolemia since 1988, obesity and occasional hearing deficiency.

Claimant worked as a bank teller for Pacific Western Bank from 1980 until 1983. During that time, he was subjected to a bank robbery and complained of work-related stress. (Ex. a-2). No claim was filed for that incident.

In July 1985, claimant began working for First Interstate Bank as a Teller Grade 5. In March 1986, after a good performance evaluation, including marks of exceeding expectations (EE) and full performance (FP), claimant was promoted to Teller Grade 6.

In 1986, claimant began experiencing stomach problems, including nausea and chest pain.

In 1987, claimant was transferred to the employer's Springfield Branch Office. In September 1987, he was promoted to Teller Grade 7 and given authorized signing authority and supervisory duties. Claimant's position included being interrupted regularly while performing complicated accounting and auditing tasks.

In July 1988, claimant complained of mood/personality changes, ongoing for three months, to Dr. Koester, M.D. In December 1988, claimant took a two week vacation.

In January 1989, claimant began receiving treatment from Dr. Mossberg, M.D., for complaints of ringing in the head, nonexertional episodes of chest pressure, light-headedness, headaches and nausea. Mossberg treated claimant conservatively. EMG and MRI studies were interpreted by Dr. Knackstedt, M.D., to be normal.

On February 15, 1989, claimant became light-headed while returning to work after a break, blacked out and fell down some stairs. He was taken to the hospital where Dr. Morgan noted no specific injuries and diagnosed an imbalance disorder, etiology unknown. Claimant missed only one day of work.

On February 22, 1989, claimant filed an injury claim for a left leg bruise resulting from the fall. That injury claim was denied on April 18, 1989.

In March 1989, after psychological counseling and relaxation exercises, claimant's complaints of headaches and depression improved. His complaints of disequilibrium continued.

In April 1989, claimant was evaluated by Dr. Tearse, neurologist. The following day, claimant was evaluated by Dr. McConochie, psychologist. McConochie referred claimant to Dr. Reed, psychologist, with whom claimant began treatment on a weekly basis.

In May 1989, claimant filed a job-related stress claim and took a 30-day leave of absence as recommended by Dr. Reed. The claim for a stress condition was denied on June 22, 1989. Claimant requested a hearing on both denials.

In June 1989, claimant underwent an independent evaluation by the Orthopaedic Consultants and a psychological evaluation by Dr. Parvaresh.

From January 1988 to March 1989, the employer's staff was reduced from 13.7 to 12.7 full-time staff. The reduction in staff resulted from a decreased need for loan services, automation of certain bank transactions and a generalized reduction in work quantity. Claimant's workload increased temporarily due to the reduction of staff, but no overtime was ever expected or requested of claimant.

The hearing was convened and closed on September 1, 1989. On November 5, 1990, claimant moved to remand for the taking of additional evidence.

ULTIMATE FINDINGS OF FACT

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

Claimant suffers from a somatization disorder with stress and anxiety. His disorder is manifested by feelings of fatigue, insomnia, disequilibrium (dizziness) and chest pains. Claimant also suffers from a personality problem that prevents him from doing an accurate self-assessment due to his needs to please others and appear competent.

Claimant's anxiety and stress did not arise out of or in the course of his employment.

Claimant's injury did not arise out of or in the course of employment.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant seeks remand for the purpose of introducing into the record a medical report authored by Dr. Reed dated October 19, 1990. The employer objects to claimant's motion, arguing that the report has no bearing on the compensability of either claimant's injury claim or his occupational disease claim. We agree with the employer and deny the motion.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). After our review of Dr. Reed's October 19, 1990 report for the purposes of determining whether remand is appropriate, we find that its contents has no bearing on the

issues before us, i.e., compensability. Therefore, we conclude that the record has not been improperly, incompletely or otherwise insufficiently developed and deny claimant's motion.

Compensability of Psychological Condition

The Referee found that claimant met his burden of establishing the compensability of his occupational disease claim for mental stress. We disagree.

Claimant must prove that he has a mental disorder with a diagnosis that is generally recognized in the medical or psychological community; and that the events which are the source of his stress exist in "a real and objective sense." ORS 656.802(1)(b) & 656.802(2(a) & (c). Moreover, he must prove by clear and convincing evidence that his condition arose out of and in the course of his employment. ORS 656.802(2)(d). To establish that his condition arose out of and in the course of his employment, claimant must prove by clear and convincing evidence that his work exposure was a material cause of his condition. ORS 656.266; Deborah Andersen, 42 Van Natta 513 (1990); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Ellen L. Crawford, 41 Van Natta 1257 (1989).

After our review of the record, we find that claimant has failed to establish by clear and convincing evidence that his condition arose out of and in the course of his employment.

First, claimant has complained of symptoms of fatigue, insomnia, dizziness and chest pain since as early as 1981. He received conservative treatment for those conditions from numerous physicians from 1981 through 1989.

Second, claimant's reports of when his stress symptoms began are inconsistent. In January 1989, claimant indicated to Dr. Mossberg that he just recently began feeling depressed for no reason. On February 9, 1989, claimant indicated to Dr. Knackstedt, M.D., that he had experienced a constant dizzy sensation with light-headedness for three to four weeks. On February 15, 1989, as a result of claimant's fall after becoming dizzy, Dr. Morgan diagnosed a balance disorder with no etiology. The following day, Dr. Tearse diagnosed idiopathic gait instability, probably due to vestibulopathy. Claimant reported to Tearse that he had experienced dizziness and an imbalance and swaying feeling for six weeks and headaches for one month.

In April 1989, claimant reported to Dr. McConochie, psychologist, that his symptoms began in December 1988 while on vacation.

In late April and May 1989, claimant reported to Dr. Reed, psychologist, that his symptoms began when he was transferred to the Springfield Branch Office, which was in September 1987. Claimant reported to Reed that the symptoms decreased while on vacation, but increased upon his return to work.

In June 1989, claimant reported to the Orthopaedic Consultants that his symptoms began as early as November 1988. That same month, claimant reported to Dr. Parvaresh that his symptoms began sometime in the fall of 1988.

Finally, the medical record provides further support that claimant's mental stress is not work-related.

Claimant reported to Dr. McConochie that his job was fine, there were no problems or changes associated with his job, he was happy with banking, and his performance evaluations had been excellent. After his evaluation, McConochie opined that claimant was an overly religious, conforming and conventional person lacking in insight with a neurotic personality. McConochie opined that an

"apparent somatization disorder and modest intelligence, complicated by underlying dependent personality and highly religious upbringing and social outlook" appear to account for claimant's problems. (Ex. 4d-2).

Dr. Parvaresh, after his evaluation, reported that claimant suffers from an anxiety, panic and psychosomatic disorder of which the etiology was unclear. Parvaresh opined that it was "medically improbable that the anxiety attacks and panic [were] materially contributed to by [claimant's] work." (Ex. 12).

Contrary to the opinions of Parvaresh and McConochie, Dr. Reed opined that claimant's stress condition was work-related. She based her opinion on claimant's reports that his symptoms were relieved while he was on vacation, but returned when he returned to work. (Ex. 7). Reed's opinion is conclusory. Therefore, we do not find it persuasive in determining whether claimant's stress is work-related. Moe v. Ceiling Systems, 44 Or App 429 (1980).

We find the more well-reasoned opinions of Drs. McConochie and Parvaresh to be persuasive. Somers v. SAIF, 77 Or App 259, 262 (1986); See Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

Given claimant's long history of symptoms, his inconsistent reports of when those symptoms actually began, and the medical opinions of Drs. Parvaresh and McConochie, we conclude that claimant has failed to prove that mental stress condition arose out of and in the course of his employment.

Compensability of Injury Claim

The Referee found that claimant's fall was caused by symptoms which were brought on by claimant's work with the employer. We disagree.

Claimant has the burden of proving by a preponderance of the evidence that his injury arose out of and in the course of his employment. ORS 656.005(8); ORS 656.266. The Supreme Court has adopted a unitary work-connection approach: "If the injury has sufficient work relationship, then it arises out of and in the course of employment and the statute is satisfied." Roger v. SAIF, 289 Or 633, 643 (1980).

We proceed to consider claimant's claim under the unitary work-connection analysis as explained in Phil A. Livesley Co. v. Russ, 296 Or 25 (1983), in which the Court adopted the "quantum" approach in regard to "arising out of" and "in the course." There are two prongs to the "quantum" approach: the "course of employment" prong and the "arising out of employment" prong.

There is no question that claimant's injury occurred in the "course of" claimant's employment. The issue is whether claimant has established that his injury "arose out of" his employment. The "arising out of employment" prong of the analysis requires that claimant show a causal link between the occurrence of the injury and a risk connected with his employment. In analyzing this risk factor we now determine whether the injury had its origin in a risk connected with the employment or rationally and naturally incidental thereto. Phil A. Livesley, supra, 296 Or at 29-30.

Here, claimant experienced a "left leg bruise," after falling down stairs at work. Claimant contends that the fall was precipitated by a dizzy spell, and asserts that the dizzy spell and subsequent black-out leading to the fall was caused by work-related stress.

As we have already found, claimant's psychological condition, i.e., mental stress and its symptoms of fatigue, dizziness, etc., did not arise out of or in the course of his employment.

Claimant's injury is not compensable if the injury was "idiopathic," i.e., caused by a condition personal to claimant rather than work-related or unexplained. An injury is unexplained if it occurred during the course of employment, and was not caused by idiopathic factors. When idiopathic causes have been eliminated, the inference arises that the injury is traceable to some risk, albeit unidentified, to which the employee was exposed at the workplace. As such, claimant has the burden of presenting affirmative evidence excluding idiopathic factors as the cause of his injury. Phil A. Livesley, supra, 296 Or at 32; Damis v. Cotter & Company, 89 Or App 219 (1988).

Here, the record establishes several possible causes of claimant's dizziness; e.g., vestibulopathy or idiopathic gait instability. However, claimant failed to present evidence which would effectively exclude idiopathic factors as the cause of his dizziness that resulted in his fall. Accordingly, we are unable to find that claimant's dizziness came about as a result of a work-related but unexplained cause. Therefore, we conclude that claimant has failed to meet his burden of establishing that his injury arose out of the course of his employment.

ORDER

The Referee's order dated November 29, 1989 is reversed. The employer's April 18, 1989 and June 22, 1989 denials are reinstated and upheld. The Referee's $4,750 attorney fee award is reversed.

December 28, 1990 Cite as 42 Van Natta 2877 (1990)

In the Matter of the Compensation of
JOHN L. RIGGS, III, Claimant
WCB Case Nos. 89-16028,89-15744, 89-16027 & 89-10021
CORRECTED ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Pamela Schultz, Defense Attorney
Randolph Harris (Saif), Defense Attorney

It has come to our attention that the Board's December 19, 1990 Order on Review contains a clerical error. Specifically, in the second paragraph on page two of the order, the names of the insurers have been transposed. To correct this error, we withdraw the aforementioned paragraph in its entirety and replace it with the following paragraph.

"We adopt that portion of the Referee's order addressing the issue of responsibility. The Referee found that claimant's work activity while employed at Liberty Northwest's insured did not independently contribute to his worsened condition. It follows that SAIF is responsible for claimant's worsened condition."

Accordingly, the Board's December 19, 1990 order is withdrawn. As corrected herein, we adhere to and republish the December 19, 1990 order, effective this date. The parties' rights of appeal shall begin from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAY A. SCHECK, Claimant
WCB Case No. 89-07699
ORDER ON RECONSIDERATION (REMANDING)
Roberts, et al., Defense Attorneys

We issued an Order on Review (Remanding) on October 31, 1990. The insurer requested reconsideration seeking clarification of our opinion on November 27, 1990. We abated our order on November 29, 1990 to give claimant an opportunity to respond. Claimant has not done so. We proceed with our reconsideration.

Claimant failed to appear at hearing, but his attorney appeared. The Referee dismissed. On review, we concluded that the administrative rule, former OAR 438-06-071, did not provide authority for dismissal in that circumstance. We concluded, however, that claimant had waived his right to appear and testify on his own behalf. In the final paragraph of our opinion we stated:

> "We remand this matter to the Referee for a hearing on the merits. At hearing, no exhibits shall be received which were not submitted in connection with the prior hearing, nor shall any witness, including claimant, be permitted to testify who was not available and planning to testify at the prior hearing or under subpoena to testify at that hearing. Mario Miranda, 42 Van Natta 405 (1990)."

The insurer seeks reconsideration only of that paragraph. It argues that it should not be precluded from introducing impeachment evidence that it would have introduced at the time of the scheduled hearing. It also argues that it should not be precluded from subpoenaing claimant for the purposes of cross-examination.

The purpose of our instructions in this case, and in similar cases such as Miranda, is to make sure that the parties are in the same place they would have been in had a hearing been convened at the time of the original hearing without claimant present. Consistent with that policy, we amend our instructions to allow the assigned Referee to decide whether the insurer should be allowed to introduce impeachment evidence or to subpoena the claimant for cross-examination.

ORDER

Our Order of October 31, 1990, as amended herein, is hereby republished. Appeal rights run from the date of this order.

In the Matter of the Compensation of
MARY S. WARREN, Claimant
WCB Case No. 89-17815
ORDER ON REVIEW
John E. Uffelman, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of that portion of Referee Peterson's order which found that claimant was entitled to temporary disability benefits from January 5, 1989 through claim closure. The insurer also seeks the admission of

an additional document as a new exhibit. We treat such a request as a motion to remand. Judy A. Britton, 37 Van Natta 1262 (1985). Claimant cross-requests review of that portion of the order which declined to assess a penalty or attorney fee for an allegedly untimely denial. On review, the issues are remand, temporary disability benefits and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant sustained a compensable injury to her neck and right shoulder in June 1981. She attempted to return to work on several occasions, but was unable to work due to increased symptoms. She last worked for the employer in November 1981. In April 1982, claimant underwent an anterior discectomy and interbody fusion at C5-6. In July 1982, claimant underwent a partial acromioplasty and resection of the distal clavice for calcific degenerative tendinitis in her right arm and shoulder.

In December 1984, claimant underwent a cervical laminotomy and facetectomy at C5-6 and C6-7, right. Her claim was closed by an October 1985 Determination Order which awarded 35 percent unscheduled permanent disability. Claimant requested a hearing concerning the October 1985 Determination Order, contending she was permanently and totally disabled. A hearing was held in late 1986 and early 1987. An earlier Referee declined to award permanent total disability, but increased claimant's unscheduled permanent disability award to 70 percent.

In May 1986, claimant was referred for vocational assistance. Vocational assistance was terminated in February 1987 to await the outcome of her hearing. Vocational assistance was reinstated in May 1987. A job as a companion for the elderly was formulated as a goal to return claimant to work. In September 1987, vocational assistance was terminated for medical reasons, including claimant's compensable injury as well as a noncompensable low back condition and noncompensable seizure disorder.

Following termination of vocational assistance, claimant looked for work in late 1987 and early 1988, within the immediate vicinity of her home. By late 1988, claimant was not looking for work due to increased neck symptoms.

In January 1989, claimant returned to her treating neurosurgeon, Dr. Nash, with increased neck complaints. By letter of January 5, 1989, Dr. Nash informed the insurer that claimant's neck condition had worsened and that she was unemployable. Dr. Nash recommended an MRI study. The MRI scan revealed a disc protrusion at C6-7, a bulging disc at C3-4 and foraminal stenosis at C5-6. Thereafter, claimant was referred to Dr. Berkeley for evaluation.

By letter of May 3, 1989, Dr. Berkeley recommended that claimant undergo discectomies and interbody fusions at C3-4 and C6-7. In September 1989, the insurer wrote claimant indicating that it was accepting responsibility for the proposed surgery, but was denying payment of temporary disability benefits on the basis that claimant had removed herself from the work force. The surgery took place on December 11, 1989.

Claimant has not been regularly employed since 1981. At the time of her January 1989 aggravation, claimant was willing to work, but was not looking for work because of her compensable neck condition and noncompensable low back condition and seizure disorder. At that time, claimant's physicians informed her that she could not work. Any effort to seek work at that time would have been futile.

CONCLUSIONS OF LAW AND OPINION

Remand

With its brief, the insurer has submitted an additional document from Dr. Garland, who previously treated claimant, and requests that the document be admitted into the record. We deny the insurer's request.

We may remand to the Referee should we find tht the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must clearly be shown that the material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 70 Or App 416 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

We are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. We acknowledge that the document was not obtainable prior to the hearing. However, the document is authored by claimant's original treating physician and deals with claimant's disability since 1981. We, therefore, find it to be cumulative. Further, the document is a one sentence report indicating that claimant has been disabled since 1981 and has been treating with Dr. Garland. We, therefore, are not persuaded that it is materially relevant to the issue at hand. Accordingly, we deny the motion for remand and do not consider the document on review.

Temporary Disability Benefits

The Referee found that claimant, although not employed, was making reasonable efforts to seek employment and was, therefore, in the work force. He, therefore, concluded that she was entitled to temporary disability benefits. Although we agree that claimant is entitled to temporary disability benefits, we modify the Referee's reasoning.

In order to receive temporary total disability benefits for a worsening of a compensable injury, claimant must have been in the work force at the time of the worsening. Cutright v. Weyerhaeuser, 299 Or 290 (1985). Claimant is deemed in the work force if: (1) she was engaged in regular gainful employment at the time of the worsening; (2) although not employed, she was making reasonable efforts to to obtain employment; or (3) although willing to work, she was not looking for employment for reasons related to the compensable injury, where such efforts would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Here, claimant was not working at the time of her January 1989 aggravation. Further, although she had made some limited attempts to obtain work in early 1988, she was not looking for work at the time of the January 1989 aggravation. Claimant testified, however, that she was willing to work, and would have looked for work, but was unable to do so because her physicians informed her she could not work due to her physical condition, which included the compensable neck condition.

Under these circumstances, we conclude that, although willing to work, claimant was not looking for work at the time of the January 1989 aggravation for reasons related to her compensable neck condition. We further conclude that any effort to seek work at that time would have been futile based on claimant's physical condition, which includes the compensable neck condition. Accordingly, claimant was in the work force at the time of her worsening and therefore is entitled to temporary disability benefits. Id.

Penalties and Attorney Fees

The Referee found that the insurer's processing of claimant's aggravation claim was reasonable. 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 action must be gauged based upon the information available to the carrier at the time of its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123 (1985).

On January 5, 1989, Dr. Nash wrote the insurer and indicated that claimant's neck condition had worsened. He requested that an MRI scan be performed. Claimant was subsequently referred to Dr. Berkeley, who informed the insurer in May 1989 that claimant needed further cervical surgery. The insurer, however, took no action until it issued its denial of temporary disability benefits in September 1989.

Dr. Nash's report indicates that claimant's compensable condition had worsened. Assuming arguendo, that it did not indicate a worsened condition, Dr. Berkeley's request for surgery clearly indicates that claimant was in need of further medical services for a worsened condition. The insurer did not take any action regarding acceptance or denial of the claim until September 1989. It offers no explanation for this delay and we find it unreasonable. Accordingly, a penalty of 25 percent and related attorney fee is warranted.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on review concerning the temporary disability benefits issue is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

Further, after considering the aformentioned factors, we find that a reasonable fee for claimant's counsel services concerning the penalty issue is $500, payable by the insurer.

ORDER

The Referee's order dated February 20, 1990 is reversed in part and affirmed in part. That portion which declined to assess a penalty and attorney fee for an untimely denial is reversed. Claimant is awarded a penalty equal to 25 percent of all temporary disability benefits payable under the Referee's order. Claimant's counsel is awarded an assessed fee of $500, payable by the insurer, for services concerning the penalty issue. The remainder of the order is affirmed. For services on review concerning the temporary disability issue, claimant's counsel is awarded an assessed attorney fee of $750, payable by the insurer.

In the Matter of the Compensation of
ROBIN R. WILSON, Claimant
WCB Case No. 89-20632
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee Mills' order which upheld the insurer's denial of her occupational disease claim for mononucleosis. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working for the employer in early 1989. In September 1989, she was diagnosed as having mononucleosis. She was taken off work due to this condition and filed a workers' compensation claim. In October 1989, the insurer denied the claim on the basis that it was not related to her employment.

Claimant's work involves the preparation of food at a restaurant. In August and September 1989, two of claimant's co-workers were also experiencing mononucleosis symptoms. Both co-workers were later diagnosed as having the disease.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not established that her mononucleosis was compensable. We agree with this conclusion, but we modify his reasoning.

To prevail on her occupational disease claim, claimant must demonstrate by a preponderance of the evidence that her work activities and exposures, when compared to nonwork activities and exposures, were the major contributing cause of the onset or worsening of her condition resulting in disability or requiring medical services. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

Claimant contends that her mononucleosis is compensable on the basis that she was exposed to two co-workers who also had mononucleosis symptoms prior to contracting mononucleosis. We generally hesitate to infer causation from the mere temporal sequence of events. See Bradshaw v. SAIF, 69 Or App 587, 589-90 (1984). We decline to infer causation here, because there are alternative causes besides the exposure to her co-workers.

Dr. Wong, claimant's treating physician, indicated that the "burden of the evidence would suggest that [claimant] did indeed get mononucleosis as a consequence of her work and in association with fellow employees who had this illness." Dr. Wong, however, acknowledged that mononucleosis is often transmitted by persons without symptoms and further acknowledged that the incubation period for the disease can be as long as six weeks. Although Dr. Wong suggests that claimant's mononucleosis is work-related, he acknowledges that claimant may have contracted the disease elsewhere. Further, Dr. Wong offers no basis for his opinion other than the temporal sequence of events. We, therefore, are not persuaded by Dr. Wong's opinion.

Conversely, Dr. Leggett opined that it was more likely that claimant did not contract mononucleosis from her co-workers and noted that the disease is more often transmitted by non-symptomatic carriers. He further indicated that

mononucleosis has a minimal infectious nature and discounted claimant's contact with the infected co-workers in light of the variety of ways in which claimant could become infected.

We conclude that claimant has failed to establish that her work activities were the major contributing cause of her mononucleosis. In reaching this conclusion, we note that ORS 656.266 places the burden on claimant to affirmatively prove that her occupational disease is work-related.

ORDER

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

December 27, 1990 Cite as 42 Van Natta 2883 (1990)

In the Matter of the Compensation of
RANDALL W. BOGGS, Claimant
WCB Case No. C0-00379
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Peter O. Hansen, Claimant Attorney
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Speer and Howell.

On November 28, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $12,000 by Safeco Insurance Company, claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

Pursuant to the disposition, claimant agrees to release any and all rights to future workers' compensation benefits, except that the insurer "will continue to remain responsible for medical services related to claimant's compensable injury as set forth in ORS Chapter 656 et seq." (Page 3, Lines 13-15). The parties further agree that the insurer's "denial of chiropractic bills will stay in a denied status." (Page 3, Lines 16-17).

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

Here, the proposed disposition purports to release claimant's rights and obligations not only under his accepted claim, but it also attempts to resolve issues pertaining to claimant's denied chiropractic bills. As previously noted, a claimant's right to medical services for a compensable injury under ORS 656.245 is expressly excluded from matters which may be disposed under ORS 656.236 and rules promulgated thereunder. See OAR 436-60-145(1), 438-09-001(1). Moreover, the latter portion of the parties' agreement does not pertain to an accepted claim and, as such, is not a proper matter for disposition under ORS 656.236 and the aforementioned administrative rules.

Inasmuch as the offensive portion of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we are without authority to approve any portion of the proposed disposition. Victor F. Lambert, 42 Van Natta 2707 (1990). Under such circumstances, we conclude that the agreement exceeds the bounds of ORS 656.236, OAR 436-60-145(1) and 438-09-001(1). Consequently, we find that the proposed disposition is unreasonable as a matter of law and must be set aside. ORS 656.236(1)(a); Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Following our standard procedure, we would be willing to consider a revised agreement which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09-001 et seq.

IT IS SO ORDERED.

December 31, 1990 Cite as 42 Van Natta 2884 (1990)

In the Matter of the Compensation of
LYLE D. BETTELYOUN, JR., Claimant
WCB Case Nos. 89-21026, 88-20072 & 89-07848
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Meyers and Radler, Defense Attorneys
Johnston & Culberson, Defense Attorneys
Bottini, et al., Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Vanport Manufacturing Company, a self-insured employer, requests review of those portions of Referee Tenenbaum's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel condition; and (2) upheld the SAIF Corporation's denial, on behalf of Hospital Linen Services, and Scott Wetzel Services' denial, on behalf of Mark's Car Clinic, of the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

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

The Referee concluded that claimant had established that his employment with Vanport was, in fact, the cause of his current bilateral carpal tunnel condition. Therefore, the Referee concluded that she need not rely upon the "last injurious exposure" rule in determining which employer is responsible for claimant's condition. See Bracke v. Baza'r, 293 Or 239 (1982). We agree with the Referee's analysis. On review, Vanport contends that application of the "last injurious exposure rule" results in assignment of responsibility to a subsequent employer/insurer. We conclude, however, that even if we were to apply the "last injurious exposure rule," we would nevertheless conclude that the Referee correctly assigned responsibility to Vanport.

In this regard, in an occupational disease context, the last injurious exposure rule provides that, if a worker proves that his disease was caused by

work conditions that existed during a period when more than one carrier or employer was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). The "onset of disability" is the triggering date for the determination of which employment is the last potentially causal employment. Bracke v. Baza'r, supra.

The onset of disability is the date upon which the claimant first becomes disabled (temporarily or permanently) as a result of the compensable condition or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983); Inez Horsey, 42 Van Natta 331 (1990). To shift responsibility to an earlier carrier or employer, the carrier or employer on the risk when claimant became disabled or sought medical treatment must establish that the work conditions while the prior carrier or employer was on the risk were the sole cause of the disease or that it was impossible for work conditions during the period when the last carrier or employer was on the risk to have caused the disease. FMC Corp v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

Here, claimant became temporarily disabled upon surgery in September 1989. His last employment prior to the onset of disability was with Mark's Car Clinic. Therefore, under the rule, responsibility would initially be assigned to Mark's. The evidence further establishes, however, that the work conditions while claimant was employed at Vanport were the sole cause of his condition. We agree in this regard with the Referee's assessment of the medical evidence. While claimant experienced subsequent exacerbations of symptoms of his condition, the preponderance of the evidence is to the effect that claimant's underlying condition did not correspondingly worsen. A symptomatic worsening, unaccompanied by a worsening of the underlying condition, does not shift liability for the disabling disease to a subsequent employer. Bracke v. Baza'r, supra at 250.

In sum, whether or not analyzed under the last injurious exposure rule, responsibility for claimant's bilateral carpal tunnel condition rests with Vanport.

Because compensability was an issue at hearing, compensability remained at risk on review as well by virtue of the Board's de novo review authority. Destael v. Nicolai Co., 80 Or App 596 (1986); see Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Because Vanport initiated review and claimant's compensation was not reduced or disallowed, claimant is entitled to an assessed fee under ORS 656.382(2). Tanya L. Baker, 42 Van Natta 1870 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's serices on review concerning the potential compensability issue is $200, to be paid by Vanport. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 2, 1990 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $200, payable by Vanport Manufacturing Company.

In the Matter of the Compensation of
EDDIE J. HANNA, Claimant
WCB Case No. 89-17671
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Podnar's order which affirmed a Determination Order award of 53 percent (3.18 degrees) for loss of use of his left little finger. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant was found medically stationary on February 13, 1989 and his claim was closed by Determination Order on March 28, 1989.

Claimant returned to work full time at the job he had at the time of injury. Claimant is right-handed.

Claimant's treating orthopedist, Dr. Gill, reported on February 13, 1989 that claimant was medically stationary and that claimant's "primary defects are loss of grip strength and dexterity." (Ex. 19-2). The proximal interphalangeal joint of claimant's left little finger is fixed at 30 degrees. Clinical findings regarding the remainder of claimant's left hand are within normal limits. (Ex. 19-1).

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusion" except as modified below.

In determining the extent of claimant's permanent disability, we apply the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See former ORS 656.283(7). Specifically, we apply the version of OAR 436-35-001 et seq, in effect at the time of the March 28, 1989 Determination Order. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Claimant suffers permanent loss of range of motion in his left little finger. The proximal interphalangeal joint of claimant's left little finger is fixed at 30 degrees for a 53 percent loss of use. Former OAR 436-35-060(4).

Claimant argues that he has sustained a loss of use or function of his left hand as a result of the loss of use of his left little finger. Conversion of finger values to a hand value may be made when there is a loss of use of two or more digits or there is documented impairment to the hand. See former OAR 436-35-070(1). Claimant has lost the use of one finger and there is no documented evidence of impairment to his hand.

Claimant contends that his loss of grip strength allows for conversion of finger values to a hand value. As the Referee found, former OAR 436-35-110(3) provides, "Decreased grip strength due to a loss in range of motion in the joints of the hand or fingers receives no rating in addition to that given for the loss of range of motion." (emphasis added).

Claimant argues that he is entitled to a greater permanent disability award than evidenced by the "standards." Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards." Former ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987). We are not persuaded that claimant has greater loss of use or function than awarded by the Determination Order.

ORDER

The Referee's order dated January 19, 1990 is affirmed.

December 31, 1990 Cite as 42 Van Natta 2887 (1990)

In the Matter of the Compensation of
EDGAR C. SIXBERRY, Claimant
WCB Case No. C0-00374
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Francesconi & Associates, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

On November 27, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $20,000 by the SAIF Corporation, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

The agreement recites that SAIF partially denied claimant's claim for right wrist strain, deQuervain's tenosynovitis, right elbow pain and right carpal tunnel syndrome on October 17, 1989. Claimant evidently requested a hearing on the partial denial. Pursuant to this agreement, however, the parties agree that "[t]he request for hearing regarding the appeal of the October 17, 1989, partial denial shall be dismissed, with the effect that those conditions listed shall remain denied" (Page 6, lines 21-23).

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

Here, the proposed disposition not only purports to release claimant's rights under his accepted claim, but also attempts to resolve issues pertaining to claimant's denied conditions. That is not a proper matter for disposition under ORS 656.236 and the aforementioned administrative rules. Randall W. Boggs, 42 Van Natta 2883 (1990); see also Victor F. Lambert, 42 Van Natta 2707 (1990).

Inasmuch as the offensive portion of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of

consideration, we are without authority to approve any portion of the proposed disposition. Victor F. Lambert, supra. Under such circumstances, we conclude that the agreement exceeds the bounds of ORS 656.236, OAR 436-60-145(1), and 438-09-001(1). Consequently, we find that the proposed disposition is unreasonable as a matter of law and must be set aside. ORS 656.236(1)(a); Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Following our standard procedures, we would be willing to consider a revised agreement which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09-001 et seq.

IT IS SO ORDERED.

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Dennis J. Blanchard, Claimant.

POWER MASTER, INC.,
Petitioner,

v.

Dennis J. BLANCHARD
and SAIF Corporation,
Respondents.

(WCB 87-05652; CA A60351)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 18, 1990.

Patrick R. Berg, Portland, argued the cause and filed the brief for petitioner.

Roger Van Hoy, Vancouver, Washington, argued the cause for respondent Dennis J. Blanchard. With him on the brief were James L. Sellers and Sellers & Jacobs, Vancouver, Washington.

No appearance for respondent SAIF Corporation.

Before Richardson, Presiding Judge, and Newman Affirmed.

DEITS, J.

Employer seeks review of a Workers' Compensation Board order setting aside its denial of a claim. The issue is whether claimant is a "worker employed in this state" within the meaning of ORS 656.126(1) or is, instead, an out-of-state employee who is not covered by the Oregon Workers' Compensation Law. The Board concluded that claimant is an Oregon worker. We agree and affirm.

Employer is an Oregon corporation with its headquarters in Portland. It has what it calls "operations offices" in Louisiana, California, Texas, Washington and Utah. It had an operations office in Portland until September, 1986, when it was relocated to Vancouver, Washington. The accounting, administration and payroll functions for all of the operations offices are performed at the Portland headquarters, and payroll checks are sent from the headquarters and are drawn on employer's Oregon account. Employer withholds Oregon taxes from the wages of Oregon employees, including claimant. Each operations office has a manager, to whom employees report for duty each day to receive their assignments.

After the Portland operations office was moved to Vancouver, employees who had worked out of that office began reporting to the new location every day. When the office was in Portland, employer paid premiums to SAIF for those employees but, when the office moved, it began paying premiums to the Washington Worker's Compensation Fund.

Employer continues to pay SAIF premiums for personnel working in the Portland headquarters.

Claimant was initially hired in 1984 at the Portland office. He worked primarily in Oregon but on two occasions he worked briefly in Washington. He was laid off but returned to work in February, 1986. Both times that he was hired, he was told that he might be required to work in other states. After he was rehired, he reported to the Portland office every morning and was then sent to his job site. From the time of the rehire through September, 1986, he worked only in Oregon. After the branch operations office was moved to Vancouver, he reported there in the morning to pick up his equipment and returned the equipment to Vancouver every night. In an average 12-hour day, he spent approximately one hour in Vancouver and the remaining time on his job assignment in Portland. In

October, 1986, he was assigned to work in Idaho, where he sustained an on-the-job injury in November. Under medical orders, he rested a few days and then returned to work in Portland.

Employer gave claimant Washington compensation claim forms, which he completed and filed. He received time loss and medical benefits on his Washington claim. He then filed a protest against the acceptance of his claim in Washington and filed this claim in Oregon. Employer denied the claim. Claimant contested the denial, and the referee and the Board determined that employer is an Oregon employer and that claimant is an Oregon worker. The Board based its determination on the facts that claimant was a continuous Oregon resident; he was hired in Oregon; he was told that he would occasionally have to work outside of Oregon; during the second period of employment, he did not work outside Oregon until the Idaho job; and, after the operations office moved to Vancouver, he spent only a small portion of his work day at that office. The Board determined that his work outside Oregon, in Washington and Idaho, was temporary. It also decided that employer is a subject employer, because it has its headquarters in Portland and has workers who are subject employees.

Employer makes three assignments of error, all of which are aimed at one point: The Board erred by concluding that claimant is an Oregon worker under ORS 656.126(1),[1] which provides, in part:

> "If a worker employed in this state and subject to ORS 656.001 to 656.794 temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and in the course of employment, the worker * * * is entitled to * * * benefits * * * as though the worker were injured within this state."

[1] Employer's first assignment raises that point directly. Its third assignment makes the related assertion that the Board misapplied the "permanent employment relation test" that we have developed for determining a worker's status under ORS 656.126(1). The second assignment is that the Board erred by concluding that employer is a "subject employer" under ORS 656.023. Obviously, it is. It has permanent employees at the Portland headquarters, for whom it pays premiums to an Oregon workers' compensation insurer. The real point of employer's argument, however, is that it is not an Oregon employer with respect to *this* claimant, because he is not an Oregon employee under ORS 656.126(1). *See also* ORS 656.126(2).

The case that we, as did the Board, consider the most analogous is *Kolar v. B & C Contractors,* 36 Or App 65, 583 P2d 562 (1978). The employer there had its main office in California, but it also maintained offices in Oregon and Washington. The claimant was hired in Bend and was first assigned to a three-day project in Klamath Falls. He was then given a long-term assignment in Washington. We concluded that the claimant was an Oregon worker, because he

> "was hired in Oregon to work for an Oregon employer. He did some work in Oregon for employer before being transferred to the company project in Washington. The company official who hired him testified claimant would have been returned to work on projects in Oregon upon completion of his work on the [Washington] project." 36 Or App at 69.

The distinction that employer emphasizes, between *Kolar* and this case, is that the immediate supervisor who assigned claimant to work in Oregon has his office in Washington, while the supervisor in *Kolar* was located in Oregon. Employer contends that claimant "was an Oregon worker at the time of his hire, but became a Washington worker" when the operations office was moved to Vancouver. Employer maintains that the fact that most of claimant's work continued to be in Oregon is irrelevant, because it understands *Kolar* and our later cases to make the place "where the control is exercised" the sole or most significant determinant of the worker's status. Employer relies in particular on *Phelan v. H.S.C. Logging, Inc.,* 84 Or App 632, 735 P2d 22, *rev den* 303 Or 590 (1987). However, *Phelan* does not support the one-factor analysis that employer advocates. We based our holding that the claimant there was not an Oregon employee on numerous facts—that he was hired from Washington, the Oregon operations were run from Washington, that paychecks were issued there and that claimant was expected to be assigned to work in Washington after his Oregon project was completed.

We reiterated in *Hobson v. Ore Dressing, Inc.,* 87 Or App 397, 400, 742 P2d 675, *rev den* 304 Or 437 (1987), that the "key inquiry" under ORS 656.126(1) "is the extent to which the claimant's work outside the state is temporary." Here, the work that claimant did in Washington after the operations office was moved to Vancouver amounted to an hour a day. The point that employer's argument misses is that the move of

the office had no significant effect on claimant's job. Vancouver became little more than a detour for claimant on his way to and from his work sites, wherever they were. This is not a case like *Hobson,* where the result of the employer's relocation was that "there was no longer an Oregon employer for which the work in California could be incidental." 87 Or App at 608. Conversely, here, the daily trips to Vancouver were incidental, and claimant's principal work continued to be in Oregon for his Oregon corporate employer. Claimant remained an Oregon employee for purposes of ORS 656.126(1).[2]

Affirmed.

[2] Employer argues that the Board's findings are not supported by substantial evidence, because its conclusion that claimant is an Oregon worker indicates that it disregarded uncontradicted testimony by employer's controller about the control that the operations office managers exercise over assignments and other aspects of the work of employees assigned to them. That argument is also based on employer's mistaken understanding that control is the decisive factor. The fact that the evidence may have compelled a certain finding about the nature of the Vancouver manager's control has no bearing on the significance of that control in comparison with the other considerations that bear on whether claimant is an Oregon worker under the statute.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Reyes S. Garcia, Claimant.

Reyes S. GARCIA,
Petitioner,

v.

BOISE CASCADE CORPORATION,
Respondent.

(WCB 85-15946; CA A46569)

On remand from the Oregon Supreme Court, *Garcia v. Boise Cascade Corp.*, 309 Or 292, 787 P2d 884 (1990).

Judicial Review from the Workers' Compensation Board.

Submitted on remand March 30, 1990.

Quintin B. Estell, Salem, for petitioner.

Paul Dakopolos, Paul J. De Muniz and Garrett, Seideman, Hemann, Robertson & De Muniz, Salem, for respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P. J.

Affirmed.

WARREN, P. J.

This case is on remand from the Supreme Court. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 787 P2d 884 (1990), which held that we incorrectly applied the standard of review when we held that the referee's findings, adopted by the Board, were not supported by substantial evidence. 309 Or at 294. In our first opinion we erroneously substituted our judgment for that of the Board. *Garcia v. Boise Cascade Corp.*, 94 Or App 362, 765 P2d 1245 (1988). We now affirm the referee's order.

Claimant has osteoarthritis in his lower back, a degenerative condition that manifested itself some time after 1980. Claimant argued at the hearing that his condition was

an occupational disease.[1] The referee concluded that claimant had failed to prove that "the work activities for this employer were the major contributing cause" of his condition. The Board affirmed.

Claimant worked for employer from 1963 to 1980,[2] when he was laid off. He then worked at several jobs involving medium to heavy labor, until he was rehired by employer in February, 1983. Then, he worked as a puller on the veneer chain until his injury in September, 1985.[3] Working on the veneer chain required claimant to "lift thin sheets of veneer off the waist-high chain and place them in appropriate carts which were located behind him."

Dr. Collada, a neurosurgeon, testified that all of claimant's activities throughout his life have contributed to his osteoarthritis, with work being a significant factor. When claimant's attorney explained the physical requirements of pulling veneer and asked whether claimant's work was the primary factor, Collada said that that type of activity can accelerate the deterioration. When asked whether work was the primary factor, he said:

> "[O]n a hypothetical basis, if he had not been involved in any

> strenuous activities and he had a fairly sedentary life outside of work activities, considering the type of work he's done, then I would say over half."

He also said, however, that genetic factors play a role in the progression of the disease.

Dr. Munson, claimant's physician since 1973, wrote:

> "Mr. Garcia is quite young at age 46 and I do not often see osteoarthritis at that age group. Wear and tear of the ligamentous and capsular structures probably cause low-grade inflammation in almost everyone and, quite commonly, the changes [*sic*] of osteoarthritis. Certainly pulling green chain at a lumber mill would tend to give you more wear and tear than perhaps selling used cars."

In another letter, he wrote:

> "His performing heavy lifting at the mill is certainly a major if not the major contributing factor aggravating his arthritis condition and degenerative disc syndrome. I feel that his employment has brought about an additional hastening of his degenerative low back condition. These changes found on his x-rays of October 11, 1985, are at least in part a result of his employment exposure."

The referee discounted Munson's opinion that "heavy lifting at the mill" was a major contributing factor, because he found that claimant's work did not involve heavy lifting. That finding is supported by substantial evidence. Claimant could not estimate how much the veneer weighed,

---

[1] At the hearing, claimant also argued that his herniated disc resulted from his September, 1985, on-the-job injury. He has not, however, pursued that theory on appeal.

[2] Claimant worked for employer for only part of 1968.

[3] Employer accepted compensability of the injury, except for the degenerative changes in claimant's lower back.

but he testified that the thickest veneer was only a quarter of an inch thick and that a cushion of air made lifting veneer easier. The trier of fact was entitled to believe either of the two conflicting medical opinions. Substantial evidence supports the decision that the work was not the major contributing cause of the condition. ORS 183.482(8)(c); *Garcia v. Boise Cascade Corp., supra,* 309 Or at 295.

Finally, claimant argues that employer should be found liable under the last injurious exposure rule. Under that rule, the last employer whose work could have caused the condition is responsible without proof of actual causation. That rule has no application here, because only one self-insured employer is involved. By bringing a claim against employer only, claimant elected to prove actual causation. *See Bracke v. Baza'r,* 293 Or 239, 250 n 5, 646 P2d 1330 (1982); *see also Runft v. SAIF,* 303 Or 493, 739 P2d 12 (1987).

Affirmed.

No. 471 October 3, 1990 513

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Elmira K. Satcher, Claimant.

WACKER SILTRONIC CORPORATION
and Liberty Northwest Insurance Corporation,
Petitioners,

v.

Elmira K. SATCHER,
Respondent.

(87-03768; CA A62476)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 13, 1990.

Jenny A. Ogawa, Salem, argued the cause for petitioners. With her on the brief was Kevin L. Mannix, Salem.

Patrick K. Mackin, Portland, argued the cause and filed the brief for respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed.

RIGGS, J.

In this workers' compensation case, employer seeks review of the Workers' Compensation Board's order affirming the referee's imposition of penalties and attorney fees for unreasonable delay in the payment of medical services. We reverse.

Employer sought Board review of a referee's order holding that claimant's injury was compensable. While that review was pending, employer denied payment for certain chiropractic services.[1] The referee set aside employer's denial of those services. Employer did not seek review of that order and did not pay for the medical services within 60 days after the order. Claimant sought enforcement of the medical services order. The referee held that employer was obligated to pay and assessed penalties and attorney fees against employer for unreasonable refusal to comply with the first referee's order. The Board affirmed.

An employer is liable for penalties and attorney fees if it "unreasonably delays or unreasonably refuses to pay compensation * * *." ORS 656.262(10). ORS 656.313 provides, in part:

> "(1) Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant.
>
> "* * * * *
>
> "(4) Notwithstanding ORS 656.005, for the purpose of this section, 'compensation' means benefits payable pursuant to the provisions of ORS 656.204 to 656.208, 656.210 and 656.214 and does not include the payment of medical services."[2]

Medical services cannot be considered compensation while

review of compensability of the injury is pending. Thus, there was no basis on which to award penalties or attorney fees.[3]

Reversed.

---

[1] Claimant's brief includes an argument relating to acupuncture services. Employer's assignment of error relates solely to the ruling about chiropractic services; therefore, we do not consider or make any determination regarding the acupuncture.

[2] ORS 656.313 has been amended, effective July 1, 1990. Or Laws 1990 (Special Session), ch 1197, § 23. The amendment is not applicable here.

[3] Claimant argues that, when employer failed to seek review of the referee's order directing payment of medical services, that order became final and employer was obligated to pay. The fact that the order became final, however, does not affect the fact that, under ORS 656.313(4), payment of medical services is not considered compensation while review of compensability of the injury is pending.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

ACCIDENT PREVENTION DIVISION,
Respondent,

v.

RLC CORP./MATLACK, INC.,
Petitioner.

(SH-88817; CA A62767)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 13, 1990.

Thomas W. Brown, Portland, argued the cause for petitioner. With him on the brief was Cosgrave, Vergeer & Kester, Portland.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P. J.

Reversed and remanded for reconsideration.

WARREN, P. J.

Employer seeks review of a Workers' Compensation Board order approving a citation by the Accident Prevention Division (Division) for a safety violation under the Oregon Safe Employment Act. ORS 654.001 *et seq.* We reverse.

Employer makes three assignments of error relating to the citation for violation of OAR 437-41-035(4), which alleged that there was a dangerous gap between a loading platform owned by a third party and employer's tanker trucks that were being filled at the loading platform. The only assignment meriting discussion relates to whether the Board applied the correct legal standard in analyzing employer's so-called "Grossman/Anning-Johnson" defense. *See Grossman Steel & Aluminum Corporation,* 4 OSHC (BNA) 1185 (1976); *Anning-Johnson Company,* 4 OSHC (BNA) 1193 (1976).

The defense is stated in Division's Field Compliance Manual:

> "3. * * * Prior to issuing citations to an employer with employees exposed to a hazard, it must first be determined whether the exposing employer(s) has a legitimate defense to the citation, as set forth below:
>
> "a. The employer did not create the hazard;
>
> "b. The employer did not have the authority or the ability to correct the hazard;
>
> "c. The employer made a reasonable effort to persuade the controlling employer to correct the hazard;

"d. The employer has instructed, and where necessary, informed employees how to avoid or minimize the dangers associated with the hazardous conditions and, where feasible, has taken alternative means of protecting employees from the hazard short of walking off the job (except when special circumstances require such extreme action).

"Note: All of these items must be documented in the case file."

The Board concluded that defendant had violated the safety rules, because "a hinged extension [to the platform] might have been considered, probably relatively inexpensively." That conclusion was made without any evidence about that possible safety measure's cost. In any event, the

question is not whether alternatives could have been considered but were not; it is whether, overall, the employer did what was reasonable under the circumstances to protect its employees from the hazard. *Anning-Johnson Company, supra,* 4 OSHC at 1198. The Board did not make any findings relating to the reasonableness of employer's actions.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Gabino R. Orozco, Claimant.

Gabino R. OROZCO,
Petitioner,

v.

U & I GROUP, INC.,
Respondent.

(WCB 85-10736; A60581)

Judicial review from Workers' Compensation Board.

Argued and submitted September 7, 1990.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

Janet Schroer, Portland, argued the cause for respondent. On the brief were Peter A. Ozanne and Schwabe, Williamson & Wyatt, Portland.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Affirmed.

EDMONDS, J.

Claimant seeks review of a Workers' Compensation Board order, dated March 23, 1989, that denied attorney fees for lack of jurisdiction under ORS 656.295(8).[1] Claimant argues that the Board had "ministerial jurisdiction" to award attorney fees. We affirm.

In December, 1986, a referee issued an order that upheld the denial of claimant's chiropractic treatment; it was affirmed by the Board. On review, we remanded to the Board for reconsideration. *Orozco v. U & I Group, Inc.*, 92 Or App 585, 758 P2d 894 (1988). In the order on remand dated February 3, 1989, the Board reversed the referee's order and set aside the denial. It said, "Inasmuch as we have not received a statement of services from claimant's attorney, we cannot award an assessed fee." Although the Board received a statement of services on February 22, 1989, the Board did not consider it until after the 30-day period in which to seek review of the February 3 order had expired. On March 23, 1989, the Board denied claimant's request for attorney fees, holding that it had no jurisdiction, because the February 3 order had become final.

Claimant argues that the Board does not need to assume jurisdiction over a case in order to perform the "post-adjudicative, ministerial function" of reviewing a statement of services and contends that this case is controlled by our opinion in *Schwabe, Williamson & Wyatt v. Workers' Comp. Board*, 101 Or App 645, 792 P2d 461 (1990). Employer argues that, because claimant failed to file a petition for review before the 30-day period expired after the February 3, 1989 order, the Board is correct.

The February 3 order, which dealt with the merits

and the issue of attorney fees, is a final order.[2] Claimant did not petition for review within the time allowed by ORS 656.295(8). Attorney fees in workers' compensation cases may be awarded only when expressly authorized by statute. *Farmers Ins. Group v. SAIF*, 301 Or 612, 619, 724 P2d 799 (1986); *McGill v. SAIF*, 91 Or App 228, 231, 754 P2d 612 (1988). Once the Board had ruled and claimant had not sought timely review, the effect of ORS 656.298(8) was to deprive the Board of jurisdiction to consider claimant's request, even though it was timely filed.

---

[1] ORS 656.295(8) provides:

"An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298. The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.298."

[2] The February 3 order contained the standard notice:

"NOTICE TO ALL PARTIES: This order is final unless, within 30 days after the date of mailing of copies of this order to the parties, one of the parties appeals to the Court of Appeals at the Supreme Court Building, Salem, Oregon 97310 for judicial review as provided by ORS 656.298."

We disagree with claimant's argument that *Schwabe, Williamson & Wyatt v. Workers' Comp. Board, supra,* controls. In that case, the Board issued an order in February, 1988, addressing the merits of the case, but not the issue of attorney fees. Two months later, the insurer's counsel sought authorization for attorney fees. Unlike here, when the Board denied the request for attorney fees in that case, the petitioner sought review of the attorney fees decision within 30 days after the Board first addressed the issue. The "continuing jurisdiction" situation in *Schwabe* does not apply to this case, because the February 3 order addressed claimant's entitlement to attorney fees as well as the merits of the case. When claimant failed within 30 days to move for a stay, request an abatement or otherwise preserve his right to seek review of the February 3 order, the order became final.

Affirmed.[3]

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[3] Claimant's other arguments do not merit discussion.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Randy R. Westfall, Claimant.

Randy R. WESTFALL,
Petitioner,

v.

RUST INTERNATIONAL and Underwriters Adjusting Company,
Respondents.

(WCB 88-01147; CA A62442)

Judicial Review from Workers' Compensation Board.

On respondents' petition for imposition of sanctions under ORS 656.390 filed June 28, 1990. Opinion filed June 27, 1990. *Westfall v. Rust International,* 102 Or App 373, 795 P2d 124.

Bradley R. Scheminske, Portland, for petition.

No appearance *contra.*

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Petition for sanctions allowed.

PER CURIAM

Employer petitions for an award of sanctions against claimant's attorney, claiming that the petition for judicial review in this case, 102 Or App 373, 795 P2d 124 (1990), was frivolous. ORS 656.390.[1] We agree and grant the petition.

Claimant filed a petition for review of an order of the Workers' Compensation Board that denied compensation for claimant's back condition. Distilled to its basic premise, claimant argued that he had testified that his back still hurt, that the referee had found his testimony credible and that the condition was not so complex that expert testimony was required. Claimant's attorney acknowledged that there were competent medical opinions to support both employer's and claimant's views. He also acknowledged "that on judicial review pursuant to ORS 656.298, this Court will not disturb the Board's weighing of competing medical opinions, in the record * * *."

The attorney knew and acknowledged that there was substantial evidence to support the Board's decision. The petition for review was frivolous.[2] We conclude that it is appropriate to award sanctions to employer. Employer shall submit within 14 days after the date of the appellate judgment on this motion a statement of reasonable expenses incurred by

reason of the petition, including reasonable attorney fees. Claimant's attorney shall have 14 days thereafter to file a response.

Petition for sanctions allowed.

---

[1] ORS 656.390 provides:

"Notwithstanding ORS 656.236, if either party appeals for review of the claim to the Court of Appeals or to the Supreme Court, or files a motion for reconsideration of the decision of the Court of Appeals or the Supreme Court, and the court finds that the appeal or motion for reconsideration was frivolous or was filed in bad faith or for the purpose of harassment, the court may impose an appropriate sanction upon the attorney who filed the appeal or motion. The sanction may include an order to pay to the other party the amount of the reasonable expenses incurred by reason of the appeal or motion, including a reasonable attorney fee."

[2] For example, the brief says:

"Claimant/Petitioner fully recognizes that on judicial review pursuant to ORS 656.298, this Court will not disturb the Board's weighing of competing medical opinions in the record; even where, as here, the opinions it chooses to give the weight to are absurd and contrary to all known facts, x-rays, and the laws of nature. There were two well-reasoned opinions in support of the claim, and two odd ones against it, but one of the latter was signed by more than one "expert," and, therefore, the Board counted them up and held that Claimant must lose.

"(This method of 'fact-finding' on *de novo* review will result, over time, in many more 'expert opinions' in compensation cases, since the last part to get one admited should always win on Board review. Nonethelss, the Legislature has prohibited this Court from instruding on such 'adjudication' of facts)."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Fees for Services
by Southern Oregon Neurological Association
for Eul Moody, Injured Worker.

SOUTHERN OREGON
NEUROLOGICAL ASSOCIATES,
Petitioner,

v.

EBI COMPANIES,
Respondent.

(WCB 88-06320; CA A49901)

Judicial Review from order of the Director of the Workers' Compensation Department.

Argued and submitted February 26, 1990.

Jeffrey W. Foxx, Medford, argued the cause and filed the brief for petitioner.

Jerald P. Keene, Portland, argued the cause for respondent. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Petitioner seeks review of a final order of the Director of the Workers' Compensation Department awarding it fees for testimony in a workers' compensation hearing.[1] Pursuant to ORS 656.704(2), we review the decision under ORS 183.482 and affirm.

The facts are not disputed: Dr. Maukonen, a principal in petitioner whose offices are located in Medford, was a treating physician of Moody, an injured worker who filed a claim against his employer, Publishers Paper Company. EBI Companies was the compensation plan administrator for the employer. EBI subpoenaed Maukonen to testify as an expert witness in a hearing scheduled in Newport. After his testimony, he submitted an itemized statement:

Services	Rate	Time	Total
Pre-Hearing Review	$100/hr	3 hrs	$ 300.00
Attendance at Hearing	200/hr	6 hrs	1,200.00
Travel Time	200/hr	12 hrs	2,400.00
Mileage	.20 mile	511 miles	102.20
Motel			67.40
Phone			6.50
Meals			35.00
Total			$4,111.10

EBI offered $900, which was rejected and the parties presented the matter to the Director as a medical fee dispute. *Former* OAR 436-10-110. The Director ordered petitioner to accept $900.[2]

Petitioner requested review. The dispute was heard by a Workers' Compensation Board referee as a matter not concerning a claim.[3] ORS 656.704(2); OAR 436-10-110(3).

The referee concluded that the Department's medical service rules applied to determine how much petitioner was entitled to be paid for testimony pursuant to subpoena. The referee ordered EBI to pay petitioner $1,326.72; $150.96 for each hour that Maukonen was at the hearing and $270 for the time he had spent in preparation. Regarding the claimed travel expenses, the referee concluded:

> "OAR 438-07-020 provides witness fees and mileage in Workers' Compensation cases are payable as in civil actions. There is a separate fee provision in the rules for expert medical testimony in Workers' Compensation cases * * *. Since Dr. Maukonen's travel time and expense in this case is [*sic*] covered by the statutory subpoena law, it would be inappropriate to stretch * * * interpretation of the scope of coverage of the CPT codes."

Petitioner first contends that Maukonen's travel expenses, including compensation for travel time, should have been awarded as part of medical expenses. It initially argues that it is entitled to the fees for the reasons expressed in *Hanna v. McGraw Bros. Sawmill*, 44 Or App 189, 605 P2d 724, *modified* 45 Or App 757, 609 P2d 422 (1980). In *Hanna*, we considered which party was responsible for payment of fees to a physician who was called as a witness only for cross-examination after his medical report was introduced in a workers' compensation hearing. We did not address the amount of fees to be paid.

Petitioner next argues that it is entitled to the claimed travel expenses pursuant to OAR 436-10-040(1)(a), which requires that an

> "insurer shall pay for all medical services which the nature of the compensable injury or the process of recovery requires."

OAR 436-10-005(20) provides:

> " 'Medical service' means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or other related services; also any drugs, medicines, crutch, prosthesis, brace, support or physical restorative device."

The more specific categories of medical services and the value assigned such service are defined in the Department's fee

---

[1] The Hearings Division of the Workers' Compensation Board heard the matter pursuant to ORS 656.704(2). OAR 436-10-008.

[2] The Director explained that he did not decide the dispute, but only issued his ruling to allow the matter to proceed to a hearing.

[3] EBI moved, in its brief, to dismiss the petition for review for lack of jurisdiction on the ground that the Workers' Compensation Board has jurisdiction. We already denied an identical motion and we do so again. EBI also moves to dismiss, because petitioner did not serve employer with a copy of the petition, as required by ORS 183.482. Although service on all parties is mandatory, it is not jurisdictional under the APA and dismissal of the petition is not warranted where there is no prejudice. *Hill v. Employment Division*, 92 Or App 357, 758 P2d 420 (1988). EBI was served with a copy of the petition for review and processed the review for employer.

schedules and the Current Procedural Terminology (CPT) codes adopted by the Department. *See* OAR 436-10-090. Petitioner argues that the travel expenses are covered by CPT

code 99082, which allows expenses for unusual travel in providing medical services or, alternatively, by OAR 436-10-090(4), which allows reasonable fees for medical services when there is no applicable CPT code.

The rules for compensation for medical services contemplate recovery for services provided in direct relation to a claimant's medical needs. Expenses arising from a physician's testimony at a workers' compenation hearing are designated neither directly or indirectly in the CPT codes or fee schedules. "Medical Services" as used in the Department's rules do not include the travel expenses claimed here. The referee correctly concluded that there is no authority in the rules to award the claimed travel expenses.

Petitioner next contends that the referee erred in reducing the fee for testifying from the ordinary fee that it charged to the amount in the fee schedule. The referee held that the doctor's preparation time and the time that he was at the hearing are covered by OAR 436-10-090(31), which prescribes fees for preparation and testimony at depositions. Such services are assigned a value by the relevant CPT code. Petitioner's principal argument is that its regular hourly rate should have been used rather than the code fee schedule, because it had an agreement with EBI to be paid the regular rate. The referee's authority to determine fees is provided by the rules and CPT codes. He does not have authority to determine fees pursuant to a contract.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Maria Campos, Claimant.

Maria CAMPOS,
Petitioner,

v.

HOOD RIVER CARE CENTER
and Western Employers,
Respondents.

(87-08331; CA A61553)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 14, 1990.

Angelo Gomez, Hillsboro, argued the cause for petitioner. With him on the brief was Ginsburg, Gomez & Neal, Hillsboro.

Nancy J. Meserow, Portland, argued the cause for respondents. With her on the brief was Scheminske & Lyons, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded for reconsideration.

NEWMAN, J.

Claimant petitions for judicial review of a Workers' Compensation Board order that affirmed the referee's order dismissing her request for a hearing. We reverse and remand.

Employer denied claimant's aggravation claim and her claim for medical treatment. She filed a request for a hearing. The referee set the hearing for December 22, 1987, and mailed notices to claimant and her attorney on November 24. Claimant did not attend the hearing, but her attorney did. He withdrew the request for a hearing on the issue of medical benefits, said that he was unprepared to proceed on the aggravation claim in claimant's absence and asked for a postponement. Employer moved for an order of dismissal, because claimant had failed to appear, and the referee orally granted the motion. He told claimant's attorney, however, that he would reconsider the order if, within 30 days after the issuance of his dismissal order, claimant presented good cause for her failure to appear.

The referee issued his dismissal order on January 4, 1988. In relevant part, it reads:

> "[Employer] moved for an order of dismissal based upon claimant's failure to appear. The motion was allowed. Therefore: IT IS HEREBY ORDERED that this matter is dismissed. [*Former*] OAR 438-06-070."[1]

Claimant timely moved for reconsideration. She asked that the order of dismissal be set aside on the ground that she had good cause for failing to appear at the hearing and asked that she be given a new hearing.[2] Contemporaneously, she also requested Board review. Claimant submitted an affidavit and supporting documents in support of both of her requests.

Claimant's affidavit asserted that she had gone to Mexico on November 23, 1987, to see a Spanish-speaking

doctor who could treat her injury and to visit her old and infirm father; she did not receive the notice of hearing before she left, and her family in the United States could not contact her by telephone; she telephoned them on December 20 and learned that a hearing was scheduled for December 22; she immediately drove back to the United States and arrived on December 25; she understood little English and spoke with her

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[1] *Former* OAR 438-06-070 was in effect on December 22, 1987. It 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."

It was amended, effective January 1, 1988.

[2] Cla[illegible]t does not argue that she had not failed to appear at the [illegible]ring of De[illegible]ber 22, given that [illegible] attorney appeared on her behalf.

lawyer through interpreters; and she did not understand what a hearing was, or that one would be scheduled in her case, and, accordingly, she did not notify her lawyer that she was leaving for Mexico. She also submitted to the referee and the Board a copy of the Mexican doctor's x-ray report, which her treating chiropractor in the United States had had translated.

The referee did not respond, by order or otherwise, to claimant's motion for reconsideration. Although claimant argued to the Board that the referee had incompletely developed the issue of good cause and asked it to remand for further evidence on the good cause issue, the Board simply issued an order that it "affirms and adopts the referee's order of dismissal."

Claimant asserts that the Board's order is inadequate for judicial review, because it contains no findings of fact or conclusions of law on the issue of inadequate record development. What claimant means by her assignment of error is that we cannot determine from the Board's order whether it considered the issue of good cause and why it reached the decision to affirm the referee, because neither the Board nor the referee made findings of fact or conclusions of law on the issue of good cause. We agree.

To be adequate for our review, an order of the Board must contain findings of fact, reasoning and conclusions of law, *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988), or it must adopt an order of the referee that has those components. *Johnston v. James River Corp.*, 91 Or App 721, 722, 756 P2d 696 (1988). Here, neither the Board nor the referee made findings of fact or conclusions of law on whether claimant had good cause for failing to appear. Indeed, the referee issued his order before claimant submitted her evidence on good cause to him. Although the referee gave claimant permission to seek reconsideration, nothing in the record indicates that he even considered the issue of good cause in the

light of the material that claimant presented in support of her motion. Obviously, his January 4, 1988 order does not respond to claimant's subsequent submission. Moreover, the Board's order does not address claimant's assertion that the record is insufficiently developed on the issue of good cause; it simply affirmed and adopted the referee's order. On review, we cannot determine why the Board decided not to remand to the referee for reconsideration. *See* ORS 656.295(5).[3]

Reversed and remanded for reconsideration.

[3] Because of our disposition of this case, we do not address claimant's other assignments of error.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Denise M. Bowman, Claimant.

Denise M. BOWMAN,
Petitioner,

v.

SYSTEMS-IMPROVEMENT ASSOC., INC.,
Respondent.

(8040; CA A62720)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 8, 1990.

Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun and Green, Portland.

William Dickas, Portland, argued the cause for respondent. With him on the brief was Kell, Alterman & Runstein, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM

Affirmed. *Howard v. Liberty Northwest Ins.*, 94 Or App 283, 765 P2d 223 (1988).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Roland L. Dawkins, Claimant.

ROLAND L. DAWKINS,
Petitioner,

v.

PACIFIC MOTOR TRUCKING,
Respondent.

(85-11265; CA A63382)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 8, 1990.

Brad G. Garber, Salem, argued the cause for petitioner. With him on the brief was Michael B. Dye, Salem.

Jeffrey S. Love, Portland, argued the cause for respondent. With him on the brief were Scott P. Monfils and Lane Powell Spears Lubersky, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM

Affirmed. *Short v. SAIF,* 305 Or 541, 754 P2d 575 (1988); *Vip's Restaurant v. Krause,* 89 Or App 214, 748 P2d 164, *on recon* 91 Or App 472, 756 P2d 47, *rev den* 306 Or 414 (1988).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Fred J. Duckett, Claimant.

CITY OF PORTLAND,
Petitioner,

v.

Fred J. DUCKETT,
Respondent.

(WCB 87-15729; CA A62930)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 25, 1990.

David L. Jorling, Deputy City Attorney, Portland, argued the cause and filed the brief for petitioner.

Frank J. Susak, Portland, filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Employer seeks review of an order of the Workers' Compensation Board. The only issue is whether, under ORS 656.222, employer should be allowed to subtract from the permanent disability award in the present case the amount of a permanent disability award already paid to claimant for a previous injury to the same body part. The Board said that employer was not entitled to an offset. We affirm.

Claimant compensably injured his left knee in 1984 and was awarded 15 percent scheduled permanent disability. In 1986, he injured his left leg and back. That injury resulted in an award for 17 percent scheduled permanent disability for his left leg. The Board found credible claimant's testimony that he had recovered completely from the 1984 injury before 1986. The Board's findings also noted that none of claimant's treating physicians mentioned the previous injury when discussing the present degree of disability in his left knee.

Employer argues that ORS 656.222 requires that the 1984 award for 15 percent scheduled permanent disability be subtracted from the 1986 award in order to avoid a double payment. Claimant argues that, because he had completely recovered from the 1984 injury, the 1986 accident was in fact responsible for the full 17 percent disability to his left leg and he should, therefore, receive the entire amount with no offset. ORS 656.222 provides:

> "Should a further accident occur to a worker who is receiving compensation for a temporary disability, or who has been paid or awarded compensation for a permanent disability, the

> award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities."

The statute was interpreted in *Norby v. SAIF*, 303 Or 536, 540, 738 P2d 974 (1987), to require "that any payments made or compensation for permanent disability awarded shall be counted in an award for a later accident." That reasoning comes from *Nesselrodt v. Compensation Department*, 248 Or 452, 435 P2d 315 (1967), where the court reduced an award for a scheduled disability by the amount of a previous award for a scheduled disability of the same body part. The rule is limited to subsequent awards for *scheduled* disability. *See American Bldg. Maint. v. McLees*, 296 Or 772, 774-75, 679 P2d 1361

(1984); *Nesselrodt v. Compensation Department, supra*, 248 Or at 455.

Were it not for the fact that claimant had completely recovered from the 1984 injury before the 1986 injury, this case would be controlled by the rule in *Nesselrodt*, and claimant's award for the 1986 injury would be offset by the award for the 1984 injury to the same scheduled body part. The statute, however, requires consideration of the "combined effect" of the previous and present injury. Claimant established that there is in fact no combined effect, because he had completely recovered from the previous injury. His recovery for the 1986 injury should not be reduced simply because he had recovered from what was thought at the time of the previous award to be a permanent disability. Had his left leg still been partially disabled at the time of the second accident, the combined effects of his injuries might have been greater than 17 percent disability. ORS 656.222 would then apply to reduce his award for the second accident. The Board did not err.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Marvin C. Wright, Claimant.

SAIF CORPORATION,
Petitioner,

v.

Marvin C. WRIGHT,
Respondent.

(WCB TP-88016; CA A51030)

Judicial Review from Workers' Compensation Board.

On respondent's petition for reconsideration filed October 4, 1990. Former opinion filed August 1, 1990. 102 Or App 598, 795 P2d 604.

David C. Force and Vick & Gutzler, Salem, for petition.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reconsideration allowed; decision modified to designate claimant as prevailing party; affirmed as modified.

RICHARDSON, P. J.

Claimant petitions for review of our decision, 102 Or App 598, 795 P2d 604 (1990), and we treat the matter as a petition for reconsideration. ORAP 9.15. Claimant seeks reconsideration of our designation of SAIF as the prevailing party and our order denying his petition for attorney fees pursuant to ORS 656.390. We allow reconsideration and modify our opinion to designate claimant as the prevailing party. We deny reconsideration of claimant's petition for attorney fees.

We concluded that the Board did not have authority to rule on SAIF's motion, reversed its decision and remanded with instructions to dismiss SAIF's motion. Because the Board's decision was reversed and the case remanded, we designated SAIF as the prevailing party. However, the Board had denied SAIF the relief that it sought, and we concurred in that denial but for a different reason. Consequently, the opinion is modified to delete its last sentence (but not note 2), and the disposition is changed to read:

> "Motion to dismiss petition for judicial review denied; motion for attorney fees denied; affirmed."

Claimant is designated as the prevailing party, and costs are allowed to him, payable by SAIF.

Reconsideration allowed; decision modified to designate claimant as prevailing party; affirmed as modified.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Joseph F. Smith, Claimant.

CIGNA INSURANCE COMPANIES/
PORTLAND RENDERING,
Petitioner - Cross-Respondent,

v.

CRAWFORD & COMPANY/
PORTLAND RENDERING,
Respondent - Cross-Petitioner,

and

Joseph F. SMITH,
Respondent - Cross-Respondent.

(87-10525; CA A62902)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 24, 1990.

Montgomery W. Cobb, Portland, argued the cause for petitioner - cross-respondent. With him on the briefs were Matthew K. Rossman and Tooze Shenker Holloway & Duden, Portland.

Margaret H. Leek Leiberan, Portland, argued the cause and filed the brief for respondent - cross-petitioner.

Glen S. Shearer, Portland, argued the cause for respondent - cross-respondent. With him on the briefs was Schouboe, Marvin & Furniss, Portland.

Before Buttler, Presiding Judge, and Deits and De Muniz, Judges.

BUTTLER, P. J.

Affirmed on petition and on cross-petition.

BUTTLER, P. J.

Cigna Insurance Companies seeks review of a decision of the Workers' Compensation Board affirming the referee's decision that claimant's asthma is compensable and holding that Cigna, and not Crawford and Company, is the responsible insurer. Crawford cross-petitions for review, contending that the Board erred in ordering it to pay claimant's attorney fees. We affirm on the petition and cross-petition.

There is substantial evidence to support the Board's finding that claimant's asthma was caused or worsened by his on the job exposure to smoke and fumes after Cigna became employer's workers' compensation carrier. Its conclusion that Cigna is responsible is affirmed.

On Crawford's cross-petition, we conclude that claimant is entitled to attorney fees pursuant to ORS 656.382(2), payable by Crawford. ORS 656.382(2) provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

Cigna did not appeal to the Board and therefore cannot be assessed fees under the statute. Crawford was held responsible by the referee, and appealed to the Board on the questions of compensability and responsibility; thus, claimant was required to defend the case before the Board or risk loss of compensation. Although Crawford prevailed on Board review, there is no indication that the shifting of responsibility to Cigna resulted in a reduction of compensation to claimant. The test under the statute is not whether the one seeking review prevails; it is whether compensation was disallowed or reduced. It was not disallowed or reduced, so claimant is entitled to his attorney fees under ORS 656.382(2) against the insurer that sought review.

Affirmed on petition and on cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Audria M. Edwards, Deceased, Claimant.

Patricia TRICE,
Personal Representative of the Estate of
Audria M. Edwards,
Petitioner,

v.

TEKTRONIX, INC.,
Respondent.

(WCB 87-11548; CA A63260)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 7, 1990.

Dennis W. Skarstad, Portland, argued the cause and filed the brief for petitioner.

Kevin Nicholas Keaney, Portland, argued the cause for respondent. With him on the brief were Judy L. Johnson and Stoel, Rives, Boley, Jones & Grey, Portland.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

RIGGS, J.

The issue in this workers' compensation case is whether the personal representative of a deceased claimant's estate has standing to recover unpaid temporary total disability benefits that accrued before claimant's death if the claimant was not survived by a spouse or dependent children. The Workers' Compensation Board concluded that the personal representative does not have standing and dismissed the case. We affirm.

The claimant was disabled as a result of work-related stress. Employer denied her claim. The referee set aside the denial and ordered employer to pay compensation, and the Board affirmed. Employer sent a check for time loss for the period of August through September 5, 1986. Claimant requested a hearing on employer's failure to pay temporary disability benefits in accordance with the referee's order. She died on October 24. At the time of her death, she was unmarried and was not survived by any minor children.

Employer filed a motion to dismiss on the ground that the claimant had died and left no statutory beneficiaries to pursue her request for a hearing. Trice, the claimant's 28-year old daughter, as the personal representative of her estate, moved for an order substituting her for the claimant in the proceeding. The referee denied the motion and granted employer's motion to dismiss the request for hearing. The referee denied reconsideration, and the Board affirmed.

The personal representative argues that the Board erred in granting employer's motion to dismiss, because the personal representative of a claimant's estate may recover any unpaid temporary disability payments that accrued before a claimant's death. *Heuchert v. State Industrial Accident Commission,* 168 Or 74, 121 P2d 453 (1942). She contends that the 1973 amendments to ORS 656.218, Or Laws 1973, ch 355, § 1, were intended to expand the recovery rights for *permanent* partial disability benefits (PPD) and that they do not restrict an estate's ability to recover *temporary* disability benefits under *Heuchert.*

Employer argues that *Heuchert* has been implicitly overruled by later case law and statutory changes. It contends that the current version of ORS 656.218 specifically limits the

right to pursue a hearing to statutory beneficiaries, regardless of whether a claim is for permanent or total disability benefits. ORS 656.218(3),(5). It also contends that, because a personal representative is not a statutory beneficiary, she is not entitled to pursue the claimant's hearing request. We agree.

ORS 656.218 provides, in part:

> "(1) In case of the death of a worker entitled to *compensation,* whether eligibility therefor or the amount thereof have [*sic*] been determined, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto.
>
> "* * * * *

"(3) 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 persons described in subsection (5) of this section shall be entitled to pursue the matter to final determination of all issues presented by the request for hearing.

"* * * * *

"(5) The payments provided in this section shall be made to the persons who would have been entitled to receive death benefits if the injury causing the disability had been fatal. In the absence of persons so entitled, a burial allowance may be paid not to exceed the lesser of either the unpaid award or the amount payable by ORS 656.204." (Emphasis supplied.)

In 1973, the legislature amended ORS 656.218, in an effort to remedy the perceived injustice of *Fertig v. State Compensation Dept.*, 254 Or 136, 455 P2d 180 (1969), which held that a claimant's surviving spouse was not entitled to recover permanent partial disability benefits, because no award had been made before the claimant's death from noncompensable causes. The amended statute provides that a surviving spouse and others who are eligible to receive death benefits pursuant to ORS 656.204 are also entitled to all permanent disability benefits, even if the benefits were undetermined at the time of death. It also granted those beneficiaries the right to be substituted for the claimant to seek disability awards.

The personal representative argues that, because the purpose of the 1973 amendments was to expand recovery rights to permanent disability benefits and because there was no discussion of temporary disability benefits, *Heuchert v. State Industrial Accident Commission, supra,* is still good law, and she can, therefore, recover any unpaid temporary disability benefits that accrued before her mother's death. We disagree.

Heuchert is no longer viable in the light of the material change in the language of the pre-1973 law.[1] Unlike its predecessor, which solely concerned permanent partial disability, the current version of ORS 656.218 expressly refers to "compensation," ORS 656.218(1), which includes *both* permanent disability *and* temporary disability benefits. *See* ORS 656.005(8).[2] We presume that the legislature, by amending the statute to refer specifically to the more inclusive term "compensation," intended a change in meaning. *See Fifth Ave. Corp. v. Washington County,* 282 Or 591, 581 P2d 50 (1978).

Nonetheless, ORS 656.218 is clear when it speaks of who can pursue a deceased claimant's hearing request. That right is limited to those who are entitled to death benefits under ORS 656.204, that is, a surviving spouse, children under 18 or a "dependent." *See* ORS 656.005(10). The claimant was unmarried when she died and had no minor children. The personal representative is not a statutory beneficiary entitled to pursue the hearing request.

Affirmed.

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[1] When *Heuchert* was decided, the statute was OCLA, § 102-1761, the predecessor of ORS 656.218. *Heuchert,* however, does not rely on that statutory provision or on any other.

[2] ORS 656.005(8) provides:

"(8) 'Compensation' 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." (Emphasis supplied.)

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Cleo I. Beswick, Claimant.

SAIF CORPORATION
and Lane Community College,
Petitioners,

v.

Cleo I. BESWICK,
Respondent.

(WCB 86-00108; CA A62962)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 7, 1990.

David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

W. D. Bates, Eugene, argued the cause and filed the brief for respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

PER CURIAM

Employer seeks review of the Workers' Compensation Board's decision affirming the referee's order that granted claimant permanent total disability. We reverse and remand.

Employer contends that the case should be remanded, because the Board failed to make a finding about whether claimant was willing to seek employment. 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."

In *SAIF v. Stephen,* 308 Or 41, 48, 774 P2d 1103 (1989), the Supreme Court held that futility excuses proof of reasonable efforts to gain employment, but proof of willingness to seek work is still required. It remanded the case for a finding on whether the claimant was willing to seek employment. *See also SAIF v. Orr,* 101 Or App 612, 792 P2d 454 (1990). Here, the Board found that any efforts by claimant to seek employment would be futile but did not address whether she was willing to seek work. We remand for that determination.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Sheila A. (Morin) Cress, Claimant.

INTERNATIONAL PAPER COMPANY,
Petitioner,

v.

Sheila A. (Morin) CRESS,
Station House and SAIF Corporation,
Respondents.

(86-15248; 87-14036; CA A63238)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 22, 1990.

Paul L. Roess, Portland, argued the cause for petitioner. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

James L. Edmunson, Eugene, argued the cause and filed the brief for respondent Cress.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General, Salem, filed the brief for respondents SAIF Corporation and Station House.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Employer International Paper Company petitions for review of an order of the Workers' Compensation Board affirming the referee's holdings that employer and not Station House and its insurer, SAIF, is responsible for claimant's wrist injury, and that claimant had demonstrated "good cause" for her failure to file her request for hearing within 60 days after notification of employer's denial. ORS 656.319(1)(b).[1] The only issue on review is good cause. We affirm.

Employer issued a denial of claimant's wrist injury claim on August 14, 1986, by certified mail. Claimant was in

[1] ORS 656.319(1)(a) and (b) provide:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial."

the process of moving and had asked her mother to pick up her mail for her. Although the return receipt bears a signature purporting to be claimant's, she testified that she did not sign it. According to her, it was either her mother or her sister who signed the receipt. The Board found that she did not know about the denial until late October, 1986. Her request for hearing was filed on November 3, 1986, which was more than 60 days, but less than 180 days, after the denial was mailed.

Employer argues that the lack of actual notice does not constitute "good cause." Notwithstanding that, under ORS 656.319(1), notification occurs when a denial is mailed, the time for requesting a hearing may be extended for good cause. Lack of actual notice may constitute good cause. There is substantial evidence to support the Board's finding, and its finding supports its conclusion that claimant had "good cause" for filing a late request for hearing. *Giusti Wine Co. v. Adams*, 102 Or App 329, 332, 794 P2d 451 (1990).

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
David L. Vorderstrasse, Claimant.

TELEDYNE WAH CHANG
and Argonaut Insurance Co.,
Petitioners,

v.

David L. VORDERSTRASSE,
Respondent.

(WCB No. 86-14401; CA A63132)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 14, 1990.

Jenny Ogawa, Salem, argued the cause for petitioners. With her on the brief was Kevin L. Mannix, P.C., Salem.

Karen M. Werner, Eugene, argued the cause and filed the brief for respondent.

Before Joseph, Chief Judge, and Newman and Deits, Judges.

JOSEPH, C. J.

Reversed and remanded to Workers' Compensation Board for reconsideration on occupational disease claim.

JOSEPH, C. J.

Employer seeks review of an order of the Workers' Compensation Board that reversed the referee and concluded that claimant's occupational disease claim is compensable.[1] We reverse and remand.

Claimant injured his right wrist while using a pneumatic grinder at work in 1982. The claim was accepted by employer as nondisabling. In 1983, claimant filed a claim for additional medical services for his right wrist, which employer denied. Claimant then began experiencing left wrist pain, for which he received medical treatment. The parties eventually stipulated that employer would pay for medical services for both the left and right wrists.

Claimant continued to suffer pain, numbness and decreased circulation in both hands. In August, 1986, he saw Dr. Ellison, a hand surgeon, who diagnosed Raynaud's Phenomenon, secondary to work activities. Employer denied that claimant's bilateral problem was related to his 1982 compensable right wrist injury and also denied that it was a compensable occupational disease, because the work was not the major contributing cause. At employer's request, after that denial, claimant saw Dr. Button, who also diagnosed Raynaud's Phenomenon, secondary to the use of grinders at work.

Claimant requested a hearing. The referee said that "[t]he denial must be clarified." She affirmed the denial of the aggravation claim, but she made no express finding of whether the 1986 condition was related to the 1982 injury. Nonetheless, she reversed the denial of the occupational disease claim to the extent that it denied the relationship of claimant's condition to work. The referee otherwise affirmed denial of compensability of the occupational disease claim, because the disease had not been disabling, nor had it required medical services. By that "clarification," the referee apparently intended to protect claimant's position should Raynaud's Phenomenon ever cause disability or require medical services.

Claimant appealed to the Board on both the aggravation claim and the occupational disease claim. The Board affirmed the referee on the aggravation claim, but reversed on the occupational disease claim, on the basis that Raynaud's Phenomenon is a disease of which the work was the major cause and diagnostic services had been rendered. Only the occupational disease claim is before us.

Employer argues that the Board's reasoning was wrong, because it supposedly first found that the medical services were compensable, then concluded that the claim was compensable because it required medical services. Employer asserts that claimant first had to prove a disease or injury, which he did not do, and then that he had incurred medical expenses or had become disabled. *Finch v. Stayton Canning Company,* 93 Or App 168, 761 P2d 544 (1988); *see also Collins v. Hygenic Corp. of Oregon,* 86 Or App 484, 739 P2d 1073 (1987). It challenges the Board's conclusion on two grounds: (1) As a matter of law, Raynaud's Phenomenon cannot be a disease, because it is identified only by symptoms; and (2), in the light of the medical evidence from both parties, there was

[1] When the claim was filed, ORS 656.802(1) (*since amended by* Or Laws 1987, ch 713, § 4) defined "occupational disease" as

> "any disease or infection which arises out of and in the scope of employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

not substantial evidence to support a conclusion that claimant suffered from a disease.

Employer's argument that Raynaud's Phenomenon cannot be a compensable disease, because it is only a group of symptoms, fails. If the medical evidence supports the conclusion that the manifested symptoms are the disease, the condition may be compensable. *Georgia-Pacific Corp. v. Warren,* 103 Or App 275, 278, 796 P2d 1246 (1990). We cannot say, as a matter of law, that Raynaud's Phenomenon is not a disease.

We review for substantial evidence to support the Board's finding. All of the evidence on whether Raynaud's Phenomenon is a disease came from employer's expert, Button.[2] On the basis of its interpretation of that testimony, the

Board found that the only way that the phenomenon is made manifest is by its characteristic symptoms. It also found that it consists of vasospasms of nerves surrounding blood vessels that temporarily shut them, causing fingers to turn blue or white and to feel cold. Although they are temporary, those are physical changes, not just symptoms. There was substantial evidence in Button's testimony to support those findings, and the findings support the conclusion that claimant has a disease.

Employer next argues that the Board's conclusion that the work was the major contributing cause of his condition is not supported by substantial evidence. It also argues that the order is insufficient for our review, because it lacks findings to substantiate and explain that conclusion.

We address the sufficiency of the order first. It states, as a finding of fact, that claimant's work activities were the major cause of Raynaud's Phenomenon without stating any evidentiary basis for that finding. Employer characterizes the Board's finding as a conclusion. Whether claimant's work activity was the major contributing cause of his disease is a mixed question of law and fact. Therefore, in this context, it is an ultimate finding required to be made in order to determine whether the claim was compensable. Notwithstanding that, employer correctly points out that the Board's order must contain a statement of the underlying facts that support the findings on each contested issue or ultimate fact, as well as an explanation of how the findings lead to the conclusion. *Armstrong v. Asten-Hill Co.,* 90 Or App 200, 205-06, 752 P2d 312 (1988).

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[2] In a deposition, Button testified about the etiology of the condition:

"In simplified terms, Raynaud's [P]henomenon relates to vasospasm of the blood vessels. The blood vessels are in a sense like tubes with valves and they may open and close. There's a fine spider-web complex of nerves which surround the vessels which controls this opening and closing mechanism, depending upon temperature, trauma and so forth. What happens in Raynaud's phenomenon is, for whichever reason, the blood vessels will suddenly go into spasm, in a sense the valves will shut down. When that occurs— it's common in fingers — people will notice that their hands will turn blue or white and feel very cold. The most common factor usually is the cold weather exposure. The phenomenon is temporary in a sense because suddenly the nerves will start to function again and the vessels will reopen and then there's a flush where the hand will actually get warmer and pinker in color than normal.

"* * * * *

"It's a temporary, intermittent phenomenon. When it occurs, it's just a temporary shutdown. But there's no permanent damage to the tissue."

The Board agreed with the referee, so it was not required to reiterate the referee's findings, if they were adequate. *Johnston v. James River Corporation,* 91 Or App 721, 722, 756 P2d 696 (1988). The difficulty is that the referee's "FINDINGS OF FACT" consist of nothing but recitations of

the procedural record and the medical evidence, except for the concluding sentence: "Claimant suffers from Raynaud's [P]henomenon." That is the only finding of fact. In her conclusions, the referee also said that "that condition has * * * neither been disabling nor required medical services." She made no express finding with respect to the issue of work connectedness.

The Board rejected the referee's conclusion that claimant's condition had not required medical treatment. For an unexplained reason, the referee ignored claimant's going to Ellison because of the pain and numbness in his hands. Ellison's diagnostic efforts could be compensable medical treatments. *See Collins v. Hygenic Corporation of Oregon, supra.* The Board's conclusion is supported by substantial evidence.

The Board also said: "Because the [r]eferee concluded that the Raynaud's [P]henomenon was caused by claimant's work, she clarified the denial to specify that it was caused by the work, albeit not compensable." Although that may be a fair interpretation drawn from the logic of the referee's opinion, it is not accurate. The referee failed to make any finding with respect to the causal effect of the work. At best, she only reviewed the evidence. Without "an ordered set of findings of fact and * * * any explanation of why facts * * * lead to its conclusion," the referee's order was inadequate, and the Board could not merely agree with the referee. *Armstrong v. Asten-Hill Co., supra.* The Board's order is inadequate for our review.

Reversed and remanded to Workers' Compensation Board for reconsideration on occupational disease claim.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Mary E. Williams, Claimant.

Mary E. WILLIAMS,
Respondent on Review,

v.

SAIF CORPORATION
and Hill Investments,
dba Sheridan Care Center,
Petitioners on Review.

(WCB 87-00078; CA A50956; SC S36867)

On review from the Court of Appeals.*

Argued and submitted April 12, 1990.

Jerome Lidz, Assistant Attorney General, Salem, argued the cause and filed the petition for petitioners on review. With him on the petition were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Darris K. Rowell, Salem, argued the cause and filed a response to the petition for respondent on review.

Jerald P. Keene, of Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland, filed an amicus curiae brief on behalf of Associated Oregon Industries, Association of Workers' Compensation Defense Attorneys, and Oregon Self-Insurer's Association.

Before Peterson, Chief Justice, and Carson, Jones,** Gillette, Van Hoomissen, Fadeley, and Unis, Justices.

GILLETTE, J.

Decision of the Court of Appeals affirmed; order of the Workers' Compensation Board reversed in part; remanded to the Workers' Compensation Board for further proceedings.

Unis, J., specially concurred and filed an opinion.

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* Judicial review of order of the Workers' Compensation Board. 99 Or App 367, 781 P2d 1269 (1989).

** Jones, J., resigned April 30, 1990.

GILLETTE, J.

This workers' compensation case involves review of an order of the Workers' Compensation Board (Board) that adopted a referee's order that dismissed with prejudice claimant's request for a hearing on the extent of her disability on the ground that claimant failed to appear at the hearing, although her attorney was present and prepared to present evidence. The Court of Appeals reversed and remanded. *Williams v. SAIF,* 99 Or App 367, 781 P2d 1269 (1989). We affirm the decision of the Court of Appeals on different grounds.

On September 29, 1987, a hearing was scheduled in Salem, Oregon, before a referee of the Hearings Division of the Workers' Compensation Board. The primary issue for resolution at that hearing was the extent of claimant's disability. The claimant was sent a notice of hearing on June 12, 1987, to her address near Port Townsend, Washington. On the date scheduled for the hearing, claimant's attorney appeared before the referee but claimant was not present. Claimant's attorney advised the referee that he had received a telephone call from claimant the day before and that claimant told him that she was not able to attend the hearing because she lacked the funds to pay for the trip to Salem. Claimant's attorney moved for a postponement of the hearing, or, in the alternative, that claimant's request for a hearing be dismissed without prejudice. The referee denied both motions. Claimant's attorney then asked the referee to "proceed on the basis of the record" and to take claimant's testimony over the telephone. The referee denied these requests and dismissed with prejudice claimant's request for a hearing.

The next day, September 30, 1987, the referee entered an order which recited the above procedural history and then stated:

> "IT IS HEREBY ORDERED that the request for hearing by the claimant in this matter shall be dismissed with prejudice based on OAR 438-06-085."

Claimant appealed to the Board, which affirmed and adopted the referee's order on all issues except one that is not relevant to this appeal. Claimant then sought review in the Court of Appeals.

The Court of Appeals reversed and remanded. *Williams v. SAIF, supra*. The court analyzed the problem this way:

> "ORS 656.283(7)[1] 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[2] 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 [sic] denied her that opportunity."

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[1] At the time of the hearing and subsequent Board review in this case, ORS 656.283(7) provided:

> "Except as otherwise provided in this section and rules of procedure established by the board, the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. The 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 prevent or 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."

ORS 656.283(7) was amended extensively by Oregon Laws 1990 (Special Session), chapter 2, section 20, in respects not pertinent to our decision in this case.

Id. at 370 (footnote omitted). We granted review to determine whether the referee, and in turn the Board, erred by dismissing claimant's claim with prejudice when claimant, although not personally present, was represented by her attorney at the hearing and was prepared to present evidence. We now conclude that our inquiry cannot proceed so far.

The scope of judicial review in this and all workers' compensation cases is that described in ORS 656.298(6), which reads:

> "The review by the Court of Appeals shall be on the entire record forwarded by the board. Review shall be as provided in ORS 183.482(7) and (8)."[3]

This case presents a classic example of the kind of error contemplated by ORS 183.482(8)(a), *viz.*, "the agency has erroneously interpreted a provision of law."

The provision of law relied upon by the referee and the Board in this case was, according to the referee's order, "OAR 438-06-*085.*" The difficulty with this citation is that OAR 438-06-085, on which the referee (and, derivatively, the Board) relied, has nothing to do with the procedural situation that the referee faced. OAR 438-06-085 provided:

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[2] The Court of Appeals *incorrectly* stated:

> "At the time of the hearing, OAR 438-06-071 provided:
>
> "(1) A request for hearing may be dismissed 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."

Williams v. SAIF, 99 Or App 367, 369, 781 P2d 1269 (1989) (footnote omitted).

In fact, a different version of OAR 438-06-071, adopted by the Board on August 26, 1987, as a temporary rule, and effective September 15, 1987, was in effect at the time of claimant's hearing on September 29, 1987. It provided:

> "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."

OAR 438-06-081, which was in effect at the time of claimant's hearing, read:

> "(1) A scheduled hearing shall not be postponed except by order of a Referee after a showing of extraordinary circumstances beyond the control of a party. 'Extraordinary circumstances' means an event or occurrence that physically prevents a party or attorney of record for a party from appearing at the time and place scheduled for the hearing or that the Referee concludes would result in extreme hardship or manifest injustice if the party or attorney were compelled to appear and to proceed with the hearing. Circumstances that shall not be considered 'extraordinary circumstances' include, but are not limited to:
>
> "(a) An attorney's conflict with administrative or judicial proceedings that were scheduled after the mailing date of the Notice of Hearing;
>
> "(b) Press of business;
>
> "(c) Unavailability of a witness not subpoenaed or not subject to subpoena; and
>
> "(d) Incomplete case preparation.
>
> "(2) As used in this section, 'Referee' means the Referee assigned to the hearing or if the Board directs, the Presiding Referee or a Referee or Referees designated by the Presiding Referee to hear requests for postponement."

> "*DISMISSAL FOR DELAY.* A request for hearing 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. Prior to dismissal an order may be entered allowing a specific time within which the party requesting the hearing will have the opportunity to show cause why the case should not be dismissed. The filing of an application for a hearing date without explanation for the prior delay, does not constitute a showing of good cause."

There is no claim in the referee's order, nor any procedural or other facts there recited, that would justify the application of OAR 438-06-085 to this case. The referee and the Board apparently read the rule otherwise, but they erred. This never was, nor did it ever purport to be, a case of "dismissal for delay." In terms of ORS 183.482(8)(a), the referee and the Board have erroneously interpreted a provision of law — in this case, by interpreting the provision of law to apply to a situation, when a correct interpretation shows it does not apply.[4]

As the case was decided in the Court of Appeals, however, its focus was not on the reason the referee gave, but rather on the referee's actual authority to dismiss under the rules. In the Court of Appeals, the employer relied on OAR 438-06-*071*,[5] which at least has the virtue of dealing with the subject of dismissal.

The problem here is that the Board and referee did not rely on this rule. Their only reliance was on an inapposite rule. It may be, as the Court of Appeals opined, that the applicable rule was OAR 436-06-071 and that, under that rule, dismissal was inappropriate. We express no opinion on either point because, as our analysis shows, both rulings were *dicta.* The Court of Appeals simply should have reversed and remanded to the Board the case the Board actually decided.

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[3] ORS 183.482(7) and (8) provide:

"(7) Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. * * * The court shall remand the order for further agency action if it finds that either the fairness of the proceedings or the correctness of the action may have been impaired by a material error in procedure or a failure to follow prescribed procedure.

"(8)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

"(A) Set aside or modify the order; or

"(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

"(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.

"(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

[4] This ruling will come as no surprise to the parties. It was clear from their oral arguments in this Court that both sides recognized that OAR 436-06-085 did not apply in this case. Neither party even mentioned the rule in its brief to the Court of Appeals.

[5] *See supra* note 2.

If follows from the foregoing that, although the Court of Appeals used the wrong analysis, the result it reached nonetheless was correct. The referee was not entitled to dismiss the proceeding before him on the basis he cited. The case must be reversed and remanded to the Board for further proceedings not inconsistent with this opinion.

Decision of the Court of Appeals affirmed; order of the Workers' Compensation Board reversed in part; remanded to the Workers' Compensation Board for further proceedings.

UNIS, J., specially concurring.

I agree with the majority's decision that this case must be reversed and remanded to the Workers' Compensation Board for further proceedings. I do not agree with the analysis used by the majority to reach that result.

We granted review in this workers' compensation case to decide whether the referee, and in turn the Board, erred by dismissing claimant's claim with prejudice when claimant, although not personally present, was represented by her attorney at the hearing and was prepared to present evidence. The majority is correct when it concludes that we cannot decide that issue. It is the analysis and reasoning used by the majority for reaching that conclusion with which I disagree. In my view, this court cannot decide that issue because

the Board's order is inadequate for judicial review. I would, therefore, affirm the decision of the Court of Appeals to reverse and remand this case to the Workers' Compensation Board, but on a different ground than that stated by the Court of Appeals or the majority of this court.

The scope of judicial review in this and all workers' compensation cases is that described in ORS 656.298(6), which provides:

> "The review by the Court of Appeals shall be on the entire record forwarded by the board. Review shall be as provided in ORS 183.482(7) and (8)."[1]

[1] ORS 183.482(7) and (8) provide:

"(7) Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. * * * The court shall remand the order for further agency action if it finds that either the fairness of the proceedings or the correctness of the action may have been impaired by a material error in procedure or a failure to follow prescribed procedure.

"(8)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

"(A) Set aside or modify the order; or

"(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

"(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.

"(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

ORS 183.482(7) and (8) do not, however, describe what a final order in a workers' compensation contested case must contain. I agree with Chief Judge Joseph of the Court of Appeals that ORS 183.470(2) "applies *in substance* to Board orders, because it states requirements which are necessary for effective judicial review" under ORS 183.482(7) and (8). *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988) (Emphasis added). ORS 183.470(2) provides:

> "A final order shall be accompanied by findings of fact and conclusions of law. The findings of fact shall consist of a concise statement of the underlying facts supporting the findings as to each contested issue of fact and as to each ultimate fact required to support the agency's order."

There are practical reasons for the requirement expressed in ORS 183.470(2) that an administrative agency state its factual findings and articulate a rational connection between the facts it finds and the legal conclusions it draws from them.[2] Such articulation facilitates meaningful judicial review, *Ross v. Springfield School Dist. No. 19,* 294 Or 357, 370, 657 P2d 188 (1982); enables the court on judicial review to give an appropriate degree of credence to the agency interpretation, *Springfield Education Assn. v. School Dist. No. 19,* 290 Or 217, 228, 621 P2d 547 (1980); "serve[s] to assure proper application of the law in the individual case," *Ross v. Springfield School Dist. No. 19,* 300 Or 507, 517, 716 P2d 724 (1986); *Ross v. Springfield School Dist. No. 19, supra,* 294 Or at 370; prevents judicial usurpation of administrative functions, Davis, *Administrative Law Text* 321, § 16.03 (3d ed 1972); assures more careful administrative consideration, *i.e.,* protects against careless or arbitrary action, *id.* at 321-322; provides a source of guidance for agency personnel as well as for persons governed by the statute, *Ross v. Springfield School Dist. No. 19, supra,* 300 Or at 517; helps develop and maintain the consistency in administration, *id.;* facilitates the parties' planning, *i.e.,* helps parties plan their cases for rehearings and judicial review, Davis, *Administrative Law Text, supra,* at 322; and keeps agencies within their jurisdiction. *Id.*

When the Board issues an order in a workers' compensation contested case, this court first should review to determine if the order is adequate for meaningful judicial review, and if so, we then should proceed to review the order as authorized by ORS 183.482(7) and (8). For an order to be adequate for meaningful judicial review, "it must articulate a tenable basis for the legal conclusions by which it applies a statute [or rule] to the facts." *See 1000 Friends of Oregon v.*

LCDC, 305 Or 384, 394, 752 P2d 271 (1988), *quoting Ross v. Springfield School Dist. No. 19, supra,* 300 Or at 517.[3] *See also Market Transport v. Maudlin,* 301 Or 727, 736-37, 725 P2d 914 (1986); *Teledyne Wah Chang v. Energy Fac. Siting Council,* 298 Or 240, 255, 692 P2d 86 (1984). A final order of the Board

[2] The Supreme Court of the United States has stated that "the orderly functioning of the process of review requires that the grounds upon which the administrative agency acted be clearly disclosed and adequately sustained." *SEC v. Chenery Corp.,* 318 US 80, 94, 63 S Ct 454, 462, 87 L Ed 626 (1943).

that contains the findings of fact and conclusions of law substantially like those required by ORS 183.470(2) is necessary for meaningful judicial review as provided in ORS 183.482(7) and (8).

I turn now to the Board's order in this case. The Board did not write its own specific findings of fact and conclusions of law in its order.[4] The Board merely affirmed and adopted the referee's order on all issues except one that is not relevant to this discussion. It is necessary, therefore, to examine the referee's order to determine whether it satisfies the above-described standards, *i.e.*, whether that order is adequate for meaningful judicial review.

As previously stated, the referee's order states that claimant's request for a hearing is "dismissed with prejudice based on OAR 438-06-085." OAR 438-06-085, which was in effect when the referee and the Board entered their respective orders in this case, provided:

> "*DISMISSAL FOR DELAY.* A request for hearing 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. Prior to dismissal an order may be

> entered allowing a specific time within which the party requesting the hearing will have the opportunity to show cause why the case should not be dismissed. The filing of an application for a hearing day without explanation for the prior delay, does not constitute a showing of good cause."

The referee's citation, in his final order, to OAR 438-06-085 is not supported by any reasoning. The referee's order is, for the most part, a recitation of the various requests made by claimant's attorney on claimant's behalf and the objections and arguments of the attorney representing claimant's employer and its insurer, followed by a bare conclusion. The referee's order does not demonstrate that claimant delayed the hearing, much less that she did so without good cause. It is devoid of specific findings of fact that would lead to and support the referee's ultimate conclusion to dismiss with prejudice claimant's request for hearing on the basis of OAR 438-06-085. The referee's order, adopted by the Board, is, therefore, inadequate to permit meaningful judicial review as provided in ORS 183.482(7) and (8). This conclusion is reinforced

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[3] In *Ross v. Springfield School Dist. No. 19*, 294 Or 357, 370, 657 P2d 188 (1982), we quoted from *Springfield Education Assn. v. Springfield School District No. 19*, 290 Or 217, 227, 621 P2d 547 (1980):

> "The requirement of ORS 183.470 that the order contain findings of fact and conclusions of law is a requirement that the reasoning by which the agency applies a statute to facts to reach a result be expressed in the order. If the statute is plain on its face, the reason is obvious and may be expressed by a simple statutory reference. If the statute requires interpretation, however, the interpretation and the agency's rationalization of it are properly a part of the reasoning of the order. Thus, under ORS 183.470, the order itself is the instrument by which an agency demonstrates that a particular interpretation or application of a statute is within a generally expressed legislative policy."

[4] The Board need not, in every instance, write its own specific findings of fact and conclusions of law in its order on *de novo* review of the decision of a referee. *See* ORS 656.295(6). *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205 n 4, 752 P2d 312 (1988). The Board "may adopt the opinion and order of a referee in whole or in part; it may write its own order in whole or in part. Its obligation is to provide for our review a final order satisfying the import of ORS 183.470(2)." *Id.*

by the following reasoning. Assume that the referee's order in this case was the same except that it stated that claimant's request for a hearing is "dismissed with prejudice" and made no reference to any rule. Such an order obviously would not be adequate for an appellate court to conduct meaningful judicial review under ORS 183.482(7) and (8). Here both parties agree that "the referee's decision, adopted by the Board, * * * cited an inapposite rule as the ground for dismissal." For purposes of determining whether a referee's order is adequate for meaningful judicial review, reliance by citation to an "inapposite rule" is no different than a failure to cite a rule.

In this case, the Court of Appeals reversed the Board on the basis that ORS 656.283(7) and OAR 438-06-071 entitled the claimant to offer her evidence even though she was absent from the hearing. At no time, however, did the referee or the Board consider that particular statute and rule. Neither of the parties argued to the referee or the Board that ORS 656.283(7) or OAR 438-06-071 were relevant in determining whether to dismiss with prejudice claimant's request for hearing. Since a remand of this case for further proceedings is necessary, *see Teledyne Wah Chang v. Energy Fac. Siting Council, supra,* 298 Or at 255-56, I express no opinion regarding the correctness of the Court of Appeals' application of ORS 656.283(7) and OAR 438-06-071.

IN THE SUPREME COURT OF THE
STATE OF OREGON

Ronald L. MARTELLI,
Respondent on Review,

v.

R.A. CHAMBERS AND ASSOCIATES,
Petitioner on Review.

(TC 87-1402; CA A49992; SC S36892)

On review from the Court of Appeals.*

Argued and submitted July 10, 1990.

Lloyd W. Helikson, Albany, argued the cause for petitioner on review. On the petition was John E. Jaqua, Eugene.

Karen Werner, Albany, argued the cause for respondent on review. On the response was James C. Egan, Albany.

Before Peterson, Chief Justice, and Carson, Gillette, Van Hoomissen, Fadeley, and Unis, Justices.

FADELEY, J.

The decision of the Court of Appeals is affirmed. The judgment of the circuit court is reversed, and the case is remanded to that court.

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* Appeal from Linn County Circuit Court, William O. Lewis, Judge. 99 Or App 524, 783 P2d 31 (1989).

FADELEY, J.

In this case the court is asked to interpret and apply the exclusive liability provisions of ORS 656.018(1)(a).[1] Defendant general contractor claims immunity under that statute from the negligent injury claim of a plaintiff who worked for defendant's subcontractor. The issue is: Are Oregon Workers' Compensation benefits the exclusive remedy of a subcontractor's employee injured allegedly because of the acts or omissions of the general contractor? The trial court granted defendant's motion for summary judgment holding that the general contractor was "immune" based on a finding "that defendant was an employer as contemplated under the Workman's [*sic*] Compensation Law."[2]

The Court of Appeals reversed and remanded, holding that the summary judgment should not have been granted because the general contractor was not the injured worker's employer as that term is used in ORS 656.018, notwithstanding ORS 656.029(1),[3] and that the exemption from liability

extends only to an actual employer as defined in ORS 656.005(14)(1985). *Martelli v. R.A. Chambers and Associates*, 99 Or App 524, 783 P2d 31 (1989). We affirm the decision of the Court of Appeals.

FACTS

Lebanon Community Hospital accepted the total bid of defendant to construct and remodel per plans and specifications provided by the hospital. In the summer of 1985 and in documents entitled "Subcontract," defendant contracted with Associated Sheet Metals, Inc., to do parts of the work which defendant had become obligated to do under its general contract with the hospital. Under the subcontract, Associated was to

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[1] ORS 656.018(1)(a) states:

"The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in ORS 656.001 to 656.794."

[2] ORS 656.005(14)(1985) stated:

" 'Employer' means any person, including receiver, administrator, executor or trustee, and the state, state agencies, counties, municipal corporations, school districts and other public corporations or political subdivisions, *who contracts to pay a remuneration for and secures the right to direct and control the services of any person.*" (Emphasis added.) This definition subsection is presently numbered ORS 656.005(13), not (14), as it was in 1985.

ORS 656.005(27) states:

" 'Worker' means any person, including a minor whether lawfully or unlawfully employed, *who engages to furnish services for a remuneration, subject to the direction and control of an employer* and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution." (Emphasis added.)

[3] ORS 656.029(1) provides in part:

"If a person awards a contract involving the performance of labor[,] * * * the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, 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."

> "furnish all materials, labor, tools, equipment and supplies necessary for performance of this subcontract as provided herein, in a proper, efficient and workmanlike manner, and in strict accordance with the subcontract and contract documents, and any and all building codes or state, county or municipal laws, orders or regulations applicable to the work."

The contract documents described the end result which Associated was to produce.

Defendant's form subcontracts required that Associated maintain several kinds of insurance, including "Statutory Workmens' Compensation as required by law," and provided that "certificates of above insurance shall be forwarded to contractor [defendant] immediately after subcontract has been accepted. All insurance policies shall include a clause that insurance shall not be cancelled or reduced, restricted or amended until ten (10) days after the contractor has received written notice."

Plaintiff, who was on Associated's payroll only, and for whom Associated in fact provided workers' compensation coverage, was assigned by Associated to work on the roof of the hospital project. A stairway constructed by defendant for use of workers on the roof collapsed, causing plaintiff's injuries, on November 5, 1985. Defendant maintained a foreman with general supervisory authority at the hospital project site.

Defendant asserts that it was plaintiff's "employer" as that term is used in ORS 656.018(1) or, alternatively, that it should be deemed plaintiff's employer because it would have

been responsible for providing workers' compensation coverage for plaintiff under ORS 656.029(1), had Associated failed to do so. Therefore, defendant generally argues that it should be granted immunity as plaintiff's employer. Because these points depend upon a construction of the relevant statutes, we turn to that subject.

LEGAL HISTORY OF THE IMMUNITY CLAIMED

Oregon's Workers' Compensation Law first came into being as an innovation adopted legislatively in 1913. Its original form included direct antecedents of present statutory provisions important to the decision of this case. Oregon Laws 1913, chapter 112, section 12, in part provided:

> "[T]he right to receive such sum or sums [as workers' compensation] shall be in lieu of all claims against his employer on account of such injury or death except as hereinafter specially provided."

Immediately following that grant to an employer of immunity from other claims by its workers, and coupled with it by sentence structure, the first compensation act provided for an injured worker's action against a negligent third party, as follows:

> "[*P*]*rovided, however,* that if the injury to a workman occurring away from the plant of his employer is due to the negligence or wrong of another not in the same employ, the injured workman * * * shall elect whether to take under this act or seek a remedy against such other, such election to be in advance of any suit, and if he take under this act the cause of action against such other shall be assigned to the State for the

benefit of the accident fund. * * * Any such cause of action assigned to the State may be prosecuted or compromised by the department in its discretion."

In return for immunity granted to his employer, the worker injured in the course of employment, and in a way defined by that act, was guaranteed compensation, regardless whether a fault or neglect on the part of the employer caused the injury. The worker, however, retained the right to seek damages from parties other than his employer where those others were at fault. And the State, for the benefit of the accident insurance fund, simultaneously acquired legal rights in any injured worker's claim against other parties at fault.

From the inception of the first compensation act,

these rights and immunities expressly depended upon who was a worker and who was his or her employer. Section 14, a definition section, in part provided:

"The term 'employer' used in this act shall be taken to mean any person, firm or corporation, but not including municipal corporations, that shall contract for and secure the *right to direct and control* the services of any person, and the term 'workman' shall be taken to mean any person, male or female, who shall engage to furnish his or her services subject to the direction or control of an employer." (Emphasis added.)

All three of these legislative ideas — the right of the worker to compensation regardless of fault, the right of the employer providing compensation insurance to immunity, and the right of both the worker and the insurance fund to recover from third parties at fault — have continued to the present day. Likewise, the "right to direct and control" was and is the test for employer status when the immunity based on that status is in issue.

When the compensation law was extensively revised in 1965 so that insurance could be provided by the employer directly, by purchasing it from a private insurer, or by purchasing it from the State Accident Insurance Fund, each of those legislative ideas was retained. Oregon Laws 1965, chapter 285, section 4(12) and (20), continued to define employer and worker in terms of "the right to direct and control the services of any person," and in terms of "remuneration" for which the worker "engages to furnish his services * * * subject to the direction and control of an employer," and for which the employer "contracts to pay," just as present ORS 656.005(27), *supra* note 2, still does. Damage recovery from a third party, to benefit both worker and the insurance carrier, was continued in sections 44-49 of Oregon Laws 1965, chapter 285, essentially as provided now in ORS 656.576 to 656.593. The immunity of an employer from any worker's claims, other than for workers' compensation, was continued in section 6 of the 1965 act, as worded in the 1913 Act, quoted *supra*, and now phrased in modern terms, in ORS 656.018(1), *supra* note 1.

The 1913 Act, section 24, provided in part:

"In respect to any injury happening to any of his workmen during the period of such default in any payment required hereunder, the defaulting employer shall not, if such default

> be after demand for payment, be entitled to any of the benefits of this act, but shall be liable to the injured workman * * * as he would have been prior to the passage of this act."

This penalty by loss of immunity, continued in section 7 of the 1965 revision, today is found in ORS 656.020 and implemented by ORS 656.578.

Unlike the Workers' Compensation Law provisions we have just discussed, ORS 656.029(1), note 3, had no direct antecedents in the 1913 Act. Its idea was not enacted until Oregon Laws 1933, chapter 116, section 2. However, the problem addressed was not unknown during the 1913 to 1933 period. Employers and workers avoided the law's protections of the worker and its corollary immunity of the employer by not establishing a direct, master-servant employment relationship. *See, e.g., Smith v. State Ind. Acc. Comm.*, 144 Or 480, 482, 23 P2d 904, *reh granted*, 25 P2d 1119 (1933) (relation of master and servant and "contract for hire" required before compensation law applies); *Vient v. State Industrial Acc. Com.*, 123 Or 334, 262 P 250 (1927) (claimant lather held independent contractor not entitled to workers' compensation under home builder's coverage because no master-servant relationship with right to exercise complete control existed).

Oregon Laws 1935, chapter 113, section 1, amending the 1933 Act, in part provided:

> "[I]f any person engaged in a business and subject to this act as an employer, in the course of such business shall let a contract the principal purpose of which is the performance of labor, such labor to be performed by the person to whom the contract was let or by such person with the assistance of others, all workmen engaged in the performance of the contract shall be deemed workmen of the person letting the contract, if the person to whom the contract was let was not engaged in a separate business involving the occupation covered by the contract at the time of commencing the performance of the contract."

The exclusion of independent contractors from the definition of who was an employer's worker for purposes of immunity remained, but where a contract for labor as such was awarded, the new legislative rule applied. Codified in 1953 as ORS 656.124, the 1935 act was repealed by Oregon Laws 1965, chapter 285, section 95. The legislative rule of 1935

proved too valuable to do without, and its pre-1965 version was re-enacted as Oregon Laws 1979, chapter 864, and codified as ORS 656.029.

During the statute's 30-year existence, the right to direct and control a worker's performance of specific tasks remained the touchstone used by the courts to determine whether an employer-worker relationship obtained, entailing the employer's immunity from other liability where workers' compensation insurance was provided by employer.

Two years after the 1935 amendments to the labor-contract provision now embodied in ORS 656.029, in *Davis v. State Ind. Acc. Com.*, 156 Or 393, 64 P2d 1330 (1937), a partner

in a sawmill was killed driving a truck for a logging company, during a time when the sawmill was shut down for lack of logs. The logging company was under contract to deliver logs to the mill, at $2.80 per thousand board feet. The court held that the partner, when killed, was an employee of the logging company and not of the mill. This holding was reached, after consideration of the statutory progenitor of ORS 656.029, because the logging company was an independent contractor obligated to pay for, and privileged to direct and control, the work of the mill-partner while he was hauling logs for the logging company. Although in a sense engaged in a common enterprise, the logging company was not "engaged in the same pursuit" as the sawmill, and the logging company provided the equipment and directed the work performed. The logging company was an "independent contractor" and the deceased was its worker, for purposes of Workers' Compensation Law.

Likewise, in *Cox v. State Ind. Acc. Com.*, 168 Or 508, 121 P2d 919 (1942), the court held that the predecessor of ORS 656.029 did not apply under the facts of that case. An injured worker was held to be the employee of a subcontractor hauling wood, not the employee of the contractor who let the contract for the hauling. In *Cox*, a farmer had a contract to supply pulpwood from his farm to a paper mill. He contracted with a neighboring second farmer, who owned a truck, to haul the pulpwood to the mill at $1.00 per cord. The second farmer hired the first farmer's son, at $.15 per cord, to assist in loading and hauling, at which task the son was injured.

Notwithstanding the statutory language, the court stated, the son was the employee of the hauling subcontractor,

as an independent contractor, because the contract did not "call for performance of labor primarily but for the transportation of wood. * * * The use of the truck was what [contractor] wanted." *Id.*, 168 Or at 513. *Accord: Reynolds et al v. Harbert et al*, 232 Or 586, 375 P2d 245 (1962) (truck owner hauling another's rock under contact to deliver it to site at so much a yard was killed while hauling; widow held entitled to sue for negligence the person who let that contract, notwithstanding predecessor to ORS 656.029 and the immunity provisions of ORS 656.018(1), because deceased was not rock-contractor's employee); *cf. Brazeale v. State Ind. Acc. Comm.*, 190 Or 565, 227 P2d 804 (1951) (driver for log-trucking company under exclusive contract to haul for logging company killed while servicing truck, as required by trucking company, was not logging company's employee; distinguishes predecessor ORS 656.029 because deceased's task when killed was performed for trucking company's purpose, not that of logging company).

Defendant's contentions that plaintiff was its employee as a matter of law under ORS 656.018(1) or 656.029 are not supported by the foregoing review of the development and application of those statutes. As this court stated in *Bell v. Hartman*, 289 Or 447, 452, 615 P2d 314 (1980), concerning the Oregon Workers' Compensation Law:

> "That the law means to anchor the compensation scheme to the employment relation is evident throughout the statute. The key term in the statutory scheme is 'subject worker.' An employer is bound to assure payment of compensation only

for 'subject workers,' ORS 656.017, *cf.* ORS 656.052. In return for the right to compensation, the subject worker and his beneficiaries are deprived of the legal remedies for injuries which they might otherwise have against his employer. ORS 656.018. The statute's coverage of an employer is derivative of its coverage of a worker * * *."

Determination of who is a subject worker depends, under our law, on who pays for the worker's services and who directs and controls the specific work. *See Bell v. Hartman, supra* (jockey was independent contractor, not employee of horse's owner or trainer, or of racetrack or racing commission); *Woody v. Waibel,* 276 Or 189, 197, 554 P2d 492 (1976) (owner-driver of log truck was sufficiently controlled by logging operator who paid him to establish that driver was in master-servant relation, not independent contractor); *Harris*

v. State Ind. Acc. Com., 191 Or 254, 268, 230 P2d 175 (1951) (union member elected by local union to negotiating committee to do bidding of local union was not International Union's employee); *Streby v. State Ind. Acc. Com.,* 107 Or 314, 215 P 586 (1923) (person painting porch at daily wage was house-owner's employee where owner directed when, where, and materials to use in painting). Defendant is not entitled to immunity from a third-party negligence claim because it is not plaintiff's employer, a relationship which ORS 656.018 explicitly requires before that statute is applicable.

Defendant contends that having its foreman at the job site, generally supervising the project, is sufficient control of the work. It is not. Defendant further argues that the foreman's presence and duties create a situation of joint supervision of the work with plaintiff's direct employer and that that is sufficient control. Plaintiff counters that, since the enactment of Oregon Laws 1975, chapter 152, joint supervision and control no longer confers immunity. Plaintiff is correct. Before the 1975 act, ORS 656.154 in part read:

"If the injury to a workman is due to the negligence or wrong of a third person not in the same employ, the injured workman, or if death results from the injury, his widow, children or other dependents, as the case may be, may elect to seek a remedy against such third person. *However, no action shall be brought against any such third person if he or his workman causing the injury was, at the time of the injury, on premises over which he had joint supervision and control with the employer of the injured workman and was an employer subject to ORS 656.001 to 656.794.*" (Emphasis added.)

After the 1975 act, only the first sentence remains as present ORS 656.154; the joint supervision defense to a third party negligence claim was repealed *in toto.*

Defendant next observes that this court has held that indirect payment of remuneration may be enough, in some circumstances, to support the conclusion that a worker receiving that remuneration is an employee and subject worker of the party originating the payment.[4] Defendant relies on *Whitlock v. State Ind. Acc. Com.,* 233 Or 166, 377 P2d 148 (1962), and *Gibson v. Safeway Stores, Inc.,* 307 Or 120, 764 P2d

[4] Of course, the Lebanon Community Hospital originated the remuneration ultimately received both by defendant's own workers and its subcontractors' workers.

548 (1988). To that list defendant could add *Blacknall v. Westwood Corporation*, 307 Or 113, 764 P2d 544 (1988), which is similar to *Gibson*.

All three cases involve use of temporary labor supplied through another entity to whom payment for the services of the worker is made for labor services provided under the direction and control of the originator of the remuneration. In *Gibson*, a security-guard service company supplied Safeway with guards who were controlled in six listed ways by Safeway, and whom Safeway could fire from the job. 307 Or at 122. In *Blacknall*, Adia Services, Inc., provided a temporary worker to its client, a construction company, which was "[b]eyond any question" exercising direction and control of the worker. 307 Or at 118. In *Whitlock*, property owners contracted with a high-school student club or organization to paint a structure and "had the right to direct and control the manner in which the services were rendered" by club members. 233 Or at 169.

Defendant's contract with its subcontractors does not provide defendant any right to direct or control the subcontractor's employees, whose labor the subcontractor is to supply along with materials, tools and equipment. Based thereon, we believe *Whitlock*, *Blacknall*, and *Gibson* do not help defendant establish as a matter of law, as it must to merit summary judgment, that it was plaintiff's employer because the subcontract calls for production of an end result. Direction and control of the subcontractor's worker is lacking. Moreover, as *Gibson*, noted, the 1975 repeal of the second sentence, formerly part of ORS 656.154, withdrew immunity of a second employer in a common enterprise.

Next, defendant contends that the general contractor is "legally obligated" or "ultimately responsible" for providing workers' compensation coverage under ORS 656.029 and 656.556 read together, *if* plaintiff's employer had not done so. Defendant then urges that these statutes have "the effect of shifting the responsibility for providing workers' compensation coverage for subcontractor employees from the subcontractor to the general contractor."

The facts of this case contradict the conditions required for any obligation of the general contractor to arise, assuming without deciding that the statutes cited would otherwise apply as defendant argues. Plaintiff's employer provided coverage. Defendant's contracts with that employer protected defendant from an unfairness which could be argued to arise from the hypothetical case defendants have constructed. Because we do not decide hypothetical cases, we do not consider this contention further.[5]

The decision of the Court of Appeals is affirmed. The judgment of the circuit court is reversed, and the case is remanded to that court.

[5] Defendant also asserts that cases from other jurisdictions should be applied to determine the meaning of Oregon statutory provisions defining "employer" and "worker." However, Oregon's statutes and those from the other jurisdictions are not similar.

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