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CONTENTS

CITE AS:

35 Van Natta ___ (1983)

ASHTON V. LAWRENCE, Claimant
Coons & McKeown, Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 79-01169 & 81-11072
April 7, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of those portions of Referee Seifert's orders which: (1) concluded that claimant was not a subject worker at the time of his alleged August 19, 1980 injury and thus upheld the SAIF Corporation's denial on behalf of the putative employer, Four M. Wood Products; and (2) concluded that claimant had not proven an aggravation of his 1977 injury while employed by Jeffries Timber, also insured by SAIF.

Determination of whether or not claimant was a subject worker on the date of the alleged 1980 injury is entirely dependent upon whose version of the facts surrounding that incident is accepted -- claimant's or the putative employer's. The Referee made no specific credibility finding, but in view of the Referee's conclusion we assume the Referee did not accept claimant's version. Based upon our de novo review, we are also unable to accept claimant's version of the events of 1980.

Claimant's argument about aggravation in connection with his prior compensable Jeffries Timber/SAIF claim is very hard to understand. That argument is cast in terms of responsibility: an aggravation theory against Jeffries Timber/SAIF or, alternatively, a new injury theory against Four M Wood Products/SAIF. But responsibility between two employers cannot actually be the issue given our finding that Four M was not claimant's employer when he was allegedly injured on August 19, 1980. The evidence is also hard to understand because much of it addresses issues resolved at hearing but not before us on review.

The principal thrust of claimant's argument on review is that somebody should be responsible for his medical treatment after August 19, 1980 -- if not Four M Wood Products/SAIF, then Jeffries Timber/SAIF. While the matter is far from clear and, therefore, easily debatable, we agree with claimant's apparent position that Jeffries Timber/SAIF remains responsible for his medical treatment after August of 1980 as treatment for compensable consequences of claimant's 1977 industrial injury. However, we do not understand anything in the Referee's orders to provide to the contrary. We affirm the Referee's order with that understanding.

ORDER

The Referee's orders dated April 8, 1982 and May 26, 1982 are affirmed.

SYLVESTER OSBORNE, Claimant
Grant, Ferguson et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-11265 & 81-11266
April 7, 1983
Order Denying Motion to Dismiss

The claimant has moved to dismiss the SAIF Corporation's request for review on the grounds that no transcript of testimony has yet been filed.

The Motion to Dismiss is denied as the transcript was mailed to the parties March 23, 1983.

IT IS SO ORDERED.

HARRY SAMPSON, Claimant
Schouboe, Marvin et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-10838
April 7, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Mulder's order which upheld the SAIF Corporation's denial of his claim for an injury allegedly arising out of and in the course of his employment with Jacqueline Shops, also known as That Shop, the putative employer herein. The Referee found that claimant was not an employe of the employer on the day in question, when claimant was involved in an apparently severe motor vehicle accident. We affirm.

A preliminary issue concerns the propriety of the Referee's evidentiary ruling concerning a portion of claimant's testimony, the testimony of claimant's mother and brother, which was objected to by SAIF as inadmissible hearsay. The testimony concerns statements allegedly made by the manager of the employer's business, which constitute admissions concerning the employment relationship between claimant and the employer on the day in question, July 3, 1980. We find that the Referee erred in refusing to consider this testimony. In making his evidentiary ruling, the Referee relied upon ORS 656.283(6) and a discussion concerning hearsay evidence contained in Professor Larson's treatise on workers compensation. We find the testimony of the witnesses recounting statements of the manager of the employer's business constitute admissions of the employer's agent and, therefore, representative admissions which can be attributed to the employer. As such, the witnesses' testimony concerning the statements do not constitute hearsay evidence and should have been considered by the Referee as substantive evidence of the matter asserted. Cf. Rule 801 Oregon Evidence Code, ORS 40.450(4)(b)(A). We have considered this testimony in our review; however, we find that it does not change the result reached by the Referee.

This case was decided by the Referee based primarily on the testimony of the witnesses at hearing. Therefore, the Referee's assessment of the relative credibility of the witnesses is crucial. The Referee found claimant's credibility "substantially eroded by inconsistencies and evasions in his testimony." We interpret this credibility finding to be, in part, a statement of the Referee's impression of claimant's demeanor. The most glaring inconsistency in claimant's testimony concerns his activities on the day of the

motor vehicle accident. He testified that, although he had been working with Montgomery Ward prior to the day of the accident, he did not work at all on that day, which he testified was his day off. SAIF called the personnel assistant from the Montgomery Ward store at which claimant was employed, who brought with her payroll and personnel records reflecting that, on July 3, 1980, claimant did, in fact, work during the morning hours. Claimant attempted to explain this inconsistency by stating that his recollection may have been impaired due to the head injuries sustained in the motor vehicle accident. We are not persuaded, and believe that we must defer to the Referee's assessment of claimant's credibility, which we find dispositive.

Subject to the foregoing, we affirm and adopt the remainder of the Referee's order.

ORDER

The Referee's order dated August 11, 1982 is affirmed.

MARY L. TATE, Claimant
Galton, Popick & Scott, Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 81-04682 & 81-05233
April 7, 1983
Supplemental Order

The Board issued its Order on Review herein on March 29, 1983. The employer has requested clarification of that portion of the order which allows claimant's attorney a reasonable attorney's fee payable out of the temporary partial disability benefits paid to claimant for the period August 18, 1981 through January 18, 1982. The employer states that the Board's order is unclear as to whether claimant's attorney's fee is to be paid out of claimant's compensation or in addition thereto.

The attorney's fee allowed by the aforementioned Order on Review is payable out of claimant's compensation and not in addition thereto. ORS 656.386(2).

IT IS SO ORDERED.

KENNETH ADAMS, Claimant
Emmons, Kyle et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 82-0308M
April 8, 1983
Own Motion Order

Claimant, by and through his attorney, has requested that the Board exercise its own motion authority and reopen his claim for injuries sustained in 1962 and 1964. Claimant's aggravation rights have expired. Both claimant and SAIF Corporation have forwarded to the Board pertinent medical documents.

As far as we can ascertain from the evidence before us, claimant's original injuries were to his left knee. The long span of time between the injuries and his current problems, with very little documented treatment, make it difficult to unequivocally establish a relationship between the injuries and claimant's current condition. Dr. Lawton strongly infers the condition today is injury-related by his report that claimant's problem is

advanced traumatic arthritis. It appears that claimant first began treatment with Dr. Lawton in January, 1982. Within just a couple of months, the doctor was recommending that claimant look for some kind of gainful employment. The possibility exists that claimant may have to have surgery on his left knee in the future.

Injuries which occurred prior to 1966 do not carry with them the right to continuing medical services as ORS 656.245 was not then in effect. It appears that Dr. Lawton is attempting to treat claimant's knee condition with exercise, heat, limited activity and medication. Under the authority granted us in ORS 656.278, we conclude claimant's claim should be reopened for the payment of medical expenses for treatment of his left knee condition.

Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $550 as a reasonable attorney's fee.

IT IS SO ORDERED.

PHILLIP D. CAMPBELL, Claimant
Robert Brasch, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 81-10465
April 12, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Foster's order which affirmed the SAIF Corporation's denial of claimant's aggravation claim regarding his right knee.

Claimant originally suffered an industrial injury to his right knee on February 22, 1980 while working as a logger. Claimant did not return to logging, but began working as a deck hand on fishing boats. On September 4, 1981, while working on a fishing boat, claimant turned and twisted his knee. He experienced immediate severe pain, which finally led to an arthroscopy, arthrotomy and meniscectomy of the right knee for a torn medial meniscus on October 13, 1981. The Referee found that the September 4, 1981 incident worsened claimant's knee condition to the extent that it had to be regarded as a new injury.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated June 30, 1982 is affirmed.

SHAWN CUTSFORTH, Claimant
Carney et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB n/a
April 12, 1983
Third Party Distribution Order

This matter is presently before the Board for resolution of a dispute concerning the proper distribution of the proceeds of a third party recovery. ORS 656.576 to 656.595. The SAIF Corporation has made application to the Board pursuant to ORS 656.593.

On October 5, 1981 claimant sustained an injury in the course of his employment when he was involved in a motor vehicle accident. The claim was accepted by the employer and workers compensation benefits were paid. Claimant elected to pursue a civil action for damages against the culpable third party. ORS 656.154, 656.578.

Claimant settled his cause of action against the third party defendant for $14,000. SAIF claims a lien for expenditures made in connection with this claim, including medical expenses, temporary disability compensation payments and reasonably to be expected future expenditures for compensation. The issues are the extent of SAIF's expenditures for which it is entitled to reimbursement -- one cost for which SAIF seeks reimbursement being a narrative medical report from claimant's treating physician which was requested by SAIF; the extent of SAIF's lien for temporary disability compensation; and the extent, if any, of SAIF's reasonably to be anticipated future expenditures.

Claimant was injured in a motor vehicle accident on October 5, 1981, was immediately taken to the hospital and was admitted to the intensive care unit. He sustained multiple contusions to his chest, abdominal and lumbar areas. A left thigh hematoma was diagnosed, as well as a right ankle sprain and pericardial contusion. Several x-rays were taken in order to rule out a ruptured spleen and pulmonary contusion, and a probable fracture of the left first transverse process was diagnosed. X-rays of the chest, right chest, right ankle, pelvis, abdomen, left femur and lumbar spine were all negative. There was also no evidence of any significant cardiac, mediastinal, pleural or pulmonary abnormalities. Claimant was discharged from the hospital on October 8, 1981.

He sought treatment with Dr. Horniman on October 22, 1981, at which time he had numerous complaints, which were listed by Dr. Horniman as: "soreness of the chest; pain in the sternum on coughing; pain in the center of his back; has to sleep on his back; unable to flex and straighten his back; sore left hip; right ankle painful and swollen; left ankle painful; hematoma of left thigh; neck gets 'tired.'" Dr. Horniman treated claimant throughout October and November of 1981, for these complaints. He diagnosed acute trochanteric bursitis, apparently in claimant's right hip, which he identified as a direct complication of claimant's industrial accident. He treated this condition with injections of hydrocortisone and local anesthetic. Dr. Horniman reported that, on November 16, 1981, claimant was free of pain in his right hip, had full range of motion in his back and treatment was being continued for claimant's ankle.

Claimant had returned to work on November 2, 1981. On December 17, 1981 Dr. Horniman reported that claimant's condition was medically stationary with no residual disability. He indicated that claimant might have a return of his trochanteric bursitis and might get stiff from time to time in his back.

The claim was closed by a Determination Order dated January 22, 1982, which awarded time loss for the period October 5, 1981 through November 1, 1981, with no award for permanent disability.

Claimant settled his third party action; a closing statement from claimant's attorney's office dated March 30, 1982, indicates that counsel received one-third of the gross third party recovery as an attorney's fee; $4,303.36 was withheld from the proceeds of the third party recovery as reimbursement to SAIF for its claim expenditures, representing $3,322 in medical expenditures and $981.36 in temporary disability benefits paid to claimant. A remaining balance of $4,990.64 was apparently disbursed to claimant.

On April 14, 1982, claimant presented himself to Dr. Horniman, complaining of "abdominal back pain." He was seen by Dr. Horniman on June 7, 1982, complaining of dysuria (painful or difficult urination). Claimant was examined on September 15, 1982, complaining of backache with no complaint of abdominal pain; and again on September 24, 1982 with complaints of abdominal pain in the right subcostal area. Claimant was examined on October 1, 1982 by Dr. Joseph, who stated it was impossible to "put a name to his problem." Claimant expressed various complaints of pain including sharp abdominal pain, pain in the back of the head and back pain.

Dr. Horniman hospitalized claimant for diagnostic procedures on October 11, 1982. His admission report indicates that claimant was convinced that the pain he was then experiencing primarily in his abdomen was in some way caused by his October, 1981 motor vehicle accident. During this hospitalization claimant was examined for possible gastrointestinal pathology. The gastroenterologist examining claimant, Dr. Rosenblatt, concluded that there was no objective data to relate claimant's abdominal and back pain to either his gastrointestinal tract, hepatobiliary system or pancreas. Dr. Rosenblatt commented that his diagnosis did not exclude the possibility that claimant's pain was musculoskeletal in origin and he expressed no opinion concerning the possible relationship between claimant's pain and the motor vehicle accident. Claimant was discharged from the hospital on October 17, 1982.

Dr. Horniman referred claimant to Dr. Fry for evaluation of claimant's recent back symptoms, and in an 827 form submitted to SAIF, Dr. Fry indicated a diagnosis of back strain with minimal scoliosis and no major abnormalities in claimant's spine, apparently manifested by low back and thoracic back pain. On this form, dated November 2, 1982, Dr. Fry indicated that claimant's condition was work related, that claimant was released for work, that he was not medically stationary and that it was undetermined whether claimant's injury would cause permanent impairment.

A November 8, 1982 letter report to SAIF from Dr. Kim states that claimant's current problems of abdominal pain and headaches stem directly from his motor vehicle accident in October of 1981.

On November 9, 1982 Dr. Horniman reported to SAIF that claimant's most recent complaints of abdominal pain were secondary to the trauma he suffered at the time of his motor vehicle accident, based upon the fact that the diagnostic procedures performed during claimant's hospitalization had ruled out the possibility that claimant's pain originated from visceral causes.

Apparently as a result of some emotional or behavioral problems which became manifest during claimant's hospitalization in October of 1982, he was referred for an examination by Dr. Bloch, a psychiatrist. His diagnoses included acute and chronic depressive disorder, somatization disorder as a manifestation of depression, mixed personality disorder with passive/dependent and borderline features.

There is no dispute concerning SAIF's entitlement to reimbursement for payment of $981.36 received by claimant in temporary total disability benefits prior to claim closure on January 22, 1981.

SAIF also apparently claims $213.34 for "time loss" paid to claimant on a diagnostic basis while he was hospitalized in October 1982; however, it is unclear whether SAIF has actually paid either this "time loss" incurred on a diagnostic basis or the costs of claimant's hospitalization in October 1982. Correspondence from SAIF's counsel in December of 1982 indicates that this "time loss" had not actually been paid, and the aforementioned correspondence from Dr. Kim and Dr. Horniman in November 1982 suggest that SAIF was questioning its responsibility for payment of claimant's then-current medical treatment. On this record, we are not satisfied that the $213.34 in question has been paid. It follows that this amount has not been established to be part of SAIF's lien.

Claimant was apparently of the impression that SAIF's lien for expenditures for medical services was in the amount of $3,322. SAIF claims it is entitled to reimbursement for payment of $3,501 in medical bills. We find that, although SAIF's higher figure is more accurate, it mistakenly includes a $94 payment to Dr. Horniman for a narrative report requested by SAIF. SAIF claims it is entitled to reimbursement for the cost of this report, which, according to its records, was obtained for "claims management" purposes. We find that this report was obtained for claim evaluation purposes, and, therefore, for reasons similar to, if not the same as, litigation reports. We have previously held that the cost of a litigation report is the responsibility of the party requesting it. Clara M. Peoples, 31 Van Natta 134 (1981). By analogy, this medical report is not properly a part of SAIF's lien, because it is not an expenditure for "compensation, first aid or other medical, surgical or hospital service." ORS 656.593(1)(c). Deducting the cost of this report from SAIF's claim of reimbursement for medical benefits paid, we find that this portion of SAIF's lien amounts to $3,407.

Based upon the record before us, therefore, SAIF's lien for its actual expenditures is in the amount of $4,388.36. SAIF also

claims a lien for reasonably to be anticipated future expenditures, in support of which it has submitted a statement from one of its claims examiner supervisors, dated May 14, 1982, who estimated future expenditures in the amount of $3,000 for possible medical costs and $1,360 for a possible award of permanent partial disability. No appeal has been taken from the January 22, 1982 Determination Order, and the one year appeal period has since passed. Accordingly, any award for permanent disability that SAIF might become responsible for would arise under ORS 656.273 by way of an aggravation claim, and expenditures incurred by a paying agency pursuant to ORS 656.273 and 656.278 are expressly excluded from the paying agency's lien for claim expenditures. ORS 656.593(1)(c).

The documentation submitted by SAIF reflecting claimant's complaints beginning in April 1982, claimant's hospitalization in October 1982 and subsequent medical treatment, have apparently been submitted in support of SAIF's claim for future expenditures. We have some doubt concerning the relevance of these documents for three reasons. First, there is no indication that SAIF has actually paid any compensation in connection with claimant's hospitalization in October 1982 or medical treatment received thereafter. Second, there is every reason to believe that SAIF has not paid for any of these medical expenses, which is strongly suggested by correspondence from Dr. Kim and Dr. Horniman in November of 1982. Third, just as any claim for permanent disability in futuro would arise under ORS 656.273 or 656.278, and would not be included as a future expenditure within the meaning of ORS 656.593(1)(c), the expenditures for which SAIF might become responsible, as reflected in the documents submitted, could be subject to the same exclusion from SAIF's lien for claim expenditures. This we need not decide, however, because, even if there was some evidence that SAIF would incur additional expenditures recoverable as part of its lien, there is no indication of what the extent of these expenditures might be. We have previously held that, in addition to proving to a reasonable certainty that the paying agency will incur future expenditures, it also must be established to a reasonable certainty what the extent of those future expenditures will be. Larry Campuzano, 34 Van Natta 734 (1982).

The only evidence before us indicating a possibility of future compensable medical services, and what the extent of those might be, is the opinion of SAIF's claims examiner. We find this opinion insufficient to establish a claim for reasonably to be anticipated future expenditures for medical services.

ORDER

The SAIF Corporation is entitled to be paid and retain the sum of $4,388.36 from the proceeds of claimant's third party recovery in full satisfaction of its lien for expenditures for compensation, including its reasonably to be expected future expenditures.

GORDON D. LOBERG, Claimant
Carney et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-05323
April 12, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Knapp's order which found that claimant was permanently and totally disabled due to a combination of compensable work injuries, preexisting disabilities and unfavorable social and vocational factors. SAIF contends that claimant has failed to satisfy the seek-work requirement set out in ORS 656.206(3), specifically noting that he filed for and received some retirement benefits in the latter half of 1981. However, at the hearing claimant's union business representative, his wife and stepson showed that claimant intended to disaffirm his retirement status and to return to work. The Referee found that considering claimant's regular contact with his union representative regarding work and considering the extent of his disabilities during the latter half of 1981, claimant has shown that he put forth a reasonable effort to secure employment as is required by ORS 656.206(3). We agree with the Referee and, therefore, affirm and adopt his order.

ORDER

The Referee's order dated May 19, 1982 is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee on Board review, payable by the SAIF Corporation.

DENNIS H. NELSON, Claimant
Jolles, Sokol et al., Claimant's Attorneys
Schwabe, Williamson et al., Defense Attorneys

WCB 81-11043
April 12, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Mulder's order which upheld the self-insured employer's denial of claimant's aggravation claim. The employer cross-requests review of those portions of the order which awarded claimant 10% unscheduled permanent partial low back disability.

Claimant, who was 35 years of age at the time of the hearing, was employed by Boise-Cascade Corporation as a truck driver. On May 14, 1980 he suffered mid and low back pain when tightening a winch bar on a load of plywood. The claim was accepted and claimant was treated by Drs. Neufeld and Gray. Dr. Neufeld reported on September 11, 1980 that he did not anticipate that there would be any permanent impairment. On September 15, 1980 Dr. Gray reported:

> "I do not feel this patient will [ever] have a sound back. I feel that he will continue intermittently to have problems with his back, probably for the rest of his life. He does have a rather marked scoliosis of his thoracic area. This evidently produces a problem area, which is very susceptible to injury."

Claimant returned to work in September of 1980.

In November of 1980 claimant apparently suffered an exacerbation. Claimant received continued physical therapy and was eventually released to return to work on February 5, 1981. Dr. Gray reported that he had some reservations concerning claimant's motivation to return to work, and:

> "In summary on this patient, we have a patient who has an area in the dorsal area of his back which has marked scoliosis, some evidence of degenerative arthritis is present also, and it would appear that this has been a long-standing problem. However, he works as a truck driver doing heavy work, etc., and he is frequently and easily injured."

Dr. Gray stated that he believed that claimant would need to take a lighter duty job or be retrained. It would appear that Dr. Gray is making this statement in regard to claimant's non-work related scoliotic condition.

A Determination Order issued on April 17, 1981 allowing claimant benefits for temporary total disability only.

On November 9, 1981 claimant returned to Dr. Gray complaining of mid and low back pain. Dr. Gray diagnosed thoracic strain. Claimant was seen by Dr. Neufeld on December 10, 1981. Dr. Neufeld reported that claimant began noticing back pain on November 5, 1981 which was precipitated by having to unload his truck at work. Dr. Neufeld diagnosed thoracic back pain associated with scoliosis.

The employer denied the aggravation claim on November 18, 1981 on the grounds that claimant's aggravation was the result of his helping to drag a deer out of the woods.

On February 3, 1982 Dr. Gray reported that claimant had not informed him of the deer hunting incident when he examined him on November 9, 1981, but that claimant told him he was working a flat bed and was lifting when the pain commenced. Dr. Gray additionally added:

> "I would have to say at this time, that if this incidence of hunting took place, and that shortly after or during this he had the onset of his pain, I would have to say that in all probability that this incident was the triggering of his condition, or the aggravation of the condition."

Claimant testified that he went deer hunting on October 31, November 1, 2 and 3, 1981 in the Estacada area. He stated that his brother shot a deer and that both of them brought it out of the woods to their truck. He further indicated that his back began aching that evening and that by the next morning it was painful enough that he called the company and said he would not be able to work on November 4, 1980. He stated that he did not return to

work on November 5, 1980 and drove a flat-bed truck to St. Helens where a loading device loaded his truck with veneer.

The Referee concluded that he could not find that claimant's November 1981 "aggravation" was related to the previous compensable injury. He additionally stated that this case was distinguishable from Grable v. Weyerhaeuser, 291 Or 387 (1981), but nevertheless concluded that claimant was entitled to an award of permanent partial disability as a result of the original May, 1980 injury.

With regard to the compensability of the November 1981 aggravation claim, we agree with the Referee and affirm those portions of his order. We additionally agree that this is not a Grable situation. Dr. Gray previously stated that claimant had no impairment as a result of the compensable injury and could return to work without restrictions, although he expected further difficulties due to claimant's preexisting scoliotic back condition, not the injury. Strictly speaking, therefore, there was no existing injury-related condition at the time of the deer hunting incident which could have been a material contributing cause of the "aggravation" suffered off-the-job. More correctly, claimant simply sustained a new strain due to his scoliotic back condition, just as Dr. Gray anticipated.

In view of the above, we are somewhat puzzled at the Referee's allowance of a 10% permanent partial disability award. This seems inconsistent with his finding that Grable was not applicable. There is nothing in the record to suggest that claimant suffered any permanent residuals as a result of the compensable injury. We understand Dr. Gray's statement that retraining might be indicated to relate to the claimant's preexisting scoliotic back condition, not to the compensable injury. The fact that claimant might not be able to return to some previous occupations involving heavy work is not, as we understand it, due to any residuals from the 1980 industrial injury. At the time of the hearing, claimant was employed in the same job as before the compensable injury. There is nothing indicating he suffered any permanent residuals as a result of that injury.

ORDER

The Referee's order dated September 1, 1982 is affirmed in part and reversed in part. Those portions of the order allowing claimant 10% unscheduled permanent partial low back disability are reversed. The remainder of the Referee's order is affirmed.

ALFONSO NUNEZ, Claimant
Kenneth C. Dixson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-11046
April 12, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Pferdner's order which awarded him 30% scheduled permanent partial disability for loss of the right foot, that being an increase of 20% over and above the October 14, 1982 Determination Order; found that the Determination Order did not prematurely close the claim; and found that the SAIF

Corporation's refusal to pay claimant temporary partial disability from July 14, 1981 to August 17, 1981, as provided for in the Determination Order, was proper since claimant refused to accept modified employment. ORS 656.325(5).

Claimant has filed no brief with the Board. In the absence of any indication what issues claimant wants reviewed or what relief claimant wants granted, we perceive no error in the Referee's order.

ORDER

The Referee's order dated August 27, 1982 is affirmed.

MARVIN L. POTTS, Claimant
SAIF Corp Legal, Defense Attorney

WCB 82-04885
April 12, 1983
Order Denying Dismissal

The Board received a request by the SAIF Corporation for dismissal of claimant's request for review based on failure of claimant to file a brief.

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

IT IS SO ORDERED.

CURTIS L. WILKERSON, Claimant
Roll & Westmoreland, Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 81-04555, 81-04556, 81-04557 & 81-09656
April 12, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Leahy's order which dismissed an appeal from a Determination Order dated January 11, 1980 as untimely filed and affirmed Determination Orders dated December 4, 1980 awarding no permanent disability for an injury to the left knee, November 25, 1980 and March 5, 1982 awarding 5% permanent disability for an injury to the right arm, and April 16, 1981 awarding no permanent disability for an injury to the low back.

Claimant concedes that the appeal from the January 11, 1980 Determination Order was untimely filed. The issue in each of the remaining cases is extent of disability.

There is a preliminary evidentiary issue. At hearing the Referee did not receive any of the proffered exhibits but rather instructed employer's legal counsel to prepare a master list of exhibits after the hearing. The Referee indicated that he would

deal with the exhibits in his order. When the employer's counsel prepared a master list of exhibits, six exhibits were inadvertently left off. Claimant notified the Referee of this. However, apparently because the employer failed to comply with a post-hearing briefing schedule, the Referee thought claimant was tendering late exhibits. In his order the Referee failed to receive any exhibits and specifically excluded the six that had been left off the master list. Upon being so notified, the Referee prepared an order of abatement but before it could be signed claimant filed his request for review, thereby divesting the Referee of the opportunity to remedy these oversights.

There does not appear to be any controversy concerning what should constitute the evidentiary record in this case. Accordingly, exhibits numbered 1 through 66 in the master list prepared by insurer's counsel are hereby received. In addition, the admission note dated July 10, 1981 (marked Exhibit 54a), Dr. Sirounian's form 1502 dated December 4, 1981 (marked Exhibit 66a), Dr. Sirounian's chart noted dated Fegruary 15, 1982 (marked Exhibit 70a), form 1292 dated February 22, 1982 (marked Exhibit 73a), form 1503 dated February 22, 1982 (marked Exhibit 73b), form 1502 dated February 22, 1982 (marked Exhibit 73c), and form 1503 dated February 24, 1982 (marked Exhibit 73d), are received in evidence.

Based on our review of the record as thus determined, together with the testimony adduced at hearing, we reach the same conclusion as the Referee that each of the Determination Orders properly on appeal should be affirmed.

ORDER

The Referee's order dated August 5, 1982 is affirmed.

MARIE H. BRADSHAW, Claimant
Jolles, Sokol et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-00795
April 14, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Neal's order which awarded claimant 50% scheduled disability to her left foot and which found that her condition was medically stationary as of September 30, 1981. The issues on review are the date claimant became medically stationary and the extent of her disability.

Claimant is a 53 year old former newspaper carrier. She compensably injured her left foot when she stepped on a nail while delivering newspapers. She had a preexisting diabetic condition which had only been treated by diet prior to her industrial injury. Because of the preexisting diabetes the puncture wound abscessed and took many months to heal. At the time of the injury she also began to exerience severe headaches. Her diabetes flared up and required treatment for a time, but has now returned to its pre-injury state. The left foot abscess has healed, but the claimant is left with a mass of scar tissue which makes it feel as though she is walking on a boil. If claimant does any extensive walking the foot swells to three times its normal size. Her

treating physician opines that there is nothing which can be done for the foot condition because surgery to remove the mass of scar tissue would simply result in a new mass of scar tissue.

I. Medically Stationary Date

A Determination Order granted claimant temporary total disability only through September 30, 1981. The Determination Order was apparently based on the report of a consulting physician, Dr. Horniman, who opined that claimant was medically stationary about October 1, 1981. Her treating physician, Dr. Machlan, while declining to assign a medically stationary date, agreed that she was medically stationary and that her condition had not changed after September 1981. We find that claimant was medically stationary on September 30, 1981.

II. The Headaches

Claimant urges us to consider her headaches in determining the extent of her permanent disability. The Referee found that she had failed to prove that her headaches were caused by her compensable injury. We agree.

A specialist, Dr. Crumpacker, said that the headaches are not causally related to the industrial injury, but are merely the result of muscle tension. Dr. Machlan said that he disagreed because muscle relaxants do not seem to help the headaches. However, he was only able to say that his best guess is that the headaches were caused by the industrial injury. He was not able to venture an opinion as to their etiology. We find that this evidence is insufficient to satisfy claimant's burden of proving by a preponderance of the evidence that the headaches were caused by the industrial injury. Accordingly, we do not consider the headaches in determining the extent of claimant's disability.

III. Permanent Total Disability

Claimant contends that she is permanently and totally disabled. The Referee held that she is not. We agree. The medical evidence alone is insufficient to establish permanent total disability. Because her headaches did not begin until after her industrial injury and because she has failed to prove that they are related to the injury, we do not consider them in determining whether she is permanently and totally disabled. Jesse E. Hardy, 35 Van Natta 171 (1983); Emmons v. SAIF, 34 Or App 605 (1978).

The Referee held and we agree that claimant has failed to prove that it would be futile for her to look for work. The only job search she has done is to attempt to return to her previous occupation. She has not participated in vocational rehabilitation.

Claimant has failed to prove that she is permanently and totally disabled. We, therefore, turn to the issue of the extent of disability to her left foot.

IV. Extent of Scheduled Disability

The Referee noted that OAR 436-65-548 is inapplicable in this case because it rates extent of foot disability only in terms of

loss of sensation and loss of motion whereas claimant's foot disability results in loss of function. The Referee correctly applied Boyce v. Sambo's Restaurant, 44 Or App 305 (1980), and rated claimant's left foot disability in terms of loss of function. The Referee awarded 50% scheduled foot disability. While we agree with the Referee's application of Boyce, on de novo review we find that the loss of function to claimant's foot is greater than that determined by the Referee.

Dr. Machlan opined that claimant's foot hurt so much she could not return to her previous occupation as a newspaper carrier. Claimant testified that it feels like she is walking on a boil. The Referee noted that claimant limped when she walked. Claimant testified that if she is on her feet forty five minutes to an hour her left foot swells to the size of a football. When it swells she needs to sit with her foot propped. She testified it takes about one day for the swelling to recede. She also takes medication to control the swelling. As a result of her foot problem she does very little housework. On the basis of this evidence, we believe claimant is entitled to an award of 70% scheduled disability for loss of her left foot.

ORDER

The Referee's order dated September 8, 1982 is modified in part. Claimant is awarded 70% scheduled permanent partial disability for loss of her left foot, in lieu of all prior awards for this condition. The remainder of the REferee's order is affirmed.

Claimant's attorney is allowed 25% of claimant's increased award of compensation, not to exceed $3,000, for services rendered at hearing and on Board review, to be paid out of and not in addition to claimant's compensation.

BARBEL U. EAGEN, Claimant
Hibbard et al., Claimant's Attorneys
Schwabe et al., Defense Attorneys

WCB 81-05998
April 14, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Neal's order which concluded that claimant's claim was not prematurely closed, that claimant had failed to prove that her worsened condition was related to her industrial injury, that claimant was not entitled to a penalty and attorney's fee for failure to accept or deny an aggravation claim within 60 days and that claimant had sustained no permanent disability as a result of her industrial injury.

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

Claimant argues that it is res judicata that her worsened condition is causally related to her industrial injury and not to prior automobile accidents. She bases this argument on the fact that a previous aggravation claim was upheld by an unappealed order of a Referee. We held in Lewis Twist, 34 Van Natta 290 (1982), that where an aggravation claim is denied, the claimant is

generally not thereafter barred by res judicata from asserting a second aggravation claim. By parity of reasoning, where an earlier aggravation claim is ordered accepted, the employer/insurer should generally not thereafter be barred by res judicata from asserting matters of defense if a second aggravation claim is made. On the evidence in this record, claimant has failed to prove that the aggravation claim here in issue is related to her industrial injury.

ORDER

The Referee's order dated July 29, 1982 is affirmed.

AMIL R. FAULKNER, Claimant
Emmons et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-06073
April 14, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Wilson's order which reversed SAIF's denial of claimant's aggravation claim. The sole issue is compensability.

We adopt the Referee's findings of fact which, in relevant part, are as follows. Claimant, now age 55, sustained a low back injury on January 2, 1980. He had been employed as a log truck driver in the timber industry for 35 years. The injury led to two surgeries. The claim was closed by Determination Order dated May 5, 1981 with an award of 45% unscheduled permanent disability. Claimant was desirous of setting up his own firewood business and needed money to purchase a truck. Claimant applied for and received his permanent disability award in a lump sum. Claimant purchased the truck but the firewood business failed to materialize because of difficulties encountered in obtaining certain permits.

Claimant filed an aggravation claim on September 8, 1981. Previous to that date, Dr. Paluska, claimant's treating physician, had submitted medical reports which supported the aggravation claim. In a June 25, 1981 report, Dr. Paluska stated that claimant's condition had worsened, that his condition had been deteriorating since the closing examination in March 1981, and that for administrative purposes, he would ascribe June 12, 1981 as the aggravation date because that was the date claimant sought medical care for "unremitting pain" that could no longer be controlled by medication.

The Orthopaedic Consultants examined claimant on August 7, 1981. Comparing Dr. Paluska's range of motion findings in his closing report of March 1981 and the Consultants' August, 1981 report reveals some loss of range of motion in the low back. In his deposition, Dr. Paluska indicated that differences in range of motion may or may not be significant because the same claimant with the same degree of impairment, depending on such factors as whether that person is having a good day or bad day, may exhibit differences in ranges of motion.

Dr. Paluska based his opinion that claimant's condition had worsened primarily upon claimant's subjective increase in pain. He testified that the muscle spasms claimant was experiencing were more intense than before. At the time claimant sought medical care in June 1981, the treatment for claimant's condition was modified to decrease reliance on pain medication which was becoming less effective and to include a transcutaneous stimulator. Later, a body cast was utilized to determine whether a fusion would benefit claimant. These factors, plus the evidence of a loss in range of motion and the fact that Dr. Paluska was claimant's treating physician since the injury, persuade us that claimant's physical condition deteriorated. Also, the record documents that there are psychological aspects to claimant's compensable condition, variously described but most often denominated as reactive depression and chronic anxiety. Dr. Seres of the Northwest Pain Center opined that these aspects of claimant's condition had worsened. Dr. Paluska's description of claimant's increasingly dishevelved appearance supports Dr. Seres' opinion.

We are aware that Dr. Paluska probably believed that claimant was permanently and totally disabled at the time of the May 1981 Determination Order. We are also aware that part of claimant's motivation in filing an aggravation claim may have been to avoid the effect of ORS 656.230(1), which bars a challenge to the sufficiency of an award of permanent disability where the claimant requests and accepts the award in a lump sum. Lastly, we are aware that the court has held that a determination of extent of disability cannot be relitigated under the guise of an aggravation claim. Deaton v. SAIF, 33 Or App 261 (1978). However, the court in Deaton specifically found that the claimant had failed to prove a change in his conditon. We believe that whether or not a claimant actually was more disabled than a previous Determination Order reflects, or the reasons why a claimant files an aggravation claim, are irrelevant. If the evidence establishes a worsening of the claimant's condition since the last arrangement of compensation, then under ORS 656.273 the claimant is entitled to have his claim reopened, and under ORS 656.268 he is entitled to have the extent of his disability redetermined. The circumstances surrounding a prior award of disability and the claimant's motivation in filing a claim may make it more difficult to persuade the trier of fact that he has sustained a worsening of his condition, but they do not change the legal standard of compensability.

SAIF argues that claimant must establish his aggravation claim by presenting objective evidence of a worsened condition. SAIF cites no relevant authority for that proposition. The cases cited by SAIF involved those situations in which the original compensable injury exacerbated a preexisting noncompensable condition, followed by a natural worsening of the condition. In those cases, there simply was a failure of proof that the worsening was attributable to the injury as distinquished from the natural worsening of the preexisting condition.

Given the nature of claimant's condition, we believe he must produce medical evidence that his condition has worsened. Based on the Orthopaedic Consultants' report and the reports and depositions of Dr. Paluska and Dr. Seres, we are satisfied that claimant has done so, and that he has proven a worsening of the physical aspects

of his condition, Mosquedo v. ESCO Corporation, 54 Or App 736 (1981), as well as the psychological aspects of his condition, Webster v. SAIF, 52 Or App 957 (1981).

ORDER

The Referee's order dated June 9, 1982 is affirmed. Claimant's counsel is awarded $500 as a reasonable attorney's fee, payable by SAIF.

GARY E. FRESHNER, Claimant
Welch, Bruun & Green, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-10556
April 14, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Fink's order which found he is not entitled to payment of compensation for medical benefits pursuant to ORS 656.245. The issue is whether claimant's present claim for medical services is foreclosed because it was, or could have been, litigated in a prior proceeding in which a Referee upheld a denial of a prior aggravation claim. The Referee found that the present claim was barred by the prior litigation. We disagree and reverse.

Claimant sustained a compensable back injury in June of 1977. That claim was processed to closure. Apparently the last award of compensation was a Stipulated Order in November of 1978. Claimant made an aggravation claim sometime in 1981, which SAIF denied by letter dated June 25, 1981. Claimant's request for hearing on that denial was resolved in a prior proceeding, WCB Case No. 81-06332, by a Referee's order dated October 5, 1981 which upheld SAIF's denial. Apparently that order has not been appealed and has become final. After entry of that order, claimant submitted various bills for medical services (mostly prescriptions) to SAIF for payment or reimbursement. SAIF denied responsibility for those bills on the ground that the Referee's order in the prior proceeding, upholding its denial of claimant's prior aggravation claim, had the effect of relieving it from any further duty to provide medical services pursuant to ORS 656.245 for the compensable consequences of claimant's 1977 injury.

SAIF's position concerning payment of claimant's present claim for medical services, therefore, is based upon principles of res judicata. We have previously held that the party asserting the bar of res judicata has the burden of proving what was and/or what could have been litigated in a prior proceeding. Lewis Twist, 34 Van Natta 52, 34 Van Natta 290 (1982). We have also held that an issue concerning entitlement to specific benefits does not arise and, therefore, cannot be litigated, unless and until a claim for those benefits has been denied prior to a hearing. Hettie M. Eagle, 33 Van Natta 671 (1981). The issue in this case, therefore, is whether SAIF has proven that its denial of claimant's prior aggravation claim put in issue before the prior hearing in WCB Case No. 81-06332 exactly the same medical services that are contested in this case.

There is no evidence in this record suggesting that the prescriptions, etc., here in question, were raised as a separate and distinct issue in the prior proceeding. Nor is there any evidence that these medical services could have been raised as separate and distinct issues in the prior proceeding, because there is no evidence that, as separate and distinct claims for compensation, these medical services were then in denied status. Hettie M. Eagle, supra.

SAIF's argument appears to be that the medical services presently in issue were "necessarily included" in its prior denial of claimant's prior aggravation claim. There are certain difficulties with this argument.

"Aggravation claim" is a generic term that covers requests for many different forms of relief. Willard B. Evans, 34 Van Natta 490 (1982). Most often an "aggravation claim" seeks claim reopening under ORS 656.273, but the term can also include a request for medical services only under ORS 656.245. Mary Ann Hall, 31 Van Natta 56 (1981). Cf. Evans v. SAIF, 62 Or App 182 (1983), reversing the Board's decision in Willard B. Evans, supra, and finding claimant entitled to the medical services claimed. We have often recognized that an "aggravation claim" that begins in the form of an effort to get a claim reopened can evolve into a question of medical services only as a necessarily included issue. See, e.g., Billie Gardner, 34 Van Natta 218 (1982). The numerous possible combinations of "aggravation claims," the reasons for denial of such claims and the relief granted, if any, when such denials are litigated, all create some obvious problems when a question arises of interpreting what previously was or could have been litigated for res judicata purposes.

Nevertheless, certain principles are clear. A claimant has continuing rights to medical services pursuant to ORS 656.245. There are very few situations in which the denial of an aggravation claim cuts off all future ORS 656.245 rights. The only such situation that comes to mind would be a completely superseding nonindustrial injury. (A new industrial injury does not terminate a claimant's ORS 656.245 rights but can shift the duty to provide those benefits to a different industrial insurer.) Stated differently, even after denial of a claimant's aggravation claim in the overwhelming majority of situations, that claimant continues to be entitled, theoretically, to some medical services; at least, it cannot be said that such a claimant is entitled to no medical services as a matter of law.

SAIF's argument in this case, as we understand it, is inconsistent with these elementary principles. The denial that gave rise to the prior proceeding in WCB Case No. 81-06332 stated:

> "From the information we have available, it appears that your current problems are not related to your 1977 injury and that your condition has not worsened due to residuals due to your 1977 injury, since claim closure."

"Has not worsened" is irrelevant to the question of entitlement to future ORS 656.245 benefits. Billie Gardner, supra. Furthermore, a reference to "current problems" is hardly appropriate language to use if the intent is to deny all future benefits. Patricia M. Dees, 35 Van Natta 120 (1983). If SAIF believed that the prior litigation in WCB Case No. 81-06332 determined that the medical services presently in issue were not related to claimant's compensable 1977 injury, SAIF had the burden to prove this contention. We find that SAIF has failed to satisfy its burden of proof. We, therefore, disagree with the Referee's conclusion that, by virtue of the prior proceedings in WCB Case No. 81-06332, claimant is foreclosed from claiming the medical services presently in issue.

The Referee's order in the prior proceeding in WCB Case No. 81-06332 was issued on October 5, 1981. The Referee in this case apparently perceived the issues to be whether medical services rendered before October 5, 1981 were barred by res judicata; and whether the claim for medical services after that date were causally related to claimant's 1977 injury, i.e., whether or not claimant had established a causal connection between medical expenses incurred after October 5, 1981 and his original industrial injury. However, we do not think that any issue of causal connection was raised by any party in this case. It is not mentioned in SAIF's denial that gave rise to the current proceeding. It is not mentioned in the request for hearing or any other document filed pre-hearing, nor was it mentioned by counsel at the hearing. The first and only mention is in the Referee's order.

We find the only issue to be whether or not claimant's present claim for medical services is foreclosed because it was or could have been litigated in the prior proceeding. We have determined that it is not. Since this is the only defense asserted by SAIF in support of its refusal to pay the compensation claimed, we find that claimant is entitled to receive payment of or reimbursement for the medical expenses claimed. Accordingly, we reverse the Referee's order finding to the contrary.

ORDER

The Referee's order dated April 9, 1982 is reversed. Claimant's claim for benefits pursuant to ORS 656.245 is remanded to the SAIF Corporation for acceptance and payment. Claimant's attorney is awarded $900 as a reasonable attorney's fee for services at hearing and on Board review, payable by the SAIF Corporation.

CARLA J. HAGEL, Claimant
Evohl F. Malagon, Claimant's Attorney
Schwabe, Williamson et al., Defense Attorneys

WCB 82-03376
April 14, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Johnson's order which upheld the SAIF Corporation's partial denial of responsibility for claimant's spondylolysis and set aside a Determination Order which awarded claimant 10% unscheduled disability for her low back. The

issues on review are whether the partial denial should be affirmed, whether claimant has proven that she has any permanent disability as a result of her industrial injuries, and, if so, the extent of her disability.

Claimant is a 26-year-old mill worker who first compensably injured her back on April 3, 1981 while pulling lumber on a green chain. She was diagnosed as having a low back strain. That claim was closed without an award of permanent disability. On May 19, 1981 claimant again hurt her low back, this time while shoveling sawdust. The condition was again diagnosed as a low back strain. SAIF reopened the April claim on the theory that claimant's condition had worsened. The claim was again closed with a Determination Order granting only time loss. On July 31, 1981 claimant again injured her low back at work while lifting some saws. The condition was again, initially, diagnosed as an acute and chronic low back strain. SAIF accepted the claim as a new injury.

Orthopaedic Consultants found that the claimant had a low back strain, but also diagnosed a condition identified as spondylolysis. Orthopaedic Consultants opined that the spondylolysis was responsible for all of claimant's pain symptoms and was not related to her industrial injuries. SAIF issued a partial denial of the spondylolysis on the basis of the Orthopaedic Consultants' reports.

The most recent claim was closed by a Determination Order of May 21, 1982 which awarded claimant 10% unscheduled disability for her low back problems excluding the condition already denied by SAIF. Both sides requested a hearing on that Determination Order.

We agree with the Referee that the partial denial should be upheld. There is no evidence that the claimant's spondylolysis is related to her industrial injuries.

We do not agree with the Referee that claimant has failed to prove that she sustained permanent disability as a result of her industrial injuries. All the physicians, other than Orthopaedic Consultants, characterize claimant's condition as chronic muscle strain. We understand the term, "chronic", to mean that it is permanent. Although Dr. Wong indicates that he concurs with Orthopaedic Consultants' report, he does not indicate exactly what he is agreeing with. His own, more detailed report, seems to indicate that he believes claimant's condition is work-related. On balance, we believe that claimant has proven that her chronic muscle strain is permanent and is caused by her industrial injuries.

Claimant argues that she is entitled to an award of disability greater than the 10% originally awarded by the Determination Order. We disagree. We conclude that award is appropriate.

ORDER

The Referee's order dated October 12, 1982 is affirmed in part and reversed in part. That portion which upheld SAIF's partial denial is affirmed. That portion which set aside the Determination Order dated May 21, 1982 is reversed, and that Determination Order is reinstated and affirmed. Claimant's attorney is awarded $600 as a reasonable attorney's fee pursuant to OAR 438-47-050(1), payable by the SAIF Corporation.

GARY D. HIGGINS, Claimant
Kenneth D. Peterson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-10297
April 14, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Mulder's order which awarded claimant compensation for permanent total disability effective September 29, 1981. SAIF contends that, although claimant has severe facial pain due to his compensable injury that may prevent him from holding a regular job, claimant is physically fit otherwise and should be able to maintain employment in which he works for himself and can regulate his own hours. The Referee found that claimant had tried a self-employment venture growing greenhouse tomato plants but was unable to succeed in that business, in spite of the fact that claimant had greater control over his working hours. The Referee concluded that as of the time of the hearing, the persuasive evidence was that claimant could not work regularly at suitable and gainful employment. We agree with the Referee and, therefore, affirm and adopt his order.

ORDER

The Referee's order dated August 11, 1982 is affirmed. Claimant's attorney is awarded $600 as a reasonable attorney's fee for services on Board review, payable by the SAIF Corporation.

DAVID A. KIMBERLY, Claimant
Evohl Malagon, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 82-00982
April 14, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The employer/insurer requests review of Referee Baker's order which set aside its January 14, 1982 denial of claimant's carpal tunnel syndrome claim. The issue for review is compensability.

Claimant, who was 31 years of age at the time of the hearing, had been employed by Brookings Plywood as a green chain puller in 1978. After working in this capacity for several months, claimant gradually began to experience pain in his right shoulder, which proceeded to move into his right arm, elbow and wrist. Claimant was treated by Dr. Samuel, a chiropractor, who diagnosed right wrist, thumb, arm and shoulder soreness. Claimant completed a form 801 on January 23, 1979. The claim was initially accepted as a nondisabling injury.

Claimant continued to experience pain in his right extremity and in April of 1979 was referred to Dr. Weinman, an orthopedist. Dr. Weinman diagnosed bicipital tendinitis, right shoulder, mild lateral humeral epicondylitis, right elbow, and DeQuervain's stenosing tenosynovitis, right wrist. Dr. Weinman treated claimant with injections and a temporary respite from work activities. On examination on May 4, 1979, Dr. Weinman found claimant to be much improved and released him to return to work on May 7, 1979.

Shortly after returning to work, claimant was terminated. He returned to Dr. Weinman on August 3, 1979 for a follow-up examina-

tion. Dr. Weinman noted full ranges of motion in both shoulders with no tenderness present in the right wrist. He stated that claimant's wrist had not been painful. Dr. Weinman found claimant to be in need of no further treatment and that he continued to be medically stationary. A Determination Order eventually issued on March 17, 1980, allowing claimant benefits for temporary total disability only. Claimant was referred for vocational assistance, but found to be not eligible on March 18, 1980 since he had no permanent residual physical disability.

Following his termination from Brookings Plywood in May or June of 1979, claimant engaged in a variety of work activities, including unloading fishing boats, which involved a lot of shoveling activity. Claimant testified that this job required a substantial amount of use of his arm and wrist, which caused some pain. Claimant also worked as a caterpillar and scraper operator helping build forest service roads. He testified that this work involved shoveling gravel and setting chokers. Claimant also testified that after leaving his job at Brookings Plywood he did some carpentry work involving construction of a barn and house. He stated that he did some work at his parents' nursery. Claimant was unclear as to the chronology of his work activities following his employment at the plywood mill.

As previously noted, claimant was examined by Dr. Weinman on August 3, 1979 and found to be essentially normal. Claimant did not seek medical assistance thereafter until February 7, 1980, at which time he returned to Dr. Samuel complaining of right extremity pain, apparently aggravated by use of a hammer. The record suggests that this return visit to Dr. Samuel was subsequent to claimant becoming involved in some of his above-noted work activities. Claimant continued to treat with Dr. Samuel for right extremity pain until March 17, 1980. There is then a hiatus of twenty-one months during which claimant sought no medical assistance for any problem related to his right extremity. In the meantime, claimant had requested a hearing in relation to the March 17, 1980 Determination Order. The hearing request was dismissed, however, after approval of a stipulation by which claimant received 15% unscheduled permanent partial disability. The stipulation was approved on October 13, 1980.

Although claimant previously had been determined to be ineligible for vocational assistance, apparently he was approved for a wage subsidy assistance program after he secured employment with Brookside Nursery on April 1, 1981. This program was apparently terminated on June 10, 1981 because claimant was no longer in need of such assistance. Claimant was employed as a management trainee at Brookside Nursery and performed work in all aspects of the business, as his employer Mr. Smith testified, "from the wheelbarrow to a shovel to putting in cuttings to stocking shelves."

On December 3, 1981 claimant returned to Dr. Samuel with complaints of wrist numbness and pain. This was claimant's first visit to Dr. Samuel for this problem in twenty-one months. Dr. Samuel authorized time loss for the claimant and referred him to Dr. Campagna. Dr. Campagna examined claimant on December 17, 1981 and diagnosed:

> "Right carpal tunnel syndrome, secondary to patient's occupation in 1979."

Dr. Campagna requested authorization for surgery from Argonaut, who insured Brookings Plywood. On January 14, 1982 Argonaut issued a denial of the claim. No claim was filed against claimant's most recent employer, Brookside Nursery.

The burden of proof in a workers compensation claim is on the claimant to prove his case by a preponderance of the evidence. Riutta v. Mayflower Farms, Inc., 19 Or App 278 (1974); Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). The current claim is based on aggravation. That being the case, the claimant must establish that the prior compensable injury or condition is a material contributing cause of his currently worsened condition. Grable v. Weyerhaeuser, 291 Or 387 (1981). Has claimant established that his prior compensable injury or condition sustained while employed by Brookings Plywood is a material contributing cause of his carpal tunnel syndrome? We think not.

Carpal tunnel syndrome presents a sufficiently complex medical question to require competent medical evidence on the issue of causation. Uris v. Compensation Department, 247 Or 420 (1967); Dimitroff v. SIAC, 209 Or 316 (1957). The only medical evidence in the record on the issue of causation comes from Dr. Campagna in his report of December 17, 1981 and from Dr. Samuel, claimant's chiropractor. Dr. Campagna, as noted above, says nothing more than claimant's carpal tunnel syndrome is "secondary to patient's occupation in 1979." Claimant testified that he spent only about 25 minutes with Dr. Campagna and that with regard to a history, he gave him "very little." Dr. Campagna's report reflects this. There is nothing in his report to indicate that he was aware of any employment activities on the part of the claimant other than the 1978-79 job at Brookings Plywood. There is, therefore, an approximate two and one-half year gap in Dr. Campagna's history. Significantly, two and one-half years in which claimant engaged in strenuous types of employment activities. This insufficient medical history renders Dr. Campagna's six-word opinion on the question of causation of little or no value. Foley v. SAIF, 29 Or App 151, 156-7 (1977); Weidman v. Union Carbide, 57 Or App 381 (1982).

The only other medical opinion on causation comes from Dr. Samuel in a letter dated March 18, 1982. This is a check-the-boxes type report where claimant's attorney set forth certain propositions and asked Dr. Samuel to indicate his agreement or disagreement by checking a line following "Yes" or "No." On previous occasions we have expressed our general dissatisfaction with "medical opinions" presented in this form. Joyce Adair, 34 Van Natta 203 (1982); William W. Hughes, 35 Van Natta 358 (1983). Dr. Samuel's "opinion" in the present case suffers from the same shortcoming. A mere yes or no answer with no further explanation is not particularly elucidating. Moreover, we believe that there is a significant question as to how much weight is to be given the opinion of a chiropractor with regard to carpal tunnel syndrome, a condition which is basically a neurosurgical problem. Dr. Samuel's "opinion" thus suffers from this additional shortcoming. The Referee was apparently of the opinion that he had no choice but to accept Dr. Samuel's answers to the questions of claimant's attorney. The above-noted shortcomings are sufficient reason for not accepting Dr. Samuel's "opinion." Furthermore, as stated in Edwin Bolliger, 33 Van Natta 559 (1981), neither this Board nor the Referees are

necessarily bound to accept uncontroverted medical opinions.

In short, claimant has presented no convincing medical evidenc linking his current condition, diagnosed as carpal tunnel syndrome to his compensable injury or condition sustained at Brookings Plywood. In finding that the claimant sustained his burden of proof, the Referee relied in part on the fact that the previous 15% stipulated award recognized the fact that claimant suffered a permanent disabling condition. That is correct in a sense. However, the conditions recognized as permanent by the stipulation were diagnosed as bicipital tendinitis of the right shoulder, lateral humeral epicondylitis of the right elbow and DeQuervain's stenosing tenosynovitis of the right wrist, not carpal tunnel syndrome. The fact that carpal tunnel syndrome may in a general way involve some of the same portions of claimant's wrist and arm as were involved in the condition which developed at Brookings Plywood is not conclusive to establish a causal relationship to the previous condition. Miller v. SAIF, 60 Or App 557 (1982); Gallea v. Willamette Industries, 56 Or App 763 (1982). This is especially true in view of our findings that the previous condition had a separate and distinct diagnosis; claimant engaged in nearly two and one-half years of strenuous labor after leaving the plywood mill (which the medical evidence establishes as a contributing cause, assuming it is competent evidence); and claimant required no medical services for his right extremity for a period of nearly two years prior to the carpal tunnel diagnosis. Although the record does establish that the injury or condition sustained at the plywood mill may have been a contributing factor to the carpal tunnel, we cannot, in view of the remaining circumstances, conclude that it was a material contributing factor to the carpal tunnel syndrome.

Apparently there is also a question of whether claimant was involved in an approved program of vocational rehabilitation at Brookside Nursery, by virtue of the wage subsidy program, at the time of the carpal tunnel syndrome diagnosis. We believe that this issue is basically a "red herring" and is not relevant to the determination of the issue of compensability. We find no evidence in the record that claimant was in an approved program of vocational rehabilitation, which in any event was not an issue at the hearing.

ORDER

The Referee's order dated September 21, 1982 is reversed. The January 14, 1982 denial issued by Argonaut is reinstated and affirmed.

VIRGINIA MERRILL, Claimant
Weber, Baumgartner et al., Claimant's Attorneys
Landerholm, Memovich et al., Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB n/a
April 14, 1983
Order on Reconsideration of Order Approving Third Party Settlement

On March 8, 1983 the Board issued an Order Approving Third Party Settlement herein. The industrial insurer thereafter requested reconsideration of that order and an Order of Abatement was entered March 29, 1983. The Board has now been advised that

the parties have resolved the issue raised by the insurer's request for reconsideration and that said request, therefore, is withdrawn. Accordingly, we republish our prior order.

ORDER

On reconsideration the Board reaffirms and republishes its March 8, 1983 Order Approving Third Party Settlement.

SHEREE MILLER, Claimant
Bauske & Eiler, Claimant's Attorneys
Macdonald et al., Defense Attorneys
Schwabe, Williamson et al., Defense Attorneys

WCB 82-04501
April 14, 1983
Order Denying Motion to Dismiss

On December 15, 1982 the Board issued an Own Motion Order Referring for Consolidated Hearing in Own Motion No. 82-0311M, referring claimant's request for reopening of her 1975 injury claim with Bumble Bee Seafoods to the Hearings Division for consolidation with claimant's pending request for hearing in WCB Case No. 82-04501, in which the SAIF Corporation is the insurer and the City of Astoria is the employer responsible for a January 30, 1981 injury. Bumble Bee Seafoods has moved the Board for an order dismissing it from these proceedings, claiming that claimant's current problems relative to her right middle finger are, as a matter of law, the responsibility of SAIF and the City of Astoria, the new injury insurer and employer. SAIF has responded in opposition.

The Motion to Dismiss filed by the employer Bumble Bee Seafoods is denied.

IT IS SO ORDERED.

MARY OFFUTT-LITTELL, Claimant
Lyle Velure, Claimant's Attorney
Schwabe et al., Defense Attorneys

WCB 81-01994
April 14, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The self-insured employer requests review of that portion of Referee Shebley's order which concluded that claimant's compensable 1976 back injury had worsened since her last award of compensation, and thus set aside the employer's March 25, 1982 denial of claimant's aggravation claim. The primary issue on review is whether claimant proved by a preponderance of the evidence that she sustained a compensable aggravation of her prior compensable back injury.

Claimant saw at least four doctors after the October 20, 1981 Determination Order, which is the last award of compensation. One of these was a chiropractor, Dr. Clibborn, who saw claimant for complaints of headaches, low back pain and numbness and pain in her left leg. As the Referee noted, it was only Dr. Clibborn who found

claimant's condition to have worsened. As the Referee also noted, when Dr. Clibborn first reported claimant's condition had worsened, he did so without the benefit of any x-rays or prior exams. Nevertheless, the Referee chose to discount the reports of the other three doctors: Dr. Smith (claimant's surgeon), Dr. Melgard and Dr. Fechtel, a chiropractor, all of whom concluded claimant remained medically stationary and none of whom found a worsening. Instead, the Referee was persuaded by claimant's testimony, which he found credible, "corroborated by that of her mother and the histories related by the physicians who have seen her since October." (Emphasis added.)

As the employer points out in its brief on review, the question of whether claimant's condition had worsened is a complicated matter, requiring expert evidence. The employer cites Jacobson v. SAIF, 36 Or App 789 (1978), which requires not only lay testimony, such as that of claimant, her mother and the histories claimant related to her doctors, but competent medical opinion to support this type of aggravation claim:

> "We think, however, that the difference between the cause of the injury and the cause of the claimed increased pain is substantial enough that a layman needs the assistance of a medical expert. This observation is particularly true with respect to back injuries because pain is frequently, but not necessarily, experienced in other parts of the body, such as the legs, hips, or buttocks; yet pain in those areas is not necessarily the result of the back injury which has been determined to be compensable. In short, the situation is not an uncomplicated one which may be resolved solely by lay testimony." 36 Or App at 792.

We conclude that the medical evidence in this record preponderates in favor of a finding that claimant's compensable low back condition has not worsened since the October 20, 1981 Detemination Order.

Claimant has moved to remand for consideration of additional medical evidence in the form of reports written in connection with claimant's recent back surgery. These additional reports could well change our conclusion about whether the preponderance of the medical evidence establishes a worsening of claimant's condition. In response to the motion to remand, however, the employer advises us that claimant has filed another aggravation claim based on her recent surgery and that a hearing is now pending on that aggravation claim. Under these circumstances, we conclude it would be inappropriate to remand this case for consideration of additional evidence regarding post-hearing medical treatment because that evidence can and should be considered when the pending request goes to hearing.

In view of these conclusions, it is necessary to reach claimant's alternative argument -- that the extent of her permanent partial disability is greater than that reflected in the October

20, 1981 Determination Order. We have considered claimant's age, education, work experience, adaptability to less strenuous physical labor, labor market findings, mental capacity, emotional and psychological findings, post-laminectomy status, impairment and disabling pain. Considering these factors and her prior disability awards, we conclude that claimant has not proven that she is entitled to more permanent partial disability than that previously awarded, which we understand to be 30% unscheduled disability.

Regarding that portion of the Referee's order entitling the employer to an offset equal to the amount of permanent partial disability it paid pursuant to the July 11, 1979 stipulated order, we note that we have taken into consideration claimant's prior receipt of money pursuant to ORS 656.222. In unscheduled disability cases, however, a strict arithmetic offset is not required. Cascade Steel Rolling Mills v. Madril, 57 Or App 398 (1982). Therefore, under the terms of this order, we understand claimant to be entitled to receive the 30% unscheduled disability previously awarded without any credit or setoff.

ORDER

The Referee's order dated July 12, 1982 is reversed.

DOUGLAS J. PETRO, Claimant
Carney et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-09852
April 14, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Pferdner's order which upheld the SAIF Corporation's denial of claimant's left foot claim. The nature of that claim is not completely clear. In 1975, before beginning the employment here in question, claimant had left foot surgery. It is not claimed that the 1975 surgery is compensable. In 1978, claimant began working in a warehouse for this employer. Thereafter, his left foot condition required more medical attention than it had previously required. We thus understand this claim to be primarily a medical services claim under ORS 656.245 for increased medical services allegedly caused by claimant's warehouse work.

The medical services in question are called "debridements" at the site of claimant's 1975 foot surgery. Dr. Noall opines that this form of treatment is a natural and inevitable consequence of the type of surgery claimant had in 1975. That opinion is supported by the fact that claimant received debridement treatments even before he began working in a warehouse.

On the other hand, the frequency of debridement treatments increased during periods of claimant's warehouse work. Claimant received eight debridement treatments while working part-time in the warehouse between June of 1978 and August of 1979. During the next 10 months (August, 1979 to May, 1980) claimant worked full-time in the warehouse office and received three debridements. Claimant then returned to actually working on the warehouse floor, now full-time, and during the following 16 months he received 12

debridement treatments. In sum, medical treatment was necessary more frequently after claimant began warehouse work in 1978 than it had previously been; and medical treatment was necessary more frequently when claimant was actually working in the warehouse than when claimant was working in the warehouse office. From these undisputed facts about the frequency of treatment, we think it is fair to infer that claimant's warehouse work caused the need for some additional treatment that would not otherwise have been necessary.

The problem we confront is that there is no direct evidence, or even evidence that we think would support a fair inference, about the frequency of treatment that would have otherwise been necessary. In this kind of case, we think that the claimant's burden of proof extends to proof of how much additional medical treatment was necessitated by work exposure. In the absence of such proof, we conclude we have no choice but to affirm the Referee's order.

ORDER

The Referee's order dated July 30, 1982 is affirmed.

MILO L. REESE, Claimant
Olson et al., Claimant's Attorneys
Schwabe et al., Defense Attorneys
Cheney & Kelley, Attorneys

WCB 82-05169
April 14, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The employer and insurer request review of Referee Quillinan's order which set aside a denial of claimant's claim for Oregon workers compensation benefits for injuries sustained in connection with his work as an interstate truck driver. (The parties agree that claimant has received and/or is entitled to receive Idaho workers compensation benefits for these injuries.)

Claimant contends that he is entitled to Oregon benefits because he is an Oregon employe. The employer responds that claimant was hired in Idaho and that its direction and control over its truck drivers is exercised from its central office in Idaho.

Since the Referee's order was issued, the Court of Appeals has rejected a very similar claim for Oregon benefits in Hollingsworth v. May Trucking Company, 59 Or App 531 (1982). We see no material distinction between the facts of Hollingsworth and the facts of this case.

ORDER

The Referee's order dated September 21, 1982 is reversed.

WILLIAM H. STOFIEL, Claimant
Danner & Scott, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 83-0088M
April 14, 1983
Own Motion Order

SAIF Corporation has forwarded to the Board pertinent medical documents relating to claimant's claim for an injury sustained on March 3, 1970. Claimant's aggravation rights have expired. SAIF has indicated a willingness to pay for the treatment of claimant's spinal stenosis under the provisions of ORS 656.245. They ask that we consider claimant's entitlement to compensation for temporary total disability.

The Board concludes that claimant is not entitled to compensation for time loss benefits for the following reasons: (1) none of claimant's physicians have authorized time loss benefits and (2) claimant has not had gainful employment for a significant period of time even prior to this most recent "aggravation." Vernon Michael, 34 Van Natta 1212 (1982). Own motion relief is hereby denied.

IT IS SO ORDERED.

DWAYNE WEISSENBUEHLER, Claimant
Galton et al., Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 81-10066
April 14, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee St. Martin's orders which set aside the employer's denial and found that claimant sustained a compensable myocardial infarction. The issue is legal causation.

The dispute in this case involves a conflict in the evidence concerning the sequence of events culminating in claimant's myocardial infarction on September 30, 1981. The history taken on claimant's admission to the emergency room is seemingly inconsistent with claimant's description of the circumstances surrounding his myocardial infarction, as set forth in an 801 form completed with the assistance of claimant's wife and signed by claimant on October 3, 1981, three days after claimant's admission to the hospital.

The medical opinions are unanimous in stating that if the series of events occurred as described by claimant, then his myocardial infarction was caused by his work activity; and that, if the events occurred as recorded by the physician who admitted claimant to the emergency room, then claimant's work activity did not contribute to his myocardial infarction. Accordingly, there is no issue concerning medical causation and the sole question is whether or not claimant has proven by a preponderance of the evidence that he sustained an accidental injury arising out of and in the course of his employment on the day in question. We find that he did, and therefore, affirm the Referee's order.

Claimant was employed as an operating engineer, which involves maintenance of the employer's facilities including general repairs and minor construction. Claimant's particular expertise involves carpentry work. On the day in question, claimant was building shelves during the morning. This involved cutting sheets of birch plywood, 4' x 8' x 3/4" thick, and drilling holes. A co-worker, Larry Bird, assisted claimant in drilling the holes by holding onto the wood while claimant drilled. Claimant testified that while he was cutting and drilling the plywood, he felt fine; however, Mr. Bird testified at the hearing that claimant appeared to be "having trouble because he was sweating profusely."

Shortly before the regular lunch break, Mr. Bird left the area in which claimant was working and claimant stopped drilling. Claimant walked to a nearby area in which sheets of plywood were leaning against a wall. Claimant testified that, in order to reach the piece of plywood he intended to remove from the pile, he had to lean over a number of objects stored in the same area. It was necessary for claimant to lean over these objects and reach behind another piece of plywood. With both hands he grabbed the piece of plywood that he wanted to remove and began to lift it, when he experienced the sudden onset of pain. "[M]y chest just kind of filled up, and the pain started, and it kind of went down my arms, and I got all hot, and just broke into a cold sweat, and I just let it go. I thought 'to heck with it', you know, and I got a drink and washed up and it was lunch time anyhow. * * * [The pain] just kind of stayed there, down to the wrists on both arms, kind of a numbish pain in the chest."

Claimant testified that he went to eat lunch and the pain continued to worsen. He testified that he remembered sitting with his co-workers, but he was uncertain whether he actually ate his lunch. According to his testimony, his last recollection was of getting up to get a drink of ice water, leaving the lunch area and going back to the boiler room. He had no recollection concerning what transpired in the emergency room upon admission.

Three co-workers testified at the hearing concerning their observations of claimant during the lunch break and thereafter. John Wood, claimant's supervisor, with whom he had spent some time during the morning hours, did not observe anything unusual about claimant on the day in question, including during the lunch break. He could not remember whether he observed claimant leave the cafeteria before the lunch break was over. Edward Coultas, another engineer, testified that he did not notice anything different about claimant's appearance during lunch, although he did notice that claimant did not finish eating his sandwich and that he left the lunch area before the break was over. Mr. Coultas sat nearby claimant. Larry Bird, who previously had been working with claimant, testified that claimant sat down next to him in the cafeteria. He testified that it was his observation that claimant did not look well, and that he was pale. He also observed that claimant ate only part of his sandwich and that claimant left before the lunch break was over. The consensus of claimant's co-workers is that claimant is a relatively quiet individual who keeps to himself more than others.

After lunch claimant was found laying across three chairs in the area of the boiler room and emergency assistance was summoned. Claimant was taken to the emergency room and admitted to the cardiac care unit. He was admitted by Dr. Porter, who testified at the hearing.

Dr. Porter testified that, in his estimation, he spent approximately one-half hour with claimant when he was admitted to the cardiac care unit, taking a detailed history, which included a description of the events leading up to claimant's admission to the hospital and general background information concerning claimant's personal and family medical history. In his testimony, Dr. Porter discussed the history he had taken from claimant upon admission:

> "Q: As best you can recall, in reviewing your notes, from the history did you specifically ask Mr. Weissenbuehler about onset of the pain he was complaining about that day?
>
> "A: Yes, I did.
>
> * * *
>
> "A. He indicated he felt well when he came to work that morning, and felt well up to the time he had lunch, and that he had eaten lunch which consisted of a sandwich of processed meat, and milk, and following completion of lunch, he began to feel ill, and lay down in the engineers' office.
>
> "The symptoms he described, in terms of how he felt ill, were that he developed a sensation of severe midretrosternal pain that radiated to both shoulders and down both arms -- the interaspects of both arms -- shortness of breath, profuse sweating, and some light-headedness, and because of these symptoms, he lay down on a cot in what he described as the engineers' office, and was found by one of his co-workers.
>
> "Q. It's your recollection, and the admission reflects, he told you he first started having symptoms of pain after he ate his lunch?
>
> "A. That is correct.
>
> "Q. When he told you his first problems arose after eating the processed meat sandwich, did you query him further as to what else he had eaten, or did you have any other possible diagnosis, other than cardiac involvement?
>
> "A. I knew from the fact that the

physician who was called from the emergency room to see him in the engineers' office had indicated to me his electrocardiogram or rhythm strip taken there, was normal except for a rather slow heart rate, and although the symptoms could reflect mild heart disease or myocardial infarction or angina pectoris, there is another, called acute esophygeal spasm, which mimics a heart attack, and causes immediate excruciating pain in the retrosternal area -- the area behind the sternum. There may be shortness of breath, pulse may be slow or fast, often sweat profusely, and often look very pale. The electrocardiogram may be normal or minimally abnormal in a nonspecific way.

"These patients are often admitted to a coronary care unit because it's impossible to immediately make a diagnosis.

"I questioned him very carefully as to what he had eaten and the relationship of what he ate to the onset of his symptoms.

"Q. Did you provide Mr. Weissenbuehler with the opportunity to elaborate on his history, when you were taking this admission history from him?

"A. When I take a history from patients, I generally ask them to tell me what transpired. I usually start out by saying 'What brings you to the emergency room', and, then, after they have given the history as they see it, I ask specific questions with regard to details I think are important."

The admission history reflects that on admission to the hospital claimant was lethargic, but Dr. Porter testified that claimant was not incoherent or confused.

Claimant's wife testified that she filled out the 801 form upon being informed by her husband of the day's events leading up to his hospitalization. She was uncertain whether claimant had told her about the alleged lifting incident on the day that he was admitted or the day after.

"A: * * * I rushed to the hospital because I was at the school, and as soon as I got there, I naturally wanted to know what happened, you know. I can't remember if he told me right away or not. I think he told me right away in pieces, but he -- I know I remember, during the weeks, asking him different questions of how it happened.

"Q: Was his story always the same?

"A: Always referred to the sheet of plywood he lifted, but I had to ask all of the questions to put them down in detail so I could see in my mind exactly how it happened.

"Q: Did he ever tell you he didn't have any problems until after lunch? Was that part of the history he gave you?

"A: He felt real thirsty when he went to lunch and he needed some cold water and so he had some ice water and didn't feel good and walked off to the boiler room. * * * *.

"Q: Did he ever tell you he was having no problems until after lunch? Did he ever give you that history?

"A: He told me he was fine in the morning. He was doing all of this running around to the Clinic and stuff, and he felt okay, and after he lifted the plywood is when he felt sweaty and had the pain down both arms. I said 'Didn't you think, automatically, of your heart?' That was my first thought, but he said 'No, and 'I just went on the lunch room.'"

The Referee did not find the admission history taken by Dr. Porter to be "controlling", apparently for the reasons that Dr. Porter is an internist and not a cardiologist, and that claimant was under the effects of morphine sulfate at the time he gave the history to Dr. Porter. He also was persuaded by the fact that Dr. Porter was apparently more concerned with making a differential diagnosis of esophageal spasm, which can mimic a heart attack, and did not inquire into any possible exertion that may have precipitated the initial onset of symptoms. We do not agree with the Referee's assessment concerning the effects of the morphine sulfate upon claimant's ability to accurately recount what had occurred; nor do we attribute significance to the fact that Dr. Porter is an internist rather than a cardiologist. Regardless of his particular specialization in the medical field, he is an experienced physician who has dealt with numerous patients in apparent cardiac distress on admission to the hospital.

We do believe, however, that Dr. Porter's interest in making a differential diagnosis explains the apparent discrepancy between the events related by claimant and the history taken by Dr. Porter. We are satisfied that the severe onset of claimant's symptoms occurred while he was eating lunch, although the initial onset of chest pain and radiating arm pain occurred immediately prior thereto as a result of the lifting episode. Although this episode commenced with the lifting incident, claimant did not immediately experience the severity of pain which eventually caused him to leave the lunch room and find a place to lie down. He initially

felt well enough to go to the cafeteria and begin his lunch. The severity of his symptoms increased while he was having lunch. It is not surprising that, when questioned by Dr. Porter as to what brought him to the emergency room, he related the onset of his acute physical stress to being in the cafeteria. It is apparent from Dr. Porter's testimony that, upon hearing the history from claimant concerning his severe pain immediately after eating part of his lunch, he became concerned with identifying other possible causes of claimant's symptoms, such as esophageal spasm, concentrating on events occurring after lunch without questioning claimant concerning events that occurred prior to lunch. We find this a reasonable inference to be drawn from the record before us; and with the aid of this inference, we find that claimant has proven the compensability of his myocardial infarction.

ORDER

The Referee's orders dated June 9, 1982 and July 19, 1982 are affirmed. Claimant's attorneys are awarded $700 as a reasonable attorneys' fee on Board review, payable by the self-insured employer.

HOWARD M. CALDWELL, Claimant
Pozzi, Wilson et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-02328
April 15, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis

The SAIF Corporation requests review of Referee Galton's order which modified the February 26, 1982 Determination Order by granting claimant an award of permanent total disability effective June 8, 1981.

The issue on review is whether claimant has proven by a preponderance of the evidence that he is permanently and totally disabled. Based on our review of the evidence, we agree with the Referee that claimant has proven that he is permanently and totally disabled as defined by ORS 656.206. Claimant is a right-handed, 67-year-old man with a 12th grade education who has worked 37 years as a carpenter, has a bilateral hearing loss, and now has no right-hand control as a result of his compensable right shoulder injury and subsequent right shoulder surgery. We conclude, as did the Referee, that claimant is so handicapped that he will not be employed regularly in any well-known branch of the labor market.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated August 24, 1982 is affirmed. Claimant's attorney is awarded $600 as and for a reasonable attorney's fee on Board review, payable by the SAIF Corporation.

LAVERTA O'NEIL, Claimant
Williamson, Williamson et al., Claimant's Attorneys
Schwabe, Williamson et al., Defense Attorneys

WCB 82-08217
April 15, 1983
Order on Reconsideration of Order of Dismissal

Claimant requested review of the Referee's order dated October 25, 1982. It appeared that the request was filed more than thirty (30) days after the date of the Referee's order and, therefore, was not timely filed. On December 21, 1982 the Board issued an order dismissing claimant's request for review as untimely filed. Claimant's attorney thereafter requested reconsideration of the Board's Order of Dismissal, directing our attention to the fact that the order failed to include a statement of the parties' right to request judicial review in the Court of Appeals pursuant to ORS 656.298. ORS 656.295(8).

Accordingly, we have reconsidered our prior order and find that claimant's request for review was filed with the Board on November 29, 1982, which is more than thirty (30) days after the date of the Referee's order. We, therefore, adhere to our formerly stated conclusion that claimant's request for review was not filed in a timely fashion, and that it must be dismissed. Any party may seek judicial review of this order in accordance with the notice set forth below.

ORDER

Claimant's request for review is dismissed as being untimely filed.

ROBERT WALKER, Claimant
Rankin et al., Attorneys

WCB 81-09592
April 15, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee St. Martin's order which upheld the employer's denial of claimant's aggravation claim and affirmed the Determination Order which made no award of permanent disability. Claimant was represented by counsel at hearing but is not represented on review. On review claimant alleges that he is in need of physical therapy for his low back condition. We construe claimant's allegation to be an argument that the Referee incorrectly affirmed the employer's refusal to reopen the claim on the basis of aggravation. Based on our review of the record we agree with the Referee that there is no basis for aggravation reopening under ORS 656.273. Under ORS 656.245, of course, claimant is entitled to necessary medical care for conditions arising from the compensable injury. We do not understand the employer to have denied, or the Referee to have decided, claimant's entitlement to future medical benefits.

ORDER

The Referee's order dated September 9, 1982 is affirmed.

FLOYD D. WILLIAMS, Claimant
Ackerman et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-06795
April 15, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Seifert's order which affirmed the Determination Order award of 5% unscheduled disability, that award being in addition to 25% unscheduled disability awarded by a previous Determination Order. The Referee concluded that claimant's present impairment attributable to the compensable injury/condition did not exceed the prior awards totalling 30% disability. We have reviewed the record de novo and agree with the Referee. Therefore, we affirm and adopt the Referee's order with the following comments.

We wish to commend counsel for both parties for discussing the evidence in terms of the administrative rules for the evaluation of unscheduled permanent disability (OAR 436-65-600 et seq.). Where the claimant takes issue with the Evaluation Division and the Referee, primarily, is in interpreting the medical reports and lay testimony on the matter of extent of impairment. Although the administrative rules attempt to quantify the measurement of impairment, the determination of extent of impairment frequently is a matter on which reasonable minds can and do differ. Such is the case here.

We did identify one flaw in the claimant's argument that deserves comment because it is an error we see from time to time when parties apply the disability evaluation rules. The administrative rules require that when there are different measures concerning the same body part (e.g., flexion, extension, rotation, etc. in the low back) those measures are to be combined as per the combining charts, not added. Likewise, when all the factors are assembled, the plus values are combined (not added) and the negative values are combined (not added).

We would also comment that we do not rate extent of disability cases based strictly on the administrative rules. As the Court pointed out in Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982), the administrative rules are guidelines for the evaluation of disability, not the last word. Comparing the results of the administrative rules as applied to the evidence in this case with awards of permanent disability in similar cases, we believe that a 30% disability award adequately compensates claimant for his lost wage earning capacity attributable to the compensable injury/condition.

ORDER

The Referee's order dated September 2, 1982 is affirmed.

FLOYD D. WILLIAMS, Claimant
Ackerman et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-06795
April 21, 1983
Order of Abatement

Due to the fact that there appears to be an error in the calculation of claimant's permanent disability award, the Board is hereby abating its Order on Review dated April 15, 1983 in the above entitled matter.

The Board will issue an Amended Order on Review within 30 days of the date of this order.

IT IS SO ORDERED.

JOHN GALANOPOULOS, Claimant
Ivan S. Zackheim, Claimant's Attorney
Robert F. Reide, Defense Attorney

WCB n/a
April 19, 1983
Third Party Distribution Order

This matter is presently before the Board for resolution of a dispute between the claimant and the industrial insurer, State Farm Insurance Company, concerning the proper distribution of the proceeds of a third party recovery obtained by claimant. ORS 656.593. A related issue is the attorney's fee which claimant's attorney is permitted to recover from the third party judgment, pursuant to ORS 656.593(1)(a) and OAR 438-47-095.

In November 1977 claimant sustained a compensable injury, spraining his right ankle. He received conservative treatment at the Kaiser Hospital, consisting of casting with an ankle brace, crutches and protective shoes. The physicians at the Kaiser Hospital released claimant to return to regular work and declared him medically stationary as of December 6, 1977. Claimant continued to experience difficulties with his right ankle after being released from treatment at the Kaiser Hospital, and on January 6, 1978, he sought treatment with Dr. Joseph Y. Aizawa, a podiatrist. Dr. Aizawa found that claimant's right foot and ankle were inflamed and tender to pressure, and he diagnosed a sprain of the "lateral colateral ligament" of the right ankle. He treated claimant initially with flexible casting and physiotherapy. The claim was closed by a Determination Order dated January 20, 1978, awarding claimant temporary total disability compensation for the period November 4, 1977 through December 5, 1977, with no award for permanent disability.

Dr. Aizawa treated claimant's right ankle conservatively for approximately two weeks with physiotherapy and injection therapy, and on February 1, 1978 he performed a surgical procedure by which he attempted to repair claimant's right ankle ligament. Even after surgery, claimant continued to experience pain and instability in his ankle, and Dr. Aizawa prescribed medication for the pain, administered physiotherapy and steroid injection therapy. Claimant treated with Dr. Aizawa for a period of 13 months, realizing no discernible benefit from treatment. Claimant was apparently released to return to work in January 1979, but was unable to work due to pain in his foot. While undergoing treatment with Dr. Aizawa, claimant was receiving temporary disability compensation

In March 1979 claimant changed physicians and began treatment with Dr. John W. Thompson, an orthopedic surgeon. On examination Dr. Thompson found instability in claimant's right ankle and a palpable mass present in the area of the incisional scar, which was very tender and painful. Dr. Thompson diagnosed chronic ligamental instability and a neuroma of the sural nerve. Dr. Thompson advised State Farm of his impressions, recommending excision of the sural nerve tumor and ligamental reconstruction. Surgery was authorized and performed in May of 1979.

After surgery and a period of post-operative treatment, claimant continued to experience difficulties with his right foot and ankle. He had pain in his ankle, although of a different nature than he experienced prior to the surgery performed by Dr. Thompson; and in addition, a sensation of numbness and burning pain of increasing frequency over the lateral side of his right foot. Claimant continued to treat with Dr. Thompson, and saw Dr. Wisdom in April 1980 for a consultation concerning the continued pain problem. Dr. Wisdom found limitation of motion in claimant's ankle as previously noted by Dr. Thompson, which was an expected consequence of the surgical reconstruction procedure performed by Dr. Thompson. Dr. Wisdom stated that claimant's sensation of numbness was a result of the injury to his sural nerve and subsequent resection of the neuroma, which was to be expected. As had Dr. Thompson, Dr. Wisdom expressed uncertainty concerning the etiology of claimant's complaints of lateral foot pain. Dr. Wisdom injected a local anesthetic into the lateral aspect of claimant's right foot, which afforded claimant temporary relief of pain. Claimant continued to treat with Dr. Thompson. He was seen in consultation by Dr. Zimmerman in June 1980, who found decreased sensation on the upper outer part of claimant's right foot. He was of the opinion that claimant's burning, shock-like pain was the type of pain that occurs after a nerve injury. He felt that claimant's condition was stationary and that claimant should attempt some physical therapy in order to increase the range of motion in his ankle. Claimant saw Dr. Thompson in July 1980, at which time Dr. Thompson advised him that there was no further treatment that he could offer.

A second Determination Order issued on April 13, 1981, awarding claimant temporary total disability for the periods January 6, 1978 through October 31, 1978 and January 29, 1979 through July 8, 1980; temporary partial disability for the period November 1, 1978 through January 28, 1979; and 13.5° for a 10% loss of claimant's right foot (ankle).

Claimant pursued a civil action for malpractice against Dr. Aizawa. The jury's verdict awarded claimant in excess of $139,000. State Farm claims a lien against the proceeds of this third party recovery, seeking reimbursement for its expenditures for compensation paid to claimant to date, as well as reasonably to be expected future expenditures. See ORS 656.580(2), 656.593(1)(c).

In an Interim Third Party Distribution Order, we determined that since the consequences of medical malpractice arising out of treatment for a compensable injury or disease are compensable, an industrial insurer is entitled to reimbursement of expenditures

incurred as a result of malpractice when a worker elects to proceed against a physician in a third party proceeding. John Galanopoulos, 34 Van Natta 615 (1982). We held that although the insurer is entitled to reimbursement for its expenditures, reimbursement must be limited to those additional expenditures incurred due to the consequences of the malpractice; and that it is the insurer's obligation, or burden of proof, to establish the extent of the additional expenditures attributable to the malpractice. The parties have now had a full opportunity to address the question of which claim expenditures incurred by State Farm, if any, are attributable to the malpractice committed by Dr. Aizawa. The insurer has made available to the Board copies of the complete transcript of the proceedings in the malpractice action, as well as copies of the complaint and trial memoranda filed by the parties to that action. The insurer has clearly set out its expenditures for medical services and temporary disability compensation, detailing the dates and rates of disability compensation payments, the dates and amounts of medical services provided, the description of the services and by whom they were rendered.

State Farm claims that its lien includes all expenditures for compensation which it incurred as of claimant's first visit with Dr. Aizawa on January 6, 1978, and thereafter, including the cost of surgery performed by Dr. Thompson, temporary disability compensation paid throughout 1978, 1979, 1980, and until claim closure in April 1981, as well as the 13.5° of scheduled permanent partial disability awarded by the April 13, 1981 Determination Order for a 10% loss of claimant's right foot (ankle). State Farm also maintains that claimant will incur future medical expenses, that claimant's permanent disability award may be increased on review of the Determination Order, and that these possible expenditures are reasonably to be anticipated future claim costs which should be included as part of State Farm's lien against claimant's third party recovery.

In addition to the transcripts of testimony presented at the trial in the malpractice action, claimant has submitted the deposition of Dr. Thompson, taken subsequent to the malpractice trial. State Farm has objected to the admission of this testimony, stating that it is not relevant to a determination of the issues presently before the Board in this proceeding. We disagree, and find Dr. Thompson's deposition highly relevant to the essential issue presently before us: the extent of the industrial insurer's claim expenditures which are attributable to the malpractice committed by Dr. Aizawa. We have considered Dr. Thompson's deposition testimony, as well as the testimony of the witnesses at trial, including Dr. Thompson. Reviewing the record before us, we find that State Farm Insurance Company has proven that a portion of its expenditures for compensation paid to claimant are attributable to the malpractice committed by Dr. Aizawa, and that it is, therefore, entitled to reimbursement for these expenditures; however, we do not find that State Farm is entitled to reimbursement to the full extent claimed.

It is apparent that, after claimant was released from treatment with the Kaiser Hospital, he continued to experience symptoms associated with pain and instability in his ankle, which caused him to seek treatment with Dr. Aizawa. There is no evidence that

claimant's ankle was fully healed when he sought treatment with Dr. Aizawa in January 1978. In fact, any inference that could be drawn is to the contrary; i.e., it would make little sense for a man who was experiencing no further problems with a medical condition to seek additional care. Although, at the trial, Dr. Thompson was asked to assume, for purposes of a hypothetical question, that, when claimant sought treatment with Dr. Aizawa his ankle condition was stable, the record presently before the Board indicates that, in fact, claimant's ankle condition was not stable at the time he sought treatment with Dr. Aizawa. Dr. Thompson indicated his opinion that claimant's ankle condition was not stable in his trial testimony, and his depositional testimony is further support for this conclusion. The fact that claimant may have persuaded the jury sitting on the malpractice action that claimant's ankle condition, once stable, was rendered unstable by Dr. Aizawa's surgery, is not evidence of that fact in view of the jury's general verdict, particularly in light of the medical evidence to the contrary.

All of the medical evidence indicates that Dr. Aizawa's malpractice consists of two elements: useless and unnecessary surgery performed directly on claimant's ligament which did not help the condition of claimant's ankle, but also did not contribute to a worsening of that condition; and, by carelessly performing the surgery, Dr. Aizawa apparently injured the sural nerve causing a neuroma to form. Another element of possible malpractice was the numerous injections administered to claimant into his ankle, which possibly could have been responsible for the formation of the neuroma, either independently of, or in conjunction with, a negligent act committed in the course of the surgical procedure.

Dr. Thompson's surgery served two functions. Primarily, he performed surgery to reconstruct claimant's ankle in order to give it more stability and prevent the possibility of future injury. Secondarily, Dr. Thompson performed surgery to explore the sural nerve and eliminate the painful neuroma. The primary procedure, i.e., reconstruction of the ankle, would have been necessary even in the absence of Dr. Aizawa's useless surgery and treatment, and was a direct result of claimant's original industrial injury of November 3, 1977. Excision of the neuroma was caused by Dr. Aizawa's negligent treatment or surgery. Because both surgical procedures were performed at one time, segregating the costs of each prevents some difficulty; however, Dr. Thompson testified in his deposition that all of the costs of the surgery would have been incurred even in the absence of the need to excise the neuroma. Therefore, the only additional medical expenditure, in terms of the surgery rendered by Dr. Thompson, was the cost of resecting the neuroma. The remaining expenditures, including hospitalization, anesthesia and the cost of Dr. Thompson's services for ankle reconstruction, would have been incurred by the insurer even in the absence of Dr. Aizawa's malpractice.

Since these expenditures would have been incurred solely as a result of claimant's original 1977 injury, even in the absence of the intervening negligent medical treatment, we are unable to find that these are additional expenditures attributable to the malpractice. State Farm's lien, therefore, does not include any expenditures for medical services rendered by Dr. Thompson, other than $140, which is the amount charged by Dr. Thompson for resection of the sural nerve tumor.

State Farm is entitled to reimbursement for the cost of the medical services rendered by Dr. Aizawa. The cost of these medical services were included, or should have been included, as an element of damages recovered by claimant in the malpractice action. Furthermore, it would make little sense to hold that the cost of treatment by a physician who has been adjudged to have committed malpractice is not itself an additional expenditure incurred by the industrial insurer as a result of the malpractice. Dr. Aizawa examined and treated claimant during the month of January 1978 prior to performing surgery on February 1, 1978, and claimant contends that the medical services rendered by Dr. Aizawa prior to the surgery should not be recoverable by the insurer as part of its lien. We do not agree because, on the basis of the record before us, there is some uncertainty as to whether the sural nerve tumor was actually caused by a negligent surgical procedure, or whether Dr. Aizawa's injection therapy caused or contributed to the formation of the neuroma. Accordingly, we find it more appropriate to allow the insurer to recover all of its expenditures associated with Dr. Aizawa's treatment, rather than solely those expenditures for treatment dating from the surgery and thereafter.

Our finding that Dr. Aizawa did not worsen the condition of claimant's ankle other than to cause a formation of a painful nerve tumor which was subsequently excised, leads us to the conclusion that if claimant had sought treatment with Dr. Thompson, as he eventually did, instead of with Dr. Aizawa, he would have continued to receive compensation for temporary total disability as a result of his original industrial accident up until the termination of payment was authorized by the Determination Order. The additional temporary total disability compensation that has been expended by the insurer as a result of Dr. Aizawa's negligence is the temporary disability compensation paid to claimant during the time that he treated with Dr. Aizawa; i.e., from January 6, 1978 until the time that claimant began treatment with Dr. Thompson, which appears to have been March 13, 1979.

There is no evidence that Dr. Aizawa's unnecessary surgery caused claimant any permanent impairment. Nor is there evidence indicating that claimant suffers from any permanent residuals as a result of the sural nerve tumor and the subsequent surgery by which it was removed. The permanent loss of use or function that claimant does suffer from is a necessary result of the surgery performed by Dr. Thompson, which was intended to stabilize claimant's ankle. This surgical procedure has resulted in a loss of motion in the ankle, which is an expected consequence. Dr. Aizawa's attempted repair of claimant's ligament did not increase, or even contribute to, this residual impairment. The evidence concerning the etiology of claimant's continuing complaints of pain does not establish whether it is due to the injury to the sural nerve or whether it is a consequence of claimant's original ankle injury. The only clear evidence of residual loss resulting from the excised tumor is a loss of sensation and numbness in claimant's foot, and there is no medical evidence to substantiate a finding that this results in a loss of use or function in claimant's foot or leg. Any permanent disability award claimant has already received or may receive in the future is, therefore, not a result of Dr. Aizawa's negligent

treatment, but is solely a result of claimant's 1977 industrial injury. Compensation for permanent disability, therefore, would have been an expenditure incurred by the insurer even in the absence of the malpractice. Accordingly, claimant's permanent disability award is not an expenditure that can be included as part of the insurer's lien against the proceeds of his third party recovery.

Having determined that claimant's permanent disability is attributable to his original industrial accident, with no contribution from the malpractice, the only remaining claim for future expenditures would be for future medical treatment. It is unnecessary for us to attempt to determine whether claimant will incur future medical expenses as a result of Dr. Aizawa's malpractice, which the insurer is required to establish to a reasonable certainty. LeRoy R. Schlecht, 32 Van Natta 261 (1981), reversed in part on other grounds, 60 Or App 449 (1982). The record does not indicate that claimant will require further treatment as a result of any condition of his ankle, let alone the problem caused by Dr. Aizawa's malpractice. In fact, the evidence is to the contrary. A July 8, 1980 office note from Dr. Thompson indicates that he advised claimant on that date that he had nothing further to offer claimant in terms of additional treatment for his ankle condition, and it was his opinion that no further treatment was indicated. The last entry in Dr. Thompson's office notes is dated November 24, 1980, which coincides with the record of the office visits paid by State Farm, and this entry does not indicate a need for continuing treatment. State Farm's counsel referred claimant to Dr. Grossenbacher for examination, and in a June 25, 1981 letter report, Dr. Grossenbacher expresses his opinion that no further orthopedic diagnostic testing or surgical care would be anticipated in the future within medical probabilities. "Therefore, minimal if any future medical expenses are anticipated." Dr. Thompson's deposition, taken September 7, 1982, contains no reference to reasonably to be anticipated future medical expenses for treatment of claimant's ankle condition. Accordingly, State Farm has failed to establish any such claim.

In conclusion, State Farm Insurance Company is entitled to be paid and retain a portion of the proceeds of claimant's third party recovery to the extent of its expenditures for compensation which are attributable to the malpractice committed by Dr. Aizawa. State Farm is entitled to reimbursement for the cost of Dr. Aizawa's medical services, which, according to the records provided by State Farm, amounts to $1,495.85, and for the cost of excision of the sural nerve tumor by Dr. Thompson, in the amount of $140. State Farm also is entitled to reimbursement for the compensation paid claimant for temporary disability for the period claimant began treatment with Dr. Aizawa until he began treatment with Dr. Thompson; i.e., from January 6, 1978 through and including March 12, 1979. The amount of these expenditures represent the full extent of State Farm's lien against the proceeds of claimant's third party recovery.

We next address the issue raised by claimant concerning claimant's attorney's entitlement to an attorney's fee equivalent to 40% of the gross recovery obtained in the malpractice action.

In our Interim Order, we found that the administrative rule governing attorney's fees in third party actions prohibited receipt of an attorney's fee in excess of one-third of the gross third

party recovery obtained by the claimant. 34 Van Natta 615 at 617. We have since reconsidered our interpretation of the administrative rules governing attorney's fees in proceedings arising out of third party actions and concluded that OAR 438-47-010(2), providing for authorization of an extraordinary fee, applies to recovery of attorney's fees in third party actions. Leonard F. Kisor, 35 Van Natta 282 (1983). In Kisor we held that this Board has the authority pursuant to ORS 656.593 to allow an attorney representing a claimant/plaintiff in third party litigation an attorney's fee in excess of one-third of the total proceeds of a third party recovery where the attorney makes a satisfactory showing that such a fee is warranted, and counsel's receipt of such a fee is consistent with the retainer agreement entered into between the attorney and client. Given the proper showing, therefore, claimant's attorney herein may be entitled to receipt of a fee equivalent to 40% of the total proceeds of the third party recovery, as requested.

As part of the information originally submitted by claimant in his application to the Board to order a proper distribution of the proceeds of his third party recovery, claimant's attorney submitted an affidavit detailing the efforts expended in preparing claimant's case for trial and in trying the malpractice action. The retainer agreement entered into between claimant and his attorney is a contingency agreement providing for counsel's receipt of 40% of the gross recovery in the event of a trial. Claimant apparently had been represented by prior counsel, who recommended that he settle his cause of action against Dr. Aizawa for $10,000. Claimant was dissatisfied with the advice of this attorney and sought the services of his present attorney, who took the matter to trial and obtained an unanimous jury verdict in excess of $139,000. Counsel's affidavit states that for three months prior to trial his representation of claimant occupied the vast majority of all of his working time. He was required to extensively interview claimant, members of his family and friends. He was required to engage in fairly extensive medical research, and he interviewed several local podiatrists regarding the standard of care for a podiatrist treating this type of injury. The trial itself lasted five days.

We are satisfied that the efforts expended by counsel in the course of preparing for and trying the malpractice action represent extraordinary services within the meaning of OAR 438-47-010(2), as evidenced by the apparently good result obtained in claimant's behalf; and that counsel is, therefore, entitled to receive an attorney's fee in excess of the 33-1/3% which is ordinarily recoverable by an attorney representing a claimant/plaintiff in third party litigation. OAR 438-47-095.

ORDER

The proceeds of claimant's third party recovery shall be distributed according to the formula set forth in ORS 656.593(1). Claimant's attorney is entitled to receive 40% of the gross recovery obtained by claimant. State Farm Insurance Company shall be paid and retain those medical expenses and compensation for temporary disability which are attributable to the malpractice committed by the third party defendant, as set forth more fully above, in full satisfaction of its lien for claim expenditures for compensation paid to or in behalf of claimant. Upon reimbursement to State Farm and satisfaction of its lien as provided herein, any balance remaining from the proceeds of the third party recovery shall be paid to and retained by claimant.

DARYL W. GARDNER, Claimant
GREENWAY EROSION CONTROL, Employer
Carl Davis, Assistant Attorney General

WCB 82-00425
April 19, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The noncomplying employer requests review of Referee Neal's order which dismissed its request for hearing. The noncomplying employer had requested a hearing to contest the SAIF Corporation's acceptance of claimant's claim. Although duly notified of the hearing, the noncomplying employer did not appear at the hearing, which led to the Referee's Order of Dismissal. That order stated it would be reconsidered if the employer showed good cause for its nonappearance.

The noncomplying employer's request for review explains it failed to appear at the hearing "through misunderstanding and poor communications in our office." The noncomplying employer has not filed any brief or affidavit elaborating on this explanation.

On this record, we do not find good cause for failure to appear at the hearing.

ORDER

The Referee's order dated October 11, 1982 is affirmed.

MELLISA P. JOHNSON, a Beneficiary
RAYMOND YORK, JR., Claimant (Deceased)
Ferder et al., Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-07371
April 19, 1983
Order on Review

Reviewed by the Board en banc.

The claimant, a minor child, requests review of Referee Baker's order which upheld a denial of her claim for benefits arising from the death of her father, Raymond York, Jr. in a compensable accident. The issue is whether claimant is a beneficiary within the meaning of either ORS 656.226 or 656.204. We find claimant's statutory construction argument unpersuasive. With respect to claimant's constitutional arguments, we previously have held that we are without the authority to decide such issues. Sidney A. Stone, 31 Van Natta 84 (1981), reversed in part on other grounds, Stone v. SAIF, 57 Or App 808 (1982), petition dismissed, 294 Or 442 (1983).

ORDER

The Referee's order dated August 20, 1982 is affirmed.

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

WCB 81-06759
April 19, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review, and the SAIF Corporation cross-requests review, of Referee Foster's order which found that, although the claimant was entitled to an unscheduled award in addition to the scheduled award granted by the July 14, 1981 Determination Order, the evidence did not indicate that claimant was permanently and totally disabled.

Claimant contends that he is permanently and totally disabled, considering his substantial physical impairment in his left hip and leg in combination with his advanced age, his limited education and his inability to return to his welding job, which he held for 37 years prior to his compensable injury.

We agree with the Referee that although claimant is suffering considerable disability due to his injury, the preponderance of the evidence shows that he is not totally precluded from performing some sort of light work such as light welding.

SAIF contends that compensation for unscheduled disability should not have been awarded by the Referee because there was no showing of impairment in the left acetabulum warranting an unscheduled. In the alternative, SAIF claims that both the scheduled and unscheduled award should be markedly reduced from that granted by the Referee.

The Referee set out the claimant's considerable physical limitations as well as his unfavorable social and vocational factors. The record indicates separate impairment exists in the left acetabulum, as well as in the left leg, justifying a separate unscheduled award. Robert L. Akins, 35 Van Natta 231 (1983); John Cameron, 34 Van Natta 211 (1982). We note that, in awarding claimant 40% unscheduled disability compensation, the Referee stated that this additional award was partially reduced because of the previous scheduled left leg award. Therefore, he did take into account some overlapping disability of the scheduled left leg and unscheduled left hip impairments.

We find that the Determination Order's scheduled award of 67.5° for claimant's scheduled left leg disability and the Referee's additional 128° unscheduled award for claimant's left hip disability are reasonable and we, therefore, affirm and adopt the Referee's order.

ORDER

The Referee's order dated October 8, 1982 is affirmed.

MARTHA MOUNT, Claimant
Evohl F. Malagon, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 82-02603
April 19, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Seymour's order which upheld the insurer's denial of claimant's aggravation claim. The insurer denied responsibility for claimant's current back difficulties on the ground that such were not due to her employment at Roseburg Lumber Company, but to a new and specific injury incurred in January of 1982 when claimant picked up a laundry basket full of clothes.

The primary issue is whether claimant's 1979 compensable industrial injury was a material cause of her worsened condition after January of 1982. A preliminary issue is variously stated: (1) that the Referee erred in denying claimant's motion to postpone the hearing; (2) that the Referee erred in denying claimant's request to keep the record open; and (3) that we should remand this case to the Referee for further evidence taking.

We find no motion to keep the record open and no ruling by the Referee on such a motion; we thus conclude there is no cognizable issue presented.

At the outset of the hearing, claimant's attorney twice moved to postpone. The first request was "so that further inquiry of Dr. Woolpert may be had." The second was "in order to gain opportunity to further explore the matter with Dr. Woolpert." The Referee denied these motions.

We agree with the Referee. Claimant filed a request for hearing and application to schedule hearing on March 24, 1982. The application to schedule recited that "claimant is ready for hearing and prepared with all medical reports and other evidence." Notice that the hearing was set for August 19, 1982 issued on June 28, 1982. When the hearing convened on August 19, it had thus been almost five months since claimant recited readiness for hearing and almost two months since notice of the hearing date issued. Claimant's request for postponement was presented orally at the beginning of the hearing. Under all of these circumstances, we agree with the Referee's decision not to postpone.

Likewise, and for substantially the same reasons, we deny the request for remand. The remand request is unusual in one regard. Ordinarily the party seeking remand tenders the evidence that would be introduced on remand so that we can assess materiality. E.g. Robert W. Dalton, 35 Van Natta 352 (1983). In this case, however, claimant has not tendered any additional evidence from Dr. Woolpert. The only references at hearing were to obtain further "inquiry" and "exploration" with the doctor. Claimant's brief on review states only that additional analysis by Dr. Woolpert "might" produce probative results. We are not even sure that this is an adequate request for remand. If it is, we find it does not satisfy the standards of Ora M. Conley, 34 Van Natta 1698 (1982), and Robert A. Barnett, 31 Van Natta 172 (1981). As we said in Barnett:

"In ongoing medical treatment or vocational training situations -- situations that frequently give rise to motions to remand -- the parties should decide when they want disputed issues resolved based on the available evidence and not rely on motions to remand based on subsequently obtained evidence as a fallback possibility." 31 Van Natta at 174.

On the merits, we affirm and adopt the Referee's order finding that claimant's back condition after January of 1982 was not proven to be a compensable aggravation of her 1979 industrial injury.

ORDER

The Referee's order dated August 31, 1982 is affirmed.

RAY LYNN YORK, a Beneficiary
RAYMOND YORK, JR., Claimant (Deceased)
Karol Wyatt Kersh, Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-07370
April 19, 1983
Order on Review

Reviewed by the Board en banc.

The claimant, a minor child, requests review of Referee Baker's order which upheld a denial of his claim for benefits arising from the death of his father, Raymond York, Jr. in a compensable accident. The issue is whether claimant is a beneficiary within the meaning of either ORS 656.226 or 656.204. We find claimant's statutory construction argument unpersuasive. With respect to claimant's constitutional arguments, we previously have held that we are without authority to decide such issues. Sidney A. Stone, 31 Van Natta 84 (1981), reversed in part on other grounds, Stone v. SAIF, 57 Or App 808 (1982), petition dismissed, 294 Or 442 (1983).

ORDER

The Referee's order dated August 20, 1982 is affirmed.

CANDY J. HESS, Claimant
Gatti & Gatti, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-08812
April 20, 1983
Order

Claimant has filed a request for review of an order of postponement dated March 21, 1983. An order of postponement is not a final order and is not within the Board's jurisdiction.

The request for review is denied.

IT IS SO ORDERED.

WAYNE H. NICHOLS, Claimant
Bischoff & Strooband, Claimant's Attorneys
Minturn et al., Defense Attorneys

WCB 81-03769
April 20, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Williver's order which upheld the SAIF Corporation's denial of his claim for a back injury allegedly sustained in January of 1981.

Claimant argues on review that he sustained a back injury as a result of a specific incident while he was lifting rocks on January 20, 1981, as corroborated by the fact that he consulted his doctor the next day. On the contrary, we find that claimant's hearing testimony contains several different versions of the events of January 1981, including a specific lifting incident on the 20th and also a description of a gradual onset of back pain over a two week period -- all of which leaves us with some doubt about what really happened. That doubt becomes dispositive when we consider Dr. Miller's April 19, 1982 report about claimant's office visit on January 21, 1981:

> "At that time, he complained of pain in his left shoulder medial to the superior angle of the scapula and was significantly relieved by ultrasound. There is no other notation about any complaint referrable to his back at that time."

ORDER

The Referee's order dated October 28, 1982 is affirmed.

JOSE A. DELOS REYES, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10236
April 20, 1983
Order

Claimant has filed a request for review of an order of postponement dated April 5, 1983. An order of postponement is not a final order and is not within the Board's jurisdiction.

The request for review is denied.

IT IS SO ORDERED.

SIDNEY C. BEATY, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-06704
April 21, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which affirmed the insurer's denial dated July 13, 1981. The Referee found that claimant was unable to substantiate that: (1) his left hip and low back condition was connected to his employment; (2) that he filed an injury claim or reported an industrial injury to

the employer within thirty days; or (3) that he had shown good cause for failing to report his injury within thirty days of the alleged October 10, 1980 injury.

Claimant has attached reports to his Board review briefs from Dr. Gerald E. Jacobs, Dr. Richard Boggess, and Dr. C. W. Davis as well as two affidavits from co-workers that were not part of the transmitted record. It appears that the record was held open for a time by the Referee in order to receive reports from certain of the claimant's treating doctors. The offered report from Dr. Jacobs, a treating doctor, was sent to the Referee before the record was closed, but it is not clear from the record whether that report was admitted into evidence or considered. Since the record was held open to admit just such a report, we have assumed that Dr. Jacob's report was meant to be part of the admitted record and, therefore, we have considered the report on review.

The record does not reveal that it was specifically held open for a report from Dr. Davis or for affidavits from claimant's co-workers. We consider the offer of these documents to be a request to remand the case to the Referee for admission of these documents into the record. However, our examination of these documents does not show that they could not have been generated prior to the hearing and submitted at that time. Therefore, these documents do not meet the requirements of Robert A. Barnett, 31 Van Natta 172 (1981), and Ora M. Conley, 34 Van Natta 1698 (1982), and remand will not be granted.

Finally, the report by Dr. Boggess, a treating doctor, was not submitted to the Referee prior to the date the record was closed. The record shows that claimant had tried to get in touch with Dr. Boggess, but was unsuccessful because the doctor had moved. It was not until claimant was preparing his brief to the Board in December 1982 that Dr. Boggess was located. Dr. Boggess' report presents the strongest case for remand under the standards of Barnett and Conley. However, we find that remand is not appropriate in this case because, regardless of whether or not Dr. Boggess' report is admitted into evidence, we would affirm the Referee's order denying compensability. Claimant has stated in his brief that Dr. Boggess' report would show that claimant did sustain a compensable injury on October 10, 1980 and that he did seek treatment from Dr. Boggess shortly thereafter on October 17, 1980. While Dr. Boggess' report would be helpful in proving claimant's contention that he actually sustained a left hip and low back injury on the job on October 10, 1980, it does nothing to sustain his contention that he reported that injury to his employer within thirty days or that he had good cause for not reporting the injury within that time period. This latter issue is the one on which claimant's claim ultimately fails.

We find there was much conflicting evidence on whether or not claimant actually reported the injury to his employer within thirty days and, if he did not, whether he had a good reason for not submitting a claim for the injury until June 1981. Much of the outcome of the determination of this issue depended on the conflicting statements of the employer, Bob Drum, and claimant's co-worker, John Walters, who were not present at the hearing. Their statements were taken by deposition. Their absence made it impossible for the Referee to make a finding regarding their credibility.

Like the Referee, we find that too many questions were left unanswered by the evidence, causing us to find that claimant has not proven by a preponderance of the evidence that he has a compensable claim because, even if he suffered an on-the-job injury on October 10, 1980, he has not proven that he reported the injury to his employer within thirty days or that he had good cause for not reporting the injury to the employer within that time period. Therefore, we affirm and adopt the Referee's order.

ORDER

The Referee's order August 6, 1982 is affirmed.

JOHN A. BEAUDIN, Claimant
Richardson, Murphy et al., Claimant's Attorneys
Mitchell et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Bottini & Bottini, Defense Attorneys

WCB 81-00203
April 21, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Daron's order which found claimant's left carpal tunnel syndrome not compensable. The issues on review are whether claimant proved by a preponderance of the evidence that his left carpal tunnel syndrome is compensable and, if so, which of two insurers, the SAIF Corporation or Argonaut, is responsible.

Claimant asserts that the medicals and his testimony establish a compensable left carpal tunnel syndrome caused by his work, and that the only issue is responsibility. We disagree. We agree instead with the Referee's determination that claimant failed to meet his burden of proof and affirm and adopt his finding that the claim is not compensable. We, therefore, do not reach the responsibility issue.

ORDER

The Referee's order dated September 15, 1982 is affirmed.

STEPHEN E. BERRY, Claimant
RICHARD L. DAY dba DAY'S TRUCKS, Employer
Michael B. McCord, Claimant's Attorney
Van Vactor et al., Attorney
SAIF Corp Legal, Attorney
Carl M. Davis, Attorney

WCB 81-09755
April 21, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer, Richard Day, requests review of Referee Daron's order which affirmed the order of the Director of the Workers' Compensation Department, declaring: (1) Day to be a non-complying subject employer between February 16 and June 14, 1981; and (2) claimant to be a subject employe.

The primary issue on review is whether claimant was a subject employe on June 13, 1981, the date claimant was injured when the brakes failed on a truck he was driving for the employer, Day. In essence, Day argues that claimant was an independent contractor or, in the alternative, that claimant falls under the casual labor exception of ORS 656.026(3)(a).

After our review of the record, we come to the same conclusion as did the Referee: that Day was a non-complying subject employer on June 13, 1981, and claimant a subject employe on that date.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated July 29, 1982 is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee on Board review, payable by the employer.

MICHAEL G. BROWN, Claimant
WILLIS W. and SANDRA K. KINDER, Employers
Welch et al., Claimant's Attorneys
Carl Burnham, Attorney
SAIF Corp Legal, Attorney
Carl Davis, Attorney

WCB 81-09209
April 21, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Danner's order which affirmed the SAIF Corporation's September 25, 1981 denial of claimant's back injury, incurred while driving the employer's truck in Idaho on June 29, 1981. The denial stated that SAIF could not accept the claim because claimant was not a subject worker of the employer, Willis and Sandra Kinder, at the time of the injury. The issue on review is the compensability of claimant's back injury, which turns upon the issue of whether claimant was a subject worker, and the Kinder's a subject employer, at the time of injury, pursuant to ORS 656.126(1).

Claimant argues that he comes within ORS 656.126(1), in that he was hired to work in Oregon and only temporarily left Oregon to work in Idaho, incidental to his Oregon employment. We agree, however, with the Referee's contrary conclusion that claimant was hired to work in Idaho permanently and was in the course of his Idaho employment when the injury occurred. We, therefore, affirm and adopt the Referee's order.

ORDER

The Referee's order dated August 24, 1982 is affirmed.

MARY A. DORAMUS, Claimant
Wade P. Bettis, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-10313
April 21, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Knapp's order which set aside its denial of claimant's left leg injury claim.

We agree with the Referee's observation that the ultimate issue is credibility. The Referee found claimant's testimony credible. Arguing that we should find to the contrary, SAIF lists a number of "inconsistencies" in claimant's testimony. We think most of these "inconsistencies" only reflect the admitted inability of some of the witnesses to remember what everybody thought at the time of the injury to be a very inconsequential occurance. Other "inconsistencies" appear to us to involve immaterial, collateral and even trivial matters. We find no comfortable basis in this record for disagreeing with the Referee's credibility finding.

ORDER

The Referee's order dated September 14, 1982 is affirmed. Claimant's attorney is awarded $425 for services rendered on Board review, payable by the SAIF Corporation.

WILLIAM B. HESS, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Spears, Lubersky et al., Defense Attorneys

WCB 81-11152
April 21, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer, Pacific Motor Trucking Company, requests review of Referee Pferdner's order which, in pertinent part, reversed the employer's denial of compensability of a claimed "exacerbation" of claimant's 1981 industrial injury. The primary issue on review is whether claimant has proven by a preponderance of the evidence that he sustained a compensable aggravation of his 1976 low back industrial injury.

We are not convinced that claimant has met his burden. The Referee stated that he did not believe claimant's testimony that he had not participated in a hunting trip, against his doctor's advice. The Referee also stated that he did not believe claimant's wife's testimony regarding the condition of the logging road upon which claimant traveled to go hunting. Further, the Referee found claimant's treating doctor to have "assumed the role of advocate in addition to his role as a healer." Thus, the Referee chose to believe the employer's investigator who, after observing claimant, concluded claimant not only drove to the hunting spot but also participated in the hunt.

We agree with the Referee's finding that claimant drove to the hunting location and participated in the hunt. Claimant did so

although his doctor advised that such a trip would be out of the question because claimant would have to walk over uneven terrain, drive over bumpy logging roads and, if successful in the hunt, drag the animal carcass back to his motor vehicle.

We disagree with the Referee's conclusion that there was no temporal relationship between the hunting trip and the alleged exacerbation of claimant's low back condition, and find that claimant's hunting trip in fact did exacerbate his low back condition. We note especially claimant's testimony that his back felt fine on October 3, 1981, the day he left to go hunting, but that two days following his return from the hunt, he saw his doctor with renewed complaints of back pain. We also note claimant's less than accurate statements made to his treating doctor. We conclude there is simply no reliable evidence upon which to base a finding that claimant sustained a compensable aggravation of his 1976 low back injury. Cf Dean Planque, 34 Van Natta 1116 (1982). We, therefore, reverse the Referee's order.

ORDER

The Referee's order dated August 4, 1982 is reversed.

CHARLES M. KEPFORD, Claimant
Evohl F. Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-04155
April 21, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Baker's order which affirmed the self-insured employer's denial of claimant's aggravation claim. The Referee also ruled that he had no jurisdiction to adjudicate an occupational disease claim raised by the claimant three weeks prior to the hearing which had neither been accepted nor denied by the employer by the time of the hearing.

We affirm and adopt the Referee's order with the following additional comment. The Referee correctly refused to consider claimant's occupational disease claim because the Board has no jurisdiction over the compensability of claims "prior to a timely acceptance or denial or prior to the expiration of the time in which the carrier may investigate and consider the claim without risking penalties." Syphers v. KW Logging, 51 Or App 769, 771 (9181). None of these events had occurred in this case at the time of the hearing.

ORDER

The Referee's order dated September 18, 1982 is affirmed.

JACK R. STEIMER, Claimant
Evohl F. Malagon, Claimant's Attorney
Garrett, Seidemann et al., Defense Attorneys

WCB 81-08623
April 21, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Foster's order which affirmed the Determination Order which awarded compensation for temporary total disability but no permanent disability.

Preliminarily, claimant filed a motion for remand on the ground that at hearing claimant was not represented by counsel, that a member of the Board had ex parte contact with the parties prior to the hearing, and that there was insufficient development of the record because claimant was not aware of the emotional sequelae of his industrial injury.

It appears from the record that claimant is average or above average in intelligence and that the Referee extensively advised him of his right to be represented by counsel at hearing; therefore, we do not regard the fact that claimant chose not to be represented by counsel as grounds for remanding this matter. The fact that a member of the Board had contact with the parties prior to the hearing may be grounds for that Board member recusing himself from the case (which he has), but it is not grounds for remanding the case to the Referee.

The psychiatrist's report which claimant offers as evidence of emotional sequelae requiring remand for further development itself indicates that claimant was aware of emotional sequelae long before this matter was set for hearing. Claimant has not alleged facts in support of a finding that, in the exercise of due diligence, he could not have sought and obtained information relating to his emotional condition prior to hearing.

Perceiving no basis for granting claimant's motion for remand, we deny the motion.

With respect to the extent of disability question, we affirm and adopt the Referee's order with the following comments. The primary injury claimant experienced as a result of an industrial accident was to his groin area. Although claimant's injuries were severe, there is no indication of impairment or loss of wage earning capacity as a result of that injury. Claimant concedes that he is not entitled to an award on that basis. There is a suggestion in the hospital admission records, and from the fact that back x-rays were taken, that claimant sustained some injury to his low back in the accident. However, there is no medical evidence of permanent impairment from that injury and no more than a suggestion from claimant that he has sustained any disability as a result of that back injury. With respect to the alleged emotional sequelae of the injury, even if we were to consider the proffered report we note that the report does not indicate that claimant has any emotional impairment or that emotional factors in any way interfere with his wage earning capacity.

Like the Referee, from a medical standpoint we sympathize with the claimant's plight, but there is no basis in Oregon law to make an award of permanent disability.

ORDER

The Referee's order dated May 11, 1982 is affirmed.

WILLIAM DRAGOWSKY, Claimant
Eichsteadt et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01340
April 22, 1983
Order on Reconsideration

Claimant has requested reconsideration of our order of March 29, 1983 on the issue of attorney's fees. Claimant contends that although the Board did not find claimant now has any compensation due, he prevailed because the Board found that in the event he incurs future medical expenses or death attributable to his asbestosis he would be entitled to compensation.

We do not believe that ORS 656.386 authorizes attorney's fees in this situation. The SAIF Corporation denied compensation in this case. We affirmed its denial of compensation presently claimed. We only reversed its denial as to possible future benefits. We interpret ORS 656.386 as only authorizing a fee in situations in which the denial of presently claimed compensation is overturned.

ORDER

On reconsidertion of the Board's Order on Review dated March 29, 1983 the Board readopts and republishes its Order on Review. Claimant's request for an award of a reasonable attorney's fee is denied.

MILDRED E. SWENSON, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01845
April 22, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Galton's order dismissing her request for hearing on the issue of extent of disability, dismissing her request for hearing on a denial of an aggravation claim and alternatively finding on the merits that claimant had failed to prove an aggravation. The issues on review are whether dismissal of the two requests for hearing was proper and, if not, the extent of disability and whether claimant has suffered an aggravation.

Claimant compensably injured her upper back, right arm and shoulder picking up a typewriter on June 25, 1979. On June 19, 1980 a Determination Order was issued awarding time loss but no permanent disability. Claimant's first attorney, Bernard K. Smith,

prepared a request for hearing on the Determination Order in October 1980. The evidence indicates that he sent the request for hearing to the SAIF Corporation but not to the Hearings Division. SAIF promptly acknowledged the request for hearing with a copy to the Hearings Division. In January 1981, still well within the one year for appealing the Determination Order, SAIF sent a letter to the Presiding Referee indicating that it had not received any Board acknowledgement of the request for hearing.

In the fall of 1981 claimant's doctors submitted medical reports which were regarded by SAIF as aggravation claims. On December 31, 1981 SAIF prepared a denial of the aggravation claims. Claimant testified that she received the denial sometime in early January of 1982. She turned the matter over to her attorney, Mr. Smith. Sometime late in February, he indicated to her that he no longer wished to handle the case and referred her to her present attorneys. They prepared a request for hearing on the denial. The request for hearing on the denied aggravation claim was received by the Hearings Division on March 2, 1982, sixty-one days after the denial was prepared by SAIF. Subsequently, an amended request for hearing was received by the Hearings Division including the issue of extent of disability awarded by the 1980 Determination Order.

The Referee dismissed claimant's request for hearing on the Determination Order on the grounds that no request for hearing contesting the Determination Order was filed within one year as required by ORS 656.319(2). The Referee is correct that failure to file a request for hearing within one year of the Determination Order requires dismissal for lack of jurisdiction. Nelson v. SAIF, 43 Or App 155 (1979). However, we disagree with his finding of fact that no request for hearing was filed within one year.

The request for hearing prepared by claimant's first attorney was never filed with the Hearings Division. SAIF did, however, "acknowledge" the request for hearing shortly thereafter. The Referee indicated there was no evidence that the "acknowledgement" was received by the Hearings Division. In January, still well within the one year period, SAIF mailed a letter to the Presiding Referee inquiring as to the status of the request for hearing. The Referee indicated that there was no evidence the letter was received by the Presiding Referee. Contrary to the Referee's statements, there is a presumption that both the "acknowledgement" and the inquiry letter were received by the Hearings Division. ORS 40.135, Oregon Evidence Code, Rule 311(q). See Madwell v. Salvation Army, 49 Or App 713 (1980). Absent evidence to the contrary, we presume that the Hearings Division received both communications from SAIF.

OAR 436-83-230 provides:

> "If a claimant sends a request for a hearing to the employer or insurer, it shall forward forthwith the request to the Hearings Division of the Board."

This regulation creates a duty of the insurer to forward misdirected requests for hearings to the Hearings Division. While SAIF did not comply with the letter of this regulation by forward-

ing the hearings request prepared by Mr. Smith, it complied with the spirit of the regulation by first acknowledging the request for hearing with a copy to the Hearings Division and, when it became apparent that the Hearings Division may not have received the request, by inquiring about it.

We find SAIF's acknowledgement combined with its inquiry letter are sufficient to constitute a request for hearing filed on behalf of the claimant. ORS 656.283(2) requires only that a request for hearing be signed on behalf of the claimant, include the address of the party requesting the hearing and state that a hearing is desired, and be mailed to the Board. Both the acknowledgement and the inquiry letter satisfy those requirements. We infer that the letters are partially on behalf of the claimant because SAIF was under a duty created by OAR 436-83-230 to forward claimant's request to the Hearings Division. The communications also indicate that a hearing was requested.

We find that a request for hearing was filed with the Hearings Division within one year of the Determination Order as required by statute. Accordingly, we reverse the Referee's dismissal of claimant's request for hearing contesting the Determination Order.

The Referee declined to rule on the issue of extent of disability because he dismissed the request for hearing on that issue at the outset of the hearing. However, he allowed the claimant to testify "under the rule" concerning the extent of her disability. There was medical evidence in the record from which the extent of claimant's disability could be determined. In the interest of administrative economy, we proceed to rate the extent of claimant's disability.

The consensus of the medical evidence is that claimant suffers from chronic cervical sprain which is superimposed on preexisting degenerative changes in her neck. Orthopaedic Consultants, the only physicians who rate the permanent impairment caused by claimant's compensable injury, opine that she suffers from minimal loss of function due to the compensable injury.

Taking into account claimant's impairment, as well as the relevant social/vocational factors, we conclude that she is entitled to 10% unscheduled permanent disability for her neck condition.

The Referee dismissed claimant's request for hearing on SAIF's denial on the grounds that claimant had failed to request a hearing within 60 days of the denial as required by ORS 656.262(7) [formerly 656.262(6)] and 656.319(1). The Court of Appeals has held that the sixty day period begins to run when the denial is mailed. Madwell v. Salvation Army, supra. The Referee found that the denial was mailed on December 31, 1981 and that the request for hearing was filed on March 2, 1982, sixty-one days after the mailing of the denial.

We disagree with the Referee's finding of fact that the denial was mailed on December 31, 1981. The Referee apparently relied on the date on the denial letter, as well as claimant's testimony that she received the denial early in January, after the New Year's

holiday. We find that the claimant's testimony concerning the date of her receipt of the denial is too vague to establish any precise date of mailing. While there is a presumption that a letter is truly dated, ORS 40.135, Oregon Evidence Code, Rule 311(p), the Court of Appeals has specifically said that "there is no presumption that a letter is mailed on the day it is dated or on the date it was written." Madwell v. SAIF, supra at 716. In Madwell the court held that the insurer has the burden of proving when a denial was mailed, and absent any evidence indicating when the denial was mailed, it would be presumed that the request for hearing was timely. SAIF has failed to provide any evidence which establishes the date the denial was mailed. Accordingly, we reverse the Referee's dismissal of the request for hearing on the denial of aggravation.

The Referee heard evidence on the aggravation issue. Even though he dismissed the request for hearing on the aggravation issue, he made a finding that if he were to reach the merits of the aggravation claim he would find that it failed on the merits. On de novo review we agree. Claimant testified that her condition was no different at the time of the alleged aggravation than it was at the time the Determination Order was issued. Therefore, claimant has failed to establish a compensable aggravation. ORS 656.273(7).

ORDER

The Referee's order dated August 10, 1982 is reversed. Claimant is awarded 10% unscheduled permanent partial disability for her neck condition. Claimant's attorney is allowed 25% of the increased compensable, payable out of claimant's award.

ARTICE WRIGHT, Claimant

Own Motion 83-0090M
April 22, 1983
Own Motion Order

The insurer has forwarded claimant's request for own motion relief to the Board for consideration under ORS 656.278. Claimant originally sustained a compensable injury on May 4, 1967 and his aggravation rights have expired. The insurer has indicated a willingness to pay claimant's related medical expenses. The sole issue before the Board is claimant's entitlement to compensation for temporary total disability.

The medical evidence indicates that claimant was hospitalized at least twice since February, 1981 (the beginning of his "aggravation"). We note, however, that claimant's treating physician has never authorized time loss benefits. Of even more importance is that claimant quit work voluntarily in approximately January, 1980 for reasons other than this compensable injury and its residuals. Under the rationale in Vernon Michael, 34 Van Natta 1212 (1982), the Board concludes that claimant is not entitled to compensation for temporary total disability. Claimant's request for own motion relief is hereby denied.

IT IS SO ORDERED.

JUAN ANFILOFIEFF, Claimant
Blair, McDonald et al., Claimant's Attorneys
Burt, Swanson et al., Attorneys
Carl Davis, Attorney

WCB 78-04612
April 25, 1983
Order of Abatement

The Board issued its Order on Review herein on March 31, 1983. Claimant's attorney thereafter requested reconsideration of that order insofar as it fails to award claimant's attorney an attorney's fee. In order to allow an opportunity for a response to claimant's request for reconsideration, the Board's March 31, 1983 Order on Review hereby is abated.

IT IS SO ORDERED.

WILLIAM JOHNS (aka BILLY RAY JACKSON), Claimant
Michael Kennedy, Claimant's Attorney
Wolf, Griffith et al., Defense Attorneys

WCB 81-7404
April 25, 1983
Order of Dismissal

The Claimant has requested review of Referee's order dated March 8, 1983. The request for review was filed with the Board on April 12, 1983 , more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

The Claimants request for review is hereby dismissed as being untimely filed.

DERRY D. BLOUIN, Claimant
Pozzi, Wilson et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-04049
April 26, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of that portion of Referee Galton's order which reversed two denials of aggravation and awarded insurer-paid attorney's fees after finding that the claim had been prematurely closed. SAIF asserts that it was unnecessary to reverse the denials because the finding of premature claim closure rendered the issue of subsequent claim reopening moot. Thus, SAIF contends that no attorney's fee should have been awarded because of the denials. Alternatively, SAIF contends that the Referee's award of $500 attorney fees for each denial was excessive.

Abstractly, we agree with SAIF. Usually a finding of premature claim closure, which results in claim reopening effective on the closure date, would render moot the question of whether a claimant was entitled to claim reopening on a later date due to a worsened condition within the meaning or ORS 656.273. In this kind of situation, litigation orders may state that a subsequent denial of aggravation reopening is moot; this would help prevent any future confusion about the effect of the denial. Litigation orders may even "reverse" such a denial as moot. However, it is important

to appreciate that such a "reversal" usually does not result in any additional benefits going to the claimant that would not otherwise go to the claimant just by virtue of finding premature closure. This is important because we think the concept expressed in ORS 656.286(1) -- insurer-paid attorney fees for prevailing on a denial -- assumes that the claimant receives some additional amount or type of benefits after the denial is reversed. If that assumption does not fit the facts, then ORS 656.386(1) does not authorize insurer-paid attorney fees.

In this case, however, we understand the two denials in question were not limited to just the question of claim reopening; rather we understand those denials also to have been directed to medical treatment and diagnostic testing that claimant or claimant's doctors had requested. As so interpreted, these denials of medical services raised issues that went beyond the issues that would be necessarily subsumed into a finding of premature closure. Stated differently, when the Referee in this case set aside these two denials of medical services, he was ordering that this claimant receive benefits in addition to those claimant was going to receive because of premature closure. As stated above, it is just this kind of receipt of additional benefits that triggers entitlement to an insurer-paid attorney fee for prevailing on a denial.

In summary, when a claim is found to have been prematurely closed, the claimant's attorney's fee is paid out of the claimant's increased compensation, i.e., additional temporary disability. Susan K. Spratt, 34 Van Natta 1028 (1982). If the finding of premature closure renders any subsequent denials of aggravation reopening completely moot, there is no basis for any additional insurer-paid attorney fees. If, however, any subsequent denials being litigated raise questions of entitlement to an additional amount or type of benefits other than additional temporary disability that will be paid because of premature closure, then reversal of such denials should warrant an award of an additional insurer-paid attorney fee. We think this last possibility fits this case. Entitlement to insurer-paid fees being thus established, we turn to SAIF's alternative argument that the Referee's award was excessive.

Attorney fee awards are based on efforts expended and results obtained. OAR 438-47-010(2). The additional attorney efforts expended in this case just on the denials of medical services appear to have been rather modest. The results obtained in the form of medical services are hard to assess because it is not even clear exactly what medical services were denied. But, generally speaking, we have often viewed "results obtained" in the form of just additional medical services to be rather modest. E.g. Curtis L. West, 31 Van Natta 106 (1981). Considering the available information to guide in applying the standards in OAR 438-47-010(2), we believe that one-half of the insurer-paid attorney fees awarded by the Referee would be more appropriate.

ORDER

The Referee's order dated August 24, 1982 is modified in part. Claimant's attorney is awarded $500 as a reasonable attorney's fee for prevailing on the claims denied on April 24, 1981 and April 14, 1982, to be paid by the SAIF Corporation. This is in lieu of the insurer-paid attorney's fee awarded by the Referee for prevailing on the denials. The remainder of the Referee's order is affirmed.

FLORINE G. JOHNSON, Claimant
Black, Hansen et al., Claimant's Attorneys
William M. Beers, Defense Attorney

WCB 81-08157
April 26, 1983
Order on Review

Reviewed by the Board en banc.

The employer/insurer requests review of Referee Brown's order which set aside the Determination Order of August 25, 1981 as premature, remanded the claim to the insurer for payment of benefits until closure occurs pursuant to ORS 656.268, and set aside the April 26, 1982 aggravation claim denial as moot. The insurer contends that the Referee erred in finding the August 25, 1981 Determination Order to have issued prematurely. We agree.

Claimant was employed as a tunnel finisher for American Linen Supply on January 18, 1978 when she began having difficulty with her right wrist. She was treated by Dr. Matthews who diagnosed synovitis with a small ganglion. Claimant continued to work, but due to continued pain, a ganglionectomy was performed on April 25, 1978 by Dr. Matthews.

Despite the surgery, claimant continued to experience pain problems with her wrist and was only able to work on a part-time basis. On July 5, 1978 Dr. Ross diagnosed chronic synovitis with a possibility of arthritis. He anticipated that the pain problem would persist indefinitely and noted that claimant's motivation to return to work was difficult to evaluate. Dr. Ross reported on November 27, 1978 that claim closure with an award for some permanent disability due to persistent pain was indicated. A Determination Order issued on January 4, 1979 awarding permanent partial right forearm disability.

On January 18, 1979 Dr. Matthews reported that there appeared to be another small ganglion at or near the site of the previous ganglion. A second ganglionectomy followed on April 17, 1979. Dr. Ross reported on July 25, 1979 that claimant was still having difficulties with swelling and pain in her wrist. He diagnosed pain secondary to arthritis and suggested light duty work. A second Determination Order issued on October 5, 1979 awarding claimant additional time loss benefits only.

Claimant thereafter sought chiropractic treatment from Dr. Kelty. Dr. Matthews reported on January 9, 1980 that claimant felt that these chiropractic treatments seemed to be helping her with regard to the range of motion in her wrist, which he found to be 90% of normal. Dr. Kelty indicated on February 14, 1980 that claimant was relieved of pain for several days at a time following one of his treatments. A third Determination Order issued on April 4, 1980 awarding claimant further time loss benefits and an additional 10% scheduled permanent partial disability, for a total of 25% scheduled disability for her right forearm.

Dr. Narrus reported on June 4, 1980 that he was in agreement with the Determination Order and felt that claimant was medically stationary. Claimant was examined by Dr. Nathan on June 17, 1980. Dr. Nathan found both of claimant's wrists to have an "excellent" range of motion and that physical therapists reported that claimant

had full use of both hands with normal strength and motion. Dr. Nathan concluded:

> "On an organic basis, I am unable to substantiate this patient's complaints. I believe that she can be gainfully employed without any restrictions.
>
> "I believe that one must look elsewhere for the source of this lady's complaints. I believe that one must explore job dissatisfaction, the possibility of 'compensationitis', problems at home or other problems not directly related to the hand.
>
> * * *
>
> "Based on this examination, I see no evidence of permanent partial impairment.
>
> "Further, I disagree with the permanent impairment rating issued earlier for this patient. . ."

On June 19, 1980 Dr. Emori reported that he thought that claimant's hand symptoms would eventually resolve with time.

Claimant thereafter entered an approved program of vocational rehabilitation at the Oregon College of Business, training for an office assistant position. Despite various difficulties, the program was eventually successfully completed and a Determination Order issued on August 25, 1981 allowing claimant benefits for the period during which she participated in the vocational rehabilitation program. It is this Determination Order that is the subject of the current appeal.

Claimant continued to treat with Dr. Emori during her program of vocational rehabilitation. On September 14, 1981 Dr. Emori reported that claimant "is not yet stationary." This is rather odd since there is no report from Dr. Emori indicating when claimant became medically unstationary. His report of June 19, 1980 was to the effect that claimant was medically stationary. His interim reports continue to indicate continuing symptomatology but give no indication that claimant became medically unstationary. On October 2, 1981 Dr. Emori reported that claimant's wrist motion was only somewhat limited and there was no obvious inflammation of the hand. He stated that his impression remained continuing undiagnosed inflammatory disease of the wrist.

Dr. Narrus examined claimant on October 5, 1981. His findings were essentially unchanged from his previous examinations. He did diagnose possible right ulnar nerve entrapment -- a diagnosis he ruled out following nerve conduction studies. Claimant was then examined by Dr. James at the request of Dr. Emori. Dr. James reported on November 4, 1981 that claimant suffered from mild synovitis of the right wrist and stated that she was medically stationary. Dr. Rosenbaum examined claimant on December 30, 1981

in order to determine whether she was suffering from an arthritic problem. Dr. Rosenbaum reported that he found no objective evidence to substantiate claimant's complaints and that it was unlikely that she was suffering from any type of inflammatory process.

On March 29, 1982 claimant was examined by Dr. Baker, a physician specializing in rehabilitative medicine. Dr. Baker diagnosed "myofascial pain syndrome, overload variety," otherwise known as lateral epicondylitis or tennis elbow. He indicated that this condition was easily treated with trigger point injections, acupressure, resistive exercises, etc. On April 26, 1982 Dr. Baker reported that:

> "The patient is excited because she has developed full return of power and is pain free in the right upper extremity after two years of trouble. * * * There is no tenderness in the muscle and she has full range of motion in the extremity."

Dr. Baker believed that claimant would be able to return to full duty work within three to four weeks. Claimant testified that Dr. Baker sent her to a therapist who would apply some type of freeze-spray to her forearm, pull and stretch the muscles of her hand and apply ultrasound. Claimant indicated that her hand "worked like new" and that she now could now do virtually everything that she was unable to do before. On April 26, 1982 the insurer denied the aggravation claim which was based on Dr. Baker's reports.

In concluding that the August 25, 1981 Determination Order was premature, the Referee relied on three considerations: (1) Dr. Baker's April 26, 1982 report; (2) the non-applicability of ORS 656.005(17) (defining "medically stationary") because it was adopted subsequent to the date of claimant's injury; and (3) the case of William Bunce, 33 Van Natta 546 (1981).

ORS 656.005(17) defines "medically stationary" as meaning "that no further medical improvement would reasonably be expected from medical treatment or the passage of time." This statute was enacted by Oregon Laws 1979 ch. 839, sec. 26 after claimant's 1978 injury. But we do not attach much significance to the date of injury versus the date of enactment because we believe ORS 656.005(17) represents a codification of prior case law which had defined "medically stationary." E.g. Pratt v. SAIF, 29 Or App 255 (1977). In other words, the Determination Order here in question in this case was only premature if claimant was not medically stationary on the date it issued. The concept of medically stationary basically has been the same at all material times, both before and after enactment of ORS 656.005(17).

The insurer next argues that the Referee's reliance on Bunce was misplaced. In Bunce, we concluded that the claim had been prematurely closed where it was discovered some six months post-closure that claimant was suffering from a herniated disc that had gone undetected at the time of the closing examination. We stated that, even though no physician realized it at the time of

closure, the "objective reality" was that the condition was misdiagnosed and the herniated disc existed all along.

The insurer argues that, unlike Bunce, this is not a case where physical infirmities in the claimant went undiagnosed prior to the August 25, 1981 Determination Order and is, therefore, distinguishable from Bunce. We agree. Prior to the 1981 Determination Order eight different physicians who examined and/or treated claimant offered diagnoses that included synovitis, rheumatoid arthritis, inflammatory arthritis, carpal tunnel syndrome, lateral epicondylitis, "compensationitis" and unknown inflammatory disease of the wrist. We find no basis in the record for finding Dr. Baker's diagnosis more accurate or persuasive than any other. His diagnosis is simply another one of many opinions. We are not persuaded that it constitutes the "objective reality" referred to in Bunce.

In Roy McFerran, 34 Van Natta 621, 625 (1982), we stated:

> "Furthermore, subject to infrequent exceptions such as in William Bunce, [citation omitted], the question of whether a worker was medically stationary at the time a Determination Order issued is reviewed based on the then, i.e., at the time the Determination Order issued, available information."

See also Paine v. Widing Transportation, 59 Or App 185 (1982). Since we have concluded Bunce is here inapplicable, the question is, whether the August 25, 1981 Determination Order was properly issued based on the information then available. We find that it was. In reality, the only purpose of the August 25, 1981 Determination Order was to establish claimant's entitlement to temporary benefits while she was in an approved program of vocational rehabilitation pursuant to ORS 656.268(5). Claimant was actually found medically stationary by the April 4, 1980 Determination Order on February 14, 1980 in accordance with Dr. Kelty's report of that date. Dr. Narrus agreed with this in his report of June 4, 1980 and Dr. Emori apparently agreed with Dr. Narrus in his report of June 19, 1980. Beyond question, Dr. Nathan shares that view. These opinions support the conclusion that claimant was medically stationary under the definition contained in ORS 656.005(17) or the definition in Pratt v. SAIF, supra, based on the then available information. Therefore, we affirm the August 25, 1981 Determination Order.

Based upon our conclusions above, we believe that this case is better decided on the basis of aggravation, rather than premature closure. Although it is somewhat difficult to conclude that claimant has established a worsening of her condition since the August 25, 1981 Determination Order, we are satisfied that such a conclusion is warranted when the reports authored by Dr. Emori subsequent to August 25, 1981 are read in conjunction with the reports of Dr. Baker. The April 26, 1982 aggravation claim denial is, therefore, set aside. We find that a valid aggravation claim was established as of March 29, 1982.

Having found that a valid aggravation claim has been established, the next question is whether there is sufficient evidence in the record to find a medically stationary date and determine the correct extent of the claimant's disability. We find that there is. In his report of April 26, 1982 Dr. Baker stated that claimant has no tenderness in her wrist and that she has full range of motion and full power. He suggested that she return to work at her usual job on an intermittent basis at first and expected a return to full duty within three to four weeks. Claimant testified at the time of the hearing that she was able to do virtually everything that she had been able to prior to her injury and that she had virtually full function in her hand. Dr. Baker's report and claimant's testimony are sufficient in this case to conclude that claimant was medically stationary at the time of the hearing, with permanent disability no greater than previously awarded, if in fact she has any at all.

ORDER

The Referee's order dated June 18, 1982 is reversed. The Determination Order dated August 25, 1981 is reinstated and affirmed.

The employer/insurer's denial dated April 26, 1982 is set aside. Claimant is entitled to benefits for temporary total disability from March 29, 1982 to May 14, 1982, less amounts previously paid, and no additional benefits for permanent partial disability.

Claimant's attorney is awarded $1,000 as a reasonable attorney's fee for previaling on a denied claim, payable by the employer/insurer.

THOMAS C. RAY, Claimant
John R. Miller, Claimant's Attorney
Moscato & Meyers, Defense Attorneys

WCB 81-01906
April 26, 1983
Order on Review

Reviewed by the Board en banc.

The self-insured employer requests review of that portion of Referee Seymour's order which awarded claimant 5% unscheduled permanent partial disability for injury to his low back. The employer does not contest the Referee's evaluation of the extent of claimant's permanent disability; rather, the sole issue raised by the employer is a procedural issue concerning the effect of an April 2, 1982 denial of claim reopening, which the employer contends forecloses an award of permanent disability.

Claimant was compensably injured on August 26, 1980. The claim was accepted and closed by a Determination Order in January, 1981 granting claimant no compensation for permanent disability. Claimant filed a timely request for hearing in February, 1981, designating the issues of temporary total and permanent partial disability.

In January of 1982, claimant's physician corresponded with claimant's former attorney indicating that claim reopening would be appropriate. This document was forwarded to the employer, who denied the claim for reopening on April 2, 1982. The denial states, in pertinent part:

> "We must inform you at this time that we are denying the request to reopen the claim. We are doing so on the basis that there is no historical evidence that your condition has worsened since claim closure for your August 26, 1980 accident. In addition, it is our position that the injury of August 26, 1980 was only temporary in nature and has not altered in any way, nor will it alter in any way, the progression of your back condition as a result of injuries incurred to your back prior to August 26, 1980."

No request for hearing contesting this denial was filed by claimant or in claimant's behalf. The extent hearing convened within 180 days of the date of the denial, and the Referee allowed claimant's attorney to orally request a hearing on the merits of the denial of claim reopening. The Referee then found that there was no good cause excusing claimant's failure to request a hearing within 60 days. See ORS 656.319.

The employer contends that its April, 1982 denial letter constitutes a denial of a "claim" for permanent disability arising out of claimant's industrial injury, and that the failure to timely request a hearing contesting the denial forecloses consideration of the extent of claimant's permanent disability. The Referee rejected this contention, and we agree.

Any party may request a hearing contesting a Determination Order within one year of the mailing of the Determination Order. 656.319(2). The employer's argument premised upon Anderson v. West Union Village Square, 44 Or App 685 (1980), that its April, 1982 denial was the only effective means of notifying claimant that the employer disclaimed any liability for alleged permanent consequences of claimant's industrial injury, is not persuasive. It is axiomatic that it is the claimant's burden to prove permanent disability attributable to an industrial injury. Anderson does not alter this rule; nor does it impose upon the employer an obligation to deny a "claim" for permanent disability by a claimant who requests a hearing contesting a Determination Order; nor does it mean that any such denial, if issued but not appealed, cuts off a claimant's right to a hearing on the pending question of extent of disability.

Moreover, if all the employer was really interested in doing was to advise the claimant of its position that claimant was not entitled to an award for permanent disability, we invite the employer's attention to OAR 436-83-245:

> "A party receiving notification of a request for hearing shall within 30 days file with the Hearings Division and serve on the other

parties a response clearly and simply indicating the respondent's position on the issues."

Accordingly, we agree with the Referee's determination that the employer's April, 1982 denial does not foreclose review of the January, 1981 Determination Order and an award of permanent partial disability. Since the sole issue raised on review by the employer is the procedural issue, we do not address the merits of the Referee's evaluation of claimant's permanent disability.

ORDER

The Referee's order dated August 23, 1982 is affirmed. Claimant's attorney is awarded $25 as a reasonable attorney's fee for services on review, payable by the self-insured employer.

CHARLIE D. COOK, Claimant
Evohl F. Malagon, Claimant's Attorney
Wolf, Griffith et al., Defense Attorneys

WCB 82-02658
April 27, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer and its insurer request review of Referee Nichols' order which, in relevant part, reversed the partial denial denying liability for an appendectomy and associated time loss. The sole issue on review is whether the employer/insurer is responsible for the surgery and time loss.

We adopt the Referee's findings of fact which, in relevant part and omitting references to the record, are as follows:

"The claimant was injured on June 20, 1980 when he was pinned between the counterweight of a heavy equipment shovel and a log and was rolled back and forth on the log.

"Upon hospitalization the claimant was diagnosed as having multiple pelvic fractures..., pelvic contusion and lumbar strain. He also developed a urinary problem which continued to bother him for several months after the injury.

"It was noted on the hospital records that the claimant experienced pain on his right side....That pain was also noted in the July 17 chart note and in August 1980, Dr. Donahoo, an orthopedist and the treating physician, recommended referral to Dr. Melvin Yeo because of the increasing abdominal pains the claimant had been having. Dr. Donahoo also found tenderness in the right lower quadrant of claimant's abdomen.

> On August 25, 1980 Dr. Donahoo felt, however, that the claimant was ready to return to work from an orthopedic standpoint. Dr. Donahoo recommended continued time loss until the evaluation of claimant's abdominal problem was done.
>
> "...Dr. Yeo performed an appendectomy on August 26, 1982 [sic, 1980], however, the appendix was found to be normal."

Claimant was examined by Dr. Donahoo for a closing evaluation in June of 1981. In his report, Dr. Donahoo recited that claimant had returned to work after the appendectomy. He found that claimant was medically stationary from an orthopedic viewpoint, but that claimant had had urinary tract problems persistently since the industrial accident. Dr. Donahoo recommended further evaluation of that condition. The next medical report in the record is dated January 11, 1982 and is a closing evaluation of claimant's urinary tract problems in which the doctor finds that condition to be medically stationary. Apparently the claim was submitted for closure soon thereafter because the Determination Order issued on February 5, 1982. It appears that except for layoffs engendered by the economy, claimant was employed on a regular basis following recovery from the appendectomy.

The Determination Order awarded time loss through August 25, 1980 (the date first identified by Dr. Donahoo by which claimant was medically stationary orthopedically) and no permanent disability. In March, 1982 claimant requested a hearing alleging among other issues premature closure and, alternatively, entitlement to an award of permanent disability. In August, 1982 the insurer denied responsibility for the surgery and associated time loss.

The record is clear that the appendix was normal and that if claimant would have had appendicitis it would have been unrelated to the compensable injury. However, in finding the surgery compensable the Referee reasoned as follows:

> "Prior to the injury the claimant had no abdominal pain. Immediately after an injury to the pelvic area the claimant complained of abdominal pain. His treating doctor referred him to another doctor for evaluation of this pain. Appendicitis as a cause of the pain was eliminated but the surgery was performed because of the abdominal pain."

We find the most telling evidence in the record to be Dr. Donahoo's chart note of August 25, 1980:

> "Examination shows rebound tenderness and tenderness over the right lower quadrant....I am concerned about his rebound tenderness as a possible early peritoneal irritation. I called Dr. Yeo, a

> general surgeon, and asked him to review his abdominal status. At the same time, I would like to confirm that there are not hernias related to his industrial injury. Dr. Yeo called and states the patient may have an early appendicitis and he plans to hospitalize him or at least watch him very closely the next few days. I asked him to return my call concerning Mr. Cook's work status once we determine what is going on in his abdomen. In the interim, time loss is authorized until this is clarified."

It seems apparent to us that claimant was referred to Dr. Yeo for diagnostic reasons. Dr. Donahoo was concerned about a hernia or peritoneal irritation as possible complications of the injury. Dr. Yeo's initial reaction was to hospitalize claimant for observation. Apparently, claimant's abdominal pain increased, resulting in surgery for appendicitis that, in retrospect, was unnecessary. Dr. Yeo subsequently opined:

> "It is also possible, in retrospect, that his fractured pelvis did contribute to his abdominal pain, resulting in his surgery for his appendix, which was found to be normal.
>
> "A fractured pelvis can cause vague abdominal pains. Although this was two months old, this injury may have somewhat clouded the picture."

Claimant did not have abdominal pains prior to the injury. Lower right-sided pains were noted upon admission to the hospital following the accident. Abdominal pains persisted thereafter. Both Dr. Donahoo and Dr. Yeo were of the opinion that claimant's injuries could have caused the abdominal pains. Thus, we believe it is more likely than not that the abdominal pains were caused by the industrial accident. The question presented, then, is whether the insurer should be liable for surgery that resulted from a misdiagnosis of claimant's condition where the symptoms that precipitated the misdiagnosis were a consequence of the compensable injury.

In attempting to answer the issue as posed, we are tempted to analyze this case in terms of whether the surgery was diagnostic or exploratory and, therefore, compensable under the rationale expressed in Jimmy Layton, 35 Van Natta 253 (1983), and Brooks v. D & R Timber, 55 Or App 688 (1982). Dr. Donahoo referred claimant to Dr. Yeo for diagnostic purposes and Dr. Yeo's initial examination of claimant (and perhaps part of the hospitalization "for observation") would be compensable under a diagnostic treatment theory. However, at the point that Dr. Yeo decided claimant had an abnormal appendix which was unrelated to the injury, the diagnosis had been made, and the diagnosis was that claimant had a condition unrelated to the injury. Thus, the appendectomy was undertaken, not to determine what condition claimant had, but rather to correct

what was at that time thought to be an abnormal appendix. Thus, since the surgery was not undertaken for diagnostic purposes, it cannot be considered compensable under the rationale expressed in the Layton and Brooks cases.

Claimant invites us to find the surgery compensable under the "masking" doctrine which holds that an otherwise noncompensable condition is compensable if an injury masked the discovery or treatment of the condition. The masking doctrine has been adopted and applied in Oregon. See Waibel v. State Compensation Department, 3 Or App 38 (1970), and Pettit v. Austin Logging Co., 9 Or App 347 (1982). However, this case does not present a masking situation. Just the opposite is true: the symptoms arising from a compensable injury mimicked the symptoms of a pathological condition (appendicitis) that did not, in fact, exist. Thus, we cannot find the surgery compensable under the masking theory.

What we have here is a simple misdiagnosis of claimant's condition, precipitated by the sequelae of a compensable injury. Larson in his treatise analyzes such cases under the "range of compensable consequences" rationale which, as applied to cases similar to this, he characterizes as follows:

> "It is now uniformly held that aggravation of the primary injury by medical or surgical treatment is compensable.
>
> "Examples include exacerbation of the claimant's condition, or death, resulting from antibiotics, antitoxins, sedatives, anesthesia, electrical treatment, or corrective or exploratory surgery.
>
> "Fault on the part of the physician, such as faulty diagnosis, improper administration of anesthesia, or a slip of the surgeons's knife, even if it might amount to actionable tortiousness, does not break the chain of causation." (Emphasis supplied, citations omitted.) 3 Larson, Workmen's Compensation Law, Vol. I, §13.20.

We hasten to add that we do not mean to imply that there was any tortious conduct on Dr. Yeo's part whatsoever. It appears from the limited record before us that Dr. Yeo reasonably suspected that claimant had appendicitis. As the court noted in Waibel, supra: "We need not be medical experts to recognize that medical science has not reached perfection and that even the most able diagnostician cannot be infallible." 3 Or App at 45.

Two cases cited by Larson appear to be on point here. In Owens v. Neeb Kearney & Co., 181 S. 2d 301 (1965), a Louisiana case, the claimant felt a pain in his side in the course of his employment as a laborer. He was sent to his employer's doctors who diagnosed a hernia and ordered surgery. It was then discovered that claimant had not sustained a hernia, but as a result of the operation claimant was no longer able to perform his work. An award of permanent disability was affirmed by the court. In

Kestenbaum v. Dunrite Painting Co., 12 A.D.2d 695 (1960), a New York case, the claimant was found unconscious near some benzine. The doctors erroneously diagnosed a brain tumor when in fact he was suffering from benzine poisoning. In the ensuing cranial operation for a brain tumor which apparently did not exist the employe died from cerebral hemorrhaging. Widow's benefits were awarded.

Similarly, in Wimer v. Miller, 235 Or 25 (1963), the court indicated that the consequences of medical malpractice committed in the course of treatment of an industrial injury are compensable consequences of the injury. See also Donald P. Neal, 34 Van Natta 237 (1982). It should be even more true that a misdiagnosis not constituting malpractice but resulting in unnecesary medical treatment is nevertheless a compensable consequence of the injury.

To summarize: Because of continuing and unexplained abdominal pains which had persisted since the accident, claimant's treating physician, an orthopedist, referred him to Dr. Yeo, a surgeon, for diagnostic reasons. Because claimant's abdominal symptoms mimicked the symptoms for appendicitis, Dr. Yeo misdiagnosed claimant's condition. Because of the misdiagnosis, an appendectomy was performed. Although in retrospect we can say that the surgery was unnecessary, it is clear that claimant would not have been operated on by Dr. Yeo but for the injury that caused abdominal pain in the first place. There is an unbroken chain of causation from the injury to the appendectomy; therefore, we agree with the Referee that the surgery and associated time loss are a compensable consequence of the original injury.

ORDER

The Referee's order dated August 26, 1982 is affirmed. Claimant's attorney is awarded $400 as a reasonable attorney's fee for services on review, payable by the insurer.

GARY PARKER, Claimant
Emmons, Kyle et al., Claimant's Attorneys
Lindsay, Hart et al., Defense Attorneys

WCB 81-09988
April 27, 1983
Order of Remand

Claimant moves to remand this case to the Referee for consideration of the complete reports of the Northwest Pain Center. By affidavit claimant's attorney states that these reports had been forwarded to the insurer's attorney well before the hearing in this case, but that he was never provided with copies of the reports until the time of hearing despite repeated requests to the insurer's attorney to provide them. Even at the time of the hearing only the opening reports were provided by the insurer's attorney. Claimant's attorney did not receive the other reports from the Northwest Pain Center until after he had directly contacted the Northwest Pain Center.

We recently held that, where the employer/insurer fails to comply with a claimant's discovery requests, we will remand to the Referee to consider the evidence withheld by the insurer/employer and to impose an appropriate penalty. Curtis H. Best, 35 Van Natta 298 (1983). Accordingly, this case is remanded to the

Referee to admit and consider the complete reports from claimant's visit to the Northwest Pain Center and for imposition of an appropriate penalty.

IT IS SO ORDERED.

DOUGLAS L. BECHTOLD, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-02895
April 28, 1983
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Baker's order which disapproved the March 4, 1982 denial of aggravation for a worsened right shoulder condition and assessed a penalty equal to 25% of the interim compensation which was not timely paid pending denial.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated October 26, 1982 is affirmed. Claimant's attorney is awarded $550 as a reasonable attorney's fee for services on Board review.

Board Member Barnes Dissenting:

Claimant injured his shoulder at work in July of 1980. Claimant again injured his shoulder lifting weights at a spa in November of 1981. Shoulder surgery was performed after the weight-lifting incident. The present question is whether that surgery and the associated disability is a compensable consequence of claimant's 1980 industrial injury.

The Referee reasoned -- and the Board majority "adopts" that reasoning -- that claimant dislocated his shoulder in July of 1980; that chronic shoulder dislocations frequently lead to the necessity of surgery; and that the dislocation at the time of the 1980 compensable injury as a material cause of the need for surgery after the 1981 weight-lifting incident. I understand the theory: one shoulder dislocation can make the shoulder more prone to dislocate again, eventually requiring surgical repair of the shoulder. The flaw, in my opinion, with application of that theory in this case is that I find no persuasive evidence that claimant actually dislocated his shoulder at the time of his 1980 industrial accident. The contemporaneous medical evidence does not document a shoulder dislocation. Although I appreciate claimant's testimony to the effect that he dislocated his shoulder in 1980, it is the kind of question that I am not willing to decide on the basis of nonexpert testimony.

I would reverse the Referee's finding that claimant's 1981 surgery and disability were compensable consequences of claimant's 1980 injury and, therefore, respectfully dissent.

ROCKY S. BRITT, Claimant
David H. Blunt, Claimant's Attorney
Peter Courtney, Attorney
Carl M. Davis, Attorney

WCB 80-11017
April 28, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The noncomplying employer, Ron L. Rhinehart, requests review of Referee Peterson's order which found that there was an employment relationship between Mr. Rhinehart and claimant at the time of claimant's September 26, 1980 injury and thus remanded claimant's claim to the SAIF Corporation for processing as a claim against a noncomplying employer.

Mr. Rhinehart has filed no brief on Board review. We assume the issue before us is the same as the issue before the Referee: Whether there was an employer-employe relationship on the date of claimant's injury or whether, as Mr. Rhinehart claimed at hearing, there was instead an informal partnership relationship.

Determination of the legal definition of the arrangement between Mr. Rhinehart and claimant depends largely on an assessment of the credibility of the witnesses. The Referee found the testimony of claimant and some witnesses to be more credible than the testimony of Mr. Rhinehart and some of his witnesses. Based on our review of the record, we find no comfortable basis for coming to any other conclusion and we thus affirm and adopt the Referee's order.

ORDER

The Referee's order dated August 11, 1982 is affirmed.

LEAH L. CURTZ, Claimant
James S. Coon, Claimant's Attorney
Minturn et al., Defense Attorneys

WCB 82-02014 & 82-08033
April 28, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review and the SAIF Corporation, as insurer of Allied Realty, cross-requests review of Referee Nichols' order which upheld SAIF's denials of claimant's aggravation claim and alternative occupational disease claim, required SAIF to pay for medical services pursuant to ORS 656.245 and refused to impose penalties on SAIF for unreasonable denial. The issues are the propriety of the two denials, whether claimant is entitled to payment of medical bills pursuant to 656.245 and whether claimant is entitled to a penalty for the alleged unreasonable denial.

We affirm and adopt the Referee's order with the following additional comments. The claimant argues that the wording of SAIF's denial of her aggravation claim constitutes a party admission that her alternative occupational disease claim is compensable. We do not believe that SAIF in its role as insurer for one employer can be considered to be a party for the purposes of considering its statements to be admission against another employer whom it also happens to insure.

Claimant also argues that her occupational disease claim is compensable because the medical reports establish that exposure at the second employer was a material cause of the claimed occupational disease. The standard in occupational disease claims is major cause, not material cause. SAIF v. Gygi, 55 Or App 570 (1982).

ORDER

The Referee's order dated October 26, 1982 is affirmed. Claimant's attorney is awarded $100 for services before the Board on the medical services claim, payable by the SAIF Corporation.

KENNETH L. DEVI, Claimant
Hayner et al., Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 81-11639
April 28, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Howell's order awarding claimant 10% unscheduled disability and finding that the employer is not responsible for paying certain chiropractic bills pursuant to ORS 656.245. The only issue on review is whether the employer is responsible for paying the chiropractic bills.

Claimant compensably injured his neck and back on October 5, 1978. Initially he reported neck and back injuries and missed no work. Eight months after the injury, he saw his family physician who described his symptoms as minor tenderness in the upper thoracic, mid thoracic and neck. In 1980 the family physician said that the only thing that could be done for the claimant was palliative.

In May 1981 a second physician said there was some tenderness in the thoracic spine but no limitation in range of motion. In June 1981 the claimant began seeing Dr. Mang, a chiropractor. In November 1981 Dr. Martens wrote that the chiropractic treatments were only palliative.

The employer sent Dr. Mang a letter in November 1981 asking him to provide a narrative report explaining the relationship between Dr. Mang's treatments and the compensable injury. That letter aknowledges that the employer had received billings from Dr. Mang covering the period between June 5, 1981 and October 16, 1981. We find, therefore, that Dr. Mang's bills were submitted to the employer by November 12, 1981.

On December 1, 1981 the employer sent a "denial" letter to Dr. Mang with a copy to the claimant. The "denial" letter did not specify claimant's appeal rights and thus was ineffective in starting claimant's appeal time running on the denial. Employers Insurance of Wausau v. Dozier, 56 Or App 627(1982). Thus, claimant's amended request for hearing raising the denial of medical services was timely.

A Determination Order issued December 11, 1981 awarding no permanent disability. The Referee has found that claimant was

entitled to 10% unscheduled disability. Neither party has challenged that finding.

Claimant argues that he is entitled to have Dr. Mang's bills paid whether they are found to be related to the compensable injury or not. We agree, but not for the reasons advanced by the claimant. He relies on OAR 436-69-801(4) which provides:

> "Failure to deny the claim within 60 days from the receipt of the first medical report shall render the insurer liable for the medical services prior to the denial."

Because there is no indication that Dr. Mang's bills were submitted prior to November 12, 1981 claimant has failed to prove that the denial was issued more than 60 days after receipt of the bills. However, even if the denial was untimely, OAR 436-69-801(4) is inapplicable in this case because claimant's compensable injury occurred on October 5, 1978 long before the effective date of the regulation, February 23, 1982. ORS 656.202(2).

At the time of the injury, medical services were considered a form of interim compensation and were payable pending acceptance or denial of a claim. Wisherd v. Paul Koch Volkswagen, 27 Or App 513, 517 (1977). The 1979 amendments which removed medical services from interim compensation are not retroactive. SAIF v. Mathews, 55 Or App 608 (1982). Accordingly, under the law applicable at the time of the injury, we find that claimant was entitled to have his medical services paid pending acceptance or denial of the claim for medical services.

ORDER

The Referee's order of August 26, 1982 is affirmed in part and reversed in part. The employer is ordered to pay the bills submitted by Dr. Mang as of December 12, 1981. Claimant's attorney is allowed an attorney's fee equivalent to 25% of the medical bills payable under the terms of this order, which in this instance are in the nature of interim compensation, as a reasonable attorney's fee.

DAVID R. HOLMAN, Claimant
Gatti & Gatti, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-01426
April 28, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Foster's order which set aside SAIF's denial of March 8, 1982 and found claimant's current cervical condition to represent an aggravation of his March 1977 industrial injury. The issue for review is compensability.

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

Despite the fact that claimant's cervical injury in 1977 was at that time considered to be a very minor problem, and despite the fact that subsequent to that injury there was a near five year

hiatus during which claimant sought no medical services for his neck, what current medical evidence there is does relate his herniated cervical disc, discovered by Dr. Buza in February of 1982, to the 1977 injury. Dr. Buza so states in his report of February 3, 1982 as do the physicians of BBV Medical Services, who performed an examination of claimant at the request of SAIF.

Claimant testified that he experienced difficulties with his neck ever since the 1977 injury, although he had continued working despite this and did not feel the problems were serious enough to see a doctor. There is nothing to indicate that the Referee found claimant to be anything but credible.

The fact that claimant's 1977 injury was minimal, and the fact that he was able to work for a near five year period without seeking medical assistance, casts severe doubt in our minds that the 1977 injury was responsible for claimant's 1982 herniated cervical disc. However, as noted in State v. Cummings, 205 Or 500, 531 (1955):

> "[e]vidence concerning the facts which does not discredit itself, which is not inherently improbable and which comes from witnesses who have not been discredited, contradicted or impeached, generally demands acceptance by the trier of fact." (Emphasis added.)

But see Edwin Bolliger, 33 Van Natta 559 (1981), (uncontroverted medical opinions not necessarily binding on Board or Referees). Although the medical evidence relating claimant's herniated cervical disc to the 1977 injury is somewhat questionable, we do not find that it quite rises to the level of being "inherently improbable" or unconvincing, and since there was no adverse credibility finding by the Referee, we affirm his order.

ORDER

The Referee's order dated November 2, 1982 is affirmed. Claimant's attorney is awarded an attorney's fee of $400 for services before the Board, payable by the SAIF Corporation.

MARK O'HARA, Claimant
C. David Hall, Claimant's Attorney
Wolf, Griffith et al., Defense Attorneys

WCB 81-09737
April 28, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer requests review of Referee Braverman's order which awarded claimant 15% unscheduled permanent partial disability as compensation for the loss of earning capacity caused by claimant's compensable contact dermatitis condition. The employer contends that claimant is not entitled to an award of permanent disability; or that, if claimant is entitled to such an award, it must be for scheduled, rather than unscheduled, disability.

Claimant worked as a transmission rebuilder, which required him to take transmissions apart, clean and reassemble them. As part of the cleaning process, claimant was required to work with

chemical solvents. In approximately October of 1980, claimant's hands began to exhibit signs of dermatitis, such as drying, cracking and bleeding. Claimant continued to work and sought medical attention for his hand condition. Claimant's dermatologist, Dr. Hahn, diagnosed contact dermatitis, which he indicated was related to claimant's work with chemical solvents. Dr. Hahn advised claimant to discontinue his work activity which exposed him to the solvents, and in fact advised claimant to change occupations. Claimant filed a claim with the employer; the claim was accepted and temporary disability was paid for a period of time. Dr. Hahn completed a supplemental medical report form on May 4, 1981 indicating that claimant was medically stationary, that no permanent impairment would result from his work exposure, and that claimant was released for work, although his work activities should be modified to preclude his coming in contact with chemical solvents. In an earlier report, Dr. Hahn had advised the insurer that claimant would be unable to continue working in his present capacity, inasmuch as it exposed him to the solvents which caused his hands to become severely erupted.

Claimant apparently continued the work activity which he had been admonished by his physician to avoid. In fact, at the time of the hearing, claimant had been working for another employer in the business of transmission repair, and his hands exhibited signs of skin disease on the day of the hearing.

The Referee awarded claimant unscheduled permanent disability, reasoning that, although there was no evidence of loss of use or function of claimant's hands, claimant was obviously precluded from returning to the only type of work he was capable of performing. The Referee stated that the criterion for determining unscheduled disability is not impairment but is loss of earning capacity, and that an award of unscheduled disability is warranted if the worker has lost the ability to compete in the labor market due to permanent restrictions attributable to a work injury or exposure.

Some of our decisions might support the Referee's award of unscheduled permanent disability, inasmuch as claimant is permanently precluded from a portion of the labor market as a result of his skin disease, which only became manifest after he was exposed to solvents in the course of his employment. See, e.g., Donald A. Godell, 34 Van Natta 50 (1982), modified, 60 Or App 493 (1982); Ardean Woodfin, 30 Van Natta 281 (1980); Larry Crane, 29 Van Natta 113 (1980). Most recently, however, we have stated that, in order for a worker to be entitled to an award of unscheduled permanent disability for skin disease, such as contact dermatitis, there must be medical evidence that the condition is systemic in nature. Donald W. Hill, 34 Van Natta 1291 (1982). Where there is no evidence that the condition is systemic in nature, and the only manifestation of the disease is present in or on a scheduled body part, any award of permanent disability must be scheduled, rather than unscheduled. Cf. Shaw v. Portland Laundry/Dry Cleaning, 47 Or App 1041, 1045 (1980).

As in Hill, the only evidence of the nature or extent of this claimant's skin disease is that it manifests itself in and is limited to his hands. Any permanent disability award must be for a scheduled disability.

We are persuaded that claimant is entitled to an award for permanent disability. Claimant testified that he never experienced any signs or symptoms of dermatitis prior to his work with this employer. Although he had previously engaged in work involving transmission repair, this previous work was apparently of a different nature, involving contact with the chemical solvents used in cleaning transmissions. He worked with these chemicals for this employer for approximately a year before the skin condition became manifest. Dr. Hahn clearly linked claimant's condition to his work activity and contact with chemical solvents. Although Dr. Hahn indicated no permanent impairment would result from this condition, he also stated that claimant no longer would be capable of functioning in any capacity involving contact with chemical solvents.

We do not agree with the Referee's apparent belief that an award of permanent disability, be it scheduled or unscheduled, can be granted in the absence of some indication of permanent impairment resulting from a work injury or exposure. Even in unscheduled disability, where the test is loss of earning capacity, physical impairment is a factor which must be present in order to entitle a worker to an award for permanent disability. Cf. OAR 436-65-600; see Jay Long, 34 Van Natta 1519 (1982).

Whereas permanent impairment is a factor in rating unscheduled disability, it is the factor in determining an appropriate award for the worker whose injury or exposure affects a scheduled body part. Permanent impairment has been defined as "any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved. . . ." Preface to the Guides to the Evaluation of Permanent Impairment (American Medical Association, 1977). The statutory standard for rating scheduled disability is the permanent loss of use or function of the affected body part due to the industrial injury or exposure. ORS 656.214(2).

The Referee found that claimant did not have any defineable physical impairment or loss of function, a finding with which we disagree. This worker sustains a loss of use of his hands to the extent that he is precluded from coming into contact with specific chemical solvents. He is permanently sensitized to these chemicals, as evidenced by his physician's advice to change occupations and avoid contact with these substances, as well as the condition of claimant's hands on the date of hearing. The uncontroverted evidence indicating that claimant had no history of a skin disorder prior to his exposure to the chemical solvents, as well as claimant's physician's vocational recommendations, persuade us that claimant's permanent sensitization results from his work exposure with this employer. And we believe that permanent sensitization is a compensable form of impairment.

In reviewing our prior decision in Donald W. Hill, supra, in which we concluded that claimant had failed to establish a permanent loss of use or function in his hands as a result of his work exposure to aluminum ore, we have determined that the result reached therein may be inconsistent with our conclusions in this case. The insurer in that case admitted that claimant did contract hand eczema as a result of exposure to aluminum ore, and that he suffered recurrences of that condition whenever he attempted to

return to work at the aluminum plant. The primary focus of our decision in Hill was concerned with the distinction between an award of scheduled disability versus an award of unscheduled disability for a skin disease manifesting itself only on a scheduled body part, where there was no evidence of a systemic disorder. We have relied upon that portion of our order in Hill in this case, using it as the guidepost for our determination that claimant is entitled to an award for a scheduled disability if he is entitled to an award for permanent disability at all. In view of the insurer's concessions in Hill, that claimant contracted his hand eczema as a result of his work related exposure, and that he was unable to return to work in an aluminum plant without experiencing recurrences of his condition, it was error for us to conclude that claimant had not established a permanent loss of use or function of his hands.

The remaining question is: to what measurable extent is claimant disabled as a result of his industrial exposure and resulting skin condition? Dr. Hahn indicated no permanent impairment as a result of claimant's condition; however, in view of our above-stated conclusions, this is inconsistent with his admonition to claimant that he not return to work involving contact with chemical solvents. Some guidance is offered by the departmental rules governing the rating of disability. OAR 436-65-530(7) contains five classifications for rating permanent disability resulting from dermatological conditions of the upper extremity. Class 1 provides for a 0%-5% impairment rating of a radical when: "(a) signs and symptoms of skin disorder are present; and (b) with treatment there is minimal limitation in the radical's functions, although certain physical and/or chemical agents may temporarily increase the extent of functional limitation." OAR 436-65-530(7)(a). We find that this description accurately characterizes the extent of claimant's affliction, and that, therefore, claimant's skin condition falls within this classification.

ORDER

The Referee's order dated August 11, 1982 is modified. Claimant is awarded 7.5° for scheduled permanent disability for loss of his left hand and 7.5° for scheduled permanent disability for loss of his right hand, for a total award of 10% scheduled permanent partial disability for loss of both hands. This award is in lieu of, and not in addition to, the Referee's award. Claimant's attorney is allowed 25% of this award, not to exceed $2,000, as a reasonable attorney's fee, in lieu of the fee allowed by the Referee's order.

CHARLES E. MURPHEY, Claimant
Roll & Westomoreland, Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 82-01190
April 28, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee Mannix's order which awarded claimant 10% permanent low back disability and ordered the employer to purchase an air cushion for claimant's work vehicle. The issues are whether the claimant has proven that his low back injury produced permanent disability and whether the employer is obligated to provide an air cushion pursuant to ORS 656.245.

Claimant is a 44-year-old carrier driver for Publisher's Paper Co. He suffered on the job low back injuries in 1974 and 1977. The second claim was closed by a settlement awarding claimant some permanent disability. The present claim arose on September 18, 1981 when claimant filed an 801 form alleging that riding on his log carrier had caused him to suffer radiating back and leg pains. No specific traumatic incident was alleged, but the claim was processed as an injury claim. The Referee held that claimant had proven that he had suffered a permanent impairment as a result of the September 1981 injury which entitled him to a 10% disability award. The Referee also found that claimant was entitled to have the employer pay for an air cushion for his log carrier pursuant to ORS 656.245. We disagree with the Referee in both instances.

The weight of the medical evidence is that claimant's low back problems are caused not by his occupational injury, but by his obesity together with residuals from his previous accepted claim. See Patricia Nelson, 34 Van Natta 1078 (1982). Dr. Martens stated that, "He has sustained no permanent impairment as a result of his September 1981 injury. * * * He is markedly obese and most of his problems are related to this." Dr. Kauffman concurred with these findings. The Good Samaritan Pain Clinic declined to accept claimant as a patient because the staff felt that claimant's problems were the result of his being overweight and that, until claimant lost weight, they could be of no assistance to him. On the basis of the evidence we conclude that claimant has failed to prove that he has sustained any permanent disability as a result of his September 1981 industrial injury.

We also conclude that claimant is not entitled to have an air cushion paid for by the employer. ORS 656.245 requires only that the employer pay for medical services for conditions resulting from the injury for such period as the process of recovery requires. In view of our conclusion that claimant's current problems are the result of his previous accepted condition and his obesity, it follows tht the air cushion is treatment for those problems, not his most recent injury.

ORDER

The Referee's order of August 23, 1982 is reversed.

KENNETH E. SCHMIDT, Claimant
Pozzi et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-00505
April 28, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Leahy's order which reversed its denial of claimant's hearing loss claim. The issue is compensability. We adopt the Referee's findings of fact and affirm his conclusion.

In summary the facts are that in 1967 claimant at age 47 began working for SAIF's insured, Omark Industries, as a shop machinist and machine maintenance person. Claimant worked within several feet of machinery and equipment that was so loud that ordinary oral communication was impossible. Claimant wore earplugs and earmuffs on an irregular basis. Claimant began noticing a hearing loss about 10 years ago and tinnitis about eight years ago. Claimant retired in November, 1981. Pre-employment audio tests administered in 1967 revealed that claimant had some hearing loss at that time. Comparison of those test results with the results of audio tests taken shortly before claimant's retirement demonstrates that claimant sustained a further hearing loss while employed by Omark.

Since claimant is alleging that his hearing loss arose over many years of exposure and is not attributable to an identifiable traumatic incident, his claim is a claim for an occupational disease. Under ORS 656.005(8)(a) and 656.804, claimant's hearing loss is compensable if it arose out of his employment and required medical services or resulted in disability. The insurer contends that correct application of the administrative rule for determining extent of permanent hearing impairment would reveal that claimant has not sustained any permanent disability. The insurer argues that, therefore, claimant has failed to satisfy that portion of the compensability test requiring a need for compensation. The insurer further contends that claimant has failed to prove that his condition arose out of his employment in the sense that exposure to noise while employed at Omark was the major contributing cause of his hearing loss.

With respect to the insurer's first contention, it is unnecessary to resort to the administrative rules for the determination of extent of permanent disability if the claimant establishes compensability by showing that the condition requires medical services or results in temporary disability. Although claimant may have retired in part because of the hearing loss he was experiencing arising from the exposure to noise at work, the record is clear that the only time loss claimant experienced was to take audiometric tests. However, claimant sought medical attention for his hearing loss and it appears from the evidence that the hearing loss can be treated by use of hearing aids. The hearing aids themselves and the medical services necessary to prescribe and fit them constitute medical services within the meaning of ORS 656.245. It follows that, apart from claimant's entitlement to temporary or permanent disability, he has satisfied that portion of the compensability test requiring proof of a need for medical services or entitlement to disability benefits by showing that the allegedly work related condition requires medical services.

Turning to whether claimant's work exposure was the major contributing cause of his condition, clearly defining what "condition" is at issue assists in the resolution of the case. The insurer seeks to characterize the issue in this case as whether the claimant proved that his at-work exposure to noise was the major contributing cause of his overall hearing loss. The insurer contends that, considering the hearing loss claimant had before he started employment at Omark and the amount of hearing loss attributable to presbycusis (the natural loss of hearing due to aging), claimant's employment was not the major contributing cause of his present hearing loss.

Where a claimant has a condition that preexists employment or arose independently of employment, the claimant has a compensable claim only if work conditions worsen the underlying condition. Weller v. Union Carbide, 288 Or 27 (1979). Thus, the determinative factors are whether there is a worsened condition and, if so, what caused it. Audiometric tests document that in this case the claimant's hearing worsened during the period of his employment with Omark Industries. Since this is an occupational disease claim, claimant must show that the exposure to noise at work was the major contributing cause of the increased hearing loss. Thus, the focus is not on claimant's overall loss of hearing but rather on that portion of his hearing loss which occurred after 1967; and the issue is whether claimant's exposure to noise at Omark Industries was the major contributing cause of that portion of claimant's hearing loss.

Although evidence was elicited concerning exposure to noise off the job as a potential causative factor in claimant's hearing loss, nothing that claimant was exposed to off the job remotely approximated the level and continuity of exposure to noise as evidenced by claimant's work environment with this employer.

The other factor the insurer points to as a potential causative factor is presbycusis, the natural loss of hearing attributable to aging. There is no medical evidence to support the employer's contention that any portion of claimant's hearing loss is due to presbycusis. (Arguably, the fact that claimant had some measurable hearing loss at the time he began employment with Omark is evidence that claimant may be affected by presbycusis. But it is equally possible that his hearing loss at the time, which was not noticable to him, was due to his exposure to noise in combat during World War II or previous employment as a machinist.) The insurer's contention that presbycusis must be considered a causative factor arises from OAR 436-65-565. That adminstrative rule prescribes the method to be used to determine the extent of hearing loss for purposes of determining entitlement to permanent partial disability and provides that a certain portion of a claimant's measurable hearing loss, depending on the person's age, must be deducted because of presbycusis.

The Referee did in fact apply the formula for calculating hearing loss as provided in the former version of OAR 436-65-565 and concluded that claimant had sustained a compensable hearing loss. The insurer contends that the Referee misapplied the rule and that a correct application of the current rule would reveal that claimant did not sustain a compensable loss of hearing.

We indicated above that it is unnecessary to resort to the administrative rule for determining extent of permanent disability in this case to satisfy the need-for-compensation-benefits portion of the compensability test. However, the commentary to OAR 436-65-565 is of some assistance in determining whether claimant's work exposure at Omark Industries since 1967 was the major contributing cause of the hearing loss as compared to the effects of presbycusis. Although claimant challenges consideration of the presbycusis factor in the absence of any evidence suggesting that claimant has age-induced hearing loss, applying the adminstrative rule guidelines reveals that, at least to the extent that the effects of presbycusis are considered by the rule, presbycusis is not the determinative factor in claimant's hearing loss after 1967. Audiometric tests taken in 1967 and 1981 measure the amount of hearing loss at varying Hz levels, measured in decibels (db). A comparison of the test results in 1967 and 1981, and taking into account the presbycusis factor in the manner required by the commentary accompanying OAR 436-65-656, reveals as follows:

(Hz)	Right Ear			Left Ear		
	(1967)	(1981)	Diff.	(1967)	(1981)	Diff.
500	-10	5	15	-10	5	15
1000	0	10	10	- 5	10	15
2000	-10	25	35	- 5	65	70
3000	50*	60	10	60*	65	5
4000	45	65	20	40	75	35
6000	25	65	40	55	90	35
	95	230	130	135	310	175
	-52**	-100**	- 48	-52**	-100**	-48
	43	130	82	83	210	127

*Taken from 1972 test scores because claimant was not tested at 3000 Hz in 1967.

**Arrived at by applying claimant's age in 1967 and 1981 respectively to the Presbycusis Value Correction Table appearing in the commentary accompanying OAR 436-65-565.

As can be see from the above table, using the values prescribed the rule, of the hearing loss experienced by claimant during the years of his employment with Omark (130 db in the right ear and 175 db in the left ear), only 48 db of the loss can be attributable to presbycusis, and 82 db and 127 db, respectively, are due to other factors. Thus, applying the adminstrative rule leads to the conclusion that consideration of the presbycusis factor does not defeat claimant's contention that his work exposure at Omark was the major contributing cause of his hearing loss after 1967.

Considering the evidence indicating that off-the-job exposure to noise and presbycusis are not significant factors in this case, and the evidence of noise exposure with this employer, we are satisfied that claimant's employment with Omark was the major contributing cause of his post-1967 hearing loss. The claimant having proven that his hearing loss increased while employed at Omark, that work conditions were the major contributing cause of the

increased hearing loss, and that his worsened condition requires medical services, it follows that the Referee correctly remanded the claim for acceptance and determination of extent of permanent disability.

ORDER

The Referee's order dated August 13, 1982 is affirmed. Claimant's attorney is awarded $150 as a reasonable attorney's fee for his services before the Board, payable by the insurer.

CHARLES L. SITTON, Claimant
Goode, Goode et al., Claimant's Attorneys
Emmons, Kyle et al., Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 80-06648, 79-09449 & 79-08876
April 28, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer has requested review of Referee Seifert's order which upheld a Determination Order awarding claimant permanent total disability. Employer contends that claimant is not permanently and totally disabled.

Claimant was 64 years old at the time of the hearing. He has worked most of his life in a plywood mill, most recently as a knife grinder. The Referee's order succinctly recites the painful course of claimant's increasing disability over the last twenty years:

> "He first injured his low back in 1963 and underwent a lumbar laminectomy. He again suffered back injury in January 1966; a finger injury in June 1967; another back injury in April 1970; another low back injury in June 1971; a right shoulder injury in April 1972; a right shoulder and back injury in January 1973; a right knee injury in February 1974; another right knee injury in July 1974; a right shoulder injury in January 1976; a serious hand injury in January 1976 in which he suffered amputated fingers on his left hand; a right finger injury in February 1977; back and leg injuries in May 1977; a head injury in January 1978; and low back, neck and right shoulder injuries on August 13, 1979."

In addition to the above injuries, claimant has been diagnosed as having carpal tunnel syndrome in both wrists and has undergone release surgery on the left wrist. A neurological exam revealed that claimant is probably also suffering from thoracic outlet syndrome and release surgery has been recommended. Lastly, claimant also suffers from arthritis in his knee. The employer has denied a claim for compensation for the arthritis.

Claimant has been awarded permanent disability compensation for a 5% unscheduled loss in his low back, 70% scheduled loss in his left forearm (hand) and a 5% scheduled loss of the right

forearm. The present case is an appeal from an October 28, 1980 Determination Order which awarded permanent total disability.

There can be no doubt that claimant is severely disabled as a result of his numerous occupational injuries and we find that he is no longer able to perform any type of regular gainful employment.

Claimant's treating physician, Dr. Moore, sent claimant to a number of specialists to get a complete and more objective evaluation of the extent of claimant's impairment and residual ability. Dr. Moore ultimately concluded in his April 14, 1981 report that he was certain that claimant was not a candidate for any type of vocational rehabilitation and was totally disabled from any type of gainful and suitable employment. Dr. Tsai's neurosurgical consultation report of April 2, 1981 states:

> "I do not believe that patient will be able to return to any gainful employment. With his total disability, based on medical probabilities, vocational rehabilitation is out of the question."

The Field Services Division of the Workers' Compensation Department referred claimant for an extensive vocational evaluation. This vocational report states:

> "...[I]t is my opinion that at this time, he would be unable to work more than approximately a four hour day with frequent alterations of positions without suffering extreme pain. Although he takes pain medication daily, it appears that this medication does not eliminate all of his existing discomforts.... [I]t is doubtful he could be competitively employed in the labor market today due to the debilitating
>
> effects of the pain he appears to suffer. He could, perhaps, maintain some partial employment in a sheltered situation or in a highly modified job which would preclude further injury possibilities."

With respect to whether claimant would be able to perform the relatively sedentary job of a security guard, the vocational report lists several limitations that would have to be observed on the job and then concludes that: "[E]ven if all the above considerations were followed. . . Mr. Sitton would not have a high degree of probability of success in returning to employment."

The employer argues that claimant is not as disabled as he claims to be, and that he has failed to satisfy the requirement of ORS 656.206(3) to make reasonable efforts to obtain employment. It relies heavily on surveillance films that it claims show claimant doing heavy labor around his farm, and thus, that claimant is capable of performing regular work in the labor market. The films show claimant helping his wife plant flowers in front of their home and moving a wheelbarrow with clippings in it. We do not find

anything in the films to convince us that claimant is any less disabled than the remainder of the record indicates.

Employer also contends that it offered claimant a job as a night watchman and that claimant refused this offer even though he was capable of performing the job. On the contrary, we find that the employer did not offer a job to claimant nor does the employer even employ any security guards. Employer contracts with private security companies for its security guards. Although the employer did state that it would recommend claimant for the next opening that the security companies had, we believe that this is too uncertain to be considered an offer of employment. Moreover, even if the security job had been offered to claimant, we do not believe that he would have been capable of performing the activities required for the position. Employer testified that the security guards would have to be outside and exposed to the climate part of the time. The vocational evaluation that was performed for the Field Services Division specifically concluded that claimant could not work outdoors.

ORDER

The Referee's order dated June 2, 1982 is affirmed. Claimant's attorney is awarded $600 as a reasonable attorney's fee for services on Board review, to be paid by Willamette Industries, Inc. This is in addition to the attorney's fee awarded by the Referee.

SIDNEY A. STONE, Claimant
Pozzi, Wilson et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 79-08878
April 28, 1983
Order on Remand

On review of the Board's Order dated May 26, 1981, the Court of Appeals reversed that portion of the Board's order which held that claimant was not entitled to receive interim compensation and remanded for reinstatement of the Referee's order, subject to a modification concerning the amount of interim compensation claimant was entitled to receive. The Supreme Court accepted review but subsequently dismissed the petition as improvidently granted.

Now, therefore, that portion of the above-noted Board order holding that claimant is not entitled to receive interim compensation is vacated, and SAIF is ordered to pay claimant interim compensation for the period July 26, 1979 to October 4, 1979.

IT IS SO ORDERED.

EUGENE VORIS, Claimant (Deceased)
Tamblyn & Bush, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-07150
April 28, 1983
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee St. Martin's order that set aside its denial of the heart disease/death claim or claims here in issue.

We are somewhat unsure exactly what claims are in issue. That uncertainty can best be described after stating our factual findings.

In 1975 Mr. Eugene Voris was diagnosed as suffering from ischemic heart disease and/or coronary artery disease and/or atherosclerosis. An angiogram performed at that time revealed complete blockage of one coronary artery and 50% blockage of another coronary artery. A coronary bypass operation was recommended in 1975, but only after Mr. Voris stopped smoking. Mr. Voris continued smoking; no surgery was performed.

On October of 1979 Mr. Voris experienced a seizure-like episode that was thought to be cardiac-related, probably paroxysmal ventricular tachycardia arrhythmia. Dr. Walden placed Mr. Voris on a restricted diet, an exercise program and prevailed upon him to stop smoking. Although there is evidence to the contrary, we find that the preponderance of the evidence is that Mr. Voris did thereafter stop smoking.

As we understand the record, Mr. Voris was never completely asymptomatic after this 1979 incident. For example, Mrs. Voris testified that she would take walks with her husband as part of his exercise program after 1979: "It was getting harder for him to walk. . . [H]e would stop, and I realized that he did have some angina pain at that time."

> "Q. Now, you told us that on walks of one block your husband would have to stop two or three times?
>
> "A. Uh-huh.
>
> "Q. If he didn't stop would he get angina pain?
>
> "A. Yes.
>
> "Q. Did he have nitroglycerin?
>
> "A. Yes.
>
> "Q. Did he take nitroglycerin?
>
> "A. Yes.
>
> "Q. Had he done that on a fairly regular basis since '79?

"A. Not a regular basis.

"Q. Was it on a constantly deteriorating basis that your husband was having more problems with his anginal pain?

"A. I think so.

"Q. From '79 right on straight forward?

"A. No. For a while he was much better.

"Q. Okay. Then when did he start getting worse again?

"A. It seemed like he was deteriorating, oh, it seemed like from --

"Q. From the time he started school again in 1980?

"A. Yes. Even then he was feeling pressure.

"Q. So his anginal problems were getting more serious all the time?

"A. Yes, I think they were."

Mr. Voris was a high school principal. There were several sources of stress in that job during the 1980-81 school year. Mr. Voris' immediate supervisor and some other top management personnel changed and there was some friction between Mr. Voris and his new supervisors. Apparently (although the matter is not well developed in the record) there was some greater-than-usual problem during 1980-81 getting voter approval for the school district budget. The most serious problem involved a charge of serious misconduct that was made against one of Mr. Voris' teachers in early 1981. Mr. Voris believed the charge was unfounded and apparently it ultimately proved to be unfounded. Mr. Voris, however, was guilty of some procrastination in resolving that matter and this delay was a source of significant friction between Mr. Voris and his supervisors.

That matter came to a head at a late afternoon conference on Thursday, May 7, 1981 between Mr. Voris and Dr. Flannery, one of his supervisors. Dr. Flannery understood that he instructed Mr. Voris that the pending charge had to be resolved. Mr. Voris understood that a case was being built for his own dismissal. Mr. Voris was very upset after this meeting. As his wife put it, she had not seen him so upset in 35 years of marriage.

There may have been another meeting between Mr. Voris and the teacher charged with misconduct on Friday morning, May 8, 1981. We find the evidence too inconclusive to conclude that this additional meeting actually took place, but we do not think this is particularly significant one way or the other. Claimant left work on Friday, May 8 with a severe angina attack and never returned to

work. Mrs. Voris testified that her husband's angina pain was greater over the weekend than it had ever been before. However, they attended some form of social function that weekend.

Mr. Voris consulted Dr. Walden on Tuesday, May 12. Mr. Voris was referred to Dr. Beitz and hospitalized for an angiogram, which revealed more severe occlusion of the coronary arteries than had been found in 1975. A triple coronary artery bypass graft was performed on June 17, 1981. Mr. Voris seemed to be recovering well after that surgery. On the morning of the day he was scheduled to be discharged from the hospital, June 24, Mr. Voris was discovered dead in the hospital bed. An autopsy report in the record reads in full:

> "Note: The following provisional diagnosis represents the conclusion based on gross inspection and is subject to revision when additional laboratory data are correlated.
>
> PROVISIONAL ANATOMIC DIAGNOSIS:
>
> I. Atherosclerotic heart disease.
>
> A. Atherosclerosis, coronary arteries.
>
> 1. Old occlusions - proximal LAD main coronary arteries.
>
> 2. Multiple moderate to severe focal stenosis, right coronary artery, LAD.
>
> B. Old myocardial infarct, healed; inferior septal.
>
> C. Status post CABG, x3 (June 17, 1981.)
>
> D. Cardiomegaly (490 grams)."

There is no other evidence in the record about the cause of Mr. Voris' death.

A. The claim or claims.

On May 13, 1981 Mr. Voris executed an 801 claim form for the angina pain he had experienced on May 8 at work. SAIF initially deferred action on that claim and paid interim compensation; apparently SAIF had neither accepted nor denied that claim at the time of Mr. Voris' death. On July 8, 1981 Mrs. Voris filed a claim for death benefits. On July 30, 1981 SAIF issued a single denial which we understand to be both a denial of the claim that Mr. Voris had filed in May and a denial of the claim that Mrs. Voris had filed earlier in July. The Referee ordered "that the above-entitled claim for widow's and beneficiaries' benefits be and the same is hereby remanded to [SAIF] for acceptance and the payment of benefits as by law provided." The Referee did not separately address the claim that Mr. Voris filed in May.

Determining exactly what claim or claims are now in issue may be important because the parties argue at length about whether this case involves an accidental injury or an occupational disease. Certain parts of the analysis necessary to answer that question are clear. Mr. Voris did not suffer a myocardial infarction in 1981 and thus this case does not involve an industrial injury in that sense. Nobody suggests that Mr. Voris' work as a high school principal caused his coronary artery disease. Rather, the medical opinions join issue on whether the stress of that work aggravated or accelerated that disease process.

The distinction between an injury and a disease depends generally on the elements of "time definiteness" and "unexpectedness." See Clarice Banks, 34 Van Natta 689 (1982); O'Neal v. Sisters of Providence, 22 Or App 9 (1975). The angina attack that Mr. Voris had at work on May 8, 1981 was sudden in result (suggesting an injury) but neither sudden in cause nor unexpected (suggesting a disease), given his history of coronary disease. But even assuming for sake of discussion that Mr. Voris' claim should be more properly regarded as an injury claim, we fail to see how it follows that Mrs. Voris' claim for death benefits should also be regarded as based on an injury theory. The autopsy report, the only evidence we have about the cause of Mr. Voris' death, certainly seems to suggest much more of a disease approach than an injury approach.

Little and/or inconclusive guidance exists in prior analogous cases. A claim for a heart condition other than an infarction was made in Gibson v. SAIF, 288 Or 45 (1979). The court noted, "No one involved seems sure whether the claim is for injury or for occupational disease," 288 Or at 47, and found the claim not compensable without finding it necessary to resolve that threshold issue. A claim similar to this one for atherosclerosis heart disease was made in Kinney v. SIAC, 245 Or 543 (1967). The claim in Kinney was found compensable as an injury, rather than a disease, based in part on the reasoning that if the claimant had suffered a myocardial infarction, the claim would be compensable as an injury under Olson v. SIAC, 222 Or 407 (1960). The continuing vitality of that premise in Kinney is questionable. In James v. SAIF, 290 Or 343 (1981), the court discussed Olson and concluded: "If the heart condition in Olson had been an occupational disease rather than an injury, it would not have been compensable." See also Duffy v. SAIF, 43 Or App 493 (1979) (heart disease claim without infarction found not compensable without discussion of injury versus disease); Wisherd v. Paul Koch Volkswagen, 27 Or App 601 (1976) (heart disease claim without infarction found not compensable without discussion of injury versus disease).

It would seem that this case involves two distinct claims: the claim by Mr. Voris for time loss and medical benefits between the date he left work (May 8, 1981) and the date of his death (June 24, 1981); and the claim by Mrs. Voris for death benefits. However, the Referee addressed only the latter and no party on review complains about the lack of a disposition on the former. Apparently the parties assume that the claims stand or fall together. Despite some doubts, we will join in that assumption.

Moreover, no party is willing to take a very specific position on whether these claims involve an injury - to be judged on a material causation standard, or a disease - to be judged on a major

causation standard. In view of the above cited cases, such unwillingness to take a position is understandable. We feel, however, that we have to take some position in order to have a starting point in deciding this case. We conclude that the claim or claims here in issue should be evaluated under occupational disease law. Specifically, we look to whether it has been proven that Mr. Voris' work during the spring and early summer of 1981 was the major cause, SAIF v. Gygi, 55 Or App 570 (1982), of a worsening of his pre-existing coronary artery disease within the meaning of Weller v. Union Carbide, 288 Or 27 (1979). (Gibson v. SAIF, supra, suggests that the Weller rule would be applicable in any event.)

Comparison of the 1975 and 1981 angiograms reveals an objective and clear worsening of an underlying disease within the meaning of Weller. However, much of the medical analysis in this case focuses instead on the period between Mr. Voris' seizure-like attack in September, 1979 and his acute angina attack in May, 1981. There is no objective evidence of a worsening during this briefer interval because no angiogram was done in 1979. But from all the evidence, we think the stronger inference is that there probably was some worsening of Mr. Voris' artherosclerosis within the meaning of Weller after 1979 (assuming that date is of any relevance). We thus turn to the medical evidence with a view to whether the major-causation requirement of Gygi has been established.

B. The Medical Evidence.

Five doctors have expressed opinions and offered some reasons for their opinions. We find some defects in the reasoning of all of these doctors.

Dr. Walden was Mr. Voris' primary treating doctor from the time of Mr. Voris' cardiac-related seizure-like episode in 1979 until the time of his death. Dr. Walden submitted reports dated October 1, 1981 and December 15, 1981. The former states that Mr. Voris' work was a "material" cause of the worsening of his coronary artery disease. The latter does not use any adjectives, but no "magic words" are required and we think that overall Dr. Walden opines that Mr. Voris' work was the major cause of his heart disease and death.

However, parts of Dr. Walden's discussion and analysis raise doubts in our minds. Dr. Walden's December 15, 1981 report refers to Mr. Voris having had a "myocardial infarction as a direct result of a very stressful [event] in the course of his duties as a principal of a school." As indicated above, we find that Mr. Voris did not have a myocardial infarction in 1981; we find Dr. Griswold's analysis of this point to be the much more persuasive. Even more troublesome is Dr. Walden's repeated reference in his reports to Mr. Voris' loss of weight between 1979 and 1981, referring at one point to Mr. Voris weighing "30 pounds less" in 1981 than he had in 1979. Actually, however, Mr. Voris' weight, as reflected in Dr. Walden's own chart notes, was as follows: 10/12/79 - 174; 11/1/79 - 178; 1/23/80 - 178; 4/23/80 - 186; 5/12/81 - 188. Either Dr. Walden does not keep very good chart notes or his reference to significant weight loss between 1979 and 1981 is simply wrong. Under these circumstances, and considering a tone of advocacy in his reports, we do not find Dr. Walden's opinion to be persuasive.

Dr. Beitz was one of the surgeons who performed Mr. Voris' bypass operation. His only report, dated June 2, 1981, states the opinion that the "precipitating etiology of [Mr. Voris'] coronary disease was not his employment" but that his employment "has certainly been an aggravating factor over the past few years." Dr. Beitz also referred to "smoking, family history, diet, and so forth"; he did not express an opinion concerning the relative degree or extent of various contributory factors. Dr. Beitz's explanation for employment being one of the contributing factors was: "I don't know of any cardiologist that would state that the type A personality that is subjected to considerable stress, does not have coronary disease aggravated by such stress." We find two flaws in this explanation. First, Dr. Walden who was involved in Mr. Voris' treatment quite a bit longer than Dr. Beitz, expressly states that he did not believe Mr. Voris a "type A personality." Second, we previously have considered a contention that a "type A personality" was part of the stress related cause of a heart condition and concluded:

> "That theory does not, however, withstand analysis because: (1) Any personality characteristic is a 24-hour-a-day, 7-days-a-week phenomenon; (2) A majority of any worker's time is spent in a non-work environment, not a work environment; (3) Therefore, any interrelationship between a worker's personality and work environment cannot be the major cause of a disease because the personality is constant, but the work environment is intermittent." John P. Ginter, 34 Van Natta 547, 549 (1982), aff'd 62 Or App 118 (1983).

Three other doctors who did not examine or treat claimant offered opinions as consultants. Of these, Dr. Wasenmiller offered the opinion least supported by explanation:

> "[Mr. Voris] exhibited a very strong family history for coronary artery disease and was a heavy smoker in addition to his stressful position as a high school principal. It is apparent that he had a genetic predisposition to the development of premature coronary atherosclerosis. This process was undoubtedly accelerated by his habit of smoking cigarettes and possibly by the stress at work.
>
> "I cannot, however, implicate the stress related to his job as the major contributing factor to his coronary artery disease. There is no doubt that stress may have aggravated symptoms of his underlying coronary artery disease but there is little evidence to support that it contributed to the progression of the underlying disease process. Smoking, on the other hand, has been shown to accelerate coronary

> atherosclerosis significantly in patients with an underlying predisposition to that disease."

As noted above, we find that Mr. Voris stopped smoking sometime after September of 1979, i.e. something like 18 months before his angina attack in May of 1981 and surgery and death in June of 1981. Dr. Wasenmiller may assume or know that the effects of tobacco on the progression of atherosclerosis continue for a period even after a person stops smoking, but he does not say so and we do not know so.

Dr. Wayne Rogers submitted reports dated January 17, 1980 and August 10, 1981. The first was in connection with a claim Mr. Voris made after his 1979 seizure-like attack - a claim that was denied and not litigated. Thus, Dr. Rogers was able to assess Mr. Voris' situation both before and after the events of May/June, 1981 that gave rise to the claim(s) here in issue.

Dr. Rogers' 1980 report states:

> "While the stresses of school teaching and being a principal are well known to me, as my mother was a teacher and my father a principal, I do not find their chronic nature as being material in precipitating an attack of ventricular tachycardia. Rather, it would appear that the documented double coronary artery occlusion, smoking heavily, sedentary life, unfavorable family history, elevated serum cholesterol and glucose were the background factors that contributed to the coronary disease in this case."

Dr. Rogers' 1981 report reviewed Mr. Voris' medical history between 1975, when the first arteriogram was performed, and 1981, and concluded: "This six-year interval is in keeping with the expected natural history of a 50% coronary stenosis having progressed to a very critical degree during this time frame without having to postulate any unusual aggravating influences." Addressing Mr. Voris' increasing problems with work between 1979 and 1981 and specifically Mr. Voris' procrastination in dealing with a serious complaint against a teacher during early 1981, Dr. Rogers speculated this was "possibly due to organic brain damage as a result of [the 1979] ventricular tachycardiac attack's reducing blood flow to his brain." Dr. Rogers discussed his understanding of various sources of stress in Mr. Voris' professional and personal life and then offered this summary:

> "In summary, I find nothing in the material you have sent me to suggest that Mr. Voris was subjected to any physical or emotional stress that probably would have aggravated the underlying course of the demonstrated progressive coronary heart disease that finally postoperatively led to his death. I would say, on the other hand, that the vascular disease that Mr. Voris had was

> probably making him more fatigued and less tolerant of work during the first half of 1981 when he was developing very marked coronary insufficiency . . . .
>
> "Finally, I have to disagree with Dr. Beitz' assertion of 6-2-81 that the stress of being a Principal aggravated the coronary disease problem. The most that can be said in this connection was contained in Dr. D. Pederson's history of 5/25/81 that 'recently' tension discussing school matters might bring on angina (a transient phenomenon and not one that permanently altered his cardiac status)."

The flaw in Dr. Roger's explanation of his opinion is that his understanding of certain specific sources of stress in Mr. Voris' personal life is contradicted by the rest of the evidence.

Dr. Griswold both submitted a report dated December 29, 1981 and testified at the hearing. His report does not address the issue that is relevant under Weller: "It would be my medical opinion that the stress of the job that Mr. Voris was subjected to . . . was a significant and material contributing factor to aggravating his underlying symptomatology." Dr. Griswold's hearing testimony, however, does make this a closer case.

In his hearing testimony, Dr. Griswold repeatedly used the word "probably" in discussing the causation of Mr. Voris' disease, and even when specifically asked would not use the term "major" causation, preferring instead to express his opinion in terms of "material and substantial" work causation. Reading all of Dr. Griswold's testimony, however, we think he was expressing the opinion that stress associated with Mr. Voris' job, especially during the spring of 1981, was the major cause of an acceleration of Mr. Voris' artherosclerosis.

Dr. Griswold testified: "I'm not saying that this work activity in the late winter and spring of 1981 caused his coronary artery disease, because we know that he had it for a number of years." Rather, the original cause was "probably [Mr. Voris'] smoking." But stress "can accelerate artherosclerosis" due to "changes in the platelets, which are the thrombocytes in the blood." Dr. Griswold believed that Mr. Voris' disease "probably would have progressed" regardless of any job stress, "but it is my medical opinion that it progressed more rapidly, more severely, because of the [job] stress."

Dr. Griswold candidly explained that his opinion was based on certain assumptions. The first was that Mr. Voris experienced a high level of work-related stress during the spring of 1981 as indicated by "his work habits changed" and "he was manifesting fatigue" - all of which suggested to Dr. Griswold that Mr. Voris "was reacting adversely to the [job-related] stress." However, Dr. Rogers offers equally plausible alternative interpretations of the same data: that the natural progression of Mr. Voris' coronary

disease during early 1981 made him "more fatiguable and less tolerant of work" and/or there was possibly some organic brain damage at the time of Mr. Voris' 1979 seizure-like attack.

Dr. Griswold also stated that he was assuming that Mr. Voris had little or no angina symptoms between September of 1979 and May of 1981, even to the point of testifying at one point that during this interval Mr. Voris was on a "physical fitness program without symptoms." On the other hand, the theory of being relatively asymptomatic during this interval is documented by the failure of Mr. Voris to seek regular medical attention during this interval. However, we find the asymptomatic theory to be inconsistent with the testimony of Mrs. Voris, quoted above, and we feel that she was in the best position to offer evidence on this point.

In summary, then, it is apparent that "holes can be poked" in the analysis of each doctor: Dr. Walden's reference to weight loss appears to be incorrect; Dr. Beitz's reliance on "type A personality" is misplaced; Dr. Wasenmiller's emphasis on tobacco smoking apparently ignores the fact that Mr. Voris stopped smoking; Dr. Rogers' references to certain specific non-job sources of stress are incorrect; and Dr. Griswold's assumption that Mr. Voris was relatively symptom-free between 1979 and 1981 is inconsistent with the testimony of Mrs. Voris about her husband's angina experiences during this period.

When the evidence is this inconclusive, we necessarily have to recall where the burden of proof lies. Are we persuaded that stress associated with Mr. Voris' job as a high school principal, especially during the spring of 1981, was the major factor that caused his pre-existing coronary artery disease to progress more rapidly than it otherwise would have progressed? We are not persuaded that the preponderance of the evidence so establishes.

ORDER

The Referee's order dated August 14, 1982 is affirmed in part and reversed in part. That portion that awarded interim compensation is affirmed because it has not been challenged on review. The remainder of the Referee's order is reversed. The SAIF Corporation's denial dated July 30, 1981 is reinstated and affirmed.

Board Member Lewis Dissenting:

I agree with the Referee's finding that the medical evidence establishes that the decedent's exposure to stress on his job aggravated his underlying coronary artery disease. This conclusion is supported by the expert opinions of claimant's treating physician, Dr. Walden, and Dr. Griswold, cardiologist and Professor of Medicine. I find the opinions of these two doctors far more persuasive than those of SAIF's consultants. The Referee's order should be affirmed.

OLIN L. YODER, Claimant
Lawrence Neer, Sr., Claimant's Attorney
Wolf, Griffith et al., Defense Attorneys

WCB 81-04213
April 28, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of that portion of Referee Braverman's order which awarded claimant compensation for a 15% unscheduled permanent partial disability for claimant's alleged lung condition. The insurer asserts that claimant has not suffered any permanent disability.

Claimant moves for dismissal of the insurer's request for review for failure to timely file its brief with the Board. Failure to timely file a brief is not grounds for dismissal of a request for review. Claimant's motion is denied.

The principal question in this case is whether claimant has sustained any permanent disability as a result of exposure to dust and fumes while working for Huntington Rubber Company. Claimant was 45 years old at the time of the hearing and has worked in the rubber and plastics industry all of his adult life. The record indicates that claimant suffered bouts of pneumonia in 1973 and 1979. The present claim arose in 1979 when claimant notified his employer that he was having respiratory difficulties and that he believed exposure to fumes and dust at work caused his problems.

Following a hunting trip, claimant was hospitalized with fever and chills on October 30, 1979. At that time, his condition was diagnosed by Drs. De Simone and Rott as bilateral pneumonia and chronic pulmonary obstructive disease. Claimant was also examined in the hospital by Dr. Conley, a pulmonary specialist. Dr. Conley's impressions were that claimant was suffering from acute pneumonia, chronic bronchitis and pneumoconiosis secondary to claimant's work. Dorland's Medical Dictionary defines pneumoconiosis as:

> "A condition characterized by permanent deposition of substantial amounts of particulate matter in the lungs, usually of occupational or environmental origin, and by the tissue reaction to its presence." 26th Ed., p. 1037 (1981).

Pulmonary function testing was done on December 5, 1979 by Dr. Patterson, a pulmonary specialist. His impression following the tests was that claimant was suffering mild obstructive lung disease. New x-rays were taken on December 11, 1979 and compared with those taken a month earlier. Dr. Lancaster opined that the x-rays indicated complete resolution of the previously reported pneumonic lung conditions and that claimant's lungs were within normal limits.

Claimant's treating general practitioner, Dr. Lisook, wrote to the employer on April 16, 1981, stating:

> "Olin Yoder exhibits chronic obstructive lung disease with evidence of chronic bronchitis and chronic bronchiectasis. In addition he has pneumoconiosis secondary to

working in the plant atmosphere at Huntington Rubber especially with exposure to the silica dust. He recently has returned to the plant work area and has had a worsening of his symptoms. We do not feel that he can medically return to an atmosphere of particulate dust especially silica."

On April 20, 1982 Dr. Patterson reported that he did not find anything specific about the x-rays to suggest a pneumoconiosis and that the pulmonary function testing did not suggest a significant restrictive lung disease. Dr. Patterson examined claimant again on June 24, 1981 and reported on July 10, 1981 that:

"Mr. Yoder's examination was entirely normal, with no physical evidence of lung disease. His physiologic testing was essentially normal, although there was some evidence of very mild obstructive lung disease (but not of a degree that one would associate with symptoms). His exercise tolerance is entirely normal with no evidence of a pulmonary limitation. At the present time, he has no physical or physiologic evidence of any pulmonary disorder.

* * * * *

"To give Mr. Yoder the benefit of the doubt, I should think that he might have had some symptoms of chronic bonchitis, particularly cough and phlegm, while working at Huntington Rubber. Certainly his cigarette consumption would have been the most significant factor, but the rubber industry is an area where there is exposure to smoke and fumes in general, and a greater incidence of industrial bronchitis."

Dr. Lisook's reports of April 16, 1981 (quoted above) and September 22, 1981 are the strongest evidence supporting claimant's contention that he has suffered permanent disability. The September report states:

"I have reviewed Dr. James Patterson's report of August 21, 1981 on Mr. Olin Yoder and I concur with Dr. Patterson's findings of a normal pulmonary function testing.

"I do feel, however, that there has been some clinical correlation of exacerbations of chronic bronchitis with Mr. Yoder's work environment. I have advised him that he should seek employment outside of any industrial enviroment where there are significant airborn irritants."

Dr. Lisook offered no explanation or objective medical evidence to support his conclusions.

The Referee found that a preponderance of the medical evidence establishes that claimant has permanent respiratory sensitivity as a result of exposure to irritants on the job. Upon reviewing the record we disagree with that conclusion. Claimant has failed to present sufficient medical evidence that he currently suffers from pneumoconiosis or any other permanent lung disease as a result of his employment at Huntington Rubber Co.

ORDER

The Referee's order dated August 31, 1982 is reversed in part. Those portions of the order which awarded compensation for a 15% unscheduled permanent partial disability and an attorney's fee from the permanent disability award are reversed. The remainder of the Referee's award is affirmed.

CYNTHIA SAWYER BURNETT, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 82-05519
April 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Nichols' order which affirmed the Determination Order closing claimant's claim with an award of 30% unscheduled disability for injuries to claimant's back. The issue is extent of permanent disability.

We affirm and adopt the Referee's order with the following comments. With respect to the adaptability factor in OAR 436-65-605, claimant argues that the Evaluation Division and the Referee erred in assigning a +5 value, contending that +5 is the value for medium work, whereas the medical reports clearly document that claimant has a residual functional capacity for only light to sedentary work. The adaptability factor attempts to measure the difference between a claimant's physical abilities (in terms of lifting ability) before and after the injury and assigns points accordingly. Thus, it is not the claimant's residual functional capacity after the injury alone which is the determinative factor; it is the residual functional capacity post-injury as compared to pre-injury functional capacity. We find from the evidence that claimant probably was capable of medium to heavy work prior to her injury and light to sedentary work post-injury. Thus, the appropriate value to assign to the adaptability factor is somewhere between +20 (heavy to sedentary) and +5 (medium to light). Considering the record as a whole, we believe a +10 value would be appropriate.

This does not change the overall award of disability, however, because the values assigned to each of the factors (impairment, age, education, adaptability, etc.) are combined as per the combining charts accompanying the administrative rules, not added. OAR 436-65-601(3). The combined result is rounded off to the nearest 5 percentage point. OAR 436-65-601(4). Accordingly, in this case, based upon our de novo evaluation of the extent of

claimant's disability we arrive at the same 30% disability figure. Comparing this figure to awards of permanent disability in similar cases, we believe that a 30% disability award accurately compensates claimant's loss of wage earning capacity attributable to the industrial injury.

ORDER

The Referee's order dated November 24, 1982 is affirmed.

JOYCE C. COOK, Claimant
Carney et al., Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 82-00076
April 29, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Leahy's order which upheld the insurer's denial of payment for medical bills for claimant's low back condition. Claimant asserts that the insurer is required to pay the bills in question as a compensable consequence of her existing low back disability under ORS 656.245.

The Referee found that a slight jolt received in an automobile accident in August of 1981 and a minor fall in October of 1981 were superseding intervening events that terminated the insurer's future responsibility for claimant's low back problems.

We believe the Supreme Court's decision in Grable v. Weyerhaeuser Co., 291 Or. 387 (1981) controls the outcome of this case. In Grable the court stated:

> "We conclude that if the claimant establishes that the compenable injury is a 'material contributing cause' of his worsened condition, he has thereby necessarily established that the worsened conditon is not the result of an 'independent, intervening' nonindustrial cause. We hold that an employer is required to pay worker's compensation benefits for worsening of a worker's condition where the worsening is the result of both a compensable on-the-job injury and a subsequent off-the-job injury to the same part of the body if the worker establishes that the on-the-job back injury is a material contributing cause of the worsened condition." 291 Or at 400.

In the present case, the insurer accepted responsibility for claimant's original injury in 1973, stipulated to a 20% award of unscheduled permanent partial disability in 1978, and paid for claimant's medical care, including surgery for removal of a ruptured L-4 disc in 1979 and a fusion from L-4 to S-1 in April of 1981. The former surgery was paid for by the insurer pursuant to a July 10, 1980 stipulation in which the insurer specifically agreed that the surgery was covered under ORS 656.245.

There is simply no evidence indicating that either of the two 1981 incidents relied upon by the insurer caused sufficient injury to claimant's back so that it now could be said that her prior injury and surgeries were no longer a material factor in her continuing symptoms.

ORDER

The Referee's order dated September 3, 1982 is reversed. The denial dated December 17, 1981 is set aside and the contested medical services are remanded for acceptance. Claimant's attorney is awarded $900 as a reasonable attorney's fee for services rendered at the hearing and on Board review, to be paid by the insurer.

GARY DECKER, Claimant
Galton et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Schwenn et al., Attorneys

WCB 81-11345 & 82-02115
April 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The employer, William C. Gardner Company, requests review of Referee St. Martin's order which set aside its denial of November 25, 1981 and remanded claimant's August 26, 1981 aggravation claim to the employer's insurer, the SAIF Corporation, for acceptance and payment of benefits.

The employer contends that the claimant did not suffer an aggravation of his compensable November 14, 1978 low back injury, or that if he did suffer a worsening of his condition in August, 1981, it is the responsibility of his then current employer, Barry Services, Inc. We agree with the Referee that claimant suffered an aggravation of his 1978 injury.

SAIF, who was also the insurer for Barry Services, requested review of that portion of the Referee's order which ordered it to pay the claimant interim time loss benfits from the date of the claimant's new injury claim, December 11, 1981, to February 3, 1982, the date of the denial of the new injury claim. The insurer contends that it should not have to pay interim compensation on the claim for new injury because it is SAIF's policy that if a claim was not timely filed (the alleged new injury occurred in August, 1981 and the claim was not filed until December, 1981), then no time loss would be paid because once the insurer has begun payments on an untimely claim, it waives the right to raise the defense of untimeliness as a bar to the claim. ORS 656.265(4)(b). We have recently stated that interim compensation must be paid for untimely filed claims if there is no denial forthcoming within fourteen days of the claim. Inez Van Horn, 35 Van Natta 342 (1983).

Finally, claimant's attorneys have moved the Board to award an extraordinary fee on Board review for counsel's efforts on behalf of the claimant. Although we find that this case was not an easy case, we do not find that the case was so extraordinarily difficult, nor was the representation of counsel so extraordinary

that claimant's counsel should be granted an attorney's fee in the requested amount of $1,676.25. Therefore, we deny the claimant's motion for an extraordinary fee on Board review.

ORDER

The Referee's order dated July 9, 1982 is affirmed. Claimant's motion for an award of an extraordinary attorney's fee on Board review is denied. Claimant's attorneys are awarded $600 as a reasonable attorney's fee for their services on Board review.

CHRISTINE D. FLETCHER, Claimant
Emmons, Kyle et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-03787
April 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Wilson's order which found claimant permanently and totally disabled. The issues are extent of disability and, if the claimant is permanently and totally disabled, the effective date of the award. Based on our review of the record, we agree with the Referee that claimant is permanently and totally disabled but modify the effective date of the award.

The claimant contends that the Referee erred in not awarding permanent total disability retroactive to: (a) the date by which claimant last became medically stationary; (b) the date of the last Determination Order; or (c) the date on which claimant received the last payment on her permanent disability award pursuant to the Determination Order. The insurer has not taken issue with claimant's contention that the Referee erred in failing to award permanent total disability retroactively. The Referee concluded that claimant was permanently and totally disabled based on medical impairment alone as well as in conjunction with social and vocational factors. Applying the rule set forth in Morris v. Denny's Restaurant, 53 Or App 863 (1981), and Wilke v. SAIF, 49 Or App 427 (1980), June 15, 1981 appears to be the date by which permanent total disability status was established. June 15, 1981 is the date of Dr. James Riley's report wherein he opines that because of claimant's impairment "she would be unable to engage in regular employment on an eight hour a day, five day a week basis."

Therefore, we adopt the Referee's findings of fact and affirm his award of permanent total disability but modify the effective date of that award.

ORDER

The Referee's order dated October 1, 1982 is modified. Claimant is awarded permanent and total disability effective June 15, 1981, less permanent partial disability paid pursuant to the Determination Order of April 7, 1981. Claimant's attorney is awarded $600 as a reasonable attorney's fee, payable by the insurer.

DON HELVIE, Claimant
Pozzi, Wilson et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-11237
April 29, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Leahy's order which dismissed claimant's request for hearing seeking penalties and attorney fees pursuant to ORS 656.262(9) and 656.382(1) for the SAIF Corporation's allegedly unreasonable resistance and refusal to comply with an order of the Multnomah County Circuit Court dated August 5, 1980, awarding the claimant's attorney a fee pursuant to ORS 656.388(2). We affirm.

By an Order on Review dated June 20, 1980 the Board awarded claimant's attorney $200 as a reasonable attorney's fee. Claimant's attorney thereafter utilized the procedure set forth in ORS 656.388(2), which provides for a summary proceeding in the circuit court when a party is dissatisfied with an attorney's fee awarded by a Referee or the Board. The Presiding Circuit Court Judge awarded claimant's attorney $1,500 in lieu of the Board's award. SAIF apparently paid $200 and failed to pay the remaining balance of $1,300 until after claimant filed the request for hearing which gave rise to this proceeding.

The Referee reasoned that claimant's counsel's remedy, in order to have obtained more timely payment of the fee awarded by the circuit court order, was to execute on the circuit court judgment order, as with any other order of the circuit court. He found that he had no authority to enforce the circuit court order by imposing penalties and attorney fees.

We agree with the Referee's conclusion that this agency lacks jurisdiction to enforce payment of an attorney's fee awarded by the circuit court in proceedings pursuant to ORS 656.388(2). Execution on the judgment order or other circuit court enforcement would be the appropriate procedure. Furthermore, as noted by the Referee,

ORS 656.283(1) provides that any party or the director may request a hearing on any question concerning a claim. Claimant's attorney is not a "party." ORS 656.005(19); Adams v. Transamerica Insurance, 45 Or App 769, 774 (1980).

ORDER

The Referee's order dated August 9, 1982 is affirmed.

52, 684

HENRY HOLMAN, JR., Claimant
Dwight R. Gerber, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-08706
April 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Peterson's order which affirmed the second Determination Order herein which awarded no additional permanent disability, the first Determination Order having awarded 15% scheduled disability for injuries to claimant's right hand.

We affirm and adopt the Referee's order with the following comments. The greater part of the tips of claimant's middle and ring fingers on his right hand were nearly completely severed in an industrial accident. The finger tips were surgically reattached but claimant was left with fused joints on those fingers and had a significant loss of grip strength. Based on these disabilities, claimant was awarded 15% scheduled permanent disability for the right hand. Because of pain and other problems, ultimately the finger tips on both fingers were surgically amputated. Applying the administrative rules for determining permanent disability for finger losses reveals that the Evaluation Division and the Referee correctly computed the compensation due for claimant's loss.

Claimant argues that if he was entitled to 15% disability when he retained his finger tips he should be entitled to more disability when they are amputated. No appeal was taken from the initial 15% disability award and we have not reevaluated that award to determine if claimant received the proper compensation. It appears from the medical evidence that probably no error was made either time. After surgical amputation of the finger tips, claimant regained grip strength that previously he did not have because of the presence of the extra sensitive finger tips. Claimant's loss of grip strength now is negligible. Apart from the compensable loss of his finger tips per se, claimant's only other cognizable loss is in the opposability function. While claimant's counsel's approach to rating loss of opposition is interesting, the method prescribed by administrative rule is reasonable and consistent with ORS 656.214. We fail to see any advantage to claimant's proposed method and are satisfied that claimant has been adequately compensated for his loss.

ORDER

The Referee's order dated October 22, 1982 is affirmed.

RAYMOND L. MADISON, Claimant
Cash Perrine, Claimant's Attorney
Minturn et al., Defense Attorneys

WCB 81-11197
April 29, 1983
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Williver's order which apparently affirmed the award of 30% unscheduled permanent partial disability granted by a December 4, 1981 Determination Order, but found claimant to be medically stationary as of June 8, 1982 rather than November 11, 1981 as found by the Determination Order, and ordered SAIF to pay claimant additional benefits for temporary total disability from November 11, 1981 to June 8, 1982. SAIF contends that the Referee erred in finding that claimant was not medically stationary as of November 11, 1981. Claimant argues that the Referee was correct in his finding and that his conclusion that claimant was not permanently and totally disabled was merely dicta.

Claimant was employed as a logger on October 16, 1980 when he fell and struck his back on a log. The claim was accepted. A myelogram performed on March 24, 1981 revealed obliteration of the nerve root at the C3-C4 level. In addition to the cervical problem, Drs. Kendrick and Goldsmith diagnosed a possible thoracic outlet compression problem based on the cyanotic condition observed at times in claimant's right arm. An anterior cervical fusion C-3 to C-5 was performed on April 29, 1981 by Dr. Kendrick. Shortly thereafter on July 29, 1981, Dr. Goldsmith performed a cervical right rib resection.

On October 16, 1981 Dr. Kendrick reported that claimant was medically stationary with some residual disability. Dr. Kendrick stated that claimant "probably should not be doing repetitive lifting greater than 50 lb." Apparently at the request of claimant's attorney, claimant was examined by Dr. Bernson, a neurosurgeon. Dr. Bernson reported on November 2, 1981 that he could find little wrong with claimant, that there was nothing to preclude him from returning to light work following a ten to fourteen day period of exercise to relieve neck stiffness, and that claimant should return to Dr. Kendrick for final release. On November 11, 1981 Dr. Goldsmith reported that he agreed with Drs. Kendrick and Bernson and that: "The patient from an objective standpoint has completely recovered and healed from the right first rib resection done on July 29, 1981." Dr. Goldsmith stated claimant could return to work, although a lighter duty and lower risk type of employment was suggested. On November 18, 1981 Dr. Robinson, a family practitioner, reported that he did not agree with the specialists that claimant should go back to work. However, Dr. Robinson apparently had nothing to offer claimant in the way of treatment. A Determination Order issued on December 4, 1981 awarding claimant 30% unscheduled permanent disability and temporary disability benefits from October 16, 1980 through November 11, 1981.

Claimant was thereafter referred to the Callahan Center for vocational assistance. The examiners at the Callahan Center found that claimant exhibited tendencies to overfocus on his physical symptoms and that there were possible elements of secondary gain present. These tendencies were previously noted by Drs. Goldsmith, Kendrick and Bernson. On February 2, 1982 Dr. Robinson reported that claimant should not participate in the Callahan Center program until he has a neurological evaluation, especially with regard to a mass in his neck. Claimant was discharged from the Callahan Center on February 2, 1982. The discharge report states: "It was the opinion of this counselor that he is very comfortable with the money he has received from his award and that he will try to get as much as he can get out of the WCD system before he will decide to find gainful employment. . ."

Claimant was examined by Dr. Melgard on February 8, 1982. Dr. Melgard's findings differed little from those of previous examiners. He recommended that claimant return to work and that his condition could be evaluated again after a period of trial employment. On May 10, 1982 claimant was examined for the first time by Dr. Cutter who stated that claimant was "100% disabled at the present time." On June 8, 1982, Dr. Robinson reported that claimant was released for participation in rehabilitation sessions.

The matter proceeded to hearing on July 8, 1982. Claimant's attorney set forth the issues to be decided as premature closure and extent of disability, including permanent total disability. The Referee directed SAIF to pay claimant temporary total disability benefits from November 11, 1981 to the June 8, 1982 rehabilitation release by Dr. Robinson. With regard to the issue of extent of disability, the Referee stated only: "The Referee does not believe that the claimant is permanently disabled, and will be able, with a period of rehabilitation, to return once again to the labor market."

We reverse with regard to the issue of claimant's entitlement to temporary disability benefits from November 11, 1981 to June 8, 1982. Drs. Kendrick and Goldsmith were claimant's original treating physicians and surgeons. Dr. Kendrick felt claimant was medically stationary as of October 16, 1981 and Dr. Goldsmith agreed in his report of November 11, 1981. Further, Dr. Bernson, a consulting neurosurgeon, agreed. Dr. Robinson's contrary opinion is not convincing. He states no reasons for his disagreement other than claimant's subjective complaints. As nearly every other examiner has noted, however, claimant has a tendency to exaggerate his symptoms. Dr. Robinson reports no objective findings which differ from the findings of other examiners. In fact, his reports are somewhat devoid of objective physical findings. In short, Dr. Robinson's reports are insufficient to overcome the opinions of Drs. Kendrick, Goldsmith, Bernson and Melgard. We believe that the evidence indicates that claimant was able to participate in vocational rehabilitation activities, but that he was unwilling to do so.

We turn to the issue of the extent of claimant's disability. We agree with the Referee that claimant is not permanently and totally disabled; we affirm the Determination Order's award of 30% unscheduled disability. Claimant was 46 years of age at the time of the hearing and had obtained his GED while serving in the Army as a motor pool sergeant. He has been employed as a ranch hand, logger, construction worker and equipment operator. His physicians have restricted him from engaging in repetitive heavy labor only. We are uncertain what Dr. Cutter meant when he stated that claimant was 100% disabled. The physical findings in his report certainly do not support such a proposition. His examination appears to have been rather limited. Apparently he only saw claimant on one occasion. Dr. Robinson's testimony during the deposition of August 24, 1982 accentuates these deficiencies, and further indicates that his opinion is based in large part on claimant's subjective complaints. We conclude that the 30% disability awarded by the Determination Order was appropriate.

Claimant's argument that the Referee's finding was dicta is not convincing. That was one of the issues submitted by the claimant to the Referee for determination. Claimant at least implicitly represented that this issue was ripe for litigation. Had the Referee found that claimant was not medically stationary at the time of the hearing, the extent issue would not have been ripe. Gary A. Freier, 34 Van Natta 543 (1982). However, the Referee found claimant medically stationary at the time of the hearing. It was, therefore, appropriate for him to rate the extent of claimant's disability, which is exactly what the claimant requested him to do. He should not now be heard to complain that there was insufficient evidence in the record to determine this issue.

ORDER

The Referee's order dated September 9, 1982 is reversed in part. Those portions of the order which found claimant entitled to benefits for temporary total disability from November 11, 1981 to June 8, 198 are reversed, and the Determination Order of December 4, 1981 is reinstated and affirmed in its entirety. The remainder of the Referee's order is affirmed.

VERNON MICHAEL, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 81-0201M
April 29, 1983
Own Motion Order

The Board issued an order on September 15, 1982 which denied claimant's request for own motion relief. Claimant requested reconsideration and due to the complexity of the matter, the case was referred to the Hearings Division for an evidentiary hearing on claimant's entitlement to own motion relief.

After a hearing held on February 2, 1983, the Referee recommended that claimant's claim be reopened for the payment of temporary total disability benefits. The major question involved is whether claimant has voluntarily retired from the labor market using the rationale found in Vernon Michael, 34 Van Natta 1212 (1982).

After thorough consideration of the evidence before it, including the transcript of the hearing before the Referee, the Board finds that claimant did make some effort to remain a part of the labor market prior to this most recent "aggravation." We find that his effort was relatively minimal; however, we also note the severity of his disability which precludes him from a substantial part of the labor market. Based on a totality of the evidence, the Board concludes that claimant is entitled to compensation for temporary total disability commencing October 12, 1981, the date he underwent a fusion, and to continue until closure under ORS 656.278.

Due to the extraordinary services required on the part of claimant's attorney, we grant him a fee equal to 25% of the increased compensation granted by this order, payable out of said compensation as paid, not to exceed $900.

IT IS SO ORDERED.

FRANK MOONEY, Claimant
Coons & McKeown, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-01124 & 82-02568
April 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

North Pacific Insurance and its insured, C.J. O'Neil & Co., request review of Referee Baker's order which disapproved their March 15, 1982 denial of responsibility for claimant's new injury claim. The primary issues on review are whether claimant sustained a compensable low back injury on February 2, 1982 and, if so, which employer is responsible: a prior employer, K-Mart, or O'Neil. A sub-issue is whether the Referee erred in refusing to admit three medical reports on the grounds that counsel for K-Mart had refused to make the authors of those reports available at the hearing.

Claimant asserts that on February 2, 1982, while in the course of his employment at O'Neil, he bent over to pick up a plastic bag and was unable to straighten up, experiencing immediate pain in his back and some pain radiating into both legs. In its denial, North Pacific stated, in essence, that no compensable incident occurred on that date while in the course of claimant's employment at O'Neil. If such is found to have occurred, O'Neil argues that any pain claimant may have experienced is due instead to a compensable injury sustained January 20, 1981 while in the course of claimant's prior employment with K-Mart. The K-Mart injury occurred when claimant, while working in the automotive department, was struck in the back by his supervisor's truck, pinning claimant between the truck and welding tanks.

We find that claimant has failed to prove by a preponderance of the evidence that he sustained a compensable injury on February 2, 1982 in the course of his employment at O'Neil. The Referee found that claimant sustained a new injury on February 2, 1982 at O'Neil in spite of the following factors: (1) that claimant gave a history to Dr. Bert on February 2, 1982 that he had been missing four to five days a week of work due to back pain the past few months; (2) that Dr. Bert prescribed strict bed rest, yet claimant failed to do so, driving his wife to and from work each day and attending a bachelor party the eve of his myelogram returning at 3 a.m.; (3) that claimant rode his motorcycle up and down his driveway before the bachelor party; (4) that the final diagnosis following the myelogram was merely "suspected, unproven lumbar disc;" (5) that EMG studies were normal; (6) that Dr. Bert noted considerable pain behavior in his February 24, 1982 examination of claimant; (7) that Dr. Bernstein noted on April 6, 1982 that claimant had no radicular lesion, that his condition was complicated by functional overlay or psychogenic pain magnification and that claimant "could be malingering;" (8) that claimant had two off-the-job motorcycle injuries; and (9) that when asked at the hearing if his back was worse after February 2, 1982, claimant said "not very much."

Based on our consideration of the evidence and taking special note of the above factors, we do not agree with the Referee's finding that claimant sustained a new compensable injury on February 2, 1982 while in the course of his employment at O'Neil. Additionally, we find claimant sustained no aggravation of his prior injury at K-Mart and any worsening he alleges was attributable to other off-the-job activities as noted above. We, therefore, reverse the Referee's order which found O'Neil responsible, and conclude that the evidence (not including the three excluded exhibits) preponderates in favor of a finding that claimant sustained neither a compensable new injury on February 2, 1982, nor a compensable worsening of his 1981 injury. We do not reach the issue of whether the Referee erred in refusing to admit the three exhibits in question or the issue of responsibility.

ORDER

The Referee's order dated October 13, 1982 is reversed in part. That portion of the order which set aside North Pacific Insurance Company's March 15, 1982 denial is reversed and that denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

VICKIE PINE, Claimant
Mitchell, Lang & Smith, Attorneys

WCB 80-05172
April 29, 1983
Order Denying Dismissal

The Board received respondent's motion for dismissal of claimant's request for Board review on the grounds that claimant has not filed an appellant's brief.

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

IT IS SO ORDERED.

DAVID A. RHODES, Claimant
Leistner & Vallerand, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-10854
April 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Baker's order which upheld the SAIF Corporation's denial of compensability for claimant's hepatitis. Claimant asserts that he contracted the disease as a result of his employment at Sacred Heart Hospital.

We affirm and adopt the Referee's findings and conclusions. Claimant has not proven that any possible exposure at work was more likely to have infected him than other potential sources of the disease off the job. Robert B. Woodruff, 35 Van Natta 249 (1983); Barbara Wasson, 34 Van Natta 1094 (1982), aff'd, Wasson v. SAIF, 62 Or. App. 399 (1983).

ORDER

The Referee's order dated October 29, 1982 is affirmed.

LINDA L. RIENING, Claimant
Jolles, Sokol, et al., Claimant's Attorneys
Moscato & Meyers, Defense Attorneys

WCB 80-01849
April 29, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Gemmell's order which upheld Georgia Pacific's denial of compensability for claimant's chronic urticaria. Claimant asserts that the condition is the result of work exposure at the employer's mill.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated October 15, 1982 is affirmed.

Board Member Barnes Dissenting:

If this Board believes that its role is limited to counting the opinions of doctors, then it seems to me that we do not need a Board at all -- compensability issues can be decided by doctors. I believe our role is and should be broader: We should weigh and assess all of the evidence, a decisional process that is considerably more complex and more subtle than counting doctors' opinions.

This is an occupational disease claim for urticaria (hives). Considering all the medical evidence as a whole, my overall impressions are: (1) medical science knows little about the cause(s) of urticaria; and (2) the leading candidates as causative factors are heredity, irritation of the skin surface and possibly allergic reactions.

Claimant's work involved exposure to wood dust and glue. Allergy testing has produced very disparate results (and in my opinion, too much of the parties' attention is devoted to these test results and the opinions based thereon). Suffice it to say that some of the tests indicate that claimant is allergic to the wood dust and glue she was exposed to at work. Some doctors stated that claimant's urticaria was more likely linked to minor skin irritation from sweating and wearing heavy clothes -- which could still make this claim compensable because claimant's cleanup work required movements while wearing heavy clothes that would have produced skin irritation.

I believe the strongest evidence in this case is circumstantial: While working in the environment that contained wood dust, contained glue and resulted in skin irritation, claimant suffered from urticaria; once removed from that

environment, claimant's urticaria condition resolved. This evidence, combined with Dr. Morgan's opinion, is sufficient to persuade me that it is more likely than not that something in claimant's work environment either caused or worsened her urticaria condition.

Accordingly, I would reverse the Referee's order and set aside the self-insured employer's denial of claimant's claim.

JAMES L. SALEEN, Claimant
Douglas Minson, Claimant's Attorney
Cheney & Kelley, Defense Attorneys

WCB 80-07245
April 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Fink's order which found that the claim had not been prematurely closed, affirmed the insurer's denial of claimant's aggravation claim but awarded 15% unscheduled disability, the Determination Order having awarded no permanent disability. The issue on review is whether the claim was prematurely closed or in the alternative whether claimant has proven a valid aggravation claim.

The determination of this issue turns on whether surgery in relation to claimant's protruding disc at L4-5 will decrease his headaches, neck pain and low back pain. Claimant's present treating physician believes it might, but numerous other physicians who have examined or treated claimant believe that the proposed surgery will do nothing for claimant. It appears from the evidence that the "protrusion" of the disc is very minimal, that claimant has a large spinal canal that will accomodate some protrusion, that claimant's nerve roots are not being impinged upon, that his discomfort is due to chronic muscle strain, and that surgery to excise the protruding part of the disc will not effect a cure of the discomfort. While we generally defer to the treating physician where the issue is the propriety of a proposed course of treatment, see, e.g., Lucine Schaffer, 33 Van Natta 511 (1981), the medical evidence in this case greatly preponderates in favor of a conclusion that claimant's residual discomfort from the injury will not be reduced by the proposed surgery. Accordingly, we affirm and adopt the Referee's order.

ORDER

The Referee's order dated August 24, 1982 is affirmed.

SHIRLEY C. TROWER, Claimant
Holmes, James, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-11097
April 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review and the claimant cross requests review of Referee Mongrain's order which awarded claimant 20% unscheduled permanent disability (right shoulder) and 20% scheduled disability (right forearm), that being an increase over the Determination Order's award of 10% unscheduled disability. The insurer contends that claimant is not entitled to any award of scheduled disability. Claimant contends that the award of unscheduled disability was insufficient. Thus, the issue is extent of permanent disability, both scheduled and unscheduled.

We adopt the Referee's findings of fact as far as they go and supplement his findings with additional facts.

Claimant, age 28 at the time of the hearing, injured her left shoulder on August 22, 1977 while working as a grocery checker. Claimant ultimately had surgery to repair "recurrent dislocation" of the shoulder. Claimant also sustained an incomplete tear of the rotator cuff, and has chronic bursitis as a result of the injury. The extent of impairment in the shoulder has been described as "marked" and "severe." Specific loss of range of motion is set forth below in the chart diagraming our calculations of the extent of unscheduled disability. In addition, claimant has sustained a loss of strength in the biceps and intrinsic muscles of the hand resulting in an overall marked loss of grip strength.

Contrary to the insurer's contentions, claimant is entitled to an award of scheduled disability as well as unscheduled disability notwithstanding that the impairments to different body parts arose from the same accident. Foster v. SAIF, 259 Or 86 (1971). The critical factor is not what part of the body sustained a trauma in the compensable incident but rather what part (or parts) of the body have residual permanent impairment causally related to the incident.

Claimant's grip strength has been rated at 30 pounds on the left versus 85 pounds on the right for a first effort and zero pounds on the left versus 70 pounds on the right on the second effort. This represents a loss of grip strength of 80% on the first effort and 100% on the second effort. Under OAR 436-65-530(5) such a loss translates into 40% impairment of the forearm.

OAR 436-65-530(2)(c) seems to provide that loss of grip strength due to decreased range of motion does not result in any further impairment allowance. On the other hand, paragraph (d) of that same subsection provides that additional impairment is allowed if the loss of grip strength is due to tissue loss or atrophy. Thus, a separate award for loss of grip strength is justified.

With respect to claimant's unscheduled disability, we rate this case as follows:

			Plus	Minus
Impairment				
Abduction	85-90°	= 4%		
Adduction	10°	= 1%		
Forward Flexion	115-130°	= 1%		
Extension	40°	= 0		
Internal Rotation	20°	= 2%		
Inability to Lift Above Waist or Chest		= 4% (est)		
Combined		= 12%	+12	
Age - 28 years				-5
Education - High school, 2 terms of college				-3
Work Experience - Grocery clerk (DOT No. 290.477-018, SVP of 3)			+3	
Adaptability - formerly was capable of light work, now limited to sedentary work			+10	
Mental Capacity - assumed to be normal				
Emotional/Psychological Factors - assumed normal				
Labor Market Findings (RFC for sedentary work, SVP of 3, and GED of 4 = 0% of the labor market			+15	
COMBINED			+35	-8

35 x .08 = 2.8; 35 - 2.8 = 32.2, rounded to the nearest 5% = 30%

As can be seen from the above chart, under the disability evaluation guidelines, claimant's unscheduled disability is rated at 30%.

The extent of claimant's shoulder and arm impairment is reflected by the difficulty she encounters in her present occupation. Claimant is working as a secretary and has arranged her work area as much as possible to allow her to use her right arm and to minimize use of her left arm. Nevertheless, after two hours or so of typing or other continuous activity of that type claimant suffers fatigue and pain in the left arm. At the end of each work day claimant experiences fatigue and pain in the left arm disproportionate to the amount of use of that arm.

Comparing this case to similar cases, we believe that an award of 40% scheduled disability (forearm) and 30% unscheduled disability accurately compensates claimant for the impairment to her arm and her lost wage earning capacity, arising from the compensable injury.

ORDER

The Referee's order dated July 14, 1982 and his Amended Order dated August 3, 1982 are modified to award claimant 40% scheduled permanent disability for loss of the left forearm and 30% unsche-

duled permanent disability for injury to the left shoulder. This award is in lieu of all previous awards. Claimant's attorney is allowed 25% of the increased permanent disability made payable by this order over and above the permanent disability awarded by Determination Order, not to exceed $1,800, as an attorney's fee for services at hearing and on review. In addition, claimant's attorney is awarded $300 as a reasonable attorney's fee, payable by the SAIF Corporation, for his services in connection with an insurer initiated appeal.

HARRY WEATHERS, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-02807
April 29, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of Referee Seifert's order which found that claimant failed to file a claim for aggravation within five years of the December 2, 1976 Determination Order and, therefore, dismissed his request for hearing. Claimant contends that the Referee erred in finding that a claim for aggravation was not timely filed.

Claimant's claim was first closed by Determination Order on December 2, 1976 and his aggravation rights thus expired on December 2, 1981. There are only two documents in the record which could be considered aggravation claims and which were submitted prior to the expiration of aggravation rights. These are the August 12 and August 27, 1981 reports of Dr. Norris-Pearce. The first of these states:

> "I saw Mr. Weathers in re-evaluation 14 July 1981 after a hiatus of approximately a year and a half. At that time Mr. Weathers was complaining that he was continuing to have back pain almost constantly. This was worse with some degree of activity, and he further stated the pain radiated to his hip. As you are probably aware from reviewing his old chart, he has had evidence of lumbar radicular problems as well as some probable peripheral nerve contusion as a result of his on the job injury. On re-examination at that time, he did show a moderate degree of limitation of motion of the low back as well as a moderate degree of bilateral lumbar paravertebral muscle spasm. The paravertebral muscles were quite tender in this area. At that time he was referred for neuroprobe treatments in my office to identify trigger points and hopefully progress him to a TENS unit for long-term pain relief."

Dr. Norris-Pearce's August 27 report states:

> "Since my last report of 12 August 1981, this patient was seen in re-evaluation on

19 August 1981. At that time he was achieving fairly good relief with his TENS unit. He exhibited only mild increased tone in the lumbar paravertebral muscles. He exhibited fairly good range of motion with movement in all directions. At that time a Load Sentinel (Powers) TENS Unit was applied for him to use as a rental unit. He was seen again on 25 August 1981 at which time he reported he was using the TENS unit about one and a half hours a day and had no severe pain for most of the day. He was having what are considered excellent results with this unit, and at that time it was prescribed for the unit to be purchased for him."

As discussed in cases like Douglas Dooley, 35 Van Natta 125 (1983), and Johnnie L. Stepp, 34 Van Natta 1685 (1982), it is often a close question whether a physician's report is a claim for aggravation reopening under ORS 656.273, or instead a claim for additional medical services under ORS 656.245, or instead no claim at all but merely a narration about ongoing treatment. Dr. Norris-Pearce's two August 1981 reports about provision of and apparent success with a TNS unit certainly could be viewed as claims for additional medical services under ORS 656.245. As so interpreted, however, there is nothing to decide because there is no indication that payment for the TNS unit was denied.

The real issue is whether the two August 1981 reports are claims for aggravation reopening under ORS 656.273. In Dooley we defined such an aggravation claim as including "reasonable notice to the employer or insurer that the worker is claiming further medical services or additional compensation for worsened conditions related to or resulting from the worker's original injury or disease." 35 Van Natta at 127. In Stepp we noted that a point of distinction was whether curative as opposed to continued palliative treatment was being proposed or provided. 34 Van Natta at 1685.

Judged by these standards, we do not think the two August 1981 reports in question constituted a claim for aggravation reopening under ORS 656.273. These reports do not suggest any worsening of claimant's condition; they indicate only that claimant was continuing to experience pain, as he had previously. The additional medical services mentioned (a TNS unit) are more palliative than curative in nature. We agree with the Referee that no claim for aggravation was filed within the appropriate time period.

Dr. Norris-Pearce submitted additional reports after the expiration of claimant's aggravation rights. In a report dated September 9, 1982, the doctor for the first time contended that claimant's condition has worsened: "The significant worsening began at about the time of my report of 12 August 1981." While this certainly would be sufficient to be an aggravation claim under Dooley, we do not think that the time of "filing" can "relate back." ORS 656.273 requires that an aggravation claim be "filed"

within a given period. Dr. Norris-Pearce's September 9, 1982 report was not "filed" within the applicable period.

Despite the fact that the claim for aggravation was not filed within five years of the first determination, this does not mean that claimant is without a remedy. The appropriate procedure is to file a request with the Board pursuant to its continuing own motion authority under ORS 656.278.

ORDER

The Referee's order dated November 5, 1982 is affirmed.

FLOYD D. WILLIAMS, Claimant
Ackerman et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-06795
April 29, 1983
Order on REconsideration

Reviewed by Board Members Lewis and Ferris.

On April 15, 1983 we issued an Order on Review herein. In that order we indicated that one error we identified in claimant's argument was that under the disability evaluation guidelines for unscheduled injuries (OAR 436-65-600 et seq.) the values assigned to the various factors are combined in the manner provided in the combining chart and not merely added. We indicated that this was true with respect to the various measures of impairment, such as flexion, extension, rotation, etc. for the low back, as well as the other disability evaluation factors such as age, education, adaptability, etc.

On April 21, 1983 we abated our Order on Review sua sponte because one of the statements in the Order was incorrect and may have affected the outcome of the case.

Upon reconsideration of the evidence in the case and the Order on Review, we are satified that there was a partial misstatement of law but that no error was made in the calculation of the extent of disability or the award of permanent disability.

With respect to the evaluation of unscheduled injuries, under the administrative rules for the evaluation of disabilities, the values arrived at for each of the major factors (impairment, age, education, adaptability, etc.) are combined according to the combining chart accompanying the disability evaluation guidelines. It also is true, as a general rule, that within the impairment factor, the different measures of impairment are combined and not added. For instance, with respect to the low back, if there has been surgery, values are assigned depending on the nature of the surgery, and if there is a sensory or motor deficit or disabling pain, those various values are combined to arrive at an overall impairment rating. However, with respect to losses of range of motion (extension, forward extension, lateral extension, etc.),

the values arrived at are added to arrive at an overall loss of range of motion value which is then combined with the other impairment factors.

At least with respect to the back, one cannot know this from merely reading the administrative rules or the accompanying commentary. In fact, the wording of OAR 436-65-615 (the rule for rating spinal impairment) and the commentary accompanying it suggest that all values are combined and not added. This is in contrast to other parts of the disability evaluation guidelines which make it clear that loss of range of motion values are to be added, not combined. See, for instance, the commentary accompanying the rule for rating ankle impairment in (OAR 436-65-545(3).

OAR 436-65-675 provides that losses not described in the administrative rules are to be rated by reference to the American Medical Association's Guidelines to the Evaluation of Permanent Impairment, 1977 Ed. or other authoritative medical reference. Extrapolating from that, where the administrative rules or the accompanying commentary fail to make clear how a factor is to be treated, we will refer to the AMA guide for assistance. In this case, reference to the AMA guide clarifies that losses of range of spinal motion are to be added, and the cumulative result combined with the other measures of impairment to determine overall impairment. Accordingly, to the extent that our Order on Review indicated that measures for losses of range of motion are to be combined rather than added, the Order is incorrect. Within the range of motion factor, losses with respect to flexion, extension, etc. are to be added, not combined. Because of the way in which the combining chart works at the loer end of the scale and the relatively small number of points allowable for even a complete loss of (in this case) thoracolumbar range of motion (30 percentage points), as a practical matter, the impact of adding the range of motion findings instead of combining them is negligible. In any event, once an overall loss of range of motion value is arrived at, that value is then combined with other measures of impairment, and the overall impairment value combined with other disability factors having a positive value.

In the course of our de novo review of this case we independently calculated the extent of claimant's compensable impairment, which in this case includes two back surgeries and loss of range of spinal motion. We have review our calculations and are satisfied that although the method of calculating the range of motion factor was incorrect, the ultimate impairment figure and disability award was correct. Accordingly, subject to the correction noted in this Order on Reconsideration, we reaffirm and republish the Order on Review issued herein and dated April 15, 1983.

IT IS SO ORDERED.

FLORINE G. JOHNSON, Claimant
Black, Hansen et al., Claimant's Attorneys
William M. Beers, Defense Attorney

WCB 81-08157
May 3, 1983
Order of Abatement

The Board has received a request for abatement of its Order on Review dated April 26, 1983, pending completion of a settlement of all issues by the parties.

In order to allow sufficient time, the above noted Board order is abated.

IT IS SO ORDERED.

PHILLIP GORRINGE, Claimant
Mitchell, Lang & Smith, Attorneys

WCB 82-01434
May 6, 1983
Order Denying Motion to Dismiss

The employer has moved to dismiss claimant's request for review on the grounds that claimant failed to mail the request to all parties within the 30-day period, pursuant to ORS 656.295(2). See ORS 656.289(3).

The Motion to Dismiss is denied. Barbara Rupp, 30 Van Natta 556 (1981); Michael J. King, 33 Van Natta 636 (1981).

IT IS SO ORDERED.

DONALD G. LAVIN, Claimant
SAIF Corp Legal, Defense Attorney

WCB 82-01671
May 6, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Peterson's order which approved the SAIF Corporation's denial of responsibility for claimant's August 11, 1972 acute psychotic episode because: (1) the claim was untimely filed, having been filed approximately nine years after the alleged injurious work exposure (see ORS 656.807(1)); and (2) even if there was some reason for excusing the untimely filing, there was no medical evidence causally relating the June 1972 work exposure to claimant's August 1972 hospitalization.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated September 28, 1982 is affirmed.

WILLIAM A. NEWELL, Claimant
R.W. Pickell, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-09980
May 6, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Wilson's order which affirmed the "denial" of the SAIF Corporation to provide medical treatment pursuant to ORS 656.245. The issue for review is whether claimant is entitled to continuing medical services pursuant to ORS 656.245 for an injury which occurred in 1954, or whether claimant's sole remedy is under the Board's continuing own motion jurisdiction under ORS 656.278. We affirm.

Claimant was employed by the City of Eugene on September 3, 1954 when he sustained an injury to his left knee. The claim was accepted by the State Industrial Accident Commission, predecessor to the State Accident Insurance Fund. On September 28, 1955 Dr. Slocum performed a medial meniscectomy on claimant's left knee and found a "bucket handle" tear of the meniscus with degenerative changes present.

In the late fall of 1979 claimant suffered what he termed a "severe dislocation" of the left knee. He was examined by Dr. Mosiman, an orthopedist in Seattle, Washington. On January 31, 1980 Dr. Mosiman performed a valgus osteotomy on claimant's left knee.

On June 26, 1981 SAIF received a letter from claimant requesting it to advise him if the original 1954 claim could be reopened. SAIF received a short report from Dr. Mosiman dated August 17, 1981 stating that there was a direct relationship between the original injury and the 1980 surgery. By letter of September 9, 1981 SAIF informed claimant that since the aggravation rights on the 1954 injury had expired, that he would have to petition the Board for further benefits pursuant to its own motion jurisdiction and that, in any event, it appeared that he had sustained a new injury in 1979. Claimant requested a hearing.

On November 6, 1981 SAIF, in a letter to claimant's attorney, reiterated what it had stated in its previous letter of September 9, 1981. In February of 1982 claimant filed an application for a hearing date, setting forth as an issue, by memorandum dated March 19, 1982 Dr. Norton, SAIF's medical consultant, indicated that the 1980 surgery appeared to be a direct result of claimant's 1954 injury, due to subsequent and related degenerative changes in the knee. In a letter dated March 29, 1982 SAIF informed the claimant that it was responsible for the 1980 surgery and requested claimant to provide information with regard to time lost from work as a result of the 1980 surgery and medical reports from his treating physician. In a letter dated May 6, 1982 SAIF requested claimant to provide information regarding any "out of pocket" expenses incurred in relation to the 1980 surgery.

The hearing convened on July 27, 1982. SAIF moved that the request for hearing be dismissed upon the grounds that claimant had no rights under ORS 656.245 since his injury occurred prior to

1965, that claimant's sole remedy was through the Board pursuant to ORS 656.278 and that the Referee, therefore, lacked jurisdiction over the matter. No testimony was taken at the hearing; the Referee only heard oral argument from claimant's and SAIF's respective counsel.

The Referee concluded:

> "Claimant would have had the right to lifetime medical benefits if he had been declared permanently and totally disabled prior to January 1, 1966, but such was not the case, and, being a substantive right bestowed by the 1965 enactment, the provision of ORS 656.245 cannot be applied retroactively to claimant's claim."

The Referee concluded that claimant had no rights pursuant to ORS 656.245, and that since continued rights to benefits were derived from ORS 656.278, claimant's remedy was exclusively a matter for the Board.

We are in complete agreement with the Referee's well-reasoned order.

ORS 656.245(1) provides:

> "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, including such medical services as may be required after a determination of permanent disability."

No similiar statute was in existence at the time of claimant's 1954 injury. ORS 656.245 was first adopted in a somewhat different form by Or Laws 1965, c. 285, §23, and became effective on January 1, 1966. ORS 656.245 entitles injured subject workers to medical services for whatever length of time is necessary in order to recover from the effects of a compensable injury. Wait v. Montgomery Ward, 10 Or App 333 (1972); Bowser v. Evans Products Company, 270 Or 841 (1974).

ORS 656.202(2) provides:

> "Except as otherwise provided by law, payment of benefits for injuries or deaths under ORS 656.001 to 656.794 shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred."

This statute, in virtually identical form, was in effect at the time of claimant's injury. See § 102-1760, O.C.L.A., as amended by Or Laws 1953, c. 669 (effective date May 12, 1953). Additionally, Or Laws 1965 c. 285 §43 provided:

"(1) Subject to the provisions of subsections (2) and (5) of this section, all proceedings, rights and remedies with respect to injuries that occurred before the fully operative date prescribed by section 97 of this 1965 Act, shall be governed by the law in effect at the time the injury occurred.

"(2) The powers, duties and functions performed by the State Industrial Accident Commission under such law shall be performed by the manager of the department except that the board shall exercise all powers, duties and functions imposed on the commission under ORS 656.278 with respect to claims arising from such injuries."

Prior to the 1965 Act, SIAC served as insurer, administrator and quasi-judicial forum. These functions were transferred to the Board by the 1965 Act. McDowell v. SAIF, 13 Or App 389 (1973); but see Thornsberry v. SAIF, 57 Or App 413 (1982), overruling McDowell in part.

The question then is, what was the law in effect at the time of claimant's injury relative to his entitlement to benefits? As noted above, ORS 656.245 did not exist prior to the 1965 Act. It is not retroactive. In Bradley v. SAIF, 38 Or App 559, 564 (1979), the court stated:

"Claimant's arguments are answered in part by our construction of ORS 656.202(2), supra. That statute governs the rights of survivors as well as workers and, unless the 1973 amendments to ORS 656.218 apply retroactively, mandates the application of the law in effect at the time of the worker's injury. The key factor in retroactive application questions is legislative intent. See, e.g., Mahana v. Miller, 281 Or 77 573 P2d 1238 (1978); Employment Div. v. Bechtel, 36 Or App 831, 585 P2d 769 (1978). That intent may be discerned from the effects of retroactive application.

* * *

"In the present case, application of current law rather than former law would change the rights and obligations arising out of past transactions. Respondent could be liable for greater payments than those for which it would have been liable under former law."

In Holmes v. SAIF, 38 Or App 145, 147-48 (1979), the court stated:

> "Claimant's second assignment of error is that the 1975 amendments to ORS 656.206 should be applied to cover claimant's 1973 injuries. In particular he desires the benefit of the amendment enlarging the extent of compensation for a scheduled injury which results in unemployability. Many principles have been judicially enunciated applying, distinguishing,
>
> abandoning or modifying the substantive procedural test for prospective or retrospective application of newly enacted statutes. * * * They boil down to the general principle that the rights and liabilities of persons affected by an event are defined and measured by the statutes in effect at the time of the event and the adjudication of those rights and liabilities is accomplished under the statutes in effect at the time of the adjudication. * * * The injury occurred prior to the amendment of the statute and therefore the claimant's entitlement to and the employer's responsibility for compensation are to be measured under the statute in effect at the time of the injury."

See also Smith v. Clackamas County, 252 Or 230 (1969), holding that statutes are presumed to be prospective, and will be considered to be retrospective only when such an intent is clearly spelled out. Such an intent is not clearly spelled out in relation to ORS 656.245.

At the time of claimant's 1954 injury, a subject worker who sustained a compensable injury was entitled to medical benefits under the following circumstances, pursuant to ORS 656.242 (1953):

> "The commission may provide, under uniform rules and regulations, first aid to workmen who are entitled to benefits under ORS 656.002 to 656.590, together with first aid supplies and transportation, medical and surgical attendance and hospital accomodations for injured workmen and to contract therefore in its discretion." (Emphasis added.)

The 1953 version of ORS 656.276 provided for a two year aggravation period during which the worker could apply to the commission for increased compensation. ORS 656.242 was amended by Or Law 1959, c. 589, §2, as follows:

> "In addition to the compensation provided for in ORS 656.206, the commission, during the period of permanent total disability,

> shall on the advice of a physician . . . provide to a workman who has been permanently, totally disabled such medical and surgical attendance, medicine and drugs, hospital accomodations . . . as may be necessary in the treatment of the disabilities resulting from the accidental injury giving rise to the claim for aggravation thereof." (Emphasis added.)

We are convinced that at the time of his injury, claimant had no direct right to continued medical services, and that it was a matter for determination by the commission whether to provide for such services in the first instance or thereafter. Although there are dangers in attempting to fathom prior legislative intent by examining subsequent legislative action, it would appear that the fact that the legislature felt it necessary to provide a right to continued medical services in a permanently and totally disabled worker in 1959 lends support to our conclusion. The fact that it was necessary to create such a right for totally disabled workers strongly implies that no such rights existed for workers less than permanently totally disabled prior to 1965. Further support can be found in Tooley v. SIAC, 239 Or 466 (1965). In Tooley, the claimant was injured in 1960 and his claim was closed by SIAC in 1963 with an award of permanent partial disability. Claimant requested that the order closing the claim be set aside and that he be afforded further medical treatment. The court concluded that closure was proper and that claimant was not entitled to continued palliative medical treatment under then current law.

We conclude that if ORS 656.245 were applied retroactively, it would serve to create an entitlement to benefits where none previously existed, and would serve to change rights and obligations arising out of past occurrences. Therefore, based on Holmes, supra, and Bradley, supra, ORS 656.245 may not be so applied.

Although there are no direct rights to continued medical services for pre-1966 injuries that do not result in total disability, the Workers' Compensation Board, as successor of the State Industrial Accident Commission, had and has jurisdiction and the authority to provide for such benefits under its own motion powers pursuant to ORS 656.278 (1953), which provided:

> "The powers and jurisdiction of the commission shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate its former findings, orders or awards if in its opinion such action is justified."

The current version of that statute is virtually identical. As noted previously, Or Laws 1965, c. 285, §43 provided that the duties and functions imposed on the commission with respect to ORS 656.278 shall be performed by the Board. There is no question, therefore, that the Board has jurisdiction for pre-1966 injuries under its own motion authority. See Barackman v. General Telephone, 25 Or App 293 (1976); Thornsberry, supra. Since claimant's injury took place prior to the effective date of ORS

656.245, and, since we have concluded that ORS 656.245 is not retroactive, the law in effect at the time of claimant's injury provided that the only "right" he had for continued medical services was to petition for own motion relief. Since Or Laws 1965, c. 285, §43 instilled in the Board the authority which the Commission formerly had under ORS 656.278, we conclude that claimant's sole remedy in this case (and, in fact, for all pre-1966 injuries for which continued medical services are sought, other than cases involving permanent total disability under the 1959 amendment) is to petition the Board under ORS 656.278. Such a petition would be addressed to the Board's discretion; there is no substantive right to such medical benefits.

ORDER

The Referee's order dated September 9, 1982 is affirmed.

KENNETH C. ALSPAUGH, Claimant
Carney, Probst et al., Claimant's Attorneys
Spears, Lubersky et al., Defense Attorneys

WCB 81-02305
May 11, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis

The self-insured employer requests review of Referee Fink's order reinstating the claimant's award of permanent total disability following a redetermination of that award. In the alternative, the self-insured employer moves for remand to consider additional evidence not available at the hearing.

We remand for consideration of new evidence only upon a showing that the proffered evidence was unavailable at the time of the hearing and is material. Robert A. Barnett, 31 Van Natta 172 (1981), and Ora M. Conley, 34 Van Natta 1698 (1982). The evidence which the employer seeks to have considered is relevant evidence. However, it is merely cumulative of evidence already in the record. Accordingly, we do not deem it material because it would in no way affect our decision of this case. The employer's motion to remand is denied.

We affirm and adopt the Referee's order because we agree that the employer has failed to sustain its burden of proving that there has been a material change in the claimant's condition. Harris v. SAIF, 292 Or 683 (1982), and Bentley v. SAIF, 38 Or App 473 (1979).

ORDER

The Referee's order of September 21, 1982 is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee for services before the Board.

PATRICIA G. DAVIS, Claimant
Pozzi et al., Claimant's Attorneys
Bruce Posey, Defense Attorney

WCB 79-10006
May 11, 1983
Order on Review

Reviewed by the Board en banc.

The self-insured employer, Pacific Northwest Bell, requests review of that portion of Referee Leahy's order which reversed its denial of compensability. The Referee also determined that claimant was permanently and totally disabled, but the employer has not raised that determination as an issue on review. Thus, the issue we decide is whether claimant sustained a compensable condition in the course of her employment, with the understanding that if we reverse the Referee on that issue the extent of disability question would be moot.

Except for incorrect references to certain dates, we adopt the Referee's findings of fact. The facts, in summary, are that claimant, age 54 at the time of hearing, first went to work as a directory assistance operator with this employer in 1948. Subsequently she quit work in order to raise her family. During this period, in 1956 (at the age of 28), claimant was afflicted with poliomyelitis (polio). She was hospitalized for 48 days and was totally paralyzed except that she was able to speak, turn her head and move her hands. Claimant recovered substantially from the effects of the disease; however, she had permanent residual weakness in the muscles f her left leg, trunk, the shoulders and the arms. Her diaphragm remains paralyzed but she has learned to breathe by use of other muscles. She wears a back brace to help support her body. Claimant also developed scoliosis of the spine as a result of the differential in strength between the muscles on each side of her back.

In 1961 claimant returned to work with the employer and resumed her duties as a directory assistance operator. Prior to March 1978 claimant sat at an arc-shaped desk with an array of information books about the size of ordinary telephone directories. The chair claimant used prior to March 1978 had arm rests enabling her to rest her arms on the chair, table or books according to which position was most comfortable. In March 1978 the employer installed video display terminals for use by directory assistance operators as part of the computerization of its directory assistance service. We quote from the Referee's order describing the new manner in which claimant was required to work:

> "Although she sat at the same U-shaped or arc-shaped table with equipment similarly to her left, in front of her and to her right, she now had to look upward at the scope of the computer terminal for the requested number, rather than down at the phone books. Instead of paging through telephone information books resting on the arms of her chair or on the table or in any position that she chose, she had to hold both arms up to type the subscriber's

> information on a keyboard. The entire operation was at least ten inches higher, which added to her discomfort. As the computer set-up became more sophisticated claimant was required to handle more calls which occasionally reached up to 90 per hour. In order to insure accuracy she had to hold a ruler on the face of the display scope to read horizontally which required reaching directly forward with her outstretched right arm."

In addition, after each call claimant was required to reach to press a button which disconnected the previous call and caused another call to be forwarded to her. Claimant is 5'1" tall, which made performance of the above duties more difficult.

Claimant sought medical attention in May 1978 complaining of pain and weakness in the neck, shoulders and both arms that had persisted since shortly after installation of the video display terminals. Claimant, with written verification from her physicians, repeatedly requested the employer to modify her work station and/or provide her with a height-adjustable chair with arm and foot rests so that claimant could carry out her duties without unnecessary pain and fatigue. The employer made no modifications in the work station and did not provide claimant with a different type of chair.

Claimant's pain and fatigue increased to the point that, in July 1979, she was on the verge of collapse and quit work. Claimant previously had filed a claim (in July 1978) which was accepted as compensable by the employer.

At some point prior to August 1979 it was discovered that claimant had a lump in her neck. That lump was surgically removed in August 1979 and identified as a small benign tumor. Claimant was hospitalized a few days and confined to her bed at home for a week or two. The compensability of the tumor and the surgery was denied and claimant requested a hearing, but it is our understanding that claimant has conceded that the tumor and surgery are not compensable.

Although copies of the orders do not appear in the record, we infer from the parties' representations that the claim was processed to closure by Determination Orders dated August 19 and August 22, 1980. Claimant appealed from the Determination Orders on the issue of extent of permanent disability. While the matter was pending for hearing, on May 4, 1981, the employer denied the compensability of the claim ab initio. (Again, although the copy of the denial itself is not in the record, we infer its existence from the parties' representations concerning it.) The matter came on for hearing on the issues of compensability and, depending on the outcome of the compensability question, extent of permanent disability.

The record includes reports and a deposition of Dr. Kennedy, who is certified in the specialty of physical medicine and rehabilitation, and is Chief of the Department of Physical Medicine and Rehabilitation at Good Samaritan Hospital in Portland where claim-

ant has been treated extensively. Dr. Calvin Kiest also testified. Dr. Kiest is an orthopedic surgeon, formerly the head of the Emanual Hospital Rehabilitation Center and the Workmens' Compensation Rehabilitation Center (now the Callahan Center).

I.

The Referee noted that the employer's backup denial was issued under the authority of Frasure v. Agripac, 290 Or 99 (1980), notwithstanding that the claim had been accepted and processed to closure. On the merits of the denial the Referee found the evidence in claimant's favor convincing. He concluded that claimant ad experienced a worsening of her condition, that her work activity after installation of the computer terminal was the cause of the worsening and that the claim was compensable.

With respect to the propriety of the employer's belated denial, the Court of Appeals recently addressed this issue and held that an insurer or employer cannot unilaterally deny a claim after an award or arrangement of compensation, or agency or judicial review thereof, has become final. Bauman v. SAIF, 62 Or App 323, 328 (1983). However, since the employer's denial herein was issued while agency review of the claim was taking place, it was appropriate under Bauman for the Referee to take cognizance of the denial.

II.

Before proceeding to a discussion of the merits of the claim, there needs to be clarification concerning which party has the burden of proof. We believe that after an insurer or employer has had a reasonable opportunity to investigate a claim and has accepted it, thereafter if the insurer/employer wishes to contest compensability, the burden of proof is on the insurer/employer to disprove compensability rather than on the claimant to prove compensability.

Under ORS 656.262(6) an insurer or self-insured employer against whom a workers compensation claim has been filed has up to 60 days to investigate a claim and either accept or deny it. In our experience, in many instances claims are placed in "deferred" status and no decision is made concerning acceptance or denial for a substantial period beyond 60 days after the claim is filed. So long as interim compensation is being paid, no sanctions append to the failure to accept or deny the claim unless and until the delay is so long that the parties' "right to know" is violated, in which case penalties and attorney's fees may be appropriate. Zelda Bahler, 33 Van Natta 478, at 479-480 (1981), rev'd on other grounds; Bahler v. Mail-Well Envelope Co., 60 Or App 90 (1982). In our experience, in many cases insurers and employers are not penalized for failing to accept or deny within 60 days, and justifiably so, because the etiology of some conditions are difficult to determine.

Thus, insurers and employers have a substantial period of time within which to investigate the circumstances of an alleged industrial injury or occupational disease and gather such other medical or expert information bearing on the compensability issue. If the insurer/employer decides a claim is compensable, it is required to

issue a written notice to the claimant so informing him or her. ORS 656.262(6). Thereafter, the status quo of the case is that it is in accepted status. The thrust of a belated denial such as the one here is to change the status quo; that is, the insurer or employer is asserting that the claim should be in denied status.

Except under ORS 656.206(3) concerning permanent total disability cases, the Workers Compensation Act does not specify which party has the burden of proof on issues arising under it. The general statutory rule is the burden of proof is on the proponent of a fact or a position. Oregon Rule of Civil Procedure (ORCP) 305-307, ORS 183.450(2). Where the claimant is seeking benefits under the Act and the employer or insurer contests that entitlement from the beginning, then it is wholly logical and fair to assign the burden of proving entitlement to the claimant. See, e.g., Coday v. Willamette Tug & Barge, 250 Or 39 (1968); Montgomery v. SIAC, 224 Or 380 (1960); and Lomm v. Silver Falls Timber Co., 133 Or 468 (1929). Likewise, where, having had the opportunity to investigate a claim a claim is accepted, and subsequently the insurer/employer is proposing, or seeking a determination, that a claim in accepted status is not compensable, the burden shifts to that party to prove the truth of that proposition. Cf. Harris v. SAIF, 292 Or 683 (1982).

Moreover, issuance of a belated denial as in this case long after the operative facts giving rise to the claim have occurred has the potential for severely prejudicing the claimant's ability to marshal evidence in support of the claim. Witnesses whose statements or testimony could have been used as evidence at a hearing may be unavailable at the time a belated denial puts the claimant on notice that compensability is being contested. Medical opinions that could have been obtained at a time when the condition was initially treated may be less reliable if rendered long after treatment, particularly where reports are not prepared contemporaneously with treatment. Indeed, in some cases surgery or other treatment may have obliterated evidence relevant to the causation issue at the heart of the compensability determination. There may have been substantial modifications in the work site or loss or destruction of other physical evidence that could have been preserved had the claimant been aware that he or she would have to prove, years later, the compensability of a claim.

We recognize that the insurer or employer also may experience difficulty gathering evidence where there is a "cold trail." However, considering the opportunity of the insurer/employer to investigate the claim in the first instance, traditional factors considered in assigning the burden of proof suggest that the burden of proof be assigned to the insurer/employer in belated denial cases. Moreover, to the extent that belated denials are based on new information received by the insurer/employer, see e.g., Frasure v. Agripac, supra, it is logical to put the burden on that party to demonstrate that the new information proves that an accepted claim should now be considered noncompensable. Lastly, where a belated denial is issued in response to an aggravation claim, as is frequently the case, the denial is in the nature of an affirmative defense. We have held that the burden of proof with respect to affirmative defenses is on the party asserting the defense. Lewis Twist, 34 Van Natta 290 (1982).

For all these reasons, we believe that in a belated denial case the employer or insurer has the burden of proving that a previously accepted claim is not compensable.

III.

Thus, the issue becomes, has the employer here proved that the claim it originally accepted as compensable is, in fact, not compensable. We believe the answer is no. It is clear that at the time claimant became reemployed she was affected with the residuals of polio. It is equally clear that from 1961 until March 1978, because of the manner in which her work station was arranged, claimant was able effectively to carry out her work without experiencing disability. In fact, the record reveals that during one eight year period claimant did not miss one work day.

The onset of pain and fatigue shortly after installation of the new computer equipment combined with claimant's description of her experience using the equipment convinces us that it was the change in the way claimant was required to do her job that required medical services and rendered claimant at least temporarily disabled. Of course, under Weller v. Union Carbide, 288 Or 27 (1979), where there is a pre-existing noncompensable condition, it is insufficient to show that an underlying condition and work activities combined to render the claimant disabled; the claimant must show that the underlying condition was actually pathologically worsened by the work activities.

Dr. Kiest explained how claimant's work activities worsened her condition. A muscle previously affected by polio but which has healed sufficiently to be used is nevertheless susceptible to permanent debilitation if it is overused to the point of fatigue. The manner in which claimant was required to lift her arms to chest and shoulder height up to 90 times per hour fatigued claimant's arm, shoulder and back muscles to the point that they are permanently debilitated. Contrary to the employer's contentions, claimant has experienced more than just symptoms of a preexisting condition.

The nature of claimant's work activities which caused her to be disabled renders this claim one for an occupational disease rather than an industrial injury. O'Neal v. Sisters of Providence, 22 Or App 9 (1975); James v. SAIF, 290 Or 343 (1981). As such, claimant's work activities must be the major contributing cause of her worsened condition. SAIF v. Gygi, 55 Or App 570 (1982). The employer points to a number of non work-related factors as causative factors in claimant's condition. First, there is evidence that polio victims frequently experience a relatively dramatic and natural worsening at age 40 to 50 years. The employer, therefore, contends that claimant's condition is merely the product of a natural worsening of claimant's condition. Suffice it to point out that claimant has not experienced a natural worsening in the other parts of her body that were affected by the residuals of the polio but were not used repetitively in her work.

The employer also points to the fact that claimant has scoliosis and somewhat advanced degenerative arthritis arising from her polio, and that she takes medication for hypertension which is

known to affect the muscles. Both Dr. Kennedy and Dr. Kiest reject the hypertension medication theory and the role of the degenerative arthritis in bringing on claimant's worsened condition. Considering the paucity of evidence connecting the scoliosis and arthritis to the worsening of claimant's condition, together with the expertise of Drs. Kennedy and Kiest who have indicated that there is no relationship, we consider those factors to have been eliminated. Dr. Kiest also testified that claimant's scoliosis played no role in the development of claimant's worsened condition.

There is persuasive evidence that the surgery in 1979 and claimant's inactivity during the recovery period from the surgery contributed to further deterioration in claimant's affected muscle tissue. However, claimant sought medical care long before the surgery and became disabled before the surgery took place. While the surgery and forced inactivity may have further worsened particular muscles, they cannot be considered causative factors for purposes of determining compensability in the first place.

Lastly, the employer points to claimant's off-work activities such as doing housework and, particularly, driving a car since, considering claimant's height, that would require her to hold and use her arms in a raised position. We are persuaded by Dr. Kiest who was of the opinion that none of claimant's off-work activities approximated the amount of damage done by the repetitive movements required by claimant's job, seven hours per day, five days a week.

We reach the same conclusion as the Referee, that claimant's work activities were the major cause of her worsened condition and disability. It should be pointed out that the employer has misinterpretated the major contributing cause test. The employer has urged that we consider the underlying condition itself, that is, the residuals from poliomyelitis, as a causative factor in her present condition and, that if we do so, it will be seen that the residuals of her polio are the major cause of her present condition. Undoubtedly that is true. However, where it is alleged that work activities worsened a preexisting condition, the focus is on the worsening, and the test is what caused the worsening, not what caused the condition as a whole.

Although we have phrased our discussion here in terms of whether the employer has satisfied its burden of proving that the previously accepted condition is not compensable, the evidence here is so convincing that even if the burden of proof were on the claimant we would still find the claim to be compensable.

IV.

As mentioned earlier, the Referee determined that claimant was permanently and totally disabled. The employer has not challenged that determination, thus, we are not inclined to discuss it at any great length. We note in passing, however, that the directory assistance operator position is a very sedentary one and claimant is foreclosed from returning to that work.

ORDER

The Referee's order dated August 4, 1982 is affirmed. Claimant's attorney is awarded $750 as a reasonable attorney's fee for services on review, payable by the employer.

Board Member Barnes Dissenting in Part:

I disagree with and dissent from the majority's conclusion that the burden of proof is on the employer/insurer who issues a backup denial, that is, issues notice of claim denial after having previously issued notice of claim acceptance. I express no view on the other issues in this case.

My disagreement with the burden of proof rule that the majority enacts is simply this: The greater the level of restrictions that are imposed on backup denials, the greater will be the number of workers compensation premium dollars that go to investigators, doctors and lawyers for the initial investigation of claims; the greater will be the number of denials of claims; and thus, the greater will be the burden on and the cost of the litigation system operated by this agency. Assuming premium dollars remain constant, that means that more of those dollars will be spent on overhead in this benefit-delivery system and less of those dollars will be spent on benefits to claimants. I cannot think of any good reason to increase the overhead of the workers compensation system while reducing benefits paid.

The majority repeatedly states that insurers and self-insured employers have 60 days to investigate claims and seems to assume that active, substantial investigation is the norm. I submit that the majority's assumption overlooks or disregards the practical realities of the insurance industry.

In reality, the act of accepting a claim is a product of two variables: (1) consideration/investigation of the merits of the claim; and (2) assessment of the probable cost of the claim. Claims that are perceived to be potentially the most expensive usually result in the most extensive investigation. Claims that are perceived to be potentially less expensive usually result in correspondingly less investigation. It never has been (and I hope never is) standard operating procedure in the insurance industry to spend thousands of dollars investigating a claim that involves a maximum possible exposure of a few hundred dollars.

Claims that can reasonably be perceived as involving little exposure are very common in workers compensation. During calendar year 1982 there were an estimated 79,896 claims that only involved medical services, claims where the claimant only wanted some doctor bills paid. During 1982 there were 31,535 accepted disabling claims, that is, claims that involved payment of compensation for temporary and/or permanent disability in addition to medical services. Of these 31,535 disabling claims, 17,502 involved payment of 21 days or less of time loss and no permanent disability.

In other words, of about 111,000 claims filed in 1982, over 97,000 involved payment of only medical bills and/or three weeks or

less of time loss. Depending on the applicable temporary disability rate and the extent of medical services, these 97,000 claims probably each cost an average of something in the neighborhood of $1,000 to $1,500. I believe that workers compensation insurers have been accepting a lot of these (reasonably perceived to be) low-exposure claims because: (1) it does not generally make sense for the cost of investigation to exceed the cost of the claim; (2) many insurers believe it is better "public relations"; and (3) if at some later point the "stakes" increase, all insurers believed they could then issue a backup denial.

That belief is no longer correct. In Bauman v. SAIF, 62 Or App 323 (1983), the Court of Appeals recently imposed a temporal limit on the ability to issue a backup denial. Now, in this case, the Board majority imposes the burden of proof upon the insurer/employer that issues a backup denial within the time limits imposed by Bauman.

I find the consequences quite easy to forecast. Even when an initial claim seems rather small, as about 97,000 claims were last year, insurers will spend more money on investigators, will spend more on independent medical consultations and will spend more for legal advice before deciding whether to accept or deny a claim. A higher percentage of relatively small claims will be denied. There will, thus, be more requests for hearing, resulting in increased cost to this agency. Insurers will always have to pay one lawyer to litigate these additional denied claims; if the denial is set aside, the insurers will have to pay both lawyers.

The majority enacts a rule that benefits investigators, doctors and lawyers. I think claimants as a group will suffer and I think the workers compensation system overall will suffer. I, therefore, respectfully dissent.

PATRICIA J. HAMMETT, Claimant
Cheney & Kelley, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-11088
May 11, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation has requested review of Referee Braverman's order which, in relevant part, ordered payment of a disputed medical bill, ordered payment of time loss for a specified period of time, imposed a 15% penalty on the time loss awarded together with an attorney's fee of $250, and awarded 25% permanent scheduled disability for claimant's right knee condition. In addition to these matters, SAIF contends that the Referee erred in admitting Exhibit 49, a letter from claimant's counsel to the physician whose medical bill is at issue.

The issues are: (1) whether claimant's original claim was closed prematurely and whether she is entitled to time loss from July 24, 1980 through October 1, 1980; (2) with respect to an aggravation claim commencing in September 1981, whether claimant is entitled to penalties and an attorney's fee because of SAIF's unreasonable delay in paying compensation; (3) whether SAIF is responsible for all or part of a medical bill, and related to that,

an evidentiary issue concerning the admissibility of a letter from claimant's attorney to the physician whose bill is at issue; and (4) extent of permanent disability.

Except as inconsistent with or supplemented by our findings herein, we adopt the Referee's findings of fact. This case arises from an injury sustained by claimant in December 1979 in the course of her employment as a custodial worker for a state psychiatric facility in Pendleton. Claimant's Form 801 describes the incident as follows: "I was coming downstairs with linen and tripped over a corner of [a] sheet and twisted my right knee trying to keep from falling."

Claimant sought medical care from her orthopedist, Dr. Weeks of Pendleton, who was unable initially to make a definitive diagnosis. Claimant was treated conservatively and subjected to various diagnostic procedures. Her condition ultimately was diagnosed "most probably" as "chondromalacia medial femoral condyle on the weight bearing surface."

I.

The first issue concerns whether the initial claim was prematurely closed. The relevant evidence is as follows. On July 2, 1980 Dr. Weeks reported as that:

> "The patient continues to have intermittent symptoms but seems to be improving on the Naprosyn * * *. She will continue her home program as outlined and return for re-evaluation in two months, may return to duty at that time."

On July 24, 1980, at SAIF's request, claimant was examined by Dr. Kaesche who diagnosed "mild ligamentous injury" and opined that claimant was medically stationary as of that date. The case was submitted for closure and, by Determination Order dated September 4, 1980, claimant was awarded time loss but no permanent disability.

On October 1, 1980 Dr. Weeks submitted a report as follows:

> "The patient was seen today for scheduled follow up visit. As noted in July 2, 1980 correspondence, the last sentence was may return to duty at that time, that is, she was not released to work on the 2nd of July. Her initial evaluation for possible return to work was this date. She remains symptomatic intermittently. Her symptoms, however, are essentially unchanged from her last examination. Further, it is felt that her condition is stationary and her case should remain closed."

On October 20, 1980 the Evaluation Division issued a second Determination Order reciting that additional information had been received concerning the claim but awarding no additional compensation.

On December 10, 1980 claimant requested a hearing. On February 18, 1982 claimant was examined by Dr. McKillop, an orthopedic surgeon in Portland, who reviewed claimant's medical records and opined that no further treatment was necessary other than continuation of the home exercise plan. He also agreed with Dr. Weeks that claimant was medically stationary with respect to the initial claim on October 1, 1980.

Based on these facts, the Referee concluded that claimant was entitled to time loss from July 24, 1980 through October 1, 1980 because claimant had not been informed by her treating physician that she was medically stationary until October 1, 1980 and it would be unfair to terminate her time loss based on the medically stationary date found by SAIF's physician but not communicated to claimant. There is authority for the Referee's rationale that it is unfair to terminate time loss where the claimant has not been informed by anyone that he or she is medically stationary and released to return to regular work. Ruby J. Hampton, 30 Van Natta 708 (1981). But see Nick L. Ward, 34 Van Natta 1739 (1982).

We take a different view of the facts concerning this issue. We believe that, as between claimant's treating physician and SAIF's examining physician who examined claimant only one time, the treating physician is in a superior position to ascertain when claimant has obtained maximum improvement in her condition. Clearly, on July 2, 1980 Dr. Weeks was not prepared to declare claimant medically stationary or release her to work. At that time, as a result of using the prescribed medication and exercising, claimant was still improving. Based on his October examination, Dr. Weeks felt that claimant was not going to return to her pre-injury status, declared her medically stationary and released her to return to modified work. Although Dr. McKillop's opinion is not as persuasive because he did not examine claimant until February 1982 and saw claimant only one time, Dr. McKillop agreed that claimant was medically stationary on October 1, 1981.

Considering the record as a whole, the evidence preponderates in favor of a finding that there was a premature closure and that claimant is entitled to time loss through October 1, 1980. In so finding, we are not unmindful that Dr. Weeks' October 1, 1980 report refers to claimant's case "remaining in closed status" and that he submitted a report in 1982 suggesting that there was no basis for time loss after July 24, 1980.

II.

While claimant's request for hearing was pending on issues arising from the Determination Orders closing the initial claim, on September 21, 1981, Dr. Weeks submitted a report which, in relevant part, stated:

> "[Claimant] continues to have symptoms referrable to the right knee, increasing discomfort in the medial aspect with rather easily subluxable patellar, right.
>
> "She is unable to do her activities of daily living i.e. routine housework without symptoms.

"It is my feeling that her symptoms apparently are progressing."

On October 21, 1981 SAIF's counsel wrote to Dr. Weeks requesting clarification whether claimant's condition had remained medically stationary or significantly worsened, what treatment was planned other than conservative care, and current diagnosis and prognosis. On October 28, 1981 Dr. Weeks replied as follows:

"Ms. Hammett's condition has had significant worsening in the past year. Secondly, if conservative treatment is of no help, as outlined in my letter dated September 21, 1981, arthroscopy, as noted will be undertaken.

"Finally, in response to question number three, current diagnosis is that of progressive chondromalacia and her prognosis is guarded."

On November 10, 1981 SAIF notified claimant's counsel that in light of Dr. Weeks' reports, claim reopening was being considered. On November 16, 1981 claimant's counsel wrote to SAIF requesting claim reopening for additional medical care and time loss. On November 20, 1981 claimant filed an amended request for hearing listing as an issue entitlement to time loss from "July 24, 1980 and continuing." On December 7, 1981 claimant was examined by Orthopaedic Consultants at SAIF's request. On December 8, 1981 claimant reiterated her request to SAIF for payment of time loss. On January 13, 1981 SAIF received the Consultants' report which, among other things, provided as follows:

"At this time, the patient states that she is asymptomatic as far as the right knee is concerned. The reason she gives for this is that she has been relatively inactive for the past 6 to 8 weeks, following a

carpal tunnel release surgery on her right wrist. She states, however, that she is sure that if she resumes normal activity, she will have recurrent symptoms."

On January 18, 1981 SAIF wrote to claimant's counsel indicating that, in light of the Consultants' report indicating that claimant was asymptomatic, time loss was not being paid for lack of medical verification of inability to work. On January 21, 1982 claimant's attorney wrote to Dr. Weeks requesting clarification of claimant's entitlement to time loss. On March 18, 1982 Dr. Weeks verified that claimant was entitled to time loss from August 1981 through February 1982. Within 14 days, apparently, SAIF paid time loss retroactive to August 21, 1981.

Based on this information, the Referee imposed a 15% penalty on the time loss payable from September 21, 1981 through February 17, 1982, reasoning that SAIF was confused at the time the aggravation claim was made and failed to exercise its affirmative duty to

investigate to determine whether time loss was due. SAIF contends that it was not confused, rather, that it was unsure whether Dr. Weeks' initial report was intended as an aggravation claim, that it sought clarification, that when clarification was forthcoming the claim was reopened, and that it did not pay time loss because it was not furnished with medical verification of inability to work.

Dr. Weeks' initial report of September 21, 1981 is not a model of clarity. SAIF concedes, however, that Dr. Weeks' initial report together with his report of November 28, 1981 was sufficient to state an aggravation claim and justify claim reopening, but argues that claim reopening is not synonymous with entitlement to temporary disability, which requires medical verification of inability to work. We agree that evidence justifying claim reopening is not necessarily the same as medical verification of inability to work because of a worsened, compensable condition. David C. Welsh, 34 Van Natta 1246 (1982). We also agree that Dr. Weeks' reference in his initial report to claimant's inability "to do her activities of daily living i.e. routine housework without symptoms" standing alone does not constitute medical verification of an inability to work. However, that does not mean that SAIF did not engage in unreasonable conduct by failing to determine whether claimant was temporarily disabled.

Claimant was employed as a custodial worker at a state institution at the time of her injury. This occupation involved duties similar to routine housework. Dr. Weeks' initial aggravation report stated that claimant was unable to do routine housework without symptoms. SAIF responded to Dr. Weeks' report requesting clarification of every element of the aggravation claim except whether claimant was disabled. Perhaps most importantly, claimant's attorney wrote to SAIF on November 16, 1981 explicitly requesting initiation of time loss payments. SAIF received correspondence or requests for hearing from claimant's attorney on four other occasions before it finally informed counsel that they considered there was insufficient verification of inability to work. Significantly, in so indicating, SAIF relied on a report from the Orthopaedic Consultants which they did not receive until December 13, 1981.

SAIF's letter to Dr. Weeks requesting clarification on every issue except whether claimant was unable to work appears to be gamesmanship rather than good faith claims processing. Considering the ambiguous nature of Dr. Weeks' initial report, however, we find that SAIF did not act so unreasonably in failing to investigate further claimant's need for time loss as to justify a 25% penalty. The 15% penalty imposed by the Referee is sufficient.

SAIF's conduct after receipt of claimant's attorney's letter of November 16, 1981 is a more serious matter. As of that date, SAIF was clearly on notice that a claim for temporary disability was being made. Yet SAIF did nothing to clarify its position on that issue until January 18, 1981, notwithstanding repeated requests from claimant's attorney for a response. This does not constitute reasonable claim processing. Claimant was clearly prejudiced because as soon as her attorney was informed of SAIF's position, he sought clarification from Dr. Weeks on that issue. Even after receiving Dr. Weeks' clarifying report in response to

claimant's attorney's request, it appears that SAIF waited until the last possible day to issue a check. Although the issue has not been raised by anyone, we note that the acceptance of the claim on January 7, 1982 was about six weeks beyond the 60 day period in which to accept or deny a claim. Under these circumstances, we think a 25% penalty for the period from November 16, 1981 onward would be warranted; however, claimant has requested that we merely affirm the Referee's order and our order will be limited to the relief requested.

Claimant's attorney rendered significant services in connection with seeking claim reopening and payment of time loss; therefore, the Referee's award of $250 as an attorney's fee in conjunction with this issue is appropriate.

III.

The medical bill issue concerns a bill for services rendered by Dr. McKillop who, as previously noted, is an orthopedist in Portland, Oregon. The Referee determined that SAIF should be responsible, apparently, for the entire bill. The facts relevant to this issue are as follows.

Dr. Weeks, claimant's treating orthopedist in Pendleton, Oregon, examined claimant on October 1, 1980 and reported that she was medically stationary, released to modified work and in need of no further curative treatment. On October 20, 1980 the second of two Determination Orders closing the original claim issued, reaffirming the previous award of time loss and no permanent disability. On December 10, 1980 claimant requested a hearing apparently raising premature closure and extent of permanent disability issues.

On January 19, 1981 claimant's attorney sent to claimant a letter which, in relevant part, stated:

> "Let me know what you think is the impairment as to the use of your leg and I will negotiate from there.
>
> "If, on the other hand, you think you are in need of additional medical care and treatment or would like to be examined by an orthopedic surgeon in Portland, I would certainly recommend Dr. Robert G. McKillop. He has taken care of me and my children and is an excellent doctor. . . . If you wish to telephone him and make an appointment, go right ahead and use my name as a reference.
>
> "It might be for your best interests to have a recheck of your condition before considering the matter of settlement of the extent of permanent partial disability to the right knee."

As noted earlier, claimant lives in Pendleton and had been treating with Dr. Weeks of Pendleton. Dr. McKillop is a Portland

orthopedist. Claimant scheduled an appointment with Dr. McKillop. Dr. McKillop wrote to claimant's attorney requesting copies of all medical reports, which the attorney furnished together with a request for a report. Dr. McKillop examined claimant on February 18, 1981 and rendered a report diagnosing "[r]esiduals from sprain to the right knee" and "[m]ild chondromalacia, right knee," opining that claimant was medically stationary and recommending no further treatment except to continue with her present exercise program, agreeing with Dr. Weeks' medically stationary date of October 1, 1980 and estimating a 15% loss of function in the right knee.

On February 25, 1981 claimant's attorney sent Dr. McKillop's bill for $219 to SAIF. He also prepared and filed an amended request for hearing listing as issues "claimant's need for medical care and treatment," entitlement to time loss from July 4, 1980 to October 1, 1980, and extent of disability.

In the meantime, beginning in January 1982, there was correspondence between claimant's attorney, Dr. McKillop's office and SAIF concerning responsibility for Dr. McKillop's bill arising from his examination of claimant. At hearing, claimant's attorney offered as an exhibit a letter dated January 13, 1982 written by himself to Dr. McKillop's office indicating, in relevant part, that he did not schedule the appointment with Dr. McKillop, that claimant scheduled the appointment and that Dr. McKillop contacted him requesting copies of medical reports. The Referee admitted the letter in question and concluded that SAIF should pay Dr. McKillop's bill. SAIF contends both actions were incorrect.

Taking the evidentiary issue first, SAIF contends that the letter is objectionable because it is hearsay and unsupported by other evidence. With respect to the hearsay objection, suffice it to point out that claimant's counsel was present at hearing and available to testify, that a good portion of the record in this case consists of correspondence to and from various parties, and that SAIF's counsel himself was called as a witness to verify a letter which was admitted as evidence. With respect to whether there is or is not other evidence to support the allegations in the letter, that objection goes to the weight not the admissibility of the document.

With respect to responsibility for the bill itself, the Referee ordered SAIF to pay the bill on the ground that the report filled a gap in the evidence of the case and inured to the insurer's benefit. We conclude that SAIF is responsible for the bill but for wholly different reasons than those given by the Referee.

Under ORS 656.245(1), the insurer is responsible for providing "medical services for conditions resulting from the injury for such period as the nature of the injury of the process of the recovery requires." Under ORS 656.245(3), an injured worker is entitled to an initial treating physician and to change treating physicians four times without prior approval.

In this case, we find that Dr. McKillop's examination was at

least in part for the purpose of obtaining a "second opinion" concerning claimant's need for further medical treatment, and whether and to what extent her condition was permanent. This information can be and was used to prepare a report which was ultimately used for negotiation and litigation purposes. However, the examination itself was in furtherance of claimant's right to seek a new treating hysician and to determine whether there would be any point in seeking further treatment. Similarly, while the report that was prepared for claimant's attorney is in the format of a report commonly used in litigation, Dr. McKillop discussed claimant's treatment history and made recommendations concerning her future treatment. Although litigation overtones are present, on this record we are not prepared to say that the examination was unrelated to claimant's right to medical treatment and right to change treating physicians. Accordingly, SAIF is responsible for the costs of the examination.

V.

With respect to the extent of claimant's permanent disability, the consensus of medical opinion is that claimant has sustained a 15% loss of function in her knee. At hearing claimant testified to the pain she experiences and how it interferes with normal usage of her right leg. In closing argument SAIF's attorney stated as follows:

> "It would be my assessment, based upon the claimant's testimony and more importantly, [various medical reports], that this claimant has loss of function amounting to 15 percent.
>
> "I think her testimony indicating continuing pain and disabling pain would raise that to the 20 to 25 percent range, so I don't think that any of us are very far off on her assessment of PPD."

The Referee awarded 25% unscheduled permanent disability. Based on the medical evidence, claimant's testimony and SAIF's argument at hearing, we are not inclined to modify that award.

ORDER

The Referee's order dated June 30, 1982 is affirmed. Claimant's attorney is awarded $475 as a reasonable attorney's fee for services on Board review, payable by the SAIF Corporation.

JO WANDA ORMAN, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-03671
May 11, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of those portions of Referee Quillinan's order which set aside its denial of claimant's aggravation claim and assessed penalties and an associated attorney's fee based on the finding that the denial was unreasonable.

Numerous other issues were raised and resolved at hearing, some of which are quite confusing, such as whether claimant's original 1976 claim was for a wrist injury or for an upper back/neck/shoulder injury and whether SAIF intended to or did issue a backup denial of that original claim. The issues on review are much more finite.

The last award of compensation is a stipulation dated March 6, 1980. That stipulation plus prior awards granted claimant a total of 30% unscheduled disability for a December 22, 1976 injury to her upper back/neck/shoulders. On February 15, 1982 claimant submitted an aggravation claim to SAIF requesting reopening of her claim: "I am unable to perform my job functions due to my neck injury." On April 9, 1982 and June 18, 1982 SAIF issued denials. While the wording of these denials was the source of some confusion at hearing, as matters now stand the issue is: Has claimant proven by a preponderance of the evidence that her neck condition worsened within the meaning of ORS 656.273, entitling her to claim reopening, after the last award of compensation, that being the March 1980 stipulation?

The question of worsening since a given date necessarily involves a comparison of circumstances before that date with present circumstances. However, we find little information in the record about claimant's pre-1980 cervical status. About the only medical details are as follows. A 1977 report: "strained muscles and ligaments of cervical spine." A 1978 report: "mild musculoligamentous cervical strain." A 1979 radiology report: "unremarkable cervical spine series." And a 1979 medical report: "Strain of the cervical spine and left arm by history. . . . There are insufficient objective findings at the present time to substantiate this patient's complaints of disability."

After the last award of compensation in 1980, claimant completed a vocational rehabilitation program in March of 1981 and began working as a data entry clerk in May of 1981. That job required claimant to sit at the keyboard of a computer terminal, to read data from documents on a typing stand to her left and to type that data into the computer. This required considerable neck rotation as claimant looked back and forth between the documents to her left and the computer terminal screen in front of her. According to claimant, the required neck movement caused an increase in neck pain. An alleged exacerbation of that pain in February of 1982 led to the present aggravation claim.

Medical treatment and examination of claimant since the last

award of compensation in March of 1980 is as follows. Claimant began receiving chiropractic treatment from Dr. Layman in November of 1980. There are four reports from Dr. Layman in the record. The first, dated December 15, 1980, suggests that since claimant's 1976 injury there was an "evident inability by the medical profession to properly diagnose" claimant's condition, resulting in a "delay in receiving proper therapy." Dr. Layman stated his own, presumably proper, diagnosis: "cervical foraminal compression"; "paracervical endema and static hypomobile cervical segments"; "multiple cervicothoracic spinal subluxations"; "cervical sprain with descending left brachial neuralgia and parasthesia"; and "cervico foraminal encroachment with associated vertigo." Dr. Layman described his own, presumably proper, treatment: "Therapy has been . . . in the form of specific directional forces of multiple vertebral segments."

Dr. Layman next reported on February 11, 1981 that part of claimant's condition was improved.

After a gap of more than one year and after claimant had left her data entry clerk position because of neck pain, Dr. Layman reported on May 10, 1982 that:

> "She was taken . . . off work . . . because of cervical/dorsal pain and associated symptoms. Work only serves to aggravate this condition and therefore this condition is not medically stationary at this time.
>
> "Manipulation aids in relieving the symptoms and correcting spinal malalignments that contribute to subjective complaints therefore therapy is necessary on a continuous basis at this time."

Dr. Layman's final report is dated June 28, 1982:

> "This patient has to type off a screen and the constant repetitive rapid cervical rotation 8 hours a day aggravated her pre-existing cervical condition and has made this condition acutely worse."
>
> * * *
>
> "Examination of the thoracic and cervical region demonstrated multiple cervical and dorsal vertebral fixations and spinal manipulation serves to restore cervical and dorsal segmental motion. Symptoms are alleviated on a short term scale but the region remains unstable due to lack of paravertebral ligamentous integrity.
>
> "In order to clarify any confusion I would like to emphasize the following: This patient continues to suffer from the same injury as that on December 1976; this

> condition is chronic and worse today than at that time; there has been no new injury, only an aggravation of the existing one from repetitive rapid cervical rotation; finally, I see no improvement in this condition in the future and therapy will be palliative from here on."

Also, since the last award of compensation in March 1980, claimant has been examined by Dr. Melgard and a Psychological Consultants panel. Dr. Melgard reported on March 12, 1982:

> "This lady has a chronic cervical muscle tension headache. I have explained to her that I don't think it is the SAIF Corporation's responsibility to cover this indefinitely. I don't think she should have a myelogram."

Psychological Consultants reported on September 28, 1982:

> "A diagnosis of hysterical personality was reinforced by the client's tendency to place undue emphasis on pain, to go into excessive details of physiological as well as psychological treatment."
>
> * * *
>
> "The diagnosis of hysterical personality is not related to the [1976 industrial] injury and reflects no current disability."
>
> * * *
>
> "The diagnosis of hysterical personality is considered stationary and not injury-related because personality disorders are generally, because of their very nature, stationary."

Considering all the evidence, we are not persuaded that claimant's injury-related cervical condition worsened after the last award of compensation in March 1980. First, it is far from clear exactly what portion of claimant's cervical problems were caused by the 1976 injury. The limited medical reports from the 1976-80 period refer only to a cervical strain or sprain. Although the record contains various descriptions of claimant's 1976 cervical injury, none of those descriptions appear to be fully consistent with all of the problems that Dr. Layman has identified.

Second, we think Dr. Layman's reports at most only indirectly support the proposition that claimant's condition has worsened since March 1980. Dr. Layman did not begin treating claimant until November 1980, and thus had at most a limited basis for expressing an opinion on worsening since the last award. Also, the opinion Dr. Layman did express -- "worse today than at that time" -- apparently refers back to 1976, not to 1980.

Third, the opinions of Dr. Melgard and Psychological Consultants are consistent with several other medical opinions expressed between 1976 and 1980 to the effect that it is not possible to objectively verify claimant's subjective complaints and claimant's personality seems to result in some exaggeration of those complaints.

Finally, and possibly most importantly, it must be remembered that claimant has received awards that total 30% unscheduled disability. Since no other forms of permanent impairment are mentioned in this record, we assume these awards were based on chronic pain. Claimant's cervical pain has "waxed and waned" over the years since her 1976 injury. There was admittedly a flare-up of that pain in February-April of 1982 because of claimant's work as a data entry operator. It appears to us, however, that claimant has experienced a fluctuating level of cervical pain since 1976 and that it is exactly this form of impairment that was the basis of the prior awards for permanent disability. Under these circumstances, we do not think that every flare-up of pain can or should be the basis of an aggravation claim when cycles of pain were reasonably to be expected and were the basis of prior awards of permanent disability. See Harmon v. SAIF, 54 Or App 121 (1981).

ORDER

The Referee's order dated August 20, 1982 is reversed. Interpreted solely as denials of an aggravation claim, the SAIF Corporation's denials dated April 9, 1982 and June 18, 1982 are reinstated and affirmed. For the sake of clarity because of other issues raised at hearing, it is recognized that claimant's original claim remains in accepted status and that SAIF continues to be responsible for causally-related medical services.

LEONARD E. RAINY, Claimant
W.D. Bates, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-02988
May 11, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Danner's order which increased claimant's scheduled permanent disability award to 47.25° for a 35% loss of claimant's left foot. A Determination Order had awarded claimant 20.25° of scheduled permanent partial disability for a 15% loss. SAIF contends that the Referee's award is excessive. We agree and, therefore, modify the Referee's order.

Claimant sustained injuries to his left leg and both feet in a sawmill accident in June 1980. As a result he suffered a partial amputation of the great toe and severe laceration of the second and third toes of the left foot. Permanent impairment has resulted only with respect to claimant's great toe and second toe. Claimant's attending physician described the residuals of the injury in the report of his closing examination:

> "In his work situation he has had to modify his activities and is a bit slower in jumping about. He finds that walking on rough and uneven ground is difficult; that

> he has a tendency to develop discomfort and pain in the toes during cold weather, or when he has to do a lot of standing, climbing or pushing off.
>
> "On examination he walks with a normal gait. He has absence of the distal segment of the great toe. There is non-functional push-off in the great toe. There is a claw-toe deformity of the second toe, with severe scarring dorsally. There is a plantar callous on the tip of the second toe. The third toe is functioning essentially normally. There is ankylosis of the interphalangeal joints of the second toe in the flexed position. There is slight diminution of sensation in the tip of the second toe. Third toe is normal. The great toe amputation area is normal as far as sensation goes."

Claimant's physician stated that, as a result of his industrial injury, claimant sustained a mild to moderate disability with regard to his left foot based upon lack of push-off and clawing of the second toe, with secondary pain and ankylosis.

After recovering from his injury claimant returned to work as a barker operator. He is able to work a full shift standing on a wooden platform, although by the end of the work day he experiences pain accompanied by occasional swelling. Claimant testified that he is unable to walk any significant distance, primarily due to the clawing of the second toe, which causes swelling in the toes and foot. He has had to give up his recreational activities including bowling, softball, fishing and hunting.

The criterion for rating scheduled disability is permanent loss of use or function of the injured member. ORS 656.214(2). The guidelines for evaluating permanent disability of the lower extremities are found in OAR 436-65-535 et seq.

Amputation of the distal segment of claimant's great toe is equivalent to a 50% loss of that toe. OAR 436-65-536. Based upon the medical evidence of ankylosis of the interphalangeal joints of claimant's second toe, we assign values of 45% loss of the toe for ankylosis in the distal interphalangeal joint and 75% for ankylosis in the proximal interphalangeal joint. OAR 436-65-538(1)(b) and (2)(b). The evidence of a slight diminution of sensation in the tip of the second toe warrants assignment of a value of 5% loss of the second toe. Combining these findings regarding the second toe, we arrive at a value of 87% loss of the second toe. Since claimant's great toe and second toe are permanently impaired as a result of this injury, and the evidence indicates that there is resulting residual loss of use or function in claimant's foot, we convert the toe values to a foot value. OAR 436-65-542. A 50% loss of the right toe converts to 7% of a foot; and 87% loss of the second toe converts to approximately 2.7% loss of the foot. Combining these

values and rounding up, we arrive at a value of 10%. Claimant's testimony clearly indicates that he suffers pain of a relatively chronic nature in that prolonged standing, walking or other activity involving the use
and function of claimant's left foot causes pain to a moderate degree. We, therefore, assign an additional value of 10% for pain, which, when combined with the 10% value based on the other findings, results in a total value of 19%, or when rounded up, 20% loss of the left foot. We find that this award adequately compensates claimant for the loss of use or function in his left foot and modify the Referee's award accordingly.

ORDER

The Referee's order dated October 20, 1982 is modified. Claimant is awarded 20% scheduled permanent partial disability for loss of his left foot in lieu of all prior awards. Claimant's attorney's fee should be adjusted accordingly.

THOMAS J. RICKEY, Claimant
Haas & Benziger, Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 82-06474
May 11, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The employer requests review of Referee Braverman's order which set aside its denial of claimant's claim for neck, right shoulder, upper back and arm pain and weakness. We reverse.

Claimant began working for this employer in its maintenance department painting trucks in September 1981. He worked in that department until about May or June, 1982 when he was transferred to the bridge department. Claimant's duties in the bridge department included painting, water blasting, and sandblasting. When blasting, claimant used a wand that weighed approximately three pounds with an attached hose weighing approximately ten pounds. When painting, claimant used a paint gun weighing approximately two pounds. It does not appear that the work was strenuous or that any frequent, heavy lifting was required. In any event, there was no specific lifting incident while working for this employer that was subsequently followed by complaints of pain or disability to claimant's supervisor or by visits to a doctor.

Approximately one week into June of 1982 claimant quit work with this employer and went to work for another employer painting trucks for two weeks, approximately ten to sixteen hours a day. On June 25, 1982 claimant sought treatment with Dr. Mason who stated that claimant was unable to continue working as a truck painter. The claimant returned to work for the bridge department on June 28, 1982 and worked three days only, at which time he stated he could not continue working due to disabling pain. This was confirmed by Dr. Mason. Claimant filed a claim on July 9, 1982 alleging a June 9, 1982 injury. The claimant later stated that the date of June 9, 1982 was picked arbitrarily as an injury date.

We find that the intervening employment as a truck painter for two weeks, from 10 to 16 hours a day, was strenuous employment that amounted to an independent cause of claimant's condition. Only after this employment did claimant seek medical treatment and lose time from work due to his neck, right shoulder, and right arm pain and weakness. Once informed of claimant's two weeks of work painting trucks, no doctor persuasively opines that claimant's bridge department work is the cause of his upper back/shoulder condition.

We finally note that the Referee made a courageous attempt to reconcile the recent court cases defining when a condition is an "injury" rather than a "disease." We adhere to the view we expressed in Clarice Banks, 34 Van Natta 689, 692 (1982), and find (if it makes any difference) that the condition now suffered by this claimant - pain and weakness caused by continuous stretching of a nerve over a bony overgrowth - is a "disease," rather than an "injury."

ORDER

The Referee's orders dated October 13, 1982 and November 3, 1982 are reversed. The employer's denial dated July 13, 1982 is reinstated and affirmed.

SAMUEL D. DAWSON, Claimant
Welch et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-06896
May 12, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of Referee Daron's order which failed to grant him compensation for time loss between January 6 and February 7, 1982 and found he was not entitled to an increased award of compensation for permanent partial disability.

After de novo review, we conclude that claimant was temporarily disabled during the period in issue due to a temporary worsening of his compensable condition. We conclude he should be compensated for that time.

We agree with the Referee that there is no evidence that claimant's loss of function of the knee is greater than it was at the time of the 1980 stipulation. Unsupported statements by Dr. Fagan that claimant's disability is first 25-30% and later 40-50% are insufficient upon which to base an increased award for permanent disability.

ORDER

The Referee's order dated July 6, 1982 is reversed in part. Claimant is granted compensation for temporary total disability for the period January 6, 1982 through February 7, 1982, inclusive. The remainder of the order is affirmed. Claimant's attorney is allowed a fee equal to 25% of the increased compensation granted by this order, payable out of said compensation as paid, not to exceed $700.

RICHARD G. HALFORD, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-01919
May 12, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Quillinan's order which affirmed the SAIF Corporation's denial of claimant's aggravation claim. The issue is compensability.

Claimant contends that his low back condition is a compensable consequence of his January 31, 1978 myelogram which was performed in relation to his compensable shoulder and cervical strain suffered in November 1977. The Referee concluded that there was insufficient evidence from which to conclude that the low back condition was caused by the myelogram. We agree.

The Referee found claimant to be credible, but the facts surrounding the January 31, 1978 myelogram are somewhat in dispute. Dr. Karasek and Dr. Norris-Pearce report that claimant fell off the table during the myelogram and struck his head on the x-ray machine table. Dr. Campagna, who actually performed the myelogram, denied that such events occurred. Claimant testified at the hearing that he never told anyone that he fell off the table and, in fact, did not fall off the table. In any event, Drs. Campagna, Norris-Pearce and Reilly all seem to agree that the most that could have happened to claimant during the myelogram was a possible small nerve root contusion, but that this would have only resulted in some temporary pain for a few days, and at the most would have lasted a few weeks and could not have persisted for over two years.

ORDER

The Referee's order dated November 5, 1982 is affirmed.

WILLIE K. WHITFORD, Claimant
Willner et al., Claimant's Attorneys
Keith Skelton, Defense Attorney

WCB 82-00542
May 12, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Menashe's order which awarded claimant 80% unscheduled permanent disability. Claimant contends that he is entitled to an award of permanent total disability. The issue is extent of disability.

We affirm and adopt the Referee's order.with the following comment. It is apparent that claimant is totally disabled. It is equally apparent that the factors which render him totally disabled include a number of forms of impairment that developed after the compensable injury and, therefore, cannot be considered for determining permanent total disability status for workers' compensation purposes. Emmons v. SAIF, 34 Or App 605 (1978).

ORDER

The Referee's order dated October 4, 1982 is affirmed.

KENT BIRDENO, Claimant
Roll & Westmoreland, Claimant's Attorneys
Anderson, Fulton et al., Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 81-02838
May 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer requests review of Referee James' order which set aside its denial of claimant's aggravation claim related to his left knee.

The Referee's order was issued prior to the time we decided Dean Planque, 34 Van Natta 1116 (1982). The employer contends that applying Planque to the facts in this case requires reversal of the Referee's order.

In this case, claimant compensably injured his left knee on June 1, 1977. His injury required several surgeries, ultimately requiring an osteochondral replacement on November 2, 1978. This type of bone graft surgery was experimental at the time it was performed and the graft site was considered somewhat fragile. The doctors were not sure how long the graft would last even under normal wear and tear conditions. On January 29, 1981 the claimant was involved in a tavern fight in which he was knocked to the floor. Although the evidence about how this fight started is typically unclear, it appears to us that claimant's assailant provoked the fight. The fight lasted for approximately five minutes. Prior to this fight claimant's left knee bone graft was solid, but after the fight X-rays revealed that a piece of the graft had broken loose. There was also evidence of a probable medial ligament tear and evidence of marked changes of the lateral femoral condyle.

Dr. Fagan, claimant's treating physician, stated:

> "Had Mr. Birdeno never had an osteochondral graft I doubt he would have had any fracture in his knee, perhaps he would have had a medial ligament tear. His subsequent surgery was required on the basis of loosening of his osteochondral graft. We do not even know if ordinary activities will not loosen his osteochondral graft requiring future knee fusion.
>
> "Therefore, I do feel that his pre-existing condition in his knee predisposed him to a far more severe injury than he would normally have had."

Relying on this opinion the Referee found that the claimant's worsened condition was related to his injury of June 1, 1977 and, therefore, the responsibility of the employer.

In Dean Planque, supra, we considered the circumstances under which an intervening off-the-job incident or injury breaks the causal connection between a worker's original compensable injury and a subsequent worsened condition. In Planque the claimant went fishing two weeks after undergoing shoulder surgery while his arm

was still immobilized and with stitches remaining in the incision. While on his fishing trip, the claimant slid down the side of a river bank, which caused his immobilized right arm to come free from the brace. This stress produced bleeding at the site of his surgical incision, from which the stitches had yet to be removed. The physician who performed the reparative surgery indicated that the fall down the river bank damaged and compromised the previous surgical repair and that, had it not been for the fall, the claimant would have recovered satisfactorily from the original compensable surgery.

We concluded:

> "We believe that actions of the claimant, after an industrial injury, that produce further injury can be so unreasonable as to become an independent, intervening cause, breaking the chain of causation from the original compensable injury. We avoid the question argued by the parties of whether the claimant's subsequent conduct was intentional or negligent; we look only to the question of whether the claimant's subsequent off-work injury producing activity or exertion was reasonable or unreasonable under all of the circumstances." 34 Van Natta at 1118.

We found that the claimant's activity of going on a fishing expedition and sliding down a steep river bank within two weeks of his shoulder surgery was unreasonable and thus broke the chain of causation between his original compensable injury and his worsened condition. As a consequence, the surgery needed to correct the damage done to the previous surgical repair was found not to be the responsibility of the employer.

In this case, relying on Planque, the employer argues that it should not be responsible for the medical services and other benefits occasioned by the claimant's left knee injuries subsequent to his participation in the tavern fight.

Planque is distinguishable. In this case, claimant was more than a year and a half post knee surgery, whereas the claimant in Planque was only two weeks post shoulder surgery, with wounds still healing, when he engaged in injury-producing activity. In this case, there was nothing inherently dangerous or unreasonable about claimant's act of going to a tavern; industrially injured workers continue to live in the real world. If claimant had been the aggressor in the tavern fight, knowing of his fragile knee condition, we might be inclined to find such conduct so unreasonable as to end the employer's responsibility for a worsened knee condition stemming from that altercation. However, we find from the evidence that claimant was at least the victim of verbal aggression that led to that fight. Under these circumstances, we find that the claimant's participation in the tavern fight was not so unreasonable as to cut off liability of the employer for claimant's subsequent worsened knee condition stemming from that altercation. The original

compensable injury continued to be a material contributing cause of claimant's worsened condition.

ORDER

The Referee's order dated July 9, 1982 is affirmed. Claimant's attorney is awarded $600 as a reasonable attorney's fee on review, payable by the employer.

BOBBIE BLAKELY, Claimant
Coons & McKeown, Claimant's Attorneys
John Snarskis, Defense Attorney

WCB 81-07215
May 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee McCullough's order which set aside its denial of claimant's occupational disease claim for her left knee condition. The issue is compensability.

Claimant began working as a utility person for VIPS Restaurant in Canyonville on September 15, 1980. Prior to that employment, claimant had sustained injuries to her right knee in April of 1977 while working as a school bus driver. Drs. Woolpert and Young performed a total of four surgeries on the right knee. Claimant eventually returned to work driving a school bus for a four to six month period in late 1977 and early 1978. Claimant did not work in 1979.

While working for VIPS in 1980, claimant spent approximately 50% of her time running a dishwasher. The remainder of her working time was devoted to a variety of tasks such as cleaning baseboard, mats and tables. Claimant testified that she used a small ladder in order to change a light bulb on two occasions and cleaned the light fixtures on one occasion. She also testified that she bussed tables on two occasions and changed the milk containers in the cooler a few times. Claimant terminated her employment at VIPS on October 27, 1980.

Claimant had been receiving conservative care for her right knee from Dr. Woolpert throughout 1980. Dr. Woolpert's chart notes of October 29, 1980 and January 30, 1981 indicate that claimant was experiencing discomfort in her left knee as well as her right, and that it was occasionally "popping." On April 29, 1981 Dr. Larson reported that claimant was experiencing intermittent retropatellar pain in the left knee and that there were minimal findings compatible with chondromalcia. On May 29, 1981 claimant filed an 801 form alleging that she had sustained a compensable occupational disease of the left knee during her employment at VIPS.

On July 21, 1981 Dr. Young reported that he concurred with Dr. Larson's diagnosis of minimal chondromalcia, and:

> ". . . we feel that this is a developmental or mild degenerative process and is not

> related to any specific injury or use. More specifically, I do not feel that any employment in the last year or two has any relationship with these symptoms."

On September 8, 1981 Dr. Larson reported that he concurred with Dr. Young's opinion. The only other medical opinion in the record relating to the issue of causation is Dr. Larson's report of March 29, 1982 in which he states:

> "I do not feel that the work itself produced the condition but any activities that require prolonged sitting, squatting, or kneeling would aggravate her problem. Much of her problem is probably related to a developmental condition inherent in her knees. It is the latter which would be the major problem and the activities would be the contributing cause as to producing her exacerbations and continued problems."

Although somewhat vague, we understand Dr. Larson to be stating that claimant's employment activities could have produced symptoms but did not cause or aggravate claimant's underlying condition.

We agree with the Referee that this is a claim based on occupational disease and that the test set forth in Weller v. Union Carbide, 288 Or 27 (1979), is applicable. We disagree with the Referee's conclusion that the major cause test of Gygi v. SAIF, 55 Or App 570 (1982), is not applicable.

The Referee stated that the Gygi test was irrelevant because there was no evidence that claimant used her knees while she was not working. In Mary E. (Southworth) Osborne, 35 Van Natta 186 (1983), we stated:

> "The fact that there may be little evidence in the record with regard to what other activities claimant might have engaged in off the job does not prove claimant's case. It is not necessary for the insurer to present evidence which, as the Referee put it, 'demonstrate[s] that claimant's household activities would be of such a nature as to compare in effect with the . . . activity of typing eight hours a day.' In other words, we do not agree that it is the burden of the insurer to prove a claim is not compensable. See Eonia Z. Stoa, 34 Van Natta 1206, 1207 (1982): 'The claimant has the burden of proof. We do not think an inference to aid the party with the burden of proof can be drawn from the adverse party's failure to produce any evidence or specific evidence.'"

Claimant must, therefore, still establish that her work activities were the major cause of her knee condition or its aggravation, despite the fact that there may be little evidence with regard to her off-the-job activities. We conclude that claimant has not established this to be the case. In particular, we rely on Dr. Young's opinion (with which Dr. Larson concurred) that claimant's work activities have no relationship with claimant's left knee condition but that, rather, it is a developmental or degenerative condition unrelated to injury or use. Dr. Larson does not appear to change his opinion in his report of March 29, 1982. Additionally, the record does not establish that claimant's kneeling and stooping activities at VIPS were anything more than de minimus; and we believe that it tends to stretch credulity to believe that claimant did not use her knees in comparable ways during her non-work hours.

In addition to satisfying the test set forth in Gygi, a claimant with a preexisting underlying symptomatic condition must also satisfy the requirements set forth in Weller, supra. Douglas Chiapuzio, 34 Van Natta 1255 (1982). In other words, claimant must also establish an actual worsening of the underlying condition itself, rather than merely a symptomatic worsening. We do not believe that this is such an uncomplicated question that medical verification of a worsening is not required and, unlike the Referee, we are unwilling to rely on "circumstantial" evidence to establish a worsening where there is no medical support for such a conclusion in this record. There is no evidence in this record indicating that claimant's underlying left-knee degenerative chondromalcia condition was worsened by her four weeks of employment at VIPS. The Referee tended to focus rather heavily on Dr. Larson's use of the term "problem" in his March 29, 1982 report as supporting an inference that claimant's underlying condition had worsened. We do not so interpret Dr. Larson's report. Although he did use the term "problem", the remainder of the report seems to indicate that Dr. Larson is speaking in terms of a symptomatic aggravation and, in any event, he concurred with Dr. Young's opinion that claimant was only experiencing symptoms.

In summary, we conclude that there is no evidence in this record which would support a finding of a compensable occupational disease. The most that the record supports would be a conclusion that claimant experienced some increased left knee symptoms possibly as a result of her rather minimal activities during the four weeks she was employed at VIPS.

The insurer has also raised the issue of the Referee's admission of certain exhibits which were tendered in violation of the ten day rule, OAR 436-83-400(3). We are inclined to agree with the insurer, see Donald J. Young, 35 Van Natta 143 (1983), Minnie Thomas, 34 Van Natta 40 (1982), but conclude it is unnecessary to address this issue because even when all exhibits are considered, we find that the claim fails.

ORDER

The Referee's order dated June 29, 1982 is reversed. The insurer's July 27, 1982 denial is reinstated and affirmed.

MICHAEL J. DYER, Claimant

Crime Victim Compensation
Case No. CV0167000
Order--Crime Victims Act
May 16, 1983

Decided by Board Member Ferris and Lewis.

Claimant requests review of the order and order on reconsideration of the Department of Justice which denied his claim for crime victims compensation on the ground that he failed to cooperate with law enforcement officials in the apprehension and prosecution of his assailants and on the ground that he substantially provoked the assault.

Based on our review of the record, we believe that the Department's findings of fact accurately reflect what happened in this case. In summary, the facts are that on July 12, 1982 claimant was in Betty's Tavern in Salem. Claimant had been playing pool with four members of a motorcycle group, sometimes informally referred to as "bikers." Claimant also had been drinking their beer, not necessarily with their permission. At some point claimant threw pool chalk into the beer of this group and said something offensive to them. One of the members of the group got up and struck claimant. Claimant then pulled out a knife described as a hunting-type knife with a five-inch blade. One of the "bikers" knocked the knife from claimant's hand and when claimant reached to retrieve the knife he was kicked in the head. Hospital and medical records establish that claimant sustained injuries as a result of this incident. Emergency room records confirm that claimant was very intoxicated at the time he was brought in.

Subsequently, when claimant was contacted by a police officer, in the course of the interview the officer suggested that if claimant "bum-beefed", i.e., filed false charges against his assailants, they likely would disapprove and there might be repercussions. Claimant indicated that several years ago he had been assaulted by the same group of individuals. Claimant declined to prosecute the assailants in the July, 1982 incident at issue here.

In relevant part, ORS 147.015 provides as follows:

> "147.015. A person is entitled to an award of compensation under ORS 147.005 to 147.365 [the Compensation of Crime Victims act] if:
>
> "(1) He is a victim...of a compensable crime that resulted in a compensable loss of more than $250;
>
> * * * *
>
> "(3) The applicant has cooperated fully with law enforcement officials in the apprehension and prosecution of the assailant or the department has found that the applicant's failure to cooperate was for good cause;

* * * *

"(5) The death or injury to the victim was not substantially attributable to his wrongful act or substantial provocation of his assailant...."

The Department of Justice initially denied the claim on the ground that claimant had failed without good cause to cooperate fully in the apprehension and prosecution of his assailants. Upon reconsideration, the claim was denied on the ground that claimant had substantially provoked the assault.

We agree that claimant is not entitled to crime victims compensation. As between the two grounds, we are more comfortable deciding the case on the ground that claimant provoked the assault. We are not oblivious to the possibility that, regardless of the merits of a criminal prosecution, some members of some "motorcycle clubs" might pose a threat of harm to the alleged victim. Moreover, in this case, although the police officer's suggestion not to press charges may have been good advice, it does tend to taint claimant's decision-making process in declining to prosecute.

However, with respect to claimant's role in the assault itself, at no point in the record does claimant dispute that he precipitated a confrontation by throwing chalk into the beer being consumed by this group of individuals or that he escalated it by pulling a knife. There is no evidence indicating that claimant was prevented from withdrawing from the altercation, thereby avoided being injured. We believe the Department properly denied compensation.

ORDER

The Department of Justice's order on reconsideration dated October 19, 1982 is affirmed.

DONALD W. HARDIMAN, Claimant
Ringo et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-03531
May 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee McCullough's order which set aside its denial of claimant's back injury claim. The issue is compensability.

The question of whether or not claimant sustained a compensable injury on March 17, 1981 while he was employed by the Linn County Road Department was determined solely on the basis of credibility. The Referee found claimant to be a credible witness who "has a somewhat inaccurate memory for dates and events." An examination of the record leaves us with the impression that this was a somewhat charitable finding. For example, the medical reports that are most contemporaneous with the alleged injury are those authored by Dr. Origer who reported that claimant could not identify any specific event at work which precipitated his back pain. Claimant

was also questioned by a SAIF investigator, and claimant denied that any specific incident took place on the day in question. Dr. Origer later reported on May 27, 1981 that claimant had returned to his office, informed him of an alleged pump-lifting incident and requested him to revise his records accordingly. We also find it somewhat unusual that claimant was unable to identify a photograph of the pump which he allegedly moved, whereas every other witness from the road crew that testified was able to do so. When the hearing reconvened on July 30, 1982 for additional testimony, claimant then testified that this was indeed the same pump. Additionally, the information submitted concerning claimant's work history with Linn County certainly leaves the impression that claimant was not a person who was particularly well-motivated to continue working, if there was any way to avoid doing so.

Despite our strong doubts concerning this claimant's credibility, we nevertheless affirm the Referee. We do so not because we necessarily agree with his finding, but because we normally defer to the Referee on matters concerning credibility unless there is a strong basis to do otherwise. Although it is a close question, we conclude that there is not quite a sufficiently strong basis to do otherwise here.

ORDER

The Referee's order dated August 30, 1982 is affirmed. Claimant's attorney is awarded an attorney's fee of $350 for services before the Board, payable by the SAIF Corporation.

JOHN R. HART, Claimant
Ferder et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01353
May 16, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Seymour's order which set aside its denial of compensability of claimant's bilateral knee "condition" and ordered SAIF to pay claimant's attorney an attorney's fee of $1,000 for prevailing on a denied claim and $300 pursuant to ORS 656.382. The issues for review are compensability, penalties and attorney's fees.

We affirm and adopt those portions of the Referee's order relating to the issue of compensability, subject to the following additional comments.

The Referee correctly noted that this is an occupational disease claim. As such it is subject to the requirements set forth in James v. SAIF, 290 Or 343 (1981), and SAIF v. Gygi, 55 Or App 570 (1982). It would serve no purpose to indulge in a lengthy recitation of the medical evidence relevant to the issue of compensability. We find that the Referee was correct in concluding that the claimant established by a preponderance of the evidence that his work activities at Bingham-Willamette Company were the major cause of his bilateral knee condition.

However, it is not clear precisely what "condition" claimant is suffering from and exactly what condition the Referee found compensable. There are multiple diagnoses from the various medical practitioners in this claim. Drs. Khan and Courogen diagnosed "overuse syndrome." Dr. Burke diagnosed degenerative arthritis in the cartilage of the knees. Orthopaedic Consultants believed the condition to be either rheumatoid or degenerative arthritis with chondromalacia. Drs. Kimberley and Schilperoort suggested degenerative osteoarthritic changes with chondromalcia.

Claimant urges that it is not necessary for there to be a specific diagnosis before a "condition" can be found compensable. See 3 Larson, Workmen's Compensation Law, §79.51(a)(1983). SAIF argues to the contrary, relying on Lorrie A. Minton, 34 Van Natta 162 (1982):

> "Determination of the work-relatedness of a disease requires identifying possible causes and weighing the relative contribution of possible causes. Practically, it is usually impossible to identify possible etiology and weigh relative contribution unless we know what disease we are talking about."

Minton discussed practicalities, not absolutes. A claimant has the burden of proving work causation and that burden is almost always going to be more difficult in the absence of a specific diagnosis. Ultimately, however, proof depends on the circumstances. If doctors suspect different diseases with different known causes, not all of which would be equally work related, the absence of a specific diagnosis may make it impossible to prove the disease is compensable. But if different possible diseases have the same or similar causes and/or all possible causes were equally present in the work environment, the absence of a specific diagnosis is not necessarily fatal to an occupational disease claim.

The practical considerations discussed in Minton are, of course, relevant in this case, and we have taken them into account. We do not find those considerations dispositive. Although there are several diagnoses of claimant's knee condition, almost all medical opinion states the cause to be standing, walking, etc., on hard concrete floors.

We do believe that SAIF's concern with the lack of a specific diagnosis is well justified for reasons unrelated to the present issue of compensability. A litigation order that states only that a, for example, "knee condition" is found to be compensable potentially plants the seeds of future litigation. For example, when future issues of aggravation or the provision of medical services arise, it is more difficult to ascertain whether a compensable disease has worsened when we do not know what disease was found to be compensable. Ideally, we believe that an employer/insurer has a right to know just what it is being held responsible for, with as much specificity as possible, when an occupational disease is found compensable.

The facts of this case do not lend themselves to as much specificity as we would prefer, but we believe that we are able to narrow the matter down somewhat. We conclude that the diagnosis of rheumatoid arthritis can be discarded. Dr. Rosenbaum states that rheumatoid arthritis is a disease process affecting the white blood cells which is caused by some as-yet-unknown form of virus or bacteria, and that it is not a disease that results from standing on concrete floors. We understand Dr. Norton to share Dr. Rosenbaum's opinion in this regard, and it seems that the Orthopaedic Consultants even discarded this as a possible diagnosis in their last report dated April 28, 1982. We believe that, when viewed as a whole, the general consensus of the medical opinions is that the claimant is suffering from a bilateral form of degenerative osteoarthritis of the knees, either caused or aggravated by his work activities. That diagnosis appears to be the thrust of the opinions of Drs. Kimberly, Burke and Schilperoort as well as the Orthopaedic Consultants. Our reading of the medical evidence indicates that chondromalacia is simply another form of this same condition, osteoarthritis, when speaking in terms of the knee. We conclude that this is the condition for which SAIF is responsible.

We turn to the issue of penalties and attorney's fees. SAIF contends that it did not act unreasonably in failing to accept or deny the claim within 60 days. This claim was apparently filed on July 14, 1981. SAIF deferred the claim but did pay interim compensation. ORS 656.262(4). SAIF, however, did not deny the claim until January 11, 1982, some six months later. Clearly SAIF was in violation of ORS 656.262(6) and virtually admits as much in its brief. SAIF argues that OAR 436-69-201(1)(a) requires that insurers "will not pay for [medical] care unrelated to the compensable injury." This justification for a late denial is certainly creative, but it should go without saying that the rule does not and cannot alter, enlarge or limit the terms of ORS 656.262.

Based on Zelda M. Bahler, 33 Van Natta 478 (1981), rev'd on other grounds, 60 Or Ap 90 (1982), the Referee concluded that SAIF's denial of the claim some four months late was an action presumed unreasonable and that there was no evidence to rebut that presumption. We agree completely. However, the Referee only assessed a $300 attorney's fee. Claimant contends that a penalty should also be imposed. We agree. Although it is true that SAIF paid claimant interim compensation, as we noted in Norman J. Gibson, 34 Van Natta 1583, 1584 (1982):

> "Although the 'then due' language of ORS 656.262(9) admittedly creates some confusion in this kind of case, we conclude the penalty should be assessed on the interim compensation payable between the sixtieth day and the date of the denial."

Accordingly, based on the criteria in Bahler and Gibson claimant is entitled to a penalty in the amount of 25% of the interim compensation from the period between the sixtieth day after notice to the date of denial. The precise date the employer or SAIF received notice of the claim is not clear in this record. However, we assume SAIF has or can obtain such information.

There is one additional matter that warrants comment. The Referee quoted from Chamberlain v. Northwest Agencies, Inc., 289 Or 201, 207 (1980), and Barber V. Capoles, 71 Or 212, 221 (1914):

> "Perhaps the testimony which least deserves credit with a jury is that of skilled witnesses. These gentlemen are usually required to speak, not to facts, but to opinions; and, when this is the case, it is often quite surprising to see with what facility and to what an extent their views can be made to correspond with the wishes or the interests of the parties who call them. They do not, indeed, willfully misrepresent what they think; their judgments become so warped by regarding the subject in one point of view that, even when conscientiously disposed, they are incapable of expressing a candid opinion."

If the Referee meant that the opinions of an expert witness called on behalf of a particular party are entitled to no weight, we reject any such analysis. The issue involved in Barber and Chamberlain was whether a jury was required to accept the uncontroverted opinion of an expert witness. The courts concluded that the jury was not so bound, and we have concluded that Referees and this Board are not so bound. Edwin A. Bolliger, 33 Van Natta 559 (1981), aff'd, 58 Or App 222 (1982). The opinions of experts in this system are to be weighed in accordance with the standards we stated in Bolliger. Such opinions are neither to be accepted nor rejected solely because of the expert's possible affinity with one party or the other. This is especially true in a field of law that has long recognized the need for expert opinion, Uris v. Compensation Department, 247 Or 420 (1967), and in a litigation system in which it is rather rare for experts who have absolutely no connection with any party to offer opinions.

ORDER

The Referee's order dated September 29, 1982 is modified in part. The SAIF Corporation is ordered to pay claimant a penalty in the amount of 25% of the interim compensation paid during the period between the sixtieth day after notice of the claim until January 11, 1982, the date of its denial. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an attorney's fee of $500 for services before the Board, payable by the SAIF Corporation.

EDWARD J. LaROQUE, Claimant
Pozzi et al., Claimant's Attorneys
Schwabe et al., Attorneys
Keith Skelton, Defense Attorney

WCB 81-11383 & 81-11347
May 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

FMC Corporation, as a self-insured employer, requests review of Referee Fink's order which assigned responsibility to it for claimant's asbestos-related lung cancer.

The only issue is responsibility under the following circumstances. Prior to October 1, 1975, FMC was insured by Liberty Mutual. On that date, FMC became self-insured. Claimant worked for FMC or its predecessor from 1957 until his retirement in 1978. He was exposed to larger amounts of asbestos earlier during this employment; lesser amounts of asbestos later during this employment. Claimant was diagnosed as having asbestos-related lung cancer in 1981. Based on the nature of the cancer and its progression, Dr. Lawyer opined that: (1) it was most likely that the cancer began in the 1960's or 1970's; (2) it was impossible for the cancer to have begun after 1976; and (3) there was a "very minimal" possibility that claimant's exposure to asbestos during the last three months of 1975, after FMC became self-insured, could have caused his cancer. Indeed, extrapolating from Dr. Lawyer's opinions, it appears to us to be about 99% probable that claimant's cancer arose while Liberty Mutual was on the risk prior to October 1, 1975.

The last injurious exposure rule, however, does not involve an assessment of probabilities. It assigns responsibility to the last employer/insurer where job exposure could have caused the illness. On this record, exposure after October 1, 1975, when FMC became self-insured, could have caused claimant's cancer, regardless of how unlikely that may be. Therefore, the Referee correctly assigned responsibility to FMC Corporation as a self-insured employer.

ORDER

The Referee's order dated November 18, 1982 is affirmed. Claimant's attorney is awarded $375 as a reasonable attorney's fee for services rendered on Board review, payable by the FMC Corporation.

HUGH MONTGOMERY, Claimant
Welch et al., Claimant's Attorneys
G. Howard Cliff, Defense Attorney

WCB 82-03877
May 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Nichols' order which affirmed the Determination Order which awarded no permanent disability. The issue is extent of disability. We conclude that claimant has sustained permanent impairment justifying a permanent disability award.

Claimant, now age 58, sustained an inguinal hernia on his right side in February 1980 when he was lifting a large garage door in the course of his employment as a general automobile and truck mechanic. In April 1980 claimant was operated on to repair the hernia. Immediately after the operation claimant was aware of pain that radiated from the surgery site up his back and into his right arm. Nevertheless, in June 1980 claimant was released to return to his regular work.

The pain that claimant experienced immediately following his surgery became severe in August 1980 and claimant sought medical attention in September 1980. Claimant's condition was diagnosed as a neuroma which had developed from nerve tissue trapped in the operative scar from the April 1980 surgery. Corrective surgery was recommended. While awaiting a surgery date, in November 1980, claimant was terminated from his employment. The reason given was claimant's decline in production. Claimant testified that he believed that he had been performing satisfactorily notwithstanding the pain from the surgery site and that he was terminated because his supervisor "had bigger fish to fry."

In January 1981 claimant underwent a second surgery to release the trapped nerves. He enjoyed immediate relief from the pain that radiated into his back and arm but continued to experience pain at the surgery site.

In March 1981 claimant was again released for regular work as a mechanic following the second surgery. At that time claimant's physician opined that there would be no permanent disability. However, claimant continued to experience pain and discomfort, particularly when engaged in the more strenuous activities or activities requiring twisting and bending while exerting pressure as required by the nature of his employment. In September 1981 claimant again sought medical attention for the problem. Trapped nerves at the surgery site were again diagnosed and in November 1981 claimant underwent a third surgery. Following a recovery period, in July 1982 claimant was again released to return to regular employment. However, claimant continued to experience about the same type and level of pain as he had experienced since the second surgery. Claimant's claim was closed with an award of temporary total disability but no permanent disability.

The Referee was impressed with the fact that claimant was released to return to his regular work after each operation, that

claimant did in fact return to his regular work following the first surgery, that his condition improved after the second operation and that claimant's doctor placed no work restrictions on him in his releases. By contrast, we are impressed by the fact that claimant was terminated from his regular employment at least in part -- we infer -- because of a decrease in productivity occasioned by the injury and the ensuing surgery. While the second surgery improved claimant's condition as far as the back and arm pain were concerned, it did nothing for the pain in his groin area which continues to interfere with his activities notwithstanding the second and third surgeries.

Claimant's physician reported:

> "The patient was informed that I considered him medically stationary as of January 8, 1982. This patient may have continued pain in his right groin. I do not feel that this will limit his activities. It must be recognized that this however is a personal opinion and cannot be based on diagnostic or laboratory tests to evaluate the amount of pain."

Claimant testified:

> "A. The doctor -- I can tell you what the doctor told me. He said he could not truthfully tell me whether I was restricted; I was the one that has to determine that.
> "Q. All right. So the doctor didn't restrict you; he told you to go back to your regular employment if you wanted to?
>
> "A. He said he knew what I would -- I would know what my restrictions were when I went back to work, yes."

The Referee found there was no medical verification of claimant's impairment. We interpret the same evidence differently. That is, we interpret the doctor's closing report as simply candor on his part: the type and degree of pain claimant experiences is a very subjective matter and the doctor cannot honestly tell what impairment claimant has as a result of it; claimant will be the best judge of that. The Referee made no specific finding that she found the claimant to be credible. The employer and its insurer make no contention that claimant was not a credible witness and, based on our review of the record, we find no basis for doubting his testimony. Accordingly, we believe that claimant, in fact, has sustained impairment in the form of disabling groin pain.

We believe this pain mildly interferes with claimant's work activities, i.e., disabling pain while engaged in heavy lifting, twisting, bending, etc. Claimant testified that he liked to think that he was still capable of performing the full range of mechanic work that he had done before his hernia. On the other hand, he also testified that lifting over 30 pounds and engaging in the contortions required of a mechanic caused groin pain, and that he would prefer confining himself to benchwork. We conclude that the

latter testimony is probably the more realistic and that claimant's groin pain probably forecloses him from the heaviest end of the labor market spectrum. While we have no reason to feel more confident than claimant's own physician about our ability to quantify the actual impact of claimant's pain on his future wage earning capacity, we conclude that an award of 15% unscheduled permanent partial disability is appropriate.

ORDER

The Referee's order dated October 20, 1982 is reversed. Claimant is awarded 48° for 15% unscheduled permanent disability related to his hernia condition. Claimant's attorney is allowed 25% of the permanent disability award up to $3,000 for his services at hearing and on review.

HAROLD L. PETERSON, Claimant
Evohl F. Malagon, Claimant's Attorney
Wolf, Griffith et al., Defense Attorneys

WCB 81-09810
May 16, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The self-insured employer requests review of Referee Quillinan's order which set aside its partial denial of claimant's claim that his 1981 psychological problems are a compensable consequence of his 1975 groin injury.

Claimant suffered a compensable injury to his right groin in 1975 while pulling green chain. That injury led to numerous surgeries, none of which relieved claimant's chronic pain in the groin area. In 1979 claimant received an award of 25% unscheduled disability.

In 1981 claimant required psychological treatment following the breakup of his marriage. In a single cryptic report the treating physician, Dr. Carter, opined that claimant's psychological condition was causally related to his 1975 injury. Although there is little detail in this report, it is apparently Dr. Carter's theory that claimant's groin pain led to sexual dysfunction which led to the breakup of his marriage which led to the psychological disability that Dr. Carter was treating.

Claimant was seen by Dr. Parvaresh at the employer's request. Dr. Parvaresh reported that claimant told him that he and his wife had long-standing difficulties which predated the 1975 industrial injury. Based on this information Dr. Parvaresh, in effect, opined that the "broken link" in Dr. Carter's apparent chain-of-causation theory was that the marriage breakup was not due to claimant's sexual dysfunction. Dr. Parvaresh also noted that, at the time of the psychological problems in 1981, claimant was working and not having serious physical problems.

Dr. Wilson, another psychiatrist, reviewed the medical reports. He opined that claimant's psychological problems were unrelated to his industrial injury:

"It seems unlikely that an injury would suddenly cause psychological distress 6 years later. He may have wished to place the responsibility for the marital problem on something outside himself rather than confront his own role in that difficulty."

Considering the relative lack of information from Dr. Carter and the opinions of Drs. Parvaresh and Wilson, we cannot affirmatively say that that the evidence preponderates in favor of finding claimant's 1981 psychological problems to be a compensable consequence of his 1975 injury.

ORDER

The Referee's order dated September 27, 1982 is reversed. The employer's partial denial dated September 29, 1981 is reinstated and affirmed.

JERRY L. PROCTOR, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-04509
May 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Seifert's order which upheld the SAIF Corporation's denial of claimant's aggravation claim. The issues are the compensability of claimant's aggravation claim and whether the stipulation and disputed claim settlement of July 28, 1980 serves to bar any future claim in relation to claimant's psychiatric condition, alleged to have arisen as a result of his November 7, 1976 industrial injury.

Claimant contends that the Referee erred in failing to find that his physical condition had worsened since the last award or arrangement or compensation, which in this case would be the stipulation and disputed claim settlement of July 28, 1980. Specifically, claimant argues that the Referee erred in relying on the August 10, 1982 report of the Orthopaedic Consultants which stated that, in comparison with their examinations performed in 1978 and 1979, claimant's condition remained unchanged. Claimant states that this finding ignores what may have happened between January of 1982, when Dr. Norris-Pearce first made the aggravation claim, and August of 1982 when claimant was examined by Orthopaedic Consultants. We disagree. We think that it is apparent that if Dr. Norris-Pearce considered claimant not medically stationary upon examination in January of 1982, that it was in relation to his exacerbated psychological condition, rather than his physical condition. This becomes more obvious when viewed in context with medical reports generated subsequent to January 15, 1982. The Referee so found and we agree with that finding.

Although we find claimant's physical condition remains unchanged since his last arrangement of compensation, it seems clear that he has experienced a worsening of his psychological and emotional condition. However, the disputed claim settlement of July 28, 1980 provided in part:

"4. Claimant additionally made claim for a psychological condition alleged to have arisen from his industrial injury.

* * *

"7. Subject to the approval of the Workers' Compensation Board, this claim for an alleged psychological condition related to Claimant's industrial injury of November 7, 1977 shall be fully and finally compromised and settled in the following manner:

a. The State Industrial Accident Insurance Fund shall pay to Claimant and his attorney the sum of $1,000.00. Payment of this amount is not an admission of the existence of the claim nor of its compensability, but is the settlement of a disputed claim."

Claimant contends that a close examination of the medical evidence indicates that the condition which was disputed and settled was a different condition than that which is currently being diagnosed and that an aggravation claim for a different injury-related psychological condition is not barred by the disputed claim settlement. Specifically, claimant argues that depressive neurosis was not a diagnosed condition at the time the parties entered into the disputed claim settlement. We disagree. We find that the pre-July 1980 medical reports indicate that claimant was diagnosed as suffering from, among other things, depression related to his injury. We, therefore, conclude that claimant's aggravation claim fails because his psychological condition, although worse, was disposed of by the July 28, 1980 disputed claim settlement.

ORDER

The Referee's order dated November 19, 1982 is affirmed.

MARK L. ROSERA, Claimant
Starr & Vinson, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-11753
May 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of those portions of Referee Quillinan's order denying SAIF's motion to dismiss and awarding claimant 30% unscheduled disability. The issues on review are the propriety of denying the motion to dismiss and extent of disability.

We affirm that portion of the Referee's order denying SAIF's motion to dismiss. We do not agree with the Referee's rating of claimant's permanent disability.

Claimant is a 25 year old logger who sustained a compensable injury on March 31, 1981 when he was struck in the back of the head by a pike pole. The medical evidence establishes that the claimant suffers dizzy spells caused by his compensable injury. His testimony establishes that he continues to suffer occasional dizzy spells.

The AMA's Guides to the Evaluation of Permanent Impairment assigns a 5% impairment rating to individuals with claimant's symptoms. Claimant's age yields a -7 factor; the labor market findings yield a +1 factor; all other factors are assigned a zero value as having no impact. After combining these values and rounding off, we conclude that the proper award of permanent disability is 5%.

ORDER

The Referee's order dated September 22, 1982 is modified in part. That portion of the order awarding claimant 30% unscheduled disability is modified, and claimant is awarded 16° for 5% unscheduled permanent disability in lieu of all prior awards. Claimant's attorney's fee should be adjusted accordingly. The remainder of the Referee's order is affirmed.

JERRETT L. TONE, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-00141 & 82-00142
May 16, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of that portion of Referee Seymour's order which set aside its denial of claimant's occupational disease claim for a low back condition.

The Referee found that claimant's low back condition was "overuse syndrome." It is far from clear to us that any doctor offers or subscribes to this diagnosis. But assuming for sake of discussion that claimant suffers from "overuse syndrome," we disagree with the Referee's finding that claimant suffers from a compensable occupational disease.

Claimant's job duties involved heavy physical work, such as bending over, twisting, pushing, pulling and lifting. However, we find that no doctor opined that claimant's work activities were the major cause of his low back problems. Dr. Baker, who apparently was claimant's primary treating physician, found that claimant's right leg was 3/4 of an inch shorter than his left leg and reported:

> "This young man was given a requisition for a 3/8 inch heel lift for the right shoe. I find no obvious physical findings except for the leg length discrepancy to account for his low backache. For this reason I am calling this a postural lumbo-sacral backache due to idiopathic leg length discrepancy. . . . I get the distinct

impression that this man does not really like his job and feels that he has to work too hard in it. This may be contributing to his present complaints."

Dr. Byerly agreed with this conclusion from Dr. Baker.

Parts of Dr. Baker's deposition testimony are hard to understand, but Dr. Baker adheres to the above-quoted opinion as we interpret his testimony. Dr. Baker also seems to be saying in the deposition that, if his leg-discrepancy theory is correct, all activities of daily life would contribute toward producing low back symptoms.

We have no quarrel with the Referee's finding that claimant's testimony was credible, but we find the present causation question sufficiently complex that we believe the required major-causation link between claimant's work activity and low back condition must be supported by persuasive expert opinion. We find none in the record.

ORDER

The Referee's order dated June 29, 1982 is reversed in part. Those portions which set aside the SAIF Corporation's denial of claimant's occupational disease claim and awarded an attorney's fee for prevailing on a denied claim are reversed; SAIF's denial dated December 7, 1981 is reinstated and affirmed. The remainder of the Referee's order is affirmed.

JUSTINA WELCOME, Claimant
Ringle et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01005
May 16, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which affirmed the SAIF Corporation's denial of further medical benefits under ORS 656.245. The issue is whether claimant's continued need for certain medical services is related to her 1970 injury or her degenerative arthritis. We find that claimant's arthritis in her low back is not related to the 1970 injury and, therefore, the medical services for treatment of that condition are not compensable. We also find that the medical services necessary to treat the musculoligamentous condition in claimant's shoulders, upper back and neck are related to the compensable injury; these medical services, therefore, are compensable.

Except as inconsistent with our findings herein, we adopt the Referee's recitation of the facts. Claimant, age 61 at the time of the hearing, injured her low back, upper back, neck, shoulders, and right arm in 1970 when she attempted to prevent a parcel of clothing from falling off a rack in a drycleaning establishment. Litigation was required to establish the compensability of all conditions except the low back condition which had been accepted as compensable. The claim ultimately was closed in 1973 and by a combination of Determination Order and a stipulation, claimant received an award for 15% unscheduled permanent disability.

Claimant was retrained as a secretary and began working in 1971 in the office of the physician who became her treating physician. Claimant continued to receive treatment for her compensable conditions, apparently primarily in the form of examinations and prescriptive medications. However, claimant was hospitalized in 1978 for one week for her back complaints. Also, in 1979 claimant received physical therapy for her back. Throughout and up until January 1982, SAIF continued to pay for these medical expenses. At that time, based upon the opinion of Dr. Reilly, consulting physician for the claimant, SAIF denied further responsibility for claimant's back, neck, shoulder, and arm problems.

In evaluating the medical evidence, we find the opinions of Drs. Pasquesi and Hoff the most persuasive. Dr. Pasquesi examined claimant in 1971 and 1972 and again in 1982. In 1972 Dr. Pasquesi indicated that claimant had a chronic strain that would exacerbate from time to time. In 1982 he opined:

> "I do feel that this patient does have chronic mild pain and that her original accident is partially responsible for this problem, however, she also has continuing ongoing degenerative processes, which are also partially responsible for this patient's problem."

Dr. Pasquesi goes on to indicate that the effects of the accident had stabilized but that the degenerative process probably would continue. However, claimant need only show that the residuals of the industrial injury are a material contributing cause of her present need for medical services and Dr. Pasquesi's report supports such a finding.

In addition, Dr. Hoff, claimant's present treating physician, opined as follows:

> "It is my feeling, from the history taken from the patient, that the scapular pain indeed is causally related to the injury. The low back, however, may indeed be the outcome of a natural process with intermittent periods of symptoms and alternating periods of well being.
>
> * * *
>
> "I feel the responsibility of the portion for the upper back was directly tied in with her November 21, 1970 injury. I am not able to place a direct causal relationship between the low back and that injury, however."

Dr. Hoff also took issue with two of the other physicians, including Dr. Reilly, because he did not find the extent of arthritic changes in claimant's back to be as marked as they did.

Dr. Reilly, whose report SAIF relied upon in denying further liability for claimant's back, etc. medical needs, focused almost exclusively on claimant's low back. As indicated above, he felt

claimant's low back problems were related to arthritic and other degenerative changes and not the 1970 injury.

Based on this evidence, we are persuaded that claimant's present low back problems are not causally related to her 1970 injury but that her upper back and shoulders problems are, and to that extent we find that those conditions remain compensable. We recognize that our Solomonesque disposition of this case is somewhat artificial in that treatment for compensable conditions may also treat noncompensable conditions or parts of the body. However, to the extent that the treatment for the lower back can be distinguished from the upper back and shoulder problems, SAIF should not be liable for treatment directed at the lower back. One way is suggested by the evidence and argued by SAIF, namely, that claimant's upper back and shoulder conditions are soft tissue strain/sprains, while her low back condition is more of a skeletal arthritic problem. To the extent that medications are designed to treat skeletal conditions as opposed to musculoligamentous conditions, they would not be compensable.

ORDER

The Referee's order dated September 30, 1982 is affirmed in part and reversed in part. With respect to claimant's low back condition, SAIF's denial of January 18, 1982 is affirmed; with respect to the remainder of the previously accepted conditions, the denial is reversed and the claim is remanded for payment of compensation as required by law. Claimant's attorney is awarded $1000 as a reasonable attorney's fee for his services on behalf of claimant at hearing and on review, payable by the SAIF Corporation.

WILLIAM L. WILLIAMS, Claimant
Doblie et al., Claimant's Attorneys
Rankin, McMurry et al., Defense Attorneys

WCB 81-05283
May 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer and its insurer request review of Referee McCullough's order which set aside the May 22, 1981 Determination Order as premature and ordered the insurer to pay claimant benefits for temporary total disability from July 11, 1980 until closure pursuant to ORS 656.268. The insurer contends that the Referee erred in finding the Determination Order to have issued prematurely.

Claimant, then 57 years of age, sustained a compensable low back injury on March 6, 1978 while employed as a faller for Willamette Industries. The 801 form indicates that claimant strained his back while carrying a large powersaw. The claim was accepted as a disabling injury. On or about June 11, 1978 a myelogram was performed which revealed a partial block at L4-5. On June 19, 1978 Dr. Tsai performed decompressive laminectomies from the L4 to S1 levels and an L4-5 discectomy.

Claimant continued to receive conservative care from Drs. Tsai and Miller. Due to persistent complaints of pain, Dr. Miller ordered a second myelogram, which was performed on March 20, 1979.

Dr. Miller reported on April 5, 1979 that the myelogram demonstrated probable arachnoiditis at the L4-5 levels and an extradural defect at the L4-5 interspace. Claimant was examined by the Orthopaedic Consultants on April 16, 1979. The Consultants concluded that claimant's condition was not stationary and stated that psychological examination was indicated in order to assist with future vocational guidance. The Consultants felt that once claimant was stationary, that he would be able to perform only light or partially sedentary work.

Claimant was subsequently referred to David Rollins, a vocational consultant, for an assessment of vocational potentials for claimant. On May 15, 1980 Mr. Rollins reported that claimant's vocational file was being closed since it appeared an unlikely possibility that claimant could be successfully returned to employment, and:

> "We have a fifty-six year old, thrice married man, whose only gainful employment roles have been in heavy laboring functions. I found him to be quite distressed over his status. Someone who appears to be in genuine physical and pain distress, and a person who has made a poor adjustment to his circumstances. It was even revealed at one point in our discussions with him that he has become occasionally so depressed that he has held a weapon to his head and contemplated suicide."

Claimant was referred by the insurer for a psychiatric examination by Dr. Quan. On July 10, 1980 Dr. Quan reported that claimant did admit to suffering some depression from being unable to work and that he admitted to having some transient suicidal thoughts in the winter of 1978, but denied ever having threatened suicide. Dr. Quan concluded:

> "I am unable to diagnose a psychiatric disorder. The patient appears to be a man in his fifties who has always done heavy labor. Though there is intellectual ability, he lacks the skills that result from an adequate formal education. Psychologically, he seems to have made an adjustment to his current situation. As a result, he is not highly motivated to resume work unless it is in the area of his previous experiences. However, I do not find psychiatric impairment which would preclude his performing gainful employment."

Claimant was thereafter referred to the Callahan Center. Claimant was examined by Dr. Wise, a psychologist. Dr. Wise concluded that claimant was experiencing a moderate amount of depression and a moderate amount of personality disturbance with a tendency to convert social and emotional problems into physical symptoms. Dr. Wise stated that it was unlikely that claimant would return to employment without some psychological intervention in the form of short-term counseling, and that medication may be benefi-

cial to reduce the effects of his depression. No such counseling was sought by claimant.

A Determination Order issued on May 22, 1981 awarding claimant 40% unscheduled permanent partial low back disability and temporary total disability benefits from March 10, 1978 through July 10, 1980. Presumably, the July 10, 1980 date is based on Dr. Miller's report of July 9, 1980 in which he states that claimant's condition is medically stationary, although chronic.

On June 16, 1981 claimant was hospitalized for another myelogram. Apparently, at the request of claimant's attorney, claimant was examined by Dr. Ackerman, a psychologist, on July 22 and July 23, 1981. Dr. Ackerman diagnosed claimant as suffering from moderate chronic depression and moderate episodic anxiety and obsessional worry as a result of the industrial injury. Dr. Ackerman further stated that a certain degree of claimant's pain was probably related to his depression and that the pain impaired his ability to be employed.

Claimant was reexamined by Dr. Quan on September 30, 1981. Dr. Quan concluded that claimant had increased symptoms of depression sufficient for him to conclude that he was suffering from depression, which could be viewed as having some effect on claimant's physical condition and contributing to the symptoms of which he complained. Dr. Quan stated that the severity of the depression was not significant enough to interfere with claimant's ability to function in a job. Although he advised treatment, he felt that claimant would not improve until there was a resolution of his disability claim. On October 5, 1981 Dr. Quan reported that claimant could receive treatment and work simultaneously:

> "In my experience, I have had patients with the equivalent degree of depression that Mr. Williams has, and they continued to be employed and apparently functioned in a productive way. I feel that Mr. Williams would resist seeking or holding employment, but in any treatment program for Mr. Williams, work must be considered as part of the therapy."

In April of 1982 Dr. Kendrick reported that claimant had exhibited a worsening of his condition in mid-1981. At the time of the hearing, the claim had been reopened retroactive to May 1981.

Several issues were presented to the Referee for determination: (1) whether or not claimant was medically stationary during the period from July 11, 1980 through May of 1981, when the claim was reopened; (2) if claimant was stationary, whether or not he was permanently and totally disabled at the time the claim was closed; (3) if claimant was stationary, whether or not the insurer was entitled to take a credit for the temporary disability benefits paid from the medically stationary date to the date the Determination Order issued; and (4) whether the insurer is subject to penalties and attorney's fees for its conduct in taking a credit for the overpayment against the permanent disability award made by the Determination Order.

The Referee concluded that claimant was not medically stationary as of July 10, 1980 and that the Determination Order had thus issued prematurely. Although orthopedically stationary, the Referee found that claimant was not psychologically stationary. Since the Referee found claimant was not medically stationary from July 10, 1980 to the time the claim was reopened in May of 1981, the Referee did not reach the issue of permanent disability. With regard to the issues involving the overpayment, since he found the Determination Order to have issued prematurely, the Referee found that the insurer was not entitled to the overpayment, but that it had not acted unreasonably in deducting the perceived overpayment from the award of permanent partial disability.

The insurer argues strenuously that the Referee erred in finding the Determination Order to have issued prematurely, and that the Referee relied on inappropriate evidence in making his determination. We agree with the insurer that the evidence does not support claimant's contention that he was not medically stationary as of July 10, 1980. Although the Referee acknowledged that Dr. Quan could not find any evidence of a psychiatric problem which would interfere with claimant's ability to work when he first examined him, the Referee stated there was other evidence in the record which caused him to doubt this conclusion. Specifically, the Referee relied heavily on the comments made by Mr. Rollins, the vocational counsultant, in his report of May 15, 1980 concerning his observations of claimant's depression. The Referee also relied on the comments made by Dr. Wise of the Callahan Center in his report of August 28, 1980. The Referee made no mention of the second report from Dr. Quan. On reconsideration, the Referee refused to alter his position.

We find that the claimant was medically stationary as of July 10, 1980 and remained so until the claim was reopened in May of 1981. The crux of the insurer's argument is that the Referee, with no basis for doing so, rejected the opinion of the more qualified expert, Dr. Quan, and accepted the opinion of a vocational counselor concerning claimant's psychiatric status. We agree with the Referee that Mr. Rollins may be competent to testify as to the facts of his observations. James Albers, 34 Van Natta 1622 (1982). However, we agree with the insurer that as to the question of whether or not claimant is suffering from a psychiatric condition which would interfere with claimant's employability, Dr. Quan's opinion must be given controlling weight. As we noted in Herb Ferris, 34 Van Natta 470 (1982), we will generally accept scientific evidence as a "higher" form of evidence over lay testimony. As we noted in Lavona Hatmaker, 34 Van Natta 950 (1982), when there is a conflict in the evidence as to whether or not a worker is medically stationary, we will generally look to the relative expertise of the witnesses. As an aside, we note that Mr. Rollins' comments were made almost two months prior to Dr. Quan's examination of claimant. All facts considered, we are more persuaded by Dr. Quan's opinion than by Mr. Rollins' comments.

Mr. Rollins' observations were not the only evidence relied upon by the Referee. There is also the August 28, 1980 report of Dr. Wise, who certainly is qualified to render an opinion as to claimant's psychological status. The question, however, is whether Dr. Wise's report indicates that claimant is medically unstationary. We think not.

The most that Dr. Wise was able to diagnose was moderate depression and a tendency for claimant to convert emotional problems into physical symptoms. The fact that some short-term counseling was recommended by Dr. Wise does not necessarily indicate an unstationary psychological condition. Dr. Quan noted in his letter of October 5, 1981 that claimant could receive such counseling while working. Dr. Wise's recommendation seems more geared to helping claimant cope with his condition rather than for treatment for a specific psychiatric condition. Even when Dr. Quan examined claimant again in September of 1981, he did not find a problem significant enough to interfere with claimant's ability to be employed, and felt it unlikely that claimant would return to work until the litigation over his workers compensation claim was over. In short, there is no evidence in the record of any psychiatric impairment that would interfere with claimant's ability to work. We also note that despite the recommendation of Dr. Wise that claimant receive some short-term counseling, that claimant neither received nor sought such counseling, even though the insurer never denied any claim for such psychological treatment. We think that the most that can be said of Dr. Wise's recommendation for short-term counseling is that it may indicate a need for palliative psychological treatment, that could be provided pursuant to ORS 656.245, had claimant been interested in receiving such treatment. See Charles A. Murray, 34 Van Natta 249 (1982). We, therefore, agree with the insurer that there is insufficient evidence in this record to conclude that claimant was psychologically unstationary at the time he was found orthopedically stationary.

Claimant urges that if we find that the Determination Order did not prematurely close the claim, we should find claimant permanently and totally disabled as of July 10, 1980. We decline to do so. At the time of the hearing the claim was in open status, having previously been reopened by the insurer. In Gary Freir, 34 Van Natta 543 (1982), we concluded that it was error for the Referee to order reopening of a claim and at the same time rate the extent of claimant's disability. The current situation is analogous, and Leedy v. Knox, 34 Or App 911 (1980), is not controlling since the claimant in that case was medically stationary and awaiting entrance in a vocational rehabilitation program.

Claimant argues that if we find that he was medically stationary as of July 10, 1980, that we should not allow the insurer to recover the overpayment of temporary total disability benefits made to him between the July 10, 1980 medically stationary date and the May 22, 1981 date upon which the Determination Order issued, and that we should assess penalties and attorney's fees against the insurer for its delay in submitting the claim for closure. Although we regard the delay in submitting the claim for closure to be unusual, we find no basis for allowing claimant the relief which he requests. Claimant received everything to which he was entitled, and he should receive no more than he is entitled to receive. The insurer should, therefore, be allowed to setoff the overpayment.

Claimant also argues that penalties and attorney's fees should be assessed against the insurer for its "unreasonable" delay in submitting the claim for closure and that ORS 436-65-010(4)

requires that insurers request determination of a claim within ten working days after the date the claim qualifies for determination. It is true that the rule so requires. However, it is also a familiar legal principle in workers' compensation that penalties and attorney's fees may not be allowed absent express statutory authority. Korter v. EBI Companies, 46 Or App 43 (1980). There is no such authority for penalties and attorney's fees in this situation.

There is one additional matter involving the alleged overpayment that requires comment. We note that the claim was reopened in May of 1981, very near in time to the date that the May 22, 1981 Determination Order issued. Once claimant becomes medically stationary again, a second Determination Order will issue, and the matter of the extent of claimant's disability will then be ripe for determination. It is possible that claimant may be found permanently and totally disabled and, if so, a specific date will necessarily have to be selected. It is indeed possible that the issue with regard to this alleged overpayment may once again arise in relation to any future finding concerning claimant's extent of disability, and we do not mean to preclude any such issue by our determination here.

ORDER

The Referee's order dated July 12, 1982 and his Order on Reconsideration dated August 30, 1982 are reversed. The May 22, 1981 Determination Order is affirmed.

CURTIS H. BEST, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-05481
May 18, 1983
Corrected Order of Remand

The Board's Order of Remand dated March 23, 1983 states that surgery was performed on claimant's right arm in June of 1980 "in Seattle, Washington." Claimant's attorney has advised us that the surgery in question was actually performed in Eugene, Oregon. While the record is not now before us, having been returned to the Hearings Division under the terms of our Order of Remand, we accept counsel's suggestion that our Order of Remand was in error and hereby correct that order accordingly.

IT IS SO ORDERED.

WILFRED PULTZ, Claimant
Welch, Bruun et al., Claimant's Attorneys
John E. Snarskis, Defense Attorney
Breathouwer & Gilman, Defense Attorneys

WCB 81-07620 & 81-08633
May 18, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer, Industrial Indemnity Company, requests review of Referee Mulder's order which found it responsible for an aggravation of claimant's 1979 injury. Industrial Indemnity claims that responsibility for the condition of claimant's back in 1981 is properly assigned to Mission Insurance, which provided the employer's workers' compensation coverage on and after January 1, 1981. Industrial Indemnity also assigns as error the Referee's award of $1,200 to claimant's attorney as an attorney's fee for prevailing on a denied claim.

We affirm and adopt that portion of the Referee's order assigning responsibility to Industrial Indemnity for the condition of claimant's back in 1981 as an aggravation of claimant's 1979 injury. We reverse that portion of the Referee's order awarding claimant's attorney $1,200 as a reasonable attorney's fee for prevailing on a denied claim.

The issues at hearing were responsibility for claimant's low back condition in 1981 and extent of permanent disability. Claimant was contesting denials issued by Mission Insurance, the new injury insurer, denials issued by Industrial Indemnity, the aggravation insurer, and a Determination Order dated March 23, 1982 which awarded claimant 5% unscheduled permanent partial disability for a February 1, 1981 injury to his low back. An Order Designating Paying Agent Pursuant to ORS 656.307 had been entered by the Compliance Division of the Workers' Compensation Department on September 22, 1981, designating Mission Insurance as the paying agent, and the Determination Order designated Mission as the responsibile insurer. When the hearing convened on May 13, 1982, counsel for the insurers appeared to litigate the question of responsibility for claimant's low back condition, and claimant and his attorney were present to litigate the extent of his permanent disability.

The Referee declined to award claimant any permanent disability in addition to that granted by the March 23, 1982 Determination Order, finding that award, together with prior awards received by claimant, adequately compensated him for his low back disability. No review of that portion of the Referee's order has been requested by any party to this proceeding. The Referee upheld the denials issued by Mission Insurance, set aside the denials issued by Industrial Indemnity, remanding to that insurer claimant's aggravation claim, and ordered Industrial Indemnity to pay claimant's attorney $1,200 in addition to claimant's compensation. Industrial Indemnity challenges this award of attorney's fees, presumably awarded by the Referee pursuant to ORS 656.386(1) and OAR 438-47-020.

We have previously addressed the question of entitlement to an award of an attorney's fee in cases involving only issues pertaining to responsibility between employers or insurers. Entitlement to an attorney's fee in such cases is governed by OAR 438-47-090, which provides, in pertinent part:

"If a claimant hires an attorney after being advised by both carriers that:

(a) The sole issue before the Referee at a hearing is which of two carriers is responsible for the payment of compensation to claimant; and

(b) An order has been issued pursuant to the provisions of ORS 656.307 designating one as the paying agent pending determination of the responsible parties; and

(c) The dispute is solely between them, that there is no question of the compensability of claimant's injury or illness, that any involvement of claimant would be solely as a witness, and that therefore it is not necessary that claimant be represented by an attorney

then the attorney will receive no fee unless he/she actively and meaningfully participates at the hearing in behalf and in defense of claimant's rights." OAR 438-47-090(1).

In Robert Heilman, 34 Van Natta 1487 (1982), we concluded that this administrative rule governed an attorney's entitlement to a fee on Board review where the only issue was responsibility; we interpreted "active and meaningful participation" to mean that claimant must advocate a position that is adverse to one of the potentially responsible employers or insurers. 34 Van Natta at 1488. In Brent Bennett, 34 Van Natta 1563 (1982), we applied our interpretation of the administrative rule in Heilman to find that the responsible insurer was not obligated to pay claimant's attorney a fee where that insurer had denied only responsibility, had not requested claimant's presence at the hearing, and claimant's attorney took no active role in litigating the issue of responsibility as between the two potentially responsible insurers. 34 Van Natta at 1564.

In this case, it is quite apparent that neither claimant nor his attorney had any preference, either expressed or implied, concerning which insurer would be found responsible for payment of claimant's compensation. In fact, in his opening remarks, claimant's attorney stated that counsel for the insurers were in attendance to litigate the issue of responsibility, and he was present to establish claimant's entitlement to an additional award of permanent disability. While counsel's statements are not dispositive, the line of questioning at hearing makes it readily apparent that claimant, in fact, was present to litigate only the issue of

extent of disability, regardless of which insurer would be responsible for payment of the compensation for permanent disability.

Under these circumstances, we do not believe that the applicable administrative rule allows the Referee or this Board to award claimant's attorney an attorney's fee for counsel's services at hearing. Claimant's attorney would have been entitled to a fee payable out of claimant's award of compensation had the Referee increased claimant's permanent disability award. OAR 438-47-025. Claimant's attorney was not instrumental in obtaining an increased award of compensation in behalf of claimant; nor did he actively and meaningfully participate in litigating the responsibility issue; therefore, it follows that claimant's attorney is not entitled to receive an attorney's fee under the applicable administrative rules.

On review claimant's attorney has filed a brief in defense of the Referee's award of an attorney's fee, contending that he appeared at the hearing, not only for the purpose of presenting the evidence regarding extent of disability, but also to be certain that a compensability issue was not raised and decided in his absence. We conclude, however, that if claimants' attorneys are to be granted "an appearance fee" in cases involving only issues of responsibility, then the administrative rules governing attorney's fees will have to be changed accordingly. For purposes of the present case and others like it, we are bound by the current administrative rules.

ORDER

The Referee's order dated September 2, 1982 is reversed in part. That portion of the order which awards claimant's attorney $1,200 as a reasonable attorney's fee for services at the hearing is reversed. The remainder of the Referee's order is affirmed.

RICHARD L. DUTTON, Claimant
Zafiratos & Roman, Claimant's Attorneys
David Horne, Defense Attorney

WCB 81-01346 & 81-01347
May 19, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of that portion of Referee Menashe's order which awarded claimant 10% unscheduled permanent disability for his October and November 1979 back injuries. The insurer contends that claimant has no permanent impairment and, therefore, claimant is not entitled to an award for permanent disability. We agree and, therefore, modify the Referee's order.

This is an unusual case in our experience. If we were to rely solely on the medical evidence, we would be inclined to affirm the Referee's award of permanent disability. The latest medical report, one from Orthopaedic Consultants dated February 24, 1982, indicates that claimant is medically stationary and that he suffers from chronic thoracic strain and possible thoracic radiculopathy. However, permanent disability is rated at the time of the hearing.

Gettman v. SAIF, 289 Or 609, 614 (1980). Claimant's own hearing testimony convinces us that he had no cognizable permanent physical impairment at that time.

Claimant testified that about three months before the hearing, and after the Orthopaedic Consultants' examination, he arose rapidly from bed one morning and felt a popping in the area of his back which had been injured. Claimant continued: "And in about a three day period it left, and since then I feel just like I did before I originally got hurt [on the job in 1979]." Upon further questioning by his attorney, claimant indicated that he has some stiffness at night but that the stiffness resolves within five minutes of arising in the morning.

The courts have ruled that "pain" is not a cognizable form of impairment, but that "disabling pain" -- pain that reduces earning capacity -- is a cognizable form of impairment. We assume the same concepts would apply to "stiffness" as a form of physical impairment.

We find no "disabling stiffness." According to claimant's testimony, his minor stiffness resolves within five minutes after arising. We do not think that brief morning stiffness has any negative impact on claimant's earning capacity.

ORDER

The Referee's order dated July 18, 1982 is modified. That portion which awarded claimant 10% unscheduled permanent partial disability is reversed. The remainder of the Referee's order is affirmed.

GARY PARKER, Claimant
Emmons, Kyle et al., Claimant's Attorneys
Lindsay, Hart et al., Defense Attorneys

WCB 81-09988
May 19, 1983
Order of Abatement

The employer/insurer has moved for reconsideration of the Board's Order of Remand dated April 27, 1983. To allow sufficient time to consider the motion, that Order of Remand is hereby abated.

Claimant's attorney is directed to file a response to the motion of the employer/insurer for reconsideration. Said response should include the claimant's position on question of how the Board should resolve an apparent conflict in the factual representations of counsel regarding compliance with OAR 436-83-460. Said response should be filed within 10 days of the date of this order.

IT IS SO ORDERED.

BILLY J. SHEFFIELD, Claimant
Pozzi et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-00504
May 19, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee McCullough's order which awarded 80° for 25% unscheduled disability for claimant's neck injury. The January 7, 1982 Determination Order had awarded no compensation for permanent disability.

There is one unusual feature to this case. Normally we consider disability as it exists at the time of hearing. However, at the conclusion of the July 13, 1982 hearing the parties stipulated that disability be rated as of the time of claim closure in January 1982. Because of the terms of this stipulation, we find most of claimant's hearing testimony to be irrelevant because it discusses disability in the present-tense (July 1982) rather than the past-tense (January 1982). Looking solely to the medical evidence as of the earlier date, we find the Referee's award to be excessive.

Claimant was injured on July 28, 1980 when struck on the right shoulder and neck by a 4" x 6" wood girder. Claimant completed his work shift on July 28 and continued working for about another week until he was laid off. Claimant first sought medical attention in October 1980.

Over the following thirteen months, claimant was treated or examined by Drs. Rabin, Bernstein, Bert, Matteri and Yamodis. All agreed that claimant's condition was a cervical strain. A myelogram was found to be basically normal.

Dr. Bert's report dated December 9, 1981 was the last report prior to claim closure:

> "CURRENT STATUS: This patient is still complaining of some neck pain. He is requiring an occasional Phenaphen #3 but has been doing light and light moderate activity.
>
> "PHYSICAL EXAMINATION: On exam he has a full range of motion of his neck. No gross motor or sensory impairment. He is tender over the posterior spinous elements of the lower cervical spine. Grip strength is good. Biceps, triceps, brachial radialis reflexes are brisk and equal. There is no obvious motor or sensory impairment.
>
> "IMPRESSION: I believe he has a prolonged cervical strain pattern which will leave him with some permanent impairment and will not allow him to be a full duty carpenter but he could be retrained for light to light moderate activity.

"RECOMMENDATION: I am going to recheck only on a prn basis. I feel his claim can be closed on the above basis."

Although Dr. Bert's (and most other doctors') examination findings seem somewhat inconsistent with the conclusion of "some permanent impairment," we resolve doubt in claimant's favor and accept the opinion that there is some unknown form of de minimis physical impairment.

Claimant was 42 years old at the time of claim closure. He completed high school and briefly attended junior college. In addition to carpentry/construction work that claimant was doing at the time of his injury, claimant has worked as a truck driver, prison guard, cement layer, gas station attendant, city maintenance worker and in some position connected with deisel mechanics. The Referee interpreted the evidence to mean that claimant was physically precluded from carpentry. We are not persuaded. We note that claimant did volunteer carpentry/construction work for his church during the summer of 1981. As of claim closure in January 1982, the most that we think can be said is that claimant was precluded from the heaviest forms of carpentry. It would appear, however, that truck driving -- a job claimant performed for 10 to 12 years -- was well within his physical capacities.

As of January 1982, claimant's physical impairment was de minimis; his age and education were average; his work experience ran the guantlet from light (guard) to moderate (driver) to heavy (cement work); and he was still physically able of performing most of these jobs, with only possible preclusion from the heaviest forms of these jobs. For all of these reasons and in light of the parties' hearing stipulation, we think that claimant would be properly compensated for his loss of earning capacity by an award of 32° for 10% unscheduled disability.

ORDER

The Referee's order dated July 6, 1982 is modified. Claimant is awarded 32° for 10% unscheduled permanent partial disability for July 1980 cervical injury; this award is in lieu of all prior awards. Claimant's attorney's fee should be adjusted accordingly.

CHARLES L. THORNTON, Claimant
McNutt, Gant et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys
Lindsay, Hart et al., Defense Attorneys

WCB 81-11025 & 81-10272
May 19, 1983
Order on Review
(Includes correction dated 5-31-83)

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Baker's order which found it partially responsible for payment of claimant's compensation arising out of an incident occurring on August 26, 1981. This is a case involving a question of responsibility between two employers, the issue being whether the 1981 incident represents a new injury or an aggravation of a 1979 injury.

The SAIF Corporation insures the employer, Beecroft Logging, claimant's employer at the time of a July 1, 1979 injury to claimant's right knee. EBI Companies insures D. L. Logging, claimant's employer on the date of the August 26, 1981 incident, which involved a fall and twisting of the same knee. The Referee found that the August 19, 1981 incident represents a new injury which is the responsibility of D. L. Logging and EBI Companies. The Referee overturned the denial of claimant's new injury claim and remanded that claim to EBI for acceptance and processing according to law. No review has been requested from this portion of the Referee's order determining that claimant's August 26, 1981 injury represents a new injury.

Based upon the reports of claimant's treating physician, the Referee also determined that the consequences of claimant's new injury on August 26, 1981, in terms of its relative contribution to the overall condition of claimant's right knee, represented only a temporary worsening of claimant's right knee condition, the consequences of which subsided on November 10, 1981. He thus remanded the new injury claim to EBI for payment of medical services and temporary disability compensation only until November 10, 1981. The Referee then proceeded to set aside SAIF's denial of claimant's aggravation claim, and ordered it to accept the claim as of November 10, 1981, remanding claimant's aggravation claim to SAIF for processing as of that date, including submitting the claim for closure pursuant to ORS 656.268. This is the portion of the Referee's order which gives rise to SAIF's request for review. SAIF contends that the Referee went beyond the scope of the issue before him, which SAIF claims is the sole question of whether the August 26, 1981 incident represents an aggravation of claimant's 1979 injury or a new injury. SAIF characterizes the portion of the Referee's order reversing its denial and remanding the claim for acceptance and processing as of November 10, 1981 as a determination of responsibility in futuro, which SAIF claims was not an issue before the Referee.

To the extent that the parties' arguments on review present an issue concerning the propriety of the Referee's finding that claimant sustained a new injury on August 26, 1981, which is the responsibility of EBI Companies and its insured, we agree with this finding and affirm this portion of the Referee's order. We reverse that portion of the Referee's order which sets aside SAIF's denial of claimant's aggravation claim and directs it to

accept and process the claim arising out of the August 1981 incident as of November 10, 1981.

EBI denied claimant's claim for injury of August 26, 1981 by an October 30, 1981 denial, stating in pertinent part:

> "Your condition has been diagnosed as degenerative arthritis and an old tear of the anterior cruciate. Medical documentation indicates this condition is not the result of the incident on August 26, 1981, but that this condition is an aggravation of a preexisting problem related to an old injury."

On January 8, 1982 SAIF denied claimant's aggravation claim. SAIF's denial stated in part:

> "Aggravation is a natural worsening of the condition caused by your original injury without a new accident or incident. Based on a careful review of all information in your file, we must inform you that we cannot accept your claim for aggravation. According to the medical information in your file, you enjoyed a complete recovery with no impairment from your July 1, 1979 accident. Our information also reveals that you then sustained a new incident in August of 1981 which resulted in right knee pain. It is our opinion, therefore, that
>
> based on this sequence of events, your current right knee problem is a direct result of this accident and cannot be considered an aggravation of your earlier injury while employed by Beecroft Construction Company."

An Order Designating Paying Agent Pursuant to ORS 656.307 was entered by the Compliance Division on March 3, 1981, designating EBI Companies as the paying agent responsible for claimant's compensation and referring the issue of insurer responsibility to the Hearings Division for resolution. The hearing convened, and the issue was framed by the Referee as follows: "A 307 order has been entered and it would appear that the basic issue is whether claimant's condition should be accepted by SAIF as an aggravation of the 1979 injury or should be accepted by EBI as a new injury. Is that correct?" Counsel for claimant and both insurers agreed with the Referee's statement of the issue.

It is typical in cases involving questions of employer or insurer responsibility for medical reports to create confusion rather than clarify issues. This case is characteristic. Dr. Whitney was claimant's attending physician after his August 1981 injury. A January 13, 1982 report from Dr. Whitney to SAIF admits the difficulty, if not impossibility, of answering the responsibility question posed.

"Having seen Mr. Thornton only after his latest injury, I can state that his anterior cruciate tear, which definitely leads to degenerative arthritis of the knee was old preexisting the latest injury, his degenerative arthritis and degeneration of the menisci. It was impossible by looking at him at that time whether these were acute-on-chronic or mostly chronic injuries. He does seem to be somewhat worse in his description of the discomfort after his last injury than he was before, but I feel the outcome of the knee was determined by his previous injuries, and even relatively minor injuries could make him more symptomatic after the preexisting degenerative arthritis and ligamentous injury."

In a February 24, 1982 report to claimant's attorney, Dr. Whitney stated that claimant's original 1979 injury was the basic problem with regard to claimant's current condition.

"The degenerative condition of his knee was preexisting. While the second injury caused some increase in discomfort, the condition of the knee was pre-existent, and I feel that this is what is causing his symptomatic problems."

In a letter to SAIF's attorney of the same date, Dr. Whitney reported:

"At the time of arthroscopy on Mr. Thornton, a lot of old injury was obvious in the knee. There was very little new aggravation of the injury. This was obviously pre-existed [sic]. The more recent injury he had just prior to my seeing him. At the time of arthroscopy there was very little evidence of new injury to the knee. I think probably what happened was a manipulation of the knee and a severe symptomatic worsening of the knee, due to the manipulation, whereas the original problem was present."

A March 10, 1982 report from Dr. Whitney to SAIF's attorney states the following conclusions:

"1. The most recent injury was the injury which brought the patient in to see me; the fall in which he twisted his knee over some sticks.

"2. The 'more recent injury' would have been the one I referred to as a manipulation of the knee.

"3. To what extent the 'more recent injury' contributed to the previous problem of the knee, I would have to say that the problem was preexisting, and the manipulation of the knee that he did probably accelerated the problem which the patient is complaining about. But I saw on inspection of the knee at time of arthroscopy no evidence of severe recent injury within the knee.

"4. Mr. Thornton was unable to work due to combination of the previous injury and the new injury. I feel that the new injury caused his immediate loss of occupation and work loss until November 10th, at which time a further loss would [be] related to his old injury of preexisting condition. The severity of the new injury should have been healed at that time."

The Referee relied upon Dr. Whitney's statement that the effects of claimant's August 19, 1981 injury resolved on November 10, 1981 to conclude that any time loss and medical services incurred after November 10, 1981 would be as a result of claimant's preexisting condition. The Referee apparently failed to note Dr. Whitney's office note of November 10, 1981, indicating that claimant could be released to return to work:

"I think we can release him to go to work as of Monday, however, he tells me that there is not a job right now. But we will still have to release him as of Monday, and check him back in a month. He has a lot of problems there, but we will have to see if he can work."

This evidence of claimant's apparent ability to return to work in November 1981, which seemingly formed the basis for Dr. Whitney's conclusion that the effects of claimant's new injury had essentially resolved by that date, is relevant to the question of the compensable consequences attributable to claimant's new injury, i.e., the extent of temporary total disability attributable to claimant's August 1981 injury. This is a determination that should be made by the insurer and possibly the Evaluation Division in the first instance, once the question of new injury versus aggravation has been determined and responsibility assigned to the proper insurer. See ORS 656.262, 656.268. The effect of the Referee's order is to determine that claimant's new injury in August 1981 had only temporary consequences, and that any continuing problems associated with claimant's right knee would be the responsibility of SAIF as an aggravation of the 1979 injury. This goes beyond the issue actually litigated by the parties, i.e., whether claimant's August 1981 incident represented a new injury or an aggravation of claimant's earlier industrial injury. Although the question of ongoing responsibility for the condition of claimant's knee is an issue that might have been resolved at this hearing, if the parties understood that it was one of the issues to be decided, we are satisfied from our review of the record that the focus of all

parties was solely the question of new injury versus aggravation. Once the Referee found claimant's August 1981 incident to be a new injury, he should have remanded the new injury claim to EBI Companies for acceptance and processing pursuant to ORS 656.262 and 656.268. It was error to also set aside SAIF's aggravation denial.

SAIF has moved the Board to remand this case to the Referee for further evidence taking concerning the question of ongoing responsibility for the condition of claimant's right knee. See ORS 656.295(5). We have been advised by the parties that there are other proceedings pending in the Hearings Division, apparently involving an aggravation claim filed by claimant against both employers. We agree with the Referee's finding that claimant's August 1981 incident represents a new injury. Accordingly, claimant has the right to file an aggravation claim against both employers, and the question of responsibility for claimant's ongoing need for medical services and/or disability compensation should be resolved in the proceedings arising from claimant's aggravation claim or claims. Cf. Carlton A. Spooner, 34 Van Natta 1594 (1982). Accordingly, we find it unnecessary to remand this case for further proceedings.

ORDER

The Referee's order dated September 22, 1982 is reversed in part. That portion of the Referee's order which sets aside the SAIF Corporation's denial of claimant's aggravation claim is reversed and that denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

JOYCE C. COOK, Claimant
Carney, Probst et al., Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 82-00076
May 20, 1983
Order on Reconsideration

The insurer requests reconsideration of the Board's Order on Review dated April 29, 1983. The insurer contends that our order appears to place the burden of proof on the insurer to show that claimant's ongoing symptoms are no longer related to her industrial injury.

No such implication was intended. We found and still find that the preponderance of evidence establishes that claimant's continuing symptoms are related to her accepted injury and subsequent surgeries. Claimant has met her burden of proof and, on reconsideration, the Board adheres to its former order.

IT IS SO ORDERED.

WILLIAM B. HESS, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Spears, Lubersky et al., Defense Attorneys

WCB 81-11152
May 20, 1983
Order on Reconsideration

The employer, Pacific Motor Trucking Company, requests reconsideration of our April 21, 1983 Order on Review in the above-entitled matter. The employer advises that on pages one and two of our order, we referred to claimant's 1976 low back injury

and that such should be corrected to read claimant's 1981 low back injury.

On reconsideration, we agree that the 1976 date is in error; the correct date of claimant's low back injury should read 1981. We, therefore, amend our previous order as requested. The Order on Review is amended and republished.

IT IS SO ORDERED.

GEORGE R. MAHONEY, Claimant
Coons & McKeown, Claimant's Attorneys
Schwabe et al., Defense Attorneys

WCB 82-05028
May 20, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Mulder's order which upheld the self-insured employer's denial of claimant's knee injury claim. The Referee reasoned that claimant's injury, suffered in an off-premises softball game, did not arise within the course of claimant's employment under the standards articulated in Richmond v. SAIF, 58 Or App 354 (1982).

We are unable to perceive any meaningful distinction between the facts of this case and the facts in Richmond, and, therefore, affirm and adopt the Referee's order.

ORDER

The Referee's order dated November 19, 1982 is affirmed.

GEORGE BEDSAUL, Claimant
Galton et al., Claimant's Attorney
Wolf, Griffith et al., Defense Attorneys

Claim # C-8121527
May 24, 1983
Interim Order Approving Third Party Settlement and Order of Partial Distribution

Claimant requests the Board to exercise its authority pursuant to ORS 656.587 and approve a settlement of claimant's third party action. The paying agency, EBI Companies, has withheld its approval of the settlement offer made by the third party defendant because of a dispute concerning the proper procedure for distribution of the settlement proceeds.

Claimant was involved in a trucking accident in California in December 1980. He sustained an injury to his right upper extremity. He filed a civil action. Claimant's attorneys obtained a settlement offer in the amount of $17,197.20 and sought EBI's approval of the settlement. When claimant sought approval from EBI, apparently in October or November of 1982, claimant's workers' compensation claim was in open status, and EBI's actual expenditures for compensation paid to claimant were approximately $88. In soliciting EBI's approval for the settlement, claimant's attorney apparently represented that claimant would waive any payment of compensation for temporary total disability or permanent partial disability "until recoupment" by EBI of the balance of the recovery paid claimant after satisfaction of EBI's lien for actual expenditures to date. See ORS 656.593(1)(d).

EBI responded by stating that it would approve the settlement of claimant's third party settlement subject to certain terms, which were that one-third of the settlement be applied to costs and attorney fees, one-third be paid to claimant and the residual be held in trust, "against EBI's lien, that lien to cover all of the costs of this claim through the first claim closure, including costs of litigation and a reserve for anticipated reasonable future expenses." EBI also stated that claimant's proposal for distribution of the proceeds of the third party recovery upon settlement was not acceptable and appeared to be in contravention of the Board's decision in Robert A. Parker, 32 Van Natta 259 (1981). The dispute has been submitted to the Board for resolution.

The reason that EBI is withholding its approval of the settlement of claimant's third party action is directly related to a dispute over how the proceeds of the settlement are to be distributed. Accordingly, an order approving the third party settlement pursuant to ORS 656.587 would be meaningless without also ordering the proper distribution of the proceeds pursuant to ORS 656.593.

We have previously concluded that, in exercising our authority to approve third party settlements pursuant to ORS 656.587, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant unless the settlement amount appears to be grossly unreasonable. Rose Hestkind, 35 Van Natta 250 (1983). EBI makes no contention in this case that the settlement offer is unreasonable. Rather, EBI's concern relates to claimant's proposal to immediately distribute the proceeds at a time that its potential claim costs are not yet known.

EBI has a lien against claimant's cause of action, which consists of "its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim. . . ." ORS 656.593(1)(c). The paying agency receives reimbursement from the proceeds of claimant's third party recovery in full or partial satisfaction of its lien, after the costs of litigation, including claimant's attorney's fee, are paid and claimant receives a minimum statutory percentage of the third party recovery. ORS 656.593(1)(a) and (b). Nothing in the statutes governing third party actions guarantees or contemplates that the paying agency will always have its statutory lien fully satisfied out of the proceeds of a third party recovery. Leon E. Cowart, 34 Van Natta 1597 (1982); James H. Roberts, 34 Van Natta 1603 (1982).

The paying agency is obligated to determine to a reasonable certainty whether and to what extent it will incur reasonably to be expected future expenditures for compensation in connection with the claim of a worker who has obtained a third party recovery, and once determined, such amounts must be retained by the paying agency. Robert A. Parker, supra, aff'd SAIF v. Parker, 61 Or App 47 (1982); LeRoy R. Schlecht, 32 Van Natta 261 (1981), reversed in part on other grounds, 60 Or App 449 (1982).

When claimant initially solicited EBI's approval of the third party's offer of settlement, the claim was in open status, and the possible residual impairment attributable to claimant's industrial injury was undetermined. As part of its submissions to the Board,

EBI has made available the report of Dr. Rosenbaum, who examined claimant on March 25, 1983. This report indicates that as of that date claimant's condition was stationary, and that the loss of function of claimant's upper extremity was in the area of mild. Prior to the date of that examination, claimant apparently had returned to his regular occupation as a truck driver, which would have provided the basis for termination of claimant's temporary total disability payments pursuant to ORS 656.268, although the claim could not be submitted for closure until a closing examination was conducted. It was thus unlikely that EBI would incur any additional liability for temporary disability payments even though claim closure had not been effected at the time claimant sought approval of the third party settlement. But see David Cheney, 35 Van Natta 21 (1983). There is no evidence to indicate that EBI has incurred any liability for temporary total disability compensation in excess of the expenditures incurred as of the time that claimant first sought approval of the settlement. EBI's expenditures for medical expenses are also a proper part of its lien against the proceeds of the third party recovery.

Dr. Rosenbaum's closing report may form the basis for an award of permanent partial disability upon closure of the claim by the Evaluation Division; however, we decline to attempt a determination of claimant's permanent disability, if any. We have previously held that where there has been a partial distribution of the proceeds of a claimant's third party recovery, pursuant to ORS 656.593(1)(a),(b) and (c), and the only remaining issue is whether the balance of the proceeds is to be paid to the worker or retained by the paying agency in whole or in part, we will defer ruling on the question of the insurer's anticipated future expenditures until the claimant's permanent partial disability is determined. John J. O'Halloran, 34 Van Natta 1504 (1982). Deferring such action

> "can cause little, if any, prejudice to either party where a partial distribution has been made and, in fact, advances the basic purposes of the third party recovery statutes, which are the payment of the worker's damages by the ultimate wrongdoer and the avoidance of a double recovery by the worker." O'Halloran, 34 Van Natta at 1504.

See also John J. O'Halloran, 34 Van Natta 1101, 1103 (1982), in which we stated a policy in favor of partial distributions pending Board resolution of disputed issues.

Accordingly, we will order a partial distribution of the proceeds of claimant's third party recovery, and hold in abeyance further proceedings concerning the proper distribution of the balance of the recovery, including any claim for reasonably to be expected future expenditures in the form of further medical expenses, until the claimant's permanent disability has been finally determined.

ORDER

Claimant is hereby authorized to settle his third party action

with the third party defendant herein for the amount stated in claimant's application to the Board. Upon receipt of the settlement proceeds, claimant shall make the following distribution: the costs of litigation shall be paid and claimant's attorney shall receive a reasonable attorney's fee in accordance with the retainer agreement and OAR 438-47-095; claimant shall receive one-third of the balance of the proceeds; EBI shall be paid and retain a sum equal to its expenditures to date for compensation paid to or on behalf of claimant, including temporary total disability payments and medical expenses. The remaining balance of the third party recovery shall be retained by claimant's attorney in trust for claimant until such time as a final determination has been made concerning the extent of claimant's permanent disability, at which time, upon being advised by the parties and receiving further evidence, the Board will order a distribution of the remaining balance.

PAULA E. BEYER, Claimant
Ferris Boothe, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05964
May 24, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Presiding Referee Daughtry's order dismissing her request for hearing for failure to prosecute.

Claimant filed a request for hearing on July 6, 1982. She indicated at that time that she had retained counsel. On September 1, 1982 the Board sent claimant's reported attorney a letter indicating that there had been no action on the case and requesting a status report. No response was received. On December 2, 1982 Referee Daughtry issued a show cause order requiring claimant to respond within 30 days and show cause why the case should not be dismissed or abandoned. No response was received to the show cause order. On January 20, 1983 Referee Daughtry dismissed the request for hearing. On January 23, 1983 claimant requested Board review and requested that the Board appoint an attorney for her because her attorney is still ill and unable to represent her.

We have no power to appoint an attorney for claimant. Our administrative rule, OAR 436-83-310, provides that a request for hearing may be dismissed for want of prosecution where there is a delay of more than 90 days without a showing of good cause. The Presiding Referee properly dismissed this case under that rule.

ORDER

The Presiding Referee's order of dismissal dated January 20, 1983 is affirmed.

KENNETH E. COX, Claimant
Coons & McKeown, Claimant's Attorneys
Macdonald et al., Defense Attorneys

WCB 82-03080
May 24, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Menashe's order which upheld the SAIF Corporation's denial of compensation for medical services pursuant to ORS 656.245. Claimant argues that there is sufficient evidence to establish that the medical treatment in question is related to his compensable injury of October 6, 1980. In the alternative, claimant argues for the first time on Board review that he has an occupational disease, that the medical treatments are related to that disease and are, therefore, compensable.

We affirm and adopt the Referee's order with the following additional comments. Although we do not understand that any issue of penalties or attorney fees has been raised on Board review, we nevertheless note that SAIF did not issue a proper denial of medical services as required by Billy J. Eubanks, 35 Van Natta 131 (1983).

As to claimant's argument that the medical services in issue are compensable as treatment for an occupational disease, we do not understand that claimant has submitted an occupational disease claim to his employer or its insurer. The occupational disease theory is mentioned for the first time in claimant's brief on Board review. In Bonnie Chytka, 35 Van Natta 86 (1983), we declined to consider an insurer's backup denial asserted for the first time in its brief on Board review. By parity of reasoning, it is inappropriate to consider claimant's occupational disease claim raised for the first time on Board review. Moreover, unless a claim has been submitted to an employer/insurer and denied, we have no jurisdiction over the claim. Syphers v. K-W Logging, Inc., 51 Or App 769 (1981).

ORDER

The Referee's order dated October 11, 1982 is affirmed.

RALPH W. GURWELL, Claimant
Kenneth D. Peterson, Claimant's Attorney
Moscato & Meyers, Defense Attorneys

WCB 82-11071
May 24, 1983
Order Denying Motion to Dismiss

The employer has moved to dismiss claimant's request for review on the grounds that claimant failed to mail the request for review to all parties pursuant to ORS 656.295(2). See ORS 656.289(3).

The motion to dismiss is denied. See Barbara Rupp, WCB Case No. 80-01803 (Order Vacating Order of Dismissal, March 4, 1981); Michael J. King, WCB Case No. 80-07413 (Order on Reconsideration of Denial of Motion to Dismiss, December 18, 1981).

IT IS SO ORDERED.

FLORINE G. JOHNSON, Claimant
Black & Hanson, Claimant's Attorneys
William Beers, Defense Attorney
R. Kenney Roberts, Defense Attorney

WCB 81-08157
May 24, 1983
Order Withdrawing Order on Review and Dismissing Request for Review

The Board issued its Order on Review herein on April 26, 1983 pursuant to the employer/insurer's request for review of Referee Brown's June 18, 1982 order. On review the Board reversed the Referee's order. The parties thereafter requested that the Board abate its Order on Review pending completion of a settlement of all issues.

The Board has now been advised that the parties have amicably disposed of this controversy and, pursuant to the parties' agreement, the employer/insurer now seeks to withdraw the request for review previously filed herein.

Now, therefore, the Order on Review issued herein and dated April 26, 1983, is withdrawn and held for naught; the employer/insurer's request for Board review is dismissed; and the Referee's order dated June 18, 1982 is reinstated and, by operation of law, is final.

IT IS SO ORDERED.

EDWARD L. METCALF, Claimant
Pozzi et al., Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys
Mitchell, Lang et al., Defense Attorneys

WCB 81-11611, 82-05138 & 82-06470
May 24, 1983
Order on Review

Reviewed by the Board en banc.

EBI Companies, as insurer for Shari's Restaurant, requests review of Referee Galton's order which: (1) set aside its partial denial to the effect that claimant's hand eczema or dermatitis condition was unrelated to his accepted hand burn injury of December 5, 1980 and awarded claimant's attorney a fee of $1,100 for prevailing on a denied claim (WCB Case No. 81-11611); (2) set aside as premature the January 4, 1982 Determination Order, which closed the burn injury claim; (3) denied EBI's requests for approval of setoff of a claimed overpayment of temporary total disability benefits in the amount of $595.77; (4) affirmed the denial issued by Fireman's Fund of claimant's alternative new injury claim against Carrows Restaurant (WCB Case No. 82-05138); and (5) set aside an oral denial of an occupational disease claim entered by EBI at the July 21, 1982 hearing and awarded claimant's attorney an additional attorney's fee of $750 for prevailing on that denial (WCB Case No. 82-06470).

I.

Claimant, who was 44 years of age at the time of the hearing, has been employed as a fry cook for approximately the last 25 years. In 1978, claimant sustained hand burns while employed at Eagen's Restaurant. This injury healed with no permanent residuals. On December 5, 1980, while employed at Shari's

Restaurant, claimant sustained burns to both hands when hot grease was spilled on him. He received treatment from Dr. Zook and continued to work on a somewhat sporadic basis. He apparently worked three days in December of 1980, half of January 1981, most of February and half of April 1981.

By the end of January 1981 claimant's hands were beginning to epithelialize and, by March 2, 1981, he was exhibiting an eczematoid reaction. Claimant was referred to Dr. Phipps, a dermatologist, who diagnosed irritant contact dermatitis as a result of the burn injury. Thereafter, claimant experienced periods of remission and exacerbation of his hand condition, which Drs. Zook and Phipps generally associated with his attempts to return to work. On April 1, 1981 Dr. Phipps took claimant off work indefinitely, although it appears that claimant nevertheless continued to work until April 13, 1981.

Claimant was examined by Dr. Wuepper, Professor of Dermatology at Oregon Health Sciences University. Dr. Wuepper was uncertain of the etiology of claimant's condition, but felt that claimant's work with a variety of foods would irritate the condition. On June 16, 1981 Dr. Phipps concluded that claimant suffered from dyshidrotic hand eczema, a chronic and inflammatory condition, and that he should not continue to work as a cook. Dr. Phipps referred claimant to Dr. Parker, Chairman of Dermatology at Oregon Health Sciences University. Claimant was treated by both Dr. Parker and Dr. Phipps, and was also examined by Dr. Parshley. Drs. Parker and Parshley questioned whether the eczema condition was a sequela of the original burn injury, and Dr. Parker suspected that the persistence of the condition suggested that it could be self-inflicted. Dr. Phipps also believed this to be a possibility, but later ruled this out after observing a vesicle appear on claimant's hand while in his office. Dr. Parker reported on October 5, 1981 that a skin biopsy revealed spongiotic dermatitis, a pattern that could be the result of contact or irritant dermatitis, nummlar eczema or nerve-induced eczemas. On November 5, 1981 Dr. Parker reported that claimant's condition was "not secondary to the burn injury he had several years ago and is independent of the injury." We do not know whether Dr. Parker was referring to the 1978 burn injury or the 1980 burn injury.

Apparently relying on Dr. Parker's report of November 5, 1981, EBI issued a partial denial on December 10, 1981 stating:

> ". . . . information in your file reveals that your spongiotic dermatitis or eczema reaction is not secondary to your burn injury. This letter is to inform you that we will not accept responsibility for ongoing medical care and treatment needed as a direct result of your spongiotic dermatitis condition."

Dr. Parker reported on December 14, 1981 and January 4, 1982 that he applied "unna boot" bandages to claimant's hands and this procedure had cleared the dermatitis completely. Dr. Parker thus opined that claimant's condition had plateaued and was medically stationary. A Determination Order issued on January 4, 1982

awarding claimant benefits for temporary total disability from December 8, 1980 through December 10, 1981. EBI continued paying temporary total disability until the issuance of the Determination Order, thus giving rise to its letter of March 5, 1982 informing claimant of an overpayment.

Following the closure of his claim, claimant became employed sometime in early 1982 at a "7-11" convenience store as a cashier and stock clerk. He quit this job because it required him to work graveyard shift and it was impossible for him to sleep in the daytime. Claimant then applied for, and secured, work at Carrows Restaurant as a cook on April 15, 1982. After three days of employment at Carrows, claimant suffered a recurrence of his dermatitis or eczema condition, and returned for treatment to Dr. Phipps. A claim was filed with Carrows which was denied by its insurer, Fireman's Fund, on May 20, 1982. At the time of the hearing, claimant had not yet recovered from this last recurrence.

II.

The Referee concluded that claimant had established that his 1980 burn injury was a material contributing cause of his hand eczema condition. We agree. The totality of the medical evidence is persuasive that the eczema reaction which claimant suffered following his 1980 burn injury was a direct sequela of that injury. Although many of the medical opinions are quite qualified, Drs. Phipps, Zook and Wuepper all generally rendered opinions supportive of this conclusion. Dr. Parshley was basically noncomittal on the issue of causation. Dr Parker did opine that the skin condition was not the result of or secondary to the 1980 burn injury. However, Dr. Parker also rendered opinions which would indicate to the contrary. Overall, we find the evidence supportive of the conclusion that claimant's eczema condition is a result of the 1980 industrial burn injury.

III.

The Referee also concluded that the January 4, 1982 Determination Order issued prematurely, that claimant was not medically stationary on December 10, 1981 and, therefore, set the Determination Order aside. We disagree.

Dr. Parker, who was one of claimant's treating physicians, reported on December 14, 1981 that claimant's condition was stationary and that the dermatitis was almost totally cleared. He recommended that claimant avoid grease, solvents and excessive exposure to water. It was based on this report that the Determination Order issued. There is no contrary evidence in the record. The Referee apparently relied upon a notation made by Dr. Phipps on an Employment Division request for medical information concerning claimant's current employability status. That questionnaire asks whether claimant has been unable to work at any time due to disability and requests the pertinent dates. Dr. Phipps responded: "Dec 80 to present." An examination of Dr. Phipps' chart notes in this regard are informative. Dr. Phipps' December 15, 1981 chart note indicates that claimant telephoned him in regard to EBI's December 10, 1981 partial denial. The January 4, 1982 chart note indicates that Dr. Phipps spoke with claimant's attorney in regard

to claimant's original 1980 burn injury. The January 8, 1982 chart note reveals that Dr. Phipps did examine claimant on that day and found: "Hands totally clear." Dr. Phipps did not see claimant again until May 7, 1982, following the exacerbation claimant suffered after working at Carrows.

The facts that Dr. Parker reported claimant to be medically stationary in December of 1981, an opinion which is uncontradicted in the record, that Dr. Phipps' chart note of January 8, 1982 also relates that claimant's condition had completely cleared up, that claimant returned to work at another job shortly thereafter, and that claimant did not see any physician between January 8, 1982 and the time of the April 1982 recurrence, all support the conclusion that the Determination Order did not issue prematurely. We give little weight to Dr. Phipps' possibly inadvertent indication to the contrary in the Employment Division questionnaire.

IV.

Since we have concluded that the January 4, 1982 Determination Order did not issue prematurely, we must also address the issue regarding EBI's claimed overpayment of $595.77 in temporary total disability benefits. The requested approval of a setoff of this overpayment is granted.

V.

All parties stipulated in unreported closing arguments that claimant would be deemed to have perfected an occupational disease claim against Shari's Restaurant and EBI, which would be deemed to have been denied. The Referee ruled, apparently in the alternative, that claimant had a valid occupational disease claim against Shari's/EBI.

We disagree with the Referee's apparent alternative holding. The Referee concluded, and we have concluded, that claimant's hand skin condition is a result of his industrial burn injury sustained in December 1980 at Shari's Restaurant. It is inconsistent with that conclusion to find the exacerbation of claimant's condition in April 1982 or any other manifestation of that condition to be an occupational disease. Admittedly, there is confusion in the medical opinions about whether the burn caused the skin condition; and, admittedly, in that confusion there are some comments that point toward the possibility of occupational disease; but we find those comments totally unpersuasive. We think it is of some significance that none of the parties understood an occupational disease claim to be involved until something was said at the time of closing argument at the conclusion of the hearing. Under all of these circumstances, we think the Referee's apparent alternative holding was merely an inappropriate foundation for the award of an additional attorney's fee.

VI.

We agree with and adopt those portions of the Referee's order which conclude that claimant's three days of employment at Carrows Restaurant in April 1982 did not contribute independently to claimant's hand skin condition and, therefore, upheld the denial issued

by Fireman's Fund on behalf of Carrows. See Wills v. Boise Cascade Corp., 55 Or App 636 (1982).

VII.

We have concluded that the January 4, 1982 Determination Order was not issued prematurely. We have concluded that claimant's hand skin condition is a sequela of his December 1980 burn injury for which Shari's/EBI is responsible. It follows from these conclusions that claimant is entitled to have his EBI claim reopened on an aggravation basis for the exacerbation of his hand skin condition in April 1982.

VIII.

We comment on one additional matter. The Referee stated that, if he had reached the question of the extent of claimant's disability, he would have granted "a substantial unscheduled permanent partial disability award." In Mark O'Hara, 35 Van Natta 587 (1983), and Donald W. Hill, 34 Van Natta 1291 (1982), we concluded that a permanent disability award for an eczema condition which was manifested only in the hands should be scheduled, not unscheduled. We assume that any future award of permanent disability will be made with the considerations we discussed in O'Hara and Hill in mind.

ORDER

The Referee's order dated July 30, 1982 is affirmed in part and reversed in part. Those portions which set aside EBI Companies' partial denial dated December 10, 1981, on behalf of Shari's Restaurant, and that upheld Fireman's Fund's denial dated May 20, 1982, on behalf of Carrows Restaurant, are affirmed. The remainder of the Referee's order is reversed.

The Determination Order dated January 4, 1982 is reinstated and affirmed as a proper closure of claimant's claim for injuries sustained in December 1980 at Shari's Restaurant. EBI's denial of July 21, 1982 of claimant's occupational disease claim is reinstated and affirmed.

Claimant's claim for injuries sustained in December 1980 at Shari's Restaurant is ordered reopened effective April 18, 1982. EBI is ordered to pay compensation for temporary total disability effective that date, less time worked and less amounts previously paid, and to process the claim to closure pursuant to ORS 656.268.

EBI is allowed to setoff its prior overpayment of $595.77 against future benefits due in the manner allowed by law.

Claimant's attorney is awarded a fee of $250, payable by EBI, for services rendered on review in connection with EBI's partial denial dated December 10, 1981.

EUGENE MUEHLHAUSER, Claimant
Galton, Popick & Scott, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 83-0027M
May 24, 1983
Order Vacating Own Motion Determination Order

The Board entered its Own Motion Determination herein on February 15, 1983, upon termination of claimant's authorized program of vocational rehabilitation, awarding claimant compensation for temporary total disability from July 19, 1983 through August 30, 1983, and no additional award for permanent partial disability. Claimant has requested that the Board rescind its order since claimant had hearing rights pending at the time the order issued.

Claimant was originally injured in 1976, and his claim was first closed by Determination Order dated April 19, 1977. The claim was subsequently reopened and reclosed by Determination Order in January 1981. Claimant thereafter entered an authorized program of vocational rehabilitation. Claimant's aggravation rights expired on April 19, 1982. Upon completion of the vocational rehabilitation program, the claim was reclosed by Determination Order dated April 20, 1982. The claim was again reopened on January 19, 1982, within one year of the most recent Determination Order, for additional vocational rehabilitation training as a locksmith. The program was interrupted and terminated on August 30, 1982 for lack of a training site.

The Department's administrative rules governing vocational rehabilitation, OAR Chapter 436, Division 61, provide:

> "Upon receipt of notice from the insurer or the division that the worker has completed or is otherwise not enrolled and actively engaged in an authorized training program, the Compliance Division shall refer the department claim file to the Evaluation Division for determination pursuant to ORS 656.268, if the worker's condition is medically stationary." OAR 436-61-410(1).

Because claimant's aggravation rights had expired, upon referral of the claim file by the Compliance Division to the Evaluation Division, the Evaluation Division in turn referred the claim file to the Board for claim closure pursuant to the provisions of ORS 656.278.

It was error, however, for the Board to exercise its own motion authority in this case for the reason that the claim was reopened within one year of the last Determination Order entered in this case, April 20, 1982, and, therefore, during the time that claimant had the right to appeal that Determination Order. The order closing the claim upon termination of claimant's authorized training program should have been entered pursuant to ORS 656.268, rather than ORS 656.278. Carter v. SAIF, 52 Or App 1027 (1981); Coombs v. SAIF, 39 Or App 293 (1979). In fact, claimant had requested a hearing contesting the April 1982 Determination Order and raising an issue concerning extent of disability, which was pending in the Hearings Division at the time the Board issued its Own Motion Determination.

ORDER

The Board's Own Motion Determination dated February 15, 1983, is hereby vacated and set aside. This claim is referred to the Evaluation Division for closure pursuant to ORS 656.268(5) and OAR 436-61-410.

DONALD POND, Claimant
Alan Tuhy, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-09131
May 24, 1983
Order Denying Motion to Dismiss

The claimant has moved to dismiss SAIF's request for review on the grounds that SAIF failed to mail the request in a timely manner. The request for review was filed with the Board on May 11, 1983, being the 30th day after the Opinion and Order dated April 11, 1983.

The motion to dismiss is denied.

IT IS SO ORDERED.

THOMAS C. RAY, Claimant
John R. Miller, Claimant's Attorney
Moscato & Meyers, Defense Attorneys

WCB 81-01906
May 25, 1983
Order on Reconsideration

The employer has moved for reconsideration of the Board's Order on Review dated April 26, 1983.

The employer's argument, considered and rejected in that Order on Review, was that its April 1982 denial (which stated, among other things, the employer's position that claimant's August 1980 injury did not result in permanent disability) foreclosed the possibility of an award for permanent disability. In the course of discussing that issue, we stated that an insurer/employer could advise a claimant of its position with respect to a pending hearing request on extent of disability by filing a response as contemplated by OAR 436-83-245.

The employer interprets our Order on Review as implying that the employer and its counsel were unaware of the administrative rule. The employer points out that it did, in fact, file a response to claimant's request for hearing, denying that claimant was entitled to any compensation in addition to that granted by Determination Order.

Our reference to the administrative rule in our Order on Review was not intended to suggest that the employer or counsel were unaware of existing procedures for responding to a claimant's request for hearing. We acknowledge that in this case the employer did file a response to claimant's request for hearing in accordance with OAR 436-83-245.

Our position was and remains, solely as an abstract proposition, that the existence of the response-to-a-hearing-request procedure created by OAR 436-83-245 is some authority for the proposition that a "denial of permanent disability" cannot foreclose the possibility of an award for permanent disability.

ORDER

As supplemented herein, the Board's Order on Review dated April 26, 1983 is republished effective this date.

ORVILLE A. BALES, Claimant
Flaxel et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 80-03397
May 26, 1983
Order on Remand

On review of the Board's order dated January 19, 1982 the Court of Appeals reversed the Board's order. The Supreme Court accepted review and remanded to the Court of Appeals for reconsideration. After reconsideration the Court of Appeals made the same disposition, reversing the Board's order.

Now, therefore, the above noted Board order is vacated and this claim is remanded to the SAIF Corporation for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

GAYLE A. BUSH, Claimant
Pozzi, Wilson et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-00585
May 26, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Seifert's order overturning its denial of claimant's industrial injury claim for a myocardial infarction.

Claimant is a 63 year old former log truck driver who sustained a mycardial infarction while driving his empty log truck to pick up logs on the morning of October 16, 1980. At the time of his hospitalization the history recited by Dr. Robinhold is:

> "He tells me that he got up at his usual early hour, climbed in his pickup and drove to his log truck, got the truck started and was driving from Roseburg towards Steamboat when he began to feel unwell."

Dr. Robinhold described the claimant as "talkative and currently in no distress." Histories noted by other physicians at about the same time are consistent with Dr. Robinhold's.

Dr. Robinhold opined in December 1980 that he did not feel there was any extraordinary stress connected with claimant's work the morning of the myocardial infarction. "I, therefore do not feel that his work activity was the cause of his acute myocardial

infarction." The other physicians who relied on this history likewise felt there was no causal connection between claimant's work and his myocardial infarction.

In January 1981 Dr. Robinhold notes that claimant was in a financial bind and very frustrated that his heart attack was not accepted by SAIF as work related.

In June 1982 claimant was sent by his attorney to see Dr. Wysham, a cardiologist. At that time claimant related a history to Dr. Wysham which was similar to that found in Dr. Robinhold's report except that he described an incident which is not contained in Dr. Robinhold's report. Claimant told Dr. Wysham that while driving through Roseburg the morning of his heart attack, a small foreign car ran a red light in front of him at a blind intersection. Claimant said he was certain he would hit the car, but miraculously did not. He said he began experiencing dryness in his throat and tightness in his chest about fifteen minutes later. Based on this history, Dr. Wysham concluded that:

> "It would appear probable that the acute episode of emotional stress was a major factor in precipitating his myocardial infarction."

Claimant related the same history at hearing. He also testified that he had not had an accident since 1950 nor had he experienced any similar close calls. He testified that the near miss had made quite an impression on him.

The Referee found claimant credible and found the claim compensable based on Dr. Wysham's opinion that the near miss was a stressful enough event to have caused the heart attack. Normally we will defer to a Referee's finding of credibility; however, in this case we are not persuaded that the claimant is credible.

> "[W]e understand the issue in this and in all credibility cases to be: Giving due deference to the Referee's advantage in seeing the witnesses, can we honestly say we are persuaded by the evidence offered [that claimant is credible. . . ." (Emphasis in original.) Dale Donaldson, 34 Van Natta 1154 (1982).

Claimant's near miss story is not corroborated by anyone despite the fact that he testified he had told friends about it over his CB radio right after the incident happened. At the time of the heart attack all physicians recorded similar histories, none of which mention a near miss. The claimant testified that the near miss made a big impression on him yet he did not even tell it to Dr. Robinhold who found him "talkative." It is only mentioned over one and one-half years after the heart attack. We find it inherently incredible that a talkative person such as the claimant who had experienced a frightening incident such as a near miss automobile/truck collision and then fifteen minutes later suffered a heart attack would not mention the incident to any physician until one and one-half years later.

Because Dr. Wysham's opinion is based on a history which we find not credible, we do not accept his conclusion that claimant's myocardial infarction was caused by his job. Rather, we accept the conclusion of Dr. Robinhold and the other physician's who opine that claimant's myocardial infarction was not caused by his job. We reverse.

ORDER

The Referee's order of November 15, 1982 is reversed.

JAMES D. COON, Claimant
Cowling et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Keith Skelton, Defense Attorney

WCB 81-06112 & 82-00929
May 26, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Mongrain's order which found SAIF, rather than Liberty Mutual Insurance Company, responsible for claimant's current low back problems and therefore reversed SAIF's May 27, 1981 denial. The issues are the compensability of, and responsibility for, claimant's current low back problems.

Claimant experienced the following injuries: (1) In September 1978 while employed by Liberty Mutual's insured, Lounsbury Ford, claimant sustained a compensable low back injury when he bent over to pick up a screwdriver; (2) in December 1978 claimant suffered an exacerbation of his symptoms while jogging; (3) in October 1979 while employed by SAIF's insured, Floyd Marshall, claimant sustained another compensable low back injury when he fell 10 to 12 feet from his chip truck; (4) about January 1980, while still in the employ of Floyd Marshall, claimant experienced significantly increased low back pain after driving his truck with broken seat springs; (5) in March 1981 claimant again experienced increased low ack pain after a bicycle ride. This most recent incident is the subject of this proceeding.

SAIF urges us to find that claimant's 1981 off-the-job bicycling incident was either: (1) An aggravation of claimant's first on-the-job injury (the 1978 bending incident at Lounsbury Ford), and thus find Liberty Mutual responsible; or (2) a new intervening injury, for which neither insurer would be responsible. Liberty Mutual points out that claimant suffers from two congenital problems, spina bifida occulta and spondylolisthesis at L5, and that all the injuries are the result of those congenital problems; thus, neither insurer is responsible. In the alternative, Liberty Mutual asserts that, if we do find claimant's current condition compensable, then SAIF should be responsible under the last injurious exposure rule.

The evidence relevant to both compensability and responsibility comes only from Dr. Heller. It is quite conclusory on compensability, i.e., that there is proof of causal link between

claimant's disability following the recent bicycling incident and any prior industrial injury or injuries; but there is no evidence to the contrary. Accepting, then, that a causal link between claimant's prior industrial injuries and current disability has been established, we understand Dr. Heller to opine that claimant's more recent 1979 and 1980 Floyd Marshall/SAIF injuries bear some, apparently material, relationship to claimant's current disability. Under these circumstances, SAIF is responsible.

ORDER

The Referee's order dated June 29, 1982 is affirmed. Claimant's attorney is awarded $350 as a reasonable attorney's fee for services rendered on Board review, payable by the SAIF Corporation.

DIANNE L. JAMES, Claimant
Galton, Popick & Scott, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 77-06474
May 26, 1983
Order on Remand

On review of the Board's order dated December 18, 1981, the Court of Appeals affirmed the Board's order finding claimant's psychological disability compensable and, based upon the parties' stipulation, remanded for an award of a reasonable attorney's fee for claimant's counsel's services before the Board on a prior remand from the Court of Appeals. See James vs. SAIF, 51 Or App 201 (1981).

Now, therefore, the above-noted Board order is modified to award claimant's attorney $750 as a reasonable attorney's fee for services before the Board on remand from the Court of Appeals.

IT IS SO ORDERED.

MILTON D. OCUMPAUGH, Claimant
Ackerman, et al., Claimant's Attorneys
Wiswall, et al., Defense Attorneys

WCB 81-06033
May 26, 1983
Order on Review

Reviewed by the Board en banc.

The employer and its insurer, the SAIF Corporation, request review, and claimant cross-requests review, of Referee Siefert's order which set aside the SAIF Corporation's partial denial of claimant's right ankle injury claim; awarded claimant 50% unscheduled permanent partial disability for his accepted head injury claim; and refused to award claimant additional temporary total disability compensation on the basis of premature closure of his head injury claim. The employer and SAIF contend that claimant has failed to prove the compensability of his July 6, 1981 ankle injury and that the Referee's award of 50% unscheduled permanent disability is excessive. They seek reinstatement of the Determination Order's award of 20% unscheduled permanent disability. The SAIF Corporation also raises a procedural issue concerning the Referee's decision to rate claimant's unscheduled permanent disability and simultaneously set aside the denial of claimant's ankle injury, remanding that claim for acceptance and payment of benefits as of

July 6, 1981 until closure pursuant to ORS 656.268. SAIF contends that it is error to rate disability attributable to one condition while another condition in accepted status is not medically stationary.

On his cross-request for review, claimant contends that the Referee's award of permanent disability is inadequate, and that he is entitled to an award of 80% unscheduled permanent partial disability as a result of his head injury. Claimant also contends that his condition was not medically stationary on January 29, 1981 and that he is, therefore, entitled to further temporary disability benefits from that date until July 7, 1981.

We affirm and adopt the Referee's order on all issues concerning the extent of claimant's temporary and permanent disability attributable to his accepted head injury claim. We reverse the Referee's order finding that claimant's ankle injury in July 1981 is a compensable consequence of his original head injury; and, because of our disposition concerning this partial denial, it is unnecessary to address the procedural issue raised by SAIF.

There is considerable confusion in the record concerning the circumstances surrounding claimant's ankle injury in July 1981. Claimant was originally injured on July 19, 1979 when he was struck on the head by a choker belt, which resulted in a lineal fracture of the skull and a concussion. As a result of this head injury, claimant suffers from a psychiatric condition diagnosed as an organic personality syndrome and a permanently exacerbated preexisting personality disorder. Claimant's treating neurologist is of the opinion that claimant suffers from an organic seizure disorder resulting from his head injury. Claimant has suffered seizures since shortly after his head injury, but there is some uncertainty as to whether he actually suffers from an organic seizure disorder, as opposed to seizures originating from and caused by his emotional/psychological/psychiatric conditions. Claimant's treating neurologist is of the opinion that, although claimant does suffer from an organic seizure disorder, not all of his seizures, or "spells," are organically caused, some of them resulting from claimant's emotional condition.

Claimant testified that on the evening of July 6, 1981, he was on a logging road in back of his parents' house, picking up empty rifle shells in an area where people target shoot when he started to experience a seizure. He testified that he attempted to keep his balance, but not having anything nearby with which to support himself, he fell to the ground and injured his ankle. His girlfriend was with him at the time. She helped him get up and took him to his parents' home nearby. Claimant's mother took him to the hospital where he was seen in the emergency room.

The emergency room record at the hospital contains a history that claimant was involved in an altercation, and that his opponent fell on his leg. The following day claimant was seen by his family physician, whose chart notes indicate that claimant injured his ankle at home the preceding evening. Claimant's family physician referred him for examination by a consulting orthopedic physician who saw claimant the following day. The record of this examination indicates that the history given by claimant to this physician was that he fell while carrying some heavy metal:

"He believes he had a mild seizure resulting in loss of balance and awareness, but doesn't think that he had a loss of consciousness. As he felt the seizure coming on, he tried to drop the metal and get out of the way, but lost his balance and it fell on his foot, apparently causing him to twist his ankle."

The office notes of Dr. Mundall, claimant's treating neurologist, reflect that on or about July 8, 1981, claimant called Dr. Mundall, informing him that he had had a "spell" the night before while he was carrying a heavy object, which he dropped to the ground. He apparently related that this heavy object rolled against his leg, causing the ankle injury in question. Claimant's ankle injury was diagnosed as a fracture with a lateral shift of the talus and probable tear of the deltoid ligament.

At the hearing, claimant denied telling any nurse or doctor at the emergency room that he injured his leg in an altercation. The only apparent mention of a fight was when claimant's brother was present in the emergency room and asked him if that was the way in which he was injured. Claimant did not remember whether or not he had responded to his brother's question about the cause of his ankle injury. Claimant also did not remember telling the orthopedic physician that he had injured his ankle by dropping a heavy metal object while experiencing a seizure.

Claimant's girlfriend testified that she was with him on the logging road on the evening in question when she saw him fall down, apparently experiencing a seizure. She was not aware of claimant carrying anything when he fell, and when she helped him to get up, he had obviously injured his ankle. She did not accompany claimant and his mother to the hospital but was present later that evening.

Claimant's mother testified that, as she was taking claimant to the hospital, he insisted upon talking to the hospital personnel by himself. She also testified that, to her knowledge, no one had told any nurse or doctor that the injury occurred in the course of an altercation. The only possibly plausible explanation for the entry in the emergency room record, regarding an altercation as the cause of claimant's injury, is that given by claimant's mother, who described claimant's embarrassment in discussing with other people the fact that he has seizures. Claimant also testified that he is embarrassed to tell others he has seizures because he is afraid that people will think less of him.

This testimony might offer a plausible explanation for the discrepancy in the various versions of what actually occurred, were it not for the fact that the version rendered by claimant and his girlfriend at the hearing is inconsistent with the version given to claimant's own treating neurologist, who certainly knew of claimant's seizure disorder, and who was told by claimant that he had dropped a heavy object on his foot as he began to experience a seizure.

Some of the discrepancies might be explained by claimant's memory loss, which is a residual effect of his head injury. If this were true, then the most reliable account would tend to be

that which was most nearly contemporaneous with the actual event, which is the emergency room record. We do not find, however, that claimant was involved in an altercation on the evening in question. We simply find that there are too many inconsistencies between the testimony at the hearing and the various versions of what occurred as related to the hospital personnel and other physicians shortly thereafter. We conclude that these inconsistencies create substantial doubt as to whether claimant's injured ankle is actually a compensable consequence of his original injury. Our doubt is of sufficient degree to prevent a finding that claimant has sustained his burden of proving by a preponderance of the persuasive evidence that his ankle injury is a compensable consequence of his accepted head injury. Accordingly, we reverse that portion of the Referee's order finding to the contrary.

ORDER

The Referee's orders dated May 26, 1982, June 28, 1982 and August 6, 1982 are reversed in part. Those portions of the Referee's orders which set aside the SAIF Corporation's November 25, 1981 partial denial of claimant's ankle injury are reversed, and SAIF's denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

JAMES G. THOMAS, Claimant
Hansen & Wobbrock, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Moscato & Meyers, Defense Attorneys

WCB 80-07525, 81-08791 & 81-10292
May 26, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The employer, Imperial Manufacturing Company, by and through its insurer, Aetna Life and Casualty Company, requests review of Referee Menashe's order which: (1) set aside its denials of September 12 and October 9, 1981 and found Aetna to be responsible for claimant's current condition on the basis of aggravation of his February 13, 1978 injury; (2) ordered that claimant be paid temporary total disability benefits from June 16, 1980 to December 22, 1981, and from the date of the termination of claimant's authorized program of vocational rehabilitation (May 12, 1982) until the date of the issuance of the June 7, 1982 Determination Order and a 25% penalty on such amount; (3) ordered Aetna to pay claimant's attorney an attorney's fee of $1,200 for prevailing on a denied claim; (4) affirmed the September 16, 1981 denial issued by EBI Companies as Imperial's new insurer; and (5) affirmed the October 29, 1981 denial issued by the SAIF Corporation as insurer for Eagle Creek Saw & Machine.

Aetna contends that the Referee erred in finding that claimant established that he suffered a worsening of his February 1978 injury, that ORS 656.268(5) does not mandate that a new Determination Order be issued before an insurer may terminate time loss benefits to a medically stationary claimant who has completed an approved program of vocational rehabilitation, and that the Referee's award of penalties and attorney's fees was unwarranted. No issue was raised regarding the extent of claimant's disability in relation to the June 7, 1982 Determination Order. That issue is the subject of a separate Order on Review issued this date in WCB Case No. 82-07390.

In this case, we find that the Referee reached the proper conclusions and results on all issues in this complex case and we, therefore, affirm and adopt his order. See also Billy Joe Jones, 34 Van Natta 655 (1982), aff'd 63 Or App 194 (May 11, 1983).

ORDER

The Referee's order dated July 14, 1982 is affirmed. Claimant's attorney is awarded an attorney's fee of $350 for services rendered on Board review, payable by Aetna.

JAMES G. THOMAS, Claimant
Hansen & Wobbrock, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-07390
May 26, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of those portions of Referee Neal's order which refused to award claimant penalties and attorney's fees for the employer's alleged unreasonable resistance to the payment of medical bills. The employer has cross-requested review of those portions of the Referee's order which awarded claimant 25% unscheduled permanent partial disability for injury to the neck, that being an increase of 10% over and above all prior awards and arrangements of compensation. The issues are penalties/attorney fees and the extent of claimant's disability.

We affirm and adopt the relevant portions of the Referee's order on the issue of penalties/attorney fees. We reverse the Referee's award of additional permanent disability.

Claimant, who was 34 years of age at the time of the hearing, suffered a compensable injury on February 13, 1978 while employed by Imperial Manufacturing Company, Inc., which at that time was insured by Aetna. Dr. Cohen diagnosed a strain of the right scapular muscle. On July 5, 1978 Dr. Cohen reported that claimant would not be able to return to the same work, which had involved repetitive lifting of heavy panels. Dr. Cohen further reported on November 15, 1978 that claimant did have some numbness of the right index and middle finger, as well as the thumb, but that he was medically stationary with some mild disability. On May 18, 1979 Dr. Cohen elaborated by indicating that claimant's disability was in the minimal range of 1 to 10%. A Determination Order issued on December 11, 1978 awarding claimant 5% unscheduled permanent partial disability. By stipulation of July 9, 1979, claimant received an additional 10% for a total of 15% permanent partial disability.

In September 1979 claimant began work as a saw maker's helper for Eagle Creek Saw & Machine, insured by SAIF. On March 28, 1980 claimant suffered an exacerbation of his neck and right shoulder pain, which SAIF accepted as a nondisabling injury.

In late May or early June 1980 claimant returned to his old job at Imperial, now insured by EBI Companies, which required lifting heavy panels. On June 16, 1980 he suffered another exacerbation of neck and arm pain. He was treated conservatively. On August 19, 1980 claimant requesting a hearing alleging that he suf-

fered an aggravation of his February 1978 Imperial/Aetna injury. Additional claims were filed against SAIF and EBI.

On December 24, 1980 Dr. Cohen reported that claimant was still having some problems with his neck and right arm as a result of the July 1980 exacerbation. In a report dated January 23, 1981 Dr. Cohen reported that claimant was medically stationary and that as a result of the March 1978 injury, he remained partially disabled. In a report dated February 10, 1981 Dr. Cohen stated:

> "I think this patient's condition at the time I last saw him on December 23, 1980, had a disability of approximately 15 percent unscheduled permanent partial disability indicating that there was no increase." (Emphasis added.)

On October 2, 1981 claimant was admitted to Holladay Park Hospital with complaints of neck pain. A myelogram was performed by Dr. Cohen which he interpreted as normal. On January 19, 1982 Dr. Cohen further reported that:

> "In answer to your notation, the patient's last injury of the 16th of June, 1980 while working for the Imperial Manufacturing Company aggravated the pre-existing injury of 1978, and that necessitated the treatment that the patient received at the hospital. His aggravation was temporary and has now returned to the condition that existed prior to the 1980 accident." (Emphasis added.)

The Referee explained her decision to increase claimant's permanent partial disability award as follows:

> "Claimant's testimony supports an increased permanent partial disability award. He is unable to lift over 50 pounds without his neck being stiff and pain in his arms and hands. His neck is stiff and sore all the time. * * * At least one or two times a day, he has tingling in his fingers and burning in his right arm."

The problem of reliance on lay testimony to establish permanent impairment is one of the chronic ambiguities in Oregon's workers compensation system. Compare, e.g., Holub v. SAIF, 57 Or App 571 (1982), and Martin v. Douglas Co. Lumber Co., 4 Or App 69 (1970), with Candee v. SAIF, 40 Or App 567 (1979). While we hesitate to wade into a problem of this magnitude, there is one yardstick that this Board has fairly consistently used: When there is direct medical evidence from a physician who has rendered significant treatment to an injured worker which clearly indicates the extent of the worker's impairment and which we have no reason to question, that expert opinion will generally be accepted and take precedence over any contrary opinion of a layman, unless there is compelling reason to do otherwise.

In this case claimant's treating physician, Dr. Cohen, unequivocally states that claimant has experienced no increased impairment as a result of the June 1980 aggravation and that the aggravation was only temporary in nature. We find no reason for doubting Dr. Cohen's opinion. Even if there were, claimant's testimony is simply repetitive of the same complaints which he had prior to the July 9, 1979 stipulation, i.e., stiffness, soreness, some numbness of the right hand fingers and inability to lift over 50 pounds on a repetitive basis. These are virtually identical to the symptoms of which claimant had prior to the last award of compensation. There is no basis for allowing an increased award of permanent disability.

ORDER

The Referee's order dated December 2, 1982 is affirmed in part and reversed in part. Those portions of the order which awarded claimant an additional 10% unscheduled permanent partial disability are reversed and the June 7, 1982 Determination Order is reinstated and affirmed. The remainder of the Referee's order is affirmed.

PETER A. ZAKLAN, Claimant
Galton, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 81-03838
May 26, 1983
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Fink's order which upheld the self-insured employer's denials dated March 17 and May 26, 1982 denying the compensability of claimant's previously accepted industrial injury claim. The primary issue at hearing was compensability. The issue argued on review is whether the employer had the authority to deny this claim where the denials were issued after the claim had been previously accepted and repeatedly reopened and closed.

I.

Claimant, 33 years of age at the time of hearing, was injured in a noncompensable automobile accident and subsequently underwent a laminectomy and discectomy in 1972. In 1976, while employed first by Bowen's Roofing Company, then later by Anderson Roofing Company, claimant filed claims for alleged back strains. Apparently, the initial claim against Bowen's Roofing was accepted. Following an alleged incident while employed at Anderson Roofing, Bowen's Roofing denied an aggravation claim and Anderson Roofing denied a new injury claim. In 1977, claimant allegedly injured his back while employed by Gheen Irrigation Company. He underwent a second laminectomy and discectomy. In 1979 there was a hearing concerning responsibility for claimant's back condition, including the 1977 surgery. The Referee in that proceeding concluded that claimant had failed to prove either an aggravation claim against Bowen's Roofing or a new injury claim against Anderson's Roofing or Gheen Irrigation. In his order, the Referee in the prior

proceeding noted that claimant had admitted receiving unemployment compensation benefits at times when he was employed and at times when he was receiving workers' compensation benefits, that claimant had been convicted of first degree burglary and that claimant generally lacked credibility.

In the meantime, following his recovery from the 1977 back surgery, in May of 1978 claimant applied for work with the employer in this case, FMC Marine and Rail. In his application, claimant did not list any of the employers against whom he had filed workers' compensation claims; he denied allergies when in fact he has allergies which require biweekly injections and occasional emergency care; he denied any back problems and back surgery and denied any off-the-job injuries.

Claimant was hired by FMC Marine and Rail, worked one full shift, then took three days authorized leave and one day unauthorized leave. Upon returning to work, he worked less than a full shift, left work without notice and called in the next day requesting his check. When asked why he was quitting, claimant indicated that he was dissatisfied with being moved from arc welding to grinding; he made no mention of an injury. Claimant did not file a claim until three days after he quit and did not seek medical care until 10 days after that. Claimant alleged that his work with this employer involved lifting 50 to 60 pound objects and considerable bending, twisting and stooping. The employer's witnesses testified that the work involved lifting objects up to 12 pounds and very little bending, twisting, etc.

The medical reports generated at that time recite claimant's version of his work exposure. Claimant's claim was accepted, and in the ensuing four years, claimant received time loss through the recovery period for his alleged on-the-job injury, continuing through several vocational rehabilitation programs which he ultimately was dropped from or quit. Four Determination Orders issued, the first three of which became final in that more than one year passed after they were issued without an appeal being taken. The last Determination Order issued January 4, 1982 awarding time loss and 5% permanent disability. Claimant appealed that Determination Order alleging entitlement to additional time loss and greater permanent disability.

Prior to January 1, 1980, the employer's workers' compensation claims were handled by a service agent. Effective that date, the employer assumed responsibility for its own claims management. In the course of preparing for litigation in response to claimant's request for a hearing arising from the January 4, 1982 Determination Order, the employer undertook an investigation and, some four years after it had accepted the claim, "discovered" information which caused it to believe that the claim should not have been accepted in the first place. Accordingly, the employer issued denials which in relevant part (1) denied that any injurious event or exposure occurred at the time alleged by claimant, (2) denied that claimant's condition arose from his employment with FMC, and (3) denied that claimant's pre-existing condition was worsened by his employment at FMC.

II.

In upholding the employer's denials, the Referee held that the Supreme Court's decision in Frasure v. Agripac, 290 Or 99 (1980), stands for the proposition that an employer or insurer can deny a claim at any time, so long as the denial is based upon a defense other than lack of notice. The Referee went on to find, on the merits, that the employer's denials were proper. The issue briefed by the parties on review was whether the employer had the authority to deny a claim that previously had been accepted and processed to closure. This issue has been decided recently in claimant's favor, see Bauman v. SAIF, 62 Or App 323 (1983). In Bauman, the claimant filed a nondisabling occupational disease claim in 1977. That claim was accepted and medical benefits paid. Apparently at some point the claim was closed. In February 1980, the claimant filed an aggravation claim alleging a worsening of his condition. In May 1980 the insurer denied the aggravation claim and in November 1980 denied the compensability of the underlying occupational disease claim asserted and originally accepted in 1977. In rejecting the November 1980 denial of compensability the Court reasoned:

> "[W]e do not understand the Supreme Court to have held in Frasure...that there can never be finality to an employer's or insurer's acceptance of a claim. The principle of those cases is that an employer's or insurer's initial acceptance of a claim does not automatically foreclose it from contesting coverage before there is an award or arrangement of compensation or while agency or judicial review of the award or arrangement remains available or is taking place.
>
> "Beyond that point, the policy reasons expressed in Frasure have no logical application. The goal of prompt processing and payment of claims needs no further encouragement after a claim has been processed and an arrangement of compensation has been made. Similarly, beyond that point, there is no further need to protect the right of employers and insurers to comply with the statutory time requirements for payment and processing and, at the same time, preserve their ability to deny claims after making further inquiry; they are simply not entitled to a third bite at the apple. Equally fundamentally, to read Frasure and our decisions as permitting SAIF's denial of this claim at this stage would introduce an element of tentativeness into the process the the relevant statutes do not seem to contemplate and which is alien to virtually all administrative and adjudicative processes." Bauman v. SAIF, 62 Or App at 328.

Thus, as we interpret it, the court in Bauman held that an insurer or employer may not deny the compensability of an accepted

claim after closure of the claim under ORS 656.268 becomes final under ORS 656.268(3) or ORS 656.319(2). The claim in question here was filed in May, 1978, accepted and processed to closure by a Determination Order issued in October, 1979. Three subsequent Determination Orders issued in July 1979, November 1980 and January 1982. The hearing below was precipitated initially by claimant's "boilerplate" request for hearing received by the Hearings Division on April 23, 1981. An amended request for hearing was received on January 21, 1982 appealing the Determination Order of January 4, 1982. In the course of preparing for the hearing on the extent of disability issue raised by the amended request for hearing, the employer "discovered" evidence it believed indicated that the claim was not then and never had been compensable. Accordingly, on March 17, 1982 the employer issued a denial and on May 26, 1982 it issued another denial clarifying its position.

The record thus reveals that at least the first two if not the first three Determination Orders closing and reclosing claimant's claim became final by operation of law in that no appeal was taken within one year of them, respectively. ORS 656.319(2). It follows that, under Bauman, the employer could not thereafter deny compensability and that the denials themselves must be set aside.

III.

However, we believe that applying Bauman to this case and setting aside the employer's belated denials do not necessarily resolve the underlying compensability issue. The court in Bauman appended a footnote to the passage quoted above. That footnote provides as follows:

> "It is noteworthy, in this connection, that the Workers' Compensation Law does contain certain express provisions relating to modification or reexamination of awards: e.g., ORS 656.278 and 656.325; see Bently v. SAIF, 38 Or App 473, 590 P2d 746 (1979). However, nothing in the statutes authorizes ongoing unilateral adjustments to compensation or reconsideration of liability on the employer's or insurer's own motion." Bauman, supra, at 329.

As we understand it, by using the term "unilateral" and referring to ORS 656.278, the court was referring to denials issued by an insurer or employer without application to the Board for relief under its ORS 656.278 own motion authority. Subject to certain exceptions not relevant here, ORS 656.278(1) provides as follows:

> "(1) ...the power and jurisdiction of the board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified."

It appears to us that the grant of authority in ORS 656.278(1) is broad and would empower the Board to act on its own motion pursuant to a request from an insurer or employer for a determination that a

claim previously accepted as compensable was in fact not compensable ab initio. There is a jurisdictional issue, however, that clouds the picture arising from the provisions of subsection (2) of ORS 656.278, which provides that:

> "(2) An order or award made by the board during the time within which the claimant has the right to request a hearing on aggravation under ORS 656.273 is not an order or award, as the case may be, made by the board on its own motion."

Although the denials of compensability in this case were issued at a time when claimant still had aggravation rights (and the right to appeal from a denied aggravation claim under ORS 656.273), we believe that the Board may have jurisdiction over the case notwithstanding the provisions of ORS 656.278(2). Based on the literal wording of ORS 656.278(2), its legislative history and a review of the appellate court and Board cases that have construed subsection (2), we have come to the conclusion that ORS 656.278(2) may not deprive the Board of own motion jurisdiction during the claimant's aggravation appeal rights period.

A careful reading of the present subsection (2) of ORS 656.278 reveals that it does not say that the Board lacks jurisdiction over the cases described therein; it merely says that an order issued during that time period is not an "own motion" order. If the legislature intended to deprive the Board of jurisdiction during the aggravation period, the language used to achieve it is decidedly awkward. Cf. the court's comments in Buell v. SIAC, 238 Or 492 at 496 (1964).

The essential provisions of subsection (2) of ORS 656.278 were added in 1957. 1957 Or Laws, c. 559, §1. At that time, ORS 656.278 had only two subsections. The first was the general grant of own motion jurisdiction that remains as subsection (1) of .278. The second contained limits on appeal rights from own motion orders or awards, basically what is now ORS 656.278(3). When the provisions of what is now subsection (2) were added in 1957, they were added to the subsection dealing with appeal rights, not to the subsection granting jurisdiction.

The 1957 legislation should be viewed in light of two earlier decisions, Hinkle v. SIAC, 163 Or 395 (1940) and Verban v. SIAC, 168 Or 394 (1942). In Hinkle, the court indicated that an order issued following a petition for claim re-opening filed during the period in which the claimant had a right to request claim reopening (i.e., an aggravation claim) was not an order issued on the Commission's own motion. Similarly, in Verban, the court held that a Board order increasing an award of permanent disability was not an "own motion" order and the claimant was not deprived of appeal rights when the order issued during the period in which the claimant had a right to invoke the Board's original jurisdiction by requesting a rehearing of the initial order closing the claim. Thus, the legislative history of ORS 656.278(2) at least is consistent with, if not a codification of, the Hinkle and Verban cases placing limits on the ability to limit appeal rights by issuing nonappealable own motion orders or awards, and suggests that the

Legislature did not intend to deprive the Board of jurisdiction during the claimant's aggravation period.

The appellate court decisions which have construed ORS 656.278(2) subsequent to its enactment have focused on whether the Board could use its own motion jurisdiction to enter orders or make awards disposing of a claim that had the effect of depriving the claimant of claim closure under ORS 656.268 and/or appellate review under ORS 656.298. Buell v. SIAC, 238 Or 492 (1964), Coombs v. SAIF, 39 Or App 293 (1979) and Carter v. SAIF, 52 Or App 1027 (1981). These cases are consistent with the issues presented to the Court in Hinkle v. SIAC, supra, and Verban v. SIAC, supra, namely, the appealability of Board orders, not lack of jurisdiction.

There are a number of cases in which this Board has held or assumed that its own motion jurisdiction only comes into being after expiration of appeal rights. See, for instance, James C. Schra, 34 Van Natta 1577 (1982); Norman Jager, 34 Van Natta 1558 (1982); Robert A. Lucas, 34 Van Natta 1553 (1982); Max D. Cutler, 34 Van Natta 1480 (1982); Glen A. Williams, 34 Van Natta 1222 (1982); Dorothy McIver, 32 Van Natta 192 (1981); David D. Blair, 30 Van Natta 407 (1981); Lenford Simmons, 30 Van Natta 400 (1981); Adelma Potterf, 30 Van Natta 275 (1981); Delbert Walker, 29 Van Natta 149 (1980); Lesley Young, 28 Van Natta 958 (1980); Herman J. Howland, 28 Van Natta 368 (1979); Marcella Holy Anderson, 27 Van Natta 119 (1979); Violet B. McKinnon, 26 Van Natta 40 (1978); Harvey Burt, 22 Van Natta 42 (1977); Raymond Presnell, 21 Van Natta 44 (1977); Bringfried Rattay, 17 Van Natta 171 (1976); Frederick J. Estabrook, 17 Van Natta 66 (1976); and George Roth, 14 Van Natta 202 (1975). See also Isla M. Halligan, 34 Van Natta 594 (1982); and Clair Vendehey, 26 Van Natta 27 (1978). This case provides an opportunity to reexamine those prior holdings and assumptions.

Upon reviewing those cases, it appears that some of them (Schra, Jager, Lucas and Cutler) involved requests for medical services in which the Board declined to exercise its own motion authority because the claimant had the right to seek medical services under ORS 656.245 and could appeal a denial through the normal appeal process. It is not apparent in these cases whether lack of jurisdiction was a consideration in the disposition of those cases. Neither ORS 656.278(2), nor any other statute that we are aware of, deprives the Board of the jurisdiction over medical services claims after expiration of aggravation rights merely because the relief being sought is cognizable under ORS 656.245. Adjudication of entitlement to medical services is a matter of concurrent jurisdiction, and the Board, in the exercise of its discretion under ORS 656.278, properly should refrain from exercising its own motion authority where another process and forum exists to handle such claims. Conceptually this is similar to the restraint historically exercised by courts of equity where the plaintiff had an adequate remedy at law.

The remainder of the cases cited above involved claimants seeking relief that could be granted pursuant to an aggravation claim or pursuant to an appeal from a determination order. In such cases, it is eminently reasonable to require the claimant to

utilize the aggravation claim provisions of ORS 656.273, claim closure under ORS 656.268 and the hearing process to adjudicate entitlement to the relief being sought. ORS 656.278(2) is consistent with such a policy. See footnote 1 in Morton v. Northwest Foundry and Furnace, 36 Or App 259 (1978):

> "Since an aggravation claim may be filed within five years after the date of injury, it is arguable under a literal construction of this provision [ORS 656.278(2)] that the Board has no power to invoke its own motion practice under ORS 656.278(1) since the original injury occurred on September 23, 1974. A more plausible construction is that ORS 656.278(2) is only intended to prevent reopening of claims under the "own motion" practice on behalf of the claimant where the remedy of an aggravation claim under ORS 656.273 is otherwise available."

We are not aware of any prior Board decisions which denied the relief sought by a party on the ground of lack of own motion jurisdiction where the relief being sought was something other than medical services or relief which could be granted pursuant to an aggravation claim. However, by contrast, there are cases in which the Board has exercised its own motion power without reference to ORS 656.273. For instance, prior to the enactment of ORS 656.206(5) providing for periodic re-evaluations of permanent total disability awards, one type of case the Board considered under its own motion jurisdiction was requests to terminate permanent total disability awards where there was evidence that the claimant's condition had improved. See Angel Albarez, 33 Van Natta 598, at 601 (1981), where, in light of the administrative rules adopted after the enactment of ORS 656.206(5), the Board terminated its practice of reevaluating permanent total disability awards under its own motion authority. Another example concerns those claimants injured prior to the enactment of ORS 656.245. We recently held that those claimants have no entitlement to ongoing medical services under ORS 656.245 and that their only remedy is to seek own motion relief. William A. Newell, 35 Van Natta 629 (WCB Case No. 81-09980, May 6, 1983).

Lastly, there are a number of Court cases involving appeals from own motion orders or awards made by the Board (or its predecessor, the Commission) apparently prior to expiration of aggravation or hearing appeal rights: D & M Products v. Workmen's Compensation Board, 30 Or App 707 (1977); Powell v. Wilson, 10 Or App 613 (1972); Pate v. SIAC, 238 Or App 499 (1964); Holmes v. SIAC, 227 Or 562 (1961); and Kennedy v. Industrial Accident Commission, 218 Or 432 (1959). In none of these cases was the Board's jurisdiction to make an order or award questioned. In addition, see the following more recent cases which also suggest that the Board may exercise its own motion authority during a claimant's aggravation rights appeal period: Bauman v. SAIF, supra, Shaw v. Portland Laundry, 61 Or App 368 (1983) and Morton v. Northwest Foundry and Furnace, 36 Or App 259 (1978).

For all these reasons, it appears that all subsection (2) may do is prevent the Board from depriving a claimant of claim closure

and appeal rights under the guise of issuing a nonappealable own motion order; it does not appear to have been intended to wholly deprive the Board of own motion jurisdiction during the aggravation appeal rights period. Although we have the jurisdiction to act during a claimant's aggravation appeal rights period, we properly refrain from exercising our own motion authority when the relief granted by the Board would limit reopening, closure and appeal rights in aggravation cases in violation of ORS 656.278(2), when a party has the right to request review of a determination order or when as a matter of administrative restraint the relief sought is obtainable under ORS 656.245. It follows that where the relief being sought by a party cannot be granted under ORS 656.245 or 656.273, it appears that the grant of authority under ORS 656.278(1) empowers the Board to act, and that ORS 656.278(2) only prevents the Board from making a nonappealable order or award.

In so suggesting, we are well aware of how the provisions of ORS 656.278(2) have been interpreted historically. However, "that is has always been so" is not necessarily a good reason for declaring that "thus it always shall be." The facts of this case highlight that some previous interpetations of ORS 656.278(2) may have been overly broad. Here, at least three Determination Orders have issued, each of which became final by operation of law and passage of time. However, the Referee below concluded, and the evidence strongly supports his conclusion, that no compensable event happened while claimant was employed with FMC Marine and Rail. Under Bauman, the employer may not now unilaterally deny compensability. If the employer has any remedy at all, it is pursuant to the Board's own motion jurisdiction under ORS 656.278(1). It would be absurd in this case to require the employer and the Board to idly stand by, allowing claimant to continue receiving workers' compensation benefits for an alleged industrial injury that may never have happened, until his aggravation rights expire, then litigate the functional equivalent of a backup denial under our own motion jurisdiction. We believe that neither reason nor ORS 656.278(2) necessarily requires such a result.

For these reasons, we believe that the Board may have jurisdiction over this case and could exercise its own motion authority to decide the compensability issue litigated at hearing.

IV.

We regard the grant of own motion authority under ORS 656.278(1) as a safety valve to be used only under extraordinary circumstances. Assuming that we have own motion jurisdiction over requests for determinations of compensability after an award or arrangment of compensation has become final even where aggravation rights have not expired, we would regard the exercise of authority under ORS 656.278(1) to terminate prior determinations of compensability "an extraordinary remedy to be granted sparingly only in the most extreme situations." Cf. Mary Lou Claypool, 34 Van Natta 943 (1982); James Leppe, 31 Van Natta 130 (1981); Alvy Osborne, 34 Van Natta 127 (1982).

Under Bauman, supra, the Board's own motion authority can be invoked only after an award or arrangment of compensation (i.e., a Determination Order or Stipulated Settlement) has become final by operation of law (i.e, by failing to appeal an award or failing to

appeal a litigation order entered by a Referee, the Board or a court). Thus, a backup denial is in the nature of a request to set aside a judgment, relief that also is granted by the courts only under extraordinary circumstances. See Oregon Rules of Civil Procedure (ORCP), Rule 71B.

In belated denial cases, we believe that "extraordinary circumstances" means more than a showing that the claim should not have been accepted because it was not compensable. There needs to be a showing of why the claim was erroneously accepted in the first place. ORCP 71B provides a reasonable set of guidelines for determining when the Board should exercise its own motion authority pursuant to a backup denial. Under that rule, a judgment can be set aside only for mistake, surprise, excusable neglect, fraud, misrepresentation or other misconduct of an adverse party. Similarly, we believe that in order to prevail on a request for own motion relief in the form of a backup denial, the employer/insurer must prove that the claim should not have been accepted initially and that the claim was accepted and processed to closure because of mistake, surprise, excusable neglect, or fraud, misrepresentation or other misconduct of the claimant. (In referring to ORCP 71B, we do not mean to imply that the Board is bound by the rule. See ORS 656.283(6). The reference to ORCP 71 is only by way of analogy.)

Likewise, we believe that after expiration of appeal rights following an award or arrangement of compensation, if the insurer/employer invokes the Board's own motion authority seeking a determination that a claim previously accepted as compensable should be declared noncompensable ab initio, the burden of proof is on the employer or insurer to prove by a preponderance of the evidence entitlement to the relief it seeks.

In Harris v. SAIF, 292 Or 683 (1982), the Supreme Court held that where an insurer/employer seeks modification of a permanent total disability award which has become final by operation of law, the burden of proof is on the insurer/employer to prove a change of circumstances indicating that the claimant has regained wage earning capacity. Similarly, once a claim has been closed and the Determination Order or other arrangement of compensation has become final by operation of law (and passage of time), it is the insurer/employer's burden to prove that the claim was not compensable ab initio.

In Patricia Davis, WCB Case No. 79-10006, 35 Van Natta 635 (May 11, 1983), we held that after formal acceptance of a claim under ORS 656.262(6) if the self-insured employer or insurer wishes to contest compensability, the burden is on the employer/insurer to disprove compensability, rather than the burden being on the claimant to prove compensability. In Davis the employer had denied compensability while the case was before the Hearings Division pursuant to the claimant's request for hearing following issuance of the Determination Order closing the claim. Since the denial in Davis was issued at a time when agency review of the award of compensation was taking place, see Bauman v. SAIF, supra, it did not involve an exercise of the Board's own motion jurisdiction. Nevertheless, for the reasons stated in Davis, we held that after acceptance of a claim the burden of proof shifts to the employer to prove the validity of its denial.

All the reasons set forth in Davis for shifting the burden of proof to the employer or insurer are equally valid here. There are additional reasons for shifting the burden of proof where a backup denial case is before the Board on its own motion authority. First, we take it to be axiomatic that the Board, in the exercise of its discretion under ORS 656.278 and depending on the nature of the case presented to the Board, consistent with law and reason, may assign the burden of proof to either the claimant or the employer/insurer. Second, we are not aware of any statutory or appellate court decisions which require the burden of proof to be on either the claimant or the employer/insurer in own motion cases, thus, we are dealing with a "clean slate." Third, we believe that, as a general rule, a party seeking to invoke the authority of the Board under its own motion jurisdiction has the burden of proving that the relief should be granted. See Alvy Osborne, supra.

In Alvy Osborne, supra, litigation before the Hearings Division and the Board on review in 1974-1975 had established that the claimant's eye condition was a compensable consequence of his industrial injury but that his upper back and related problems were not. Subsequently, the claimant sought a determination that his upper back and related problems were compensable. Likewise, the insurer sought a determination that the eye condition was not compensable. In denying relief to both parties, we did not rely on the provisions of ORS 656.278 but rather held that "we believe that the reasons underlying the doctrine of res judicata support very sparing use of authority to reverse findings of compensability or noncompensability only for compelling reasons and based on clear and convincing evidence." We went on to hold with respect to the insurer's request for relief that the evidence did not clearly and convincingly persuade us that claimant's eye condition was due to an exotic eye disease rather than the compensable injury.

Osborne is consistent with our suggestion here that the party seeking own motion relief has the burden of proving entitlement to the relief sought. With respect to the standard of proof (preponderance of the evidence versus clear and convincing evidence), in Osborne the condition the insurer sought to have declared not compensable had previously been litigated and determined to be a compensable consequence of the accepted industrial injury. This case is dissimilar in that there has been no prior determination by litigation concerning the compensability of the claim. We are suggesting here that when a claim has been accepted without litigation and during the claimant's aggravation appeal rights period the employer seeks a determination that the claim was in fact noncompensable ab initio, the employer has the burden of proving that fact by a preponderance of the evidence. That is not inconsistent with Osborne being applicable to own motion cases where prior litigation has established the compensability of a claim or condition.

V.

To summarize: (1) The employer's attempt here to deny this claim after several Determination Orders had become final cannot be recognized; (2) the Board may have jurisdiction under ORS 656.278(1) and notwithstanding ORS 656.278(2) to make compensability determinations pursuant to the functional equivalents to backup

denials where the insurer/employer is foreclosed from denying compensability under Bauman; (3) if the Board has jurisdiction over such cases, the employer must show that the claim was accepted and processed to closure because of mistake, surprise, excusable neglect, or fraud, misrepresentation or other misconduct on claimant's part; and (4) the burden of proof is on the employer to establish that the claim is not compensable.

Having marched up the mountain, we will now march back down again: The employer here has not petitioned the Board to exercise its own motion authority to reach the compensability issue litigated at hearing, probably because of the Board's long standing interpretation of ORS 656.278(2) to the effect that own motion jurisdiction does not exist where the claimant still has aggravation appeal rights. The application of ORS 656.278(1) and the interpretation of ORS 656.278(2) suggested herein is a major departure from prior practice. The parties have not had an opportunity to brief either the issue whether the Board may assert own motion jurisdiction under the facts of this case or the compensability issue itself. Accordingly, we decline to exercise our own motion authority and reach the compensability issue. Confining ourselves to the issues raised and briefed by the parties, our holding is that, given the facts of this case and the holding of Bauman, the employer here may not now unilaterally deny the compensability of the underlying claim. The denials must be set aside and the claim remanded to the Referee for further proceedings on the premature closure and extent of permanent disability issues originally raised by claimant's requests for hearing.

ORDER

The Referee's order dated July 23, 1982 is reversed. The employer's denials dated March 17, 1982 and May 26, 1982 are set aside and the claim remanded to the Referee for further proceedings. Claimant's attorney is awarded $1500 for his services at hearing and on review for prevailing on a denied claim.

LOU RAE FOWLER, Claimant
Elliott Lynn, Claimant's Attorney
Cheney & Kelley, Defense Attorneys

WCB 81-09543
May 27, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Pferdner's order which: (1) upheld the employer's partial denial of claimant's left inguinal hernia claim; and (2) affirmed the Determination Order which awarded no permanent disability with respect to claimant's accepted right inguinal hernia and colon conditions.

In November 1976 claimant experienced pain when she lifted a 32 pound box in the course of her employment as a parts finisher for a dental or surgical supply concern. Claimant is 5'2" in height and weighs approximately 100 pounds. Claimant sought medical attention in March 1977 at which time she complained of tenderness in the left side of the abdomen. Upon examination, the treating physician found a bulge on the right side and diagnosed a right inguinal hernia. Later that month claimant underwent surgical repair of the right hernia. Subsequently claimant developed

colon problems. In August 1977 claimant underwent exploratory surgery because of continuing abdominal pain and pain in the right groin. No pathology was found at that time. Because of continuing right groin and leg pain claimant underwent three additional surgeries in the right groin area, two of them for the avulsion of nerves in the right groin.

In 1978 a claim was filed alleging a left inguinal ligament strain arising from the 1976 injury. The insurer denied the claim and claimant requested a hearing. Subsequently, claimant withdrew her request for hearing.

On September 17, 1981 a Determination Order issued awarding time loss but no permanent disability with respect to the right hernia and colon conditions. On September 18, 1981 claimant sought medical attention for left inguinal pain that radiated into the inner aspect of her leg. Exploratory surgery was undertaken and that surgery revealed nodules on the left round inguinal ligament and an indirect left inguinal hernia which were corrected. The employer denied a claim for these conditions and surgery in October 1981. Claimant requested a hearing concerning the September 1981 Determination Order and the October 1981 denial.

The Referee held that claimant had failed to prove the compensability of her left inguinal hernia and ligament conditions. We agree. Considering that claimant sought medical attention in March 1977 for pain in the lower left quadrant of the abdomen, it is possible that claimant sustained a bilateral hernia in the September 1976 lifting incident. That possibility is reinforced by mention of lower left quadrant pain again in September 1977, April 1978 and August 1978. However, we conclude it is more significant that claimant was examined or received medical attention far more often than on the specific dates reflected in the chart notes indicating lower left quadrant pain, yet no mention is made of similar pain on those numerous other occasions.

Claimant argues that the pain arising from the left inguinal hernia was not diagnosed earlier because the pain from her colitis condition masked the hernia pain. Claimant was examined by no fewer than 16 physicians between her September 1976 injury and the September 1981 discovery of a left inguinal hernia. We simply cannot believe that 16 physicians, including gastrointestinal specialists and surgeons, failed to distinguish between the effects of colitis in the abdomen and a hernia in the groin. It is always possible that all the doctors over five years were wrong, but the evidence preponderates to the contrary. We are not persuaded that claimant sustained a left inguinal hernia or any other left groin condition as a result of the September 1976 lifting incident.

With respect to the extent of disability question, claimant has had five surgeries attempting to correct the sequelae from the right inguinal hernia. While some of the more acute discomfort has resolved, there is residual pain. Moreover, it is apparent that claimant is restricted to lighter work because of an inability to engage in the level of lifting she was capable of prior to her injury, a level evidenced by the incident which gave rise to the

hernia in the first place. We thus conclude that claimant is entitled to an award of disability for the loss of wage earning capacity reflected by lifting limitations.

Claimant's colon condition is more problematical. Claimant's hearing testimony suggests considerable impairment, possibly as much as 35% under the criteria discussed in the AMA Guides to the Evaluation of Permanent Impairment, at p. 117-118. However, the Referee found: "None of the medical reports support her testimony as to the frequency, severity or duration of her bowel problems."

We only partially agree. The report of claimant's three-day hospitalization because of colon problems in January 1979 points out the severity of those problems at that time. Nevertheless, we agree with the Referee's apparent analysis to the extent that it is very difficult to fully accept claimant's hearing testimony in the face of relatively little mention of the claimant's colon difficulties in the medical evidence, and virtually no mention of those problems in reports that are relatively contemporaneous with the October 1982 hearing. We think it is a closer question than the Referee's order reflects, but we agree with his conclusion that there is no persuasive evidence of permanent colon impairment.

We thus only consider claimant's impairment arising from the right hernia injury and subsequent surgeries. The residual effects preclude claimant from heavier forms of work that she was able to do pre-injury. Claimant is relatively young (33) and of average education (high school graduate). We conclude that claimant would be properly compensated for her loss of wage earning capacity attributable to the 1976 injury by an award of 10% permanent disability.

ORDER

The Referee's order dated October 20, 1982 is modified in part. Claimant is awarded 32° for 10% unscheduled permanent partial disability; this award is in lieu of all prior awards. Claimant's attorney is allowed 25% of the award granted by this order for services at hearing and on review. The remainder of the Referee's order is affirmed.

SUSIE F. RAGAN, Claimant
Galton, et al., Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 82-00988
May 27, 1983
Order on Review (Remanding)

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Shebley's order which set aside the employer's denial and ordered provision of a surgical procedure recommended by claimant's physician. Claimant contends she is entitled to claim reopening pursuant to ORS 656.273 for a worsening of her compensable condition and payment of compensation for temporary total disability. The employer contends that the proposed surgery is neither reasonable nor necessary treatment; and that even if surgery is indicated, it is not causally related to claimant's April 6, 1980 industrial injury. We reverse.

Claimant was compensably injured on April 6, 1980, when she slipped and fell on her right arm and hand, injuring her wrist. She also sustained a minor injury to her back, but that apparently resolved and is not an issue in this proceeding. The wrist injury was diagnosed as a sprain or strain and accepted as a disabling injury. An X-ray of claimant's right wrist revealed deformity of the right distal radius and ulna consistent with a Madelung's deformity, and the radiology report stated that these findings were probably a combination of a prior fracture and congenital malformation. No acute changes were noted.

Claimant fractured her right wrist when she was an adolescent, approximately 15 years before this industrial injury. Her wrist was in a cast for about 6 weeks at that time, and she testified that after the cast was removed she experienced no difficulties thereafter with her wrist or forearm until the industrial injury in April of 1980. She testified that her wrist was completely functional and asymptomatic from the time of the wrist fracture during her teens until the time of her industrial injury, and that she frequently was able to engage in such activities as bowling, softball, tennis and water-skiing. She sustained no other injuries to her hand, wrist or arm after this childhood incident.

After this industrial injury claimant came under the care of Dr. Waldram, an orthopedic physician. He referred her for a neurological consultation and electrodiagnostic studies of the right hand after her April 1980 injury. At that time she was experiencing numbness in her second and third fingers and a constant throbbing sensation. The consulting neurologist stated his impression that the studies conducted were normal, and there was no evidence of carpal tunnel syndrome or other neuropathy.

Dr. Waldram initially treated claimant conservatively with repetitive casting during a period of approximately six weeks. After conservative treatment failed to improve claimant's complaints of irritation and pain in the wrist area, Dr. Waldram recommended surgical intervention in order to alleviate what he diagnosed as possible median nerve entrapment probably related to swelling in claimant's wrist. In a May 30, 1980 report Dr. Waldram expressed his impression that claimant had sustained an injury to the radial ulnar joint, which had become symptomatic as a result of her industrial injury.

Madelung's deformity is defined as "radial deviation of the hand secondary to overgrowth of the distal ulna or shortening of the radius," Dorland's Illustrated Medical Dictionary (25th Edition 1974); and as "distortion of the radius at its lower end with ulnar displacement backward," Taber's Cyclopedic Medical Dictionary (14th Edition 1981).

We understand Dr. Waldram's impression regarding the interrelationship of claimant's pre-existing deformity and her industrial injury in 1980 to be that the industrial injury aggravated a previously asymptomatic deformity necessitating surgical intervention. Claimant was admitted to the hospital in July 1980 for a surgical procedure intended to relieve her persisting right wrist pain. The assessment at that time was "status post right wrist fracture with subluxation of the distal radial ulnar joint, pain and carpal tunnel syndrome."

Dr. Waldram performed surgery identified as: "Darrach procedure, right wrist, carpal tunnel release, right wrist." The operative report describes part of the surgical procedure performed as removal of the distal ulna, which was found to be dorsally subluxated. Claimant was discharged 2 days after surgery. Dr. Waldram's office notes indicate that during September and October of 1980 claimant continued to experience pain and weakness in her wrist, being unable to perform repetitive lifting with her right arm. On October 27, 1980, Dr. Waldram found claimant's condition was improved, and he advised her to return to work but to avoid repetitive lifting and heavy labor.

Claimant was examined by Dr. Stewart, an orthopedic physician, on November 3, 1980. He found claimant still in the postoperative rehabilitation phase, stating the opinion that surgery of the type performed by Dr. Waldram was characterized by a slow recovery necessitating rehabilitation and resultant residual pain and loss of motion. Dr. Waldram reported on November 26, 1980 that claimant was not recovering well, and he suspected some ulnar entrapment.

Claimant was examined by Dr. Nathan at the Portland Hand Surgery Center in January 1981, at which time claimant was complaining of numbness in the dorsal and ulnar aspect of the 4th and 5th metacarpals of her right hand, inability to grip with her hand or turn her arm completely over (supination). Nerve conduction studies were performed in conjunction with this examination and were found to be normal. No EMG abnormalities were evident. Claimant was evaluated by two therapists at the hand center apparently on two separate occasions. Dr. Nathan characterized claimant's complaints as "nebulous" at the time of her initial examination. At the time of her second evaluation, range of supination and pronation in the right forearm was increased. All of the findings were apparently improved at the time of the second evaluation, including some increased grip strength in the right hand. This report states that claimant was able to lift a five pound brick, although doing so caused her pain, but that she was unable to lift a three pound brick, which she stated was too difficult to accomplish. Dr. Nathan stated that both examinations appeared to be essentially within normal limits, and that the therapists were unable to confirm claimant's subjective complaints.

Dr. Nathan found claimant medically stationary, recommending claim closure. He found no evidence of permanent impairment relating to claimant's median nerve, identifying claimant's persistent limited range of motion in her right forearm and wrist as a direct result of the initial injury during claimant's adolescence. He found no aggravation of claimant's "underlying complaints" as a result of her industrial injury.

> "I am unable to substantiate her subjective complaints on an organic basis, but feel it should be expected that these are a result of her initial injury fourteen years ago. In conclusion, I believe that Ms. Ragan may be gainfully employed without any restrictions, and I see no evidence of permanent partial impairment related to the incident of April 6, 1980."

Dr. Waldram completed a Form 828 dated January 14, 1981 indicating that claimant was released to return to regular work and was medically stationary as of December 5, 1980. He noted that claimant's impairment was undetermined. In a subsequent narrative report, he stated his basic agreement with Dr. Stewart's report and findings on examination. He reiterated his impression that claimant's industrial injury had aggravated her underlying "Madeline's deformity" (sic), necessitating the surgical procedure he had performed. This report, dated January 19, 1981, states that claimant was continuing to experience some causalgia and irritation, which Dr. Waldram anticipated would improve in a slow fashion.

By letter of February 17, 1981, Dr. Waldram expressed his disagreement with Dr. Nathan's conclusion that claimant's subjective complaints concerning her right forearm and wrist were not related to her industrial injury but were a sequelae of her adolescent right wrist fracture. Dr. Waldram reiterated his impression of a median nerve entrapment and swelling problem associated with her work injury by history, with no prior history of significant median nerve symptomatology, and a post injury pain pattern markedly intensified over her pre-injury status.

Claimant's claim was closed by a Determination Order in March 1981, which awarded her temporary disability and 52.5° of scheduled permanent partial disability for a thirty-five percent loss of her right forearm (wrist).

Claimant moved to San Diego, California, sometime prior to the closure of her claim. She continued to experience problems with her hand, wrist and forearm. She was examined in April 1981 by Dr. Sadick, an osteopathic physician in San Diego, who found a previous dislocation of the distal ulna, interruption of ulnar nerve and loss of rotation of the carpal bones, which he believed probably was due to scarring and an inability to rotate without pain and discomfort. He sought a neurological and orthopedic consultation. Claimant was seen by Dr. Braun, an orthopedic surgeon in San Diego apparently specializing in reconstructive surgery of the hand. In a February 22, 1982 report, Dr. Braun described claimant's complaints as throbbing and pain in her wrist, cold intolerance, weak-

ness and inability to lift or manipulate objects. His findings on examination indicated a restricted range of motion in claimant's wrist joint compatible with post traumatic arthritis. His recommendations for treatment included a possible exploration of the ulnar nerve, because he suspected a scar entrapment phenomenon following resection of the distal ulna; and a radiocarpal arthrodesis in order to provide stability and obviate the problem of arthritis at the radiocarpal joint. It was Dr. Braun's impression that, although this arthrodesis procedure, i.e., surgical immobilization of the joint, would result in some impairment in the motion of the wrist joint, it would have the positive result of eliminating claimant's problems of weakness and pain in her wrist, which he found seriously impaired her ability to use her right dominant hand. Dr. Sadick reported his concurrence with Dr. Braun's diagnosis and recommendations, which he found to be the same as his own.

Subsequent reports from Dr. Braun in March and May of 1982 reflect his opinion that the proposed surgery was necessary in order to create a stable joint in claimant's wrist, which would allow for improvement of her grip strength, pronation and supination. He stated that if claimant's history was truly as she reported it, i.e. that she had no symptoms prior to her industrial injury, then it was reasonable to assume that her accident led to the deterioration of her pre-existing wrist anomaly.

> "There may have been some bony abnormality present due to an injury she sustained when she was 13; however, it seems unreasonable to blame an earlier accident for symptoms that apparently began with the industrial accident of 4-6-80 when the patient fell onto her wrist while walking across a waxed floor. There is certainly enough force present in an injury such as the one described to explain the patient's symptoms and presently disabled condition. The only other alternative is that the accident caused a worsening of the patient's previous condition which I believe to be a similar situation to the one where the accident caused all of the symptoms in that the patient states that prior to the accident, she was asymptomatic."

Claimant was examined by Dr. Borden, another orthopedic physician in San Diego, also apparently specializing in hand surgery. All of the reports of physicians previously examining claimant, including Dr. Braun and Dr. Sadick, were made available. His examination revealed limitation of motion in the wrist and full range of motion of the hand. Findings were positive for ulnar nerve compression at the wrist. In measuring grip strength of the right hand, Dr. Borden recorded two separate measurements, the first of which indicates findings of "3 -- 0 -- 0," the second of which indicates findings of "20 -- 15 -- 20." The second set of findings is preceded by the notation: "When partially distracted, grip in the right hand measures. . . ." Dr. Borden stated that

claimant's assertion that her right arm was normal prior to her industrial injury was "obviously not the case as she sustained no fracture during that injury." He stated, however, that her injury did constitute an aggravation of her pre-existing Madelung's deformity. "She obviously had limitation of supination and pronation pre-operatively due to that deformity and the surgery in all probability, improved that range of motion."

Dr. Borden concluded that claimants complaints at the time of his examination were secondary to her pre-existing Madelung's congenital deformity, and not her industrial injury. He stated that although it was conceivable that the surgical procedure performed by Dr. Waldram may have caused some scarring that presently was causing her ulnar symptoms at the wrist, he believed that the proposed arthrodesis of the radiocarpal joint was not indicated based upon his findings that the joint moved painlessly, smoothly and without crepitous or grinding. He stated that the bony deformities had been present claimant's entire life and provided adequate function; and that claimant probably could be performing her usual occupation with minimal limitations if she had the desire to do so.

On April 30, 1982, the employer denied "responsibility for the radiocarpal arthrodesis," apparently on the basis that this surgical procedure was not related to her injury but was related to a preexisting condition which was neither temporarily nor permanently worsened by her industrial injury. The denial letter states that palliative care reasonable and necessary for treatment of the condition caused by her industrial injury would be provided, and that the proposed exploration of the ulnar nerve did not appear to be warranted. The denial also states that claimant's inability to work was attributable to the "arthodesis condition" which was unrelated to any condition resulting from her industrial injury, and denied claim reopening for aggravation. Finally the denial stated:

> "Also, in accordance with ORS 656.245, the employer has the right to choose the doctor with whom a claimant shall treat when the claimant is living out of the State of Oregon. Therefore, we have chosen Dr. Borden to be your treating physician."

In a report dated June 2, 1982 addressed to the employer's insurance adjuster, Dr. Braun expressed his disagreement with Dr. Borden's conclusions. He stated that the critical factor in assessing the interrelationship of claimant's pre-existing abnormality, her 1980 industrial injury and the surgical procedure he had proposed, was the fact that claimant specifically had stated that her wrist was completely asymptomatic prior to her accident, and that she was capable of full activity and employment at the time of her injury, but not thereafter. He stated his impression that claimant was desirous of undergoing the surgery he proposed, not for reasons associated with secondary gain, but because her wrist was truly symptomatic and was preventing her from working.

Dr. Nathan again communicated with the employer by letter of July 14, 1982. He apparently had been provided copies of reports from Drs. Braun, Sadick and Borden. He "strongly" felt that claimant's symptoms were not industrially related. "We do know that on

the date of her injury (April 6, 1980) she already had a significantly deformed right wrist, and it is inconceivable that this wrist did not already suffer a limitation of motion as well as some discomfort."

Dr. Nathan expressed his doubt concerning the relationship between claimant's industrial injury and the subsequent surgical procedure performed by Dr. Waldram. On review of his chart notes and those of other examining physicians, Dr. Nathan found no evidence of arthrosis within the wrist itself, the major problem being the dorsal angulation of the distal radius, which, in itself, he found not to be any indication for further surgery.

> "Also, it must be understood that though this patient presented with a significant amount of pain, this pain was not substantiated by the physical examination or on evaluation by the therapists at the Portland Hand Rehabilitation Center. An angled bone does not cause pain in and of itself. It is the arthrosis (arthritis) which develops -- if in fact it does develop -- which will cause subsequent discomfort. The patient did not show any evidence of arthrosis. * * *.
>
> "More probably than not, the displacement of the bone and disturbance of the articulation of one bone against the other is the result of the intial injury the patient sustained in childhood (age 12). These changes are consistent with the dorsal angulation of the radius which occurred at that time.
>
> "I concur with Dr. Borden that surgery should not be contemplated in this patient. His findings on examination, with distraction of the patient, of increased grip would confirm our findings of less-than-maximal effort when examined by us, and further, in part, reaffirms our findings of significant pain behavior, which means that there was a description of pain by the patient without objective evidence or reasoning for it."

Dr. Nathan concluded that, in order to justify surgery, some objective findings should be considered necessary, and subjective complaints alone were an insufficient basis for the decision to perform the surgery in question. With regard to the findings of Drs. Braun and Sadick indicating that claimant had ulnar sensory symptoms which required decompression, Dr. Nathan stated that these findings should be objectively verified by diagnostic procedures such as nerve conduction studies, which were not performed.

The Referee found the opinions of Dr. Braun and Dr. Sadick more pursuasive than the opinions of Dr. Borden or Dr. Nathan. He

reasoned, in part, that the opinions of Drs. Braun and Sadick were consistent with Dr. Waldram's earlier views regarding the effects of claimant's 1980 injury, and that Dr. Waldram's opinion was adopted and Dr. Nathan's rejected when the employer originally accepted the claim and paid for the surgery performed by Dr. Waldram. We do not agree with the Referee's assessment of the medical evidence.

This claim was accepted by the employer in April of 1980. Surgery was performed by Dr. Waldram in July of 1980. Dr. Nathan examined claimant at the request of the employer for the first time in January 1981 and for the purpose of claim closure. Even at that time, Dr. Nathan expressed the opinion that claimant's subjective complaints were not the result of her industrial injury but were the result of her initial injury many years before.

The issue in this case is not whether the employer can now deny liability for a previously accepted condition. In fact, the employer, by the very terms of its denial letter, has reaffirmed its responsibility for the consequences of claimant's injury. The issue is: what are the consequences of claimant's industrial injury; and, specifically, is the treatment proposed by Drs. Braun and Sadick, as well as claimant's current symptomatology, causally related to her industrial injury and, if so, is the proposed surgery reasonable and necessary for treatment of those consequences. Cf. Dorothy J. Swift, 34 Van Natta 1509 (1982).

We find Dr. Nathan's opinions more persuasive than those of Drs. Braun and Sadick in resolving the issue of the causal connection between the surgical procedures proposed and claimant's industrial injury. Dr. Braun has repeatedly stated that the crucial factor in determining the question of causation is claimant's assertion that prior to her 1980 injury she had normal use and function of her right arm, wrist and hand. His conclusions are based upon the assumption that claimant's history of being asymptomatic prior to her fall at work is true. Dr. Nathan and Dr. Borden have both expressed incredulity regarding claimant's assertion that she was completely symptom-free after a short period of recovery from her fall as an adolescent. Although the Referee found claimant to be a credible witness, we conclude this finding is entitled to little weight in view of the fact that he was unable to observe claimant's demeanor while she testified over the telephone from her present home in Alabama. His credibility finding seemed to have been based upon his review of the record, which he found to be lacking in evidence indicating that claimant was anything less than credible. We do not agree. Claimant has been found by at least two examining physicians to have a tendency to exaggerate her signs and symptoms, as reflected in the report of the examination by the physicians at the Portland Hand Rehabilitation Center in 1981, when she was able to lift a five pound brick, but not a three pound brick; and Dr. Borden's examination in 1982 reflecting different findings on grip strength depending upon whether or not claimant was distracted during the testing procedure. As mentioned by Dr. Braun, "the dynamometer is under the volitional control of the patient."

Based upon these findings, Dr. Braun's almost sole reliance upon claimant's history and subjective complaints of pain creates some doubt in our mind as to the reliability of his opinion.

Furthermore, with regard to the reliability of Dr. Waldram's findings, which seemingly formed part of the basis for the Referee's decision, even before the surgery in 1980, a neurologist had performed nerve conduction studies and electromyography, which were found to be normal, showing no evidence of carpal tunnel syndrome or other neuropathy. Dr. Waldram nevertheless performed a carpal tunnel release in addition to the Darrach procedure.

We find that claimant has failed to establish by a preponderance of the pursuasive evidence that the surgical procedures recommended by Drs. Braun and Sadick, including the proposed radiocarpal arthrodesis or wrist fusion and the suggested procedure for exploration and decompression of the ulnar nerve, are causally related to her 1980 industrial injury. It follows, therefore, that this surgery is neither reasonable nor necessary for treatment of any condition resulting therefrom.

That portion of the employer's denial asserting its right to choose claimant's treating doctor under the express terms of ORS 656.245 while claimant is out of the State of Oregon was not addressed in the proceedings before the Referee or on this review. Therefore, that defense to payment of the compensation claimed is not an issue before us.

As an alternative issue to claimant's request for claim reopening in conjunction with the proposed surgery, claimant had requested a hearing concerning the permanent disability awarded by the March 31, 1981 Determination Order. In view of his disposition "reopening" the claim for the proposed surgical procedures, the Referee did not reach the issue of extent of permanent disability. Having found that the employer's denial should stand, it is necessary for us to remand this case for further proceedings on the issue of the extent of permanent disability attributable to claimant's April 6, 1980 industrial injury.

ORDER

The Referee's orders dated August 27, 1982 and September 13, 1982 are reversed and the employer's denial dated April 30, 1982 is reinstated and affirmed. This case is remanded to the Referee for determination of the extent of claimant's permanent disability.

THOMAS BLACKWELL, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-10230
May 31, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Galton's order affirming the SAIF Corporation's denial of claimant's occupational disease claim for coronary artery disease.

Claimant is a 52 year old long haul truck driver who sustained a myocardial infarction on July 21, 1981 while in Los Angeles as part of his job. Claimant does not claim that the myocardial infarction was an industrial injury but rather that it was the culmination of his coronary artery disease. He contends that his work

exposure was the major contributing cause of his coronary artery disease. In particular he contends that he ate more greasy foods and smoked more cigarettes than he otherwise would have because of his employment as a long haul truck driver.

The Referee found, apparently based on the opinion of Dr. Mundall, that claimant's coronary artery disease was accelerated by his habitual cigarette smoking and apparent hypertension. Dr. Mundall stated:

> "The factors outlined in your letter regarding diet, cigarette consumption and sedentary activity is [sic] specifically what I was referring to. It is my opinion that these factors are a major contributing factor to the precipitation of coronary artery disease, and therefore precipitation of myocardial infarction for Mr. Blackwell."

The Referee found that:

> "Claimant's cigarette smoking was doubled by his industrial exposure which contributed in a significant way to his coronary artery disease and resultant hypertension."

The Referee concluded that the evidence proved that claimant's work exposure was a major contributing cause of claimant's cornoary artery disease. However, he did not find the coronary artery disease compensable because claimant had failed to prove that his work exposure was the major contributing cause.

We are unsure of the meaning of the distinction which the Referee made between "a major contributing cause" and "the major contributing cause." Our understanding of the phrase "major contributing cause" is that the factor contributes more than fifty percent to the disease. Based on that understanding it is contradictory to say something is "a" major contributing cause but not "the" major contributing cause. Perhaps the distinction the Referee was making was between a material contributing cause and a major contributing cause.

However, even assuming that the Referee's order is intended to mean that claimant has proven that his work exposure was a material contributing cause of the coronary artery disease, we disagree. In Gordon L. Ogden, 34 Van Natta 1567 (1982), claimant argued that his occupation as a police officer had caused him to increase his smoking and to gain weight due to poor dietary habits. We held that the claimant was required to prove that it was the stress of his job which had caused him to increase his cigarette smoking and eat poorly. See also Schwenn v. SAIF, 17 Or App 50 (1974).

The only evidence in this case concerning the cause of claimant's increased smoking and consumption of greasy foods is his testimony that he smoked more on the job out of boredom and ate more greasy foods on the job because they were more available. There is also the very general report of Dr. Mundall to the effect that truck drivers tend to eat poorly and smoke a lot of cigarettes

due to the nature of their jobs. On the other hand, claimant testified that following his heart attack he quit smoking and changed his diet even though he had returned to work and was still stopping at the same restaurants.

We find this evidence insufficient to prove that claimant's job caused his increased smoking and poor dietary habits. Claimant's own testimony establishes that his increased smoking and dietary habits were apparently a matter of personal choice and comfort rather than incidences of his employment. He was able to stop smoking and eat better and still do his job.

The fact that Dr. Mundall considered claimant's increased cigarette smoking and poor diet a major contributing cause of his coronary artery disease is irrelevant because we find that he has not proven that his job caused the increased smoking and poor diet.

Accordingly, we find that claimant has failed to prove by a preponderance of the evidence that his on the job exposure was even a material cause of his coronary artery disease. We agree with the Referee that he has failed to prove that it was the major contributing cause of his coronary artery disease.

ORDER

The Referee's order dated November 22, 1982 is affirmed.

Board Member Barnes Concurring:

I agree with and join the Board's order. I write separately only to express my own emphasis on one facet of this case.

There is absolutely no proven causal link between claimant's work and his coronary artery disease as I understand the concept of causation. To the limited extent that any cause of any person's coronary artery disease can be identified, this claimant's disease is due to the tobacco he chose to smoke and the foods he chose to eat. Claimant's work did not cause his tobacco smoking in any fair sense of that term. Claimant's work did not cause his menu selections in any fair sense of that term. Those were claimant's volitional decisions, plain and simple.

Those of us with unhealthy habits like to rationalize that we are the victims of external forces that dictate, control and "cause" our actions and inactions. While I enjoy a good rationalization as much as any other tobacco smoker, the harsh reality is, unfortunately, to the contrary. In reality, each of us is individually and solely responsible for the health consequences of our own volitional decisions.

BERNIE HINZMAN, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 83-0097M
May 31, 1983
Own Motion Order and Own Motion Determination on Reconsideration

Claimant's attorney has requested the Board reconsider the attorney fee granted to him by our April 29, 1983 Own Motion Order and Own Motion Determination. The attorney contends his fee should be paid by the insurer rather than out of claimant's compensation. Based on OAR 438-47-070(2), we hereby deny claimant's attorney's request.

IT IS SO ORDERED.

RAEANN M. NAJAR, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01470
May 31, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of that portion of Referee Daron's order which upheld the SAIF Corporation's denial of claimant's claim for an injury to, or more likely an occupational disease in, her right wrist.

We affirm and adopt those portions of the Referee's order relating to the issue of compensability. We also note that the Referee's assessment of a 25% penalty on the interim compensation he ordered paid was not within the range we indicated was appropriate in Zelda M. Bahler, 33 Van Natta 478 (1981), rev'd on other grounds, 60 Or App 90 (1982), and there is no indication in the Referee's order why he departed from that range. However, SAIF does not raise any issue regarding the amount of the penalty ordered by the Referee.

ORDER

The Referee's order dated July 14, 1982 is affirmed.

ANNA M. SCHEIDEMANTEL, Claimant
Steven C. Yates, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorney

WCB 81-00719
May 31, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of Referee Seifert's order which upheld the SAIF Corporation's denial of medical services and aggravation reopening of claimant's 1979 back injury claim. Claimant apparently contends that she received compensable medical treatment and/or was entitled to aggravation reopening in December 1980 and/or in April 1981. Claimant further argues that, in any event, she is entitled to interim compensation, penalties and attorney fees.

Claimant suffered a compensable injury to her back on June 27, 1979. Dr. Smith diagnosed a dorsolumbar strain and reported on March 4, 1980 that claimant had only minimal residual disability. He found claimant to be medically stationary and stated that no additional treatment would be necessary. A Determination Order issued on April 9, 1980 allowing claimant benefits for temporary total disability only.

On June 19, 1980 Dr. Rabin reported that he had seen claimant twice in June of 1980; that she presented complaints of thoracic and lumbodorsal discomfort; that he found claimant's spine to be essentially normal; that he felt her complaints of pain were exaggerated; and that he had nothing to offer her in the way of treatment. Responding to Dr. Rabin's report as an aggravation claim, SAIF issued a denial on June 24, 1980.

On June 2, 1980 Dr. Martin conducted a psychiatric examination of claimant. Dr. Martin stated that he found no evidence of a severe psychiatric disorder but "was impressed with the possibility of a conversion reaction being present." Claimant was examined by Dr. Whitney on August 2, 1980. Dr. Whitney reported that claimant had sustained an injury to her back in June 1979, had returned to work in November of that year, but had experienced increased back pain in April 1980. Dr. Whitney stated: "My impression is that she is not hurting as severely as she claims to be. . . ."

On December 8, 1980 a stipulation was entered into by which claimant received 7.5° unscheduled permanent disability. Her request for hearing on SAIF's aggravation denial was dismissed.

On December 20, 1980 claimant presented herself at the Bay Area Hospital with complaints of back pain. The admission report states that the current episode began about two weeks prior to admission when claimant was trying to get into her car. Claimant was discharged the following day. The discharge report states that claimant "came in last night and has had instant cure with bedrest and traction and wants to go home this afternoon." SAIF did not receive copies of the hospital reports until February 17, 1981.

On December 30, 1980 claimant was examined by Dr. Golden at the request of Dr. Cox. Dr. Golden stated that claimant probably had some degree of chronic lumbosacral spine strain, but that he felt she was exhibiting signs of functional overlay. Dr. Golden's

report was received by SAIF on January 9, 1981. It contains no mention of claimant's December 1980 one-day hospitalization, and claimant did not thereafter return to Dr. Golden.

Claimant was again hospitalized from April 30 to May 9, 1981 for back pain. Dr. Cox's discharge narrative states:

> "This 18 year old white female has had a long history of back complaints, starting with an on the job injury at the Thunderbird in 1979, she has been seen by Dr. Whitney and has been referred to Dr. Serbu in Eugene with no grossly abnormal findings. I felt that there was a functional overlay to her pain. She had not been seen until she phoned in to say she was having severe back pain again, with a history that she had been mud wrestling approximate[ly] a week or so before. . . ."

This report was received by SAIF on May 26, 1981.

Claimant was again examined by Dr. Golden on July 20, 1981. Dr. Golden reported that he was unable to find any significant pathology. He repeated his impression that functional overlay was present and felt that the claimant should return to work.

On December 21, 1981 SAIF issued the denial that gives rise to this proceeding. That denial states that the original injury remained in an accepted status, but that the exacerbation resulting in hospitalization in April 1981 appeared to be the result of an injury incurred in a mud-wrestling match and was, therefore, denied.

I.

The Referee concluded that there was insufficient medical evidence from which to conclude that claimant suffered a worsening of her injury related condition in December 1980, or that the original injury was a material contributing cause of the April 1981 exacerbation. We agree.

Virtually every physician who has treated or examined claimant has been unable to find any objective evidence to substantiate her physical complaints; virtually every physician has felt that she was exaggerating her problem. This view is shared by the physicians who examined and treated claimant during her December 1980 and April 1981 hospitalizations. Additionally, with regard to claimant's April 1981 hospitalization, we find that claimant has not established that the 1979 industrial injury was a material contributing cause of the condition for which she was then treated. There is no statement from any physician indicating that the 1979 injury, as opposed to claimant's mud-wrestling activity prior to her April 1981 hospitalization, was a material cause of her exacerbated condition. Grable v. Weyerhaeuser, 291 Or 387 (1981).

II.

It is difficult to understand claimant's position regarding

interim compensation, penalties and attorney fees. To the extent that claimant claimed SAIF should pay for medical services rendered at the time of her hospitalizations in December 1980 and 1981, at first blush SAIF's December 1981 denial seems far beyond the 60 days allowed to accept or deny -- except there is no evidence of when SAIF received any bills for those medical services and thus no basis for knowing when the 60 days started to run. We thus assume that these issues involve the duty to pay interim compensation on a claim for aggravation reopening and penalties and attorney fees for failure to do so. This leads to ORS 656.273(6), which requires medical verification of inability to work to trigger the duty to pay interim compensation.

The Referee in effect concluded that the medical reports concerning claimant's December 1980 and April 1981 hospitalizations were insufficient verification of inability to work. We agree with the Referee with regard to the December 1980 hospitalization. Claimant entered the hospital on a Saturday evening and was released on Sunday afternoon following an "instant cure." Knowing only this and nothing more -- and there is nothing more in anything that could conceivably be called an aggravation claim -- common sense dictates that there was no medical verification of inability to work.

The reports relating to claimant's second hospitalization are another matter. These reports state that claimant was hospitalized for 10 days for bedrest, traction and a myelogram. Except under the most unusual circumstances, such as one weekend evening in the hospital producing an instant cure, common sense also dictates that there can be no greater verification of inability to work than a report that a claimant is or was hospitalized.

In Douglas Dooley, 35 Van Natta 125, 127 (1983), we defined an aggravation claim as including "reasonable notice to the employer or insurer that the worker is claiming further medical services or additional compensation for worsened conditions relating to or resulting from the worker's original injury or disease." We appreciate that the reports concerning claimant's April 1981 hospitalization suffer from the vagueness that we discussed at length in Dooley, but we think that a report of hospitalization for back treatment that recites a history of back complaints "starting with an on the job injury" is sufficient to be an aggravation claim under Dooley and to trigger the duties to respond as required by law.

Given our conclusion that the report of hospitalization was sufficient verification of inability to work, the required responses include payment of interim compensation starting on the date of notice or knowledge of the claim, Donald Wischnofske, 32 Van Natta 136 (1981), 34 Van Natta 664 (1982), unless the claim is denied within 14 days. As previously noted, SAIF received the reports of claimant's April 1981 hospitalization on May 26, 1981. That should have been the starting date for interim compensation.

Ordinarily interim compensation continues until a claim is denied, which in this case would mean until December 21, 1981. There is, however, an unusual twist in this case. On July 21, 1981 Dr. Golden opined that claimant could return to work. Should interim compensation continue beyond a release to work?

We previously noted, but did not resolve, this issue in Bonnie R. Tolladay, 35 Van Natta 198, 201 (1983).

> "The next issue is whether claimant is entitled to interim compensation after January 22, 1982, the date by which Dr. Hummel released claimant 'to any job she chooses, including any of the job descriptions [the employer] brought to the office.' We have concluded that interim compensation is not payable to a claimant who is actually working. Anthony A. Bono, 35 Van Natta 1 (1983). By parity of reasoning, possibly interim compensation is not payable to a claimant who is released for regular work."

Since our Tolladay decision, the Court of Appeals has observed:

> ". . .there is little difference between TTD on an accepted claim and 'interim compensation' paid by an undecided insurer. Both are derived from the same statute: ORS 656.210." Petshow v. Ptld. Bottling Co., Or App 614, 619 (1982).

Looking to the relevant concepts as presumptively applicable in both contexts, time loss on an accepted claim can be terminated upon an injured worker's medical release to return to work; it follows that interim compensation on a deferred claim can likewise be terminated upon an injured worker's release to return to work. We now so hold.

In summary, on May 26, 1981 SAIF received what we deem sufficient to be an aggravation claim accompanied by what we deem to be sufficient verification of inability to work (a report of hospitalization); on July 20, 1981 Dr. Golden released claimant to return to work; claimant is entitled to interim compensation during that interval and an award of penalties and attorney fees.

ORDER

The Referee's order dated August 4, 1982 is affirmed in part and reversed in part. Those portions of the Referee's order which found that claimant was not entitled to interim compensation, penalties and attorney fees are reversed. The SAIF Corporation is ordered to pay claimant interim compensation from April 30, 1981 to July 20, 1981. SAIF also is ordered to pay claimant a penalty of 25% of the interim compensation due under the terms of this order. SAIF also is ordered to pay claimant's attorney a fee of $400 pursuant to ORS 656.382(1). The remainder of the Referee's order is affirmed.

LOWELL D. SLAMA, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-03475
May 31, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Pferdner's order which approved the SAIF Corporation's May 24, 1982 aggravation claim denial. The issues on review are the compensability of the aggravation claim, penalties and attorney's fee.

Claimant, age 27 at the time of the hearing, began working for Meining Brothers, Inc. in late 1978 as a furnace and sheet metal installer. In November or December of 1979 claimant began having difficulties with his hands. He was examined by Dr. Goodkin on March 4, 1980 who diagnosed irritant contact dermatitis. Patch testing revealed that claimant was allergic to potassium dichromate, a compound found in galvanized metals and cement. He was also determined to have an irritant reaction to grease, soaps and solvents. On March 18, 1980 claimant submitted a letter of resignation to Meining Brothers stating that he would be unable to continue working there due to his allergy to galvanized metals and that "This will not only help the allergy I have developed but will also lessen the compensation exposure to Meining Oil Company."

A claim was filed with SAIF and it was apparently accepted for a Determination Order dated October 13, 1980 awarded claimant benefits for temporary total disability from March 4, 1980 through March 14, 1980. There was no award of permanent partial disability.

Following termination of his employment with Meining Brothers, claimant obtained a job with Quality Furnace Cleaning in late March or early April. He was forced to quit, however, after four to six weeks because he was again exposed to irritants on that job. Claimant was apparently unemployed for a short period of time before obtaining employment with Hedin Air Conditioning in May 1980. He worked for Hedin until December 1980 at which time he was laid off due to a combination of lack of work and his inability to adequately perform his work due to his dermatitis. Claimant was again unemployed for a period of time until he secured a job with Imperial Mechanical in April of 1981 as a furnace and sheet metal installer.

Between September 1980 and December 1981 claimant did not seek medical treatment for his condition. He testified, however, that he continued to experience some difficulties with his hands and that he treated this himself with various types of hand creams. Between December 1981 and January 1982 claimant's hands worsened to the point where he could no longer continue working. He returned to Dr. Goodkin in January 1982 for additional treatment. Dr. Goodkin's chart notes of January 18, 1982 indicate that claimant's condition had never completely healed, but that it was relatively quiescent until two or three months earlier when it again flared up. He indicated that claimant was not medically stationary. On May 11, 1982 Dr. Russell of the Portland Dermatology Clinic reported that claimant's condition prevented him from performing his regular work as a furnace installer.

Claimant continued to work at Imperial until February 1982 when he took a leave of absence because his condition was not improving. Rather than simply not working and waiting for his condition to improve, claimant sought, and immediately obtained new employment at the end of February as a mechanic parts runner for Columbia West. His work at Columbia West consisted of locating and transporting parts for machines which broke down. Apparently this job had the added benefit of not exposing claimant to materials he was allergic to, thus allowing his condition to clear, which it apparently had done by the time of the hearing. Claimant's work at Columbia West paid $5 per hour initially, and $6 per hour when he obtained a raise in September or October of 1982. His job at Imperial paid $9 per hour and he was paid $6.50 per hour while employed by Meining Brothers.

On March 19, 1982 claimant, through his attorney, filed a claim for aggravation with SAIF. On April 9, 1982 SAIF had claimant's file examined by Dr. Girod. Dr. Girod reported that claimant's condition was a continuation of the condition contracted at Meining Brothers. On May 24, 1982 SAIF issued a partial denial stating that since claimant was able to work and was currently employed, that the claim could not be reopened but that medical benefits pursuant to ORS 656.245 would continue to be provided.

The Referee stated that he had no doubt that claimant's condition had worsened, that he was entitled to but never received any permanent disability award when the Determination Order was issued and that claimant had lost time from work for which he was never compensated. The Referee concluded, however, that despite claimant's condition having aggravated on or about March 1, 1982 ". . . the fact remains, at that time he was working and he could receive medical care and treatment under ORS 656.245 without the claim being reopened. I, therefore, find defendant's denial must be sustained."

Claimant contends that the Referee erred in affirming SAIF's denial of reopening on the grounds that he was employed at the time the aggravation claim was made. Specifically, claimant argues that he was entitled to compensation in the form of temporary partial disability benefits until he became medically stationary, based on the difference between his wage received at Columbia West ($5 per hour), and that which he was receiving when he initially contracted his condition at Meining Brothers ($6.50 per hour).

SAIF's defense on appeal appears to be restricted to the proposition that the Referee was correct in concluding that claimant had not suffered a worsening of his condition since October 13, 1980.

We address SAIF's argument first, as it can be disposed of fairly rapidly. SAIF is simply incorrect in its contention that the Referee concluded that claimant's condition had not worsened. On the contrary, as we have noted above, the Referee specifically found that claimant's condition had worsened. He concluded, however, that he did not believe that he could order the claim reopened since claimant was working. We concur with the Referee that claimant has established that his condition has worsened since the last award or arrangement of compensation, which in this case

is the October 1980 Determination Order. We believe that the medical evidence, when read as a whole, unequivocally supports such a finding. Had claimant received a permanent partial disability award for his condition, however, it is questionable whether he would be able to establish a claim for aggravation. See Francis Knoblauch, 35 Van Natta 218 (1983). Even so, we would be satisfied under the facts of this case that claimant has experienced an actual worsening of his condition rather than simply a cyclical exacerbation.

The only viable issue in this case thus boils down to the question of whether an insurer may refuse to reopen a claim to provide temporary partial disability to a medically unstationary claimant claimant once again becomes medically stationary, when that claimant has accepted or secured the equivalent of modified employment at a lower rate of pay. There is no doubt in our minds that the answer is "no."

ORS 656.210 relates to the provision of temporary total disability benefits. ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which his loss of earning power at any kind of work bears to his earning power existing at the time of the occurrence of the injury."

ORS 656.273(6) states that when a claim for aggravation is made that:

> "A claim submitted in accordance with this section shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, . . ."

ORS 656.262(2) states that:

> "The compensation due under this chapter shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim . . ." (Emphasis added.)

There is no specific definition of "compensation" in the above quoted statutes. However, the general definition statute, ORS 656.005(9) provides:

> "Compensation includes all benefits, including medical services, provided for a compensable injury to a subject worker . . . by a direct responsibility employer or the

State Accident Insurance Fund Corporation
pursuant to this chapter."

Claimant argues that there is thus no differentiation between temporary total disability benefits and temporary partial disability benefits.

Although there is no case directly on point, it seems inconceivable that the definition of "compensation," which has been defined as including temporary total disability benefits, would not include temporary partial disability benefits as well. See Jones v. Emanuel Hospital, 280 Or 147 (1977); SAIF v. Mathews, 55 Or App 608 (1982); Ohlig v. FMC Rail & Marine Equip't Divn., 291 Or 586 (1981); Williams v. Burns Int'l Security, 36 Or App 769 (1978). To hold otherwise would mean, contrary to the statute and the above-noted cases, that compensation does not include "all benefits."

As noted above, ORS 656.212 provides that a temporary partial disability is a disability which is temporary in nature and not fully disabling. That is, the worker is not incapacitated from performing some work at a gainful occupation. The statute requires that in such situations the worker receive that proportion of payments provided for temporary total disability which his loss of earning power bears to his earning power existing at the time of the injury. OAR 436-54-222 provides the specific methodology for the correct calculation of such benefits.

The following situation is analagous to the current case. Claimant is engaged in heavy work and suffers a back strain which temporarily precludes him from heavy work. Claimant's employer provides modified employment for the claimant which is within appropriate medical restrictions, but is compensated for at a lower rate of pay than claimant was earning when injured. Clearly, under the statute, the employer or its insurer is required to provide claimant with temporary partial disability benefits until claimant is once again able to engage in heavy work or, if not, until claimant is declared medically stationary and his claim closed by Determination Order.

We see little difference in the current case other than the fact that claimant simply suffers from a different condition. The medical evidence clearly indicates that claimant was not medically stationary and was unable to continue to engage in his work which involved exposure to irritants to which he was allergic. Rather than waiting idly for his condition to once again become medically stationary, claimant actively sought and secured other employment, at an occupation which did not expose him to irritants and allowed his condition to clear, while he was simultaneously earning wages and thus lowering the insurer's compensation exposure. In this situation claimant should be considered to have secured modified employment. It would seem that in such a situation the insurer should be more than willing to provide temporary partial disability benefits. This is not similar to the situation in Anthony A. Bono, 35 Van Natta 1 (1983).

There seems to be little question that claimant will probably never be able to return to his previous employment as a furnace and sheet metal installer. Perhaps this is why SAIF and the Referee

concluded claimant was not entitled to temporary partial disability benefits. We conclude that in a situation where a claimant suffers a worsening of his condition which renders him unable to continue working at his job, but he is able to and does engage in modified employment or the equivalent thereof, that he is entitled to temporary partial disability benefits until he is released to perform his regular work, or he is declared medically stationary and his claim is properly closed. The claimant in the current case is, therefore, entitled to have his claim reopened and temporary partial disability benefits beginning January 18, 1982, the date which Dr. Goodkin indicated that claimant was no longer medically stationary. Since claimant continued to work for Imperial until sometime in February 1982, the temporary partial disability to which he would be entitled from January 18, 1982 until he began working with Columbia-West will likely be equal to zero. Anthony A. Bono, supra. To avoid creating a potentially large overpayment which may not be recoverable from a permanent disability award, it would appear appropriate for us to establish a cessation date for time loss benefits. Based upon claimant's testimony and the Referee's observations of claimant's hands at the hearing, it appears likely that claimant's condition was medically stationary at least as of the date of the hearing. This date is not binding on the Evaluation Division which, in accordance with ORS 656.268, will determine the medically stationary date, award compensation and make such adjustments in the compensation as may be necessary. Clyde Hargens, 31 Van Natta 177 (1981) and David Cheney, 35 Van Natta 109 (1983).

With regard to the issues of penalties and attorney's fees, we affirm and adopt the relevant portions of the Referee's order.

ORDER

The Referee's order dated November 29, 1982 is affirmed in part and reversed in part. The SAIF Corporation's partial denial dated May 24, 1982 is set aside. Claimant is entitled to temporary partial disability benefits to be paid in accordance with our above holding. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an attorney's fee of $1,000, payable by the SAIF Corporation.

GERHARD VON KOHLBECK, Claimant
Carney, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-03170 & 82-08310
May 31, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests and claimant cross-requests review of Referee Galton's order which set aside SAIF's April 2, 1982 denial of claimant's alleged low back injury claim of January 8, 1982, set aside SAIF's "oral" denial entered at the September 14, 1982 hearing concerning the same injury and affirmed another "oral" denial entered by SAIF at the hearing in relation to claimant's alleged January 11, 1982 back injury or occupational disease claim as moot. The issue is compensability.

Claimant, who was 52 years of age at the time of the hearing, was employed by the Corbett School District as a groundskeeper and maintenance man. He was simultaneously employed by the City of Troutdale as a caretaker for a city park. In exchange for his services at the park, claimant was allowed use of a dwelling at the park for his personal residence, the rental value of which was stated to be equal to $350 per month. In addition to his employment by the school district and City of Troutdale, claimant was also employed at the same time by the Menukha Camp and Conference Grounds as groundskeeper and maintenance man.

On January 29, 1982 claimant signed an 801 form alleging that he sustained injuries on January 8, 1982 and January 11, 1982 while working for the school district. The claim form stated that claimant was repairing some bleachers at the school on January 8, when he fell over backwards onto the gymnasium floor. It further indicated that he continued working without difficulty until January 11, when he was unable to straighten his back while putting down a plywood floor in a bus shed. Claimant did not work for the school district beyond January 11, 1982. SAIF deferred the claim but did not pay interim compensation.

On February 5, 1982 Dr. Perry reported that claimant was first examined on January 18, 1982 and that he was complaining of back pain which began about one week previous and, "In retrospect he noted that he had discomfort while stepping on a bleacher, slipping and tilting backward to the left." Dr. Perry diagnosed degenerative disc disease L-5, S-1, with osteoarthritic spurring of the lumbar bodies. Additional x-rays taken on February 8, 1982 revealed considerable zygapophyseal (the articular process of a vertebra) and vertebral body spurring, especially at L-5, S-1. Dr. Perry referred claimant to Dr. Noall, an orthopaedist. Dr. Noall reported on February 12, 1982 that claimant denied having back problems until five or six years ago. (There is no reason to believe that Dr. Noall was actually referring to the January 8, 1982 back incident which he reported as having occurred five or six years before because of, we infer, communication difficulties with claimant who speaks with a heavy German accent.) Dr. Noall diagnosed degenerative disc disease at L-5, S-1 with mechanical low back pain, felt that surgery was not indicated but recommended that claimant avoid awkward lifting in the future.

Claimant submitted his resignation from his school district job on March 1, 1982. He did continue to perform his duties as caretaker at the city park. These duties included cleaning gutters, raking, general clean-up, cleaning rest-rooms, pruning and spraying shrubs and removing stumps. Claimant apparently did not work for the Meukha Camp after January 8, 1982. Claimant was still performing his caretaker functions for the city park at the time of the hearing.

On March 1, 1982 Dr. Perry attempted to clarify the historical aspects of claimant's back difficulties. Dr. Perry reported that claimant had stated on January 18, 1982 that his back pain was gradual in onset, that when he returned for a follow-up examination the next week claimant informed him of the bleacher incident, that he had experienced low back pain for the last 10 to 15 years with no specific precipitating events, and:

> "In my opinion, the patient has a history of low back pain based on degenerative disc disease with an increase in his back discomfort in January, related, he states, to an injury that occurred on the job. I think that this was a pre-existing back problem but that the injury certainly aggravated a basically degenerative condition." (Emphasis added.)

Dr. Perry suggested a weight loss program for claimant and referred him to Dr. Parsons, a neurosurgeon.

Dr. Parsons performed a complete examination of claimant on March 10, 1982 and reported that claimant had sustained an injury on January 8, 1982 when he fell while repairing some bleachers and landed on his elbows and back, that he suffered no immediate back pain, but that he felt severe back pain later while installing a plywood floor. Dr. Parsons further reported that claimant experienced back discomfort for the last seven years related to activity. He diagnosed degenerative disc disease with arthritic changes at the lumbosacral level. He stated that claimant's present complaints "are related to his injury of January 8, 1982."

On March 4, 1982 SAIF submitted a question to Dr. Parsons:

> "Do you feel that the incident of January 8, 1982 materially worsened the underlying condition?"

Dr. Parsons replied on April 1, 1982, following his examination of claimant:

> "No. His injury caused pain at the site of pre-existing arthritic changes, but did not worsen the arthritis."

On April 2, 1982 SAIF issued the denial that gave rise to this proceeding.

At the hearing claimant testified that he experienced intermittent back pain for many years prior to January of 1982, beginning in the 1960s. He indicated that he would develop back pain when he did too much heavy lifting work, that it would last about a day, but that he never sought medical attention for it, although he occasionally had to take part of a day off from work. He stated that the pain was constant after January 1982 whereas it was only occasional prior to that time. He further testified that he did not actually land on his back when he fell on January 8, 1982 but rather on his right elbow and buttocks and that he did not experience any back pain as a result of that incident, but that the pain came on gradually while installing plywood on January 11, 1982.

When the hearing convened on September 14, 1982 the parties stipulated that claimant had made two separate claims for industrial injury and/or occupational disease based on the January 8 and

January 11, 1982 occurrences, and that both claims were deemed denied on the date of the hearing if not previously denied. The Referee then assigned a separate WCB case number for the January 11, 1982 claim.

The Referee concluded that claimant proved by a preponderance of the evidence that he sustained a compensable injury on January 8, 1982. He specifically rejected Dr. Parsons' opinion that claimant's underlying condition was not worsened by either the January 8 or January 11, 1982 incidents or activities. The Referee gave controlling weight to Dr. Perry's use of the word "aggravate" in his report of March 1, 1982. Since he found that claimant sustained a compensable injury on January 8, 1982, he concluded that any issue with relation to occupational disease and the alleged injury claim of January 11, 1982 were moot. We disagree with the Referee, reverse his order and affirm SAIF's denial of April 2, 1982, as well as its "oral" denials of September 14, 1982.

This case presents a certain amount of difficulty due to the somewhat inconsistent manner in which the January 8, 1982 incident was reported to various examiners at various times. SAIF agrees that claimant may have sustained a minor injury to his elbow as a result of the January 8, 1982 fall, but it appears that no claim was ever filed in relation to the elbow and no treatment was sought by claimant for any elbow problem. There was no mention in the medical reports of any problem with the elbow and it was not an issue before the Referee nor is it an issue before the Board.

We perceive the key question in this case to be: Did claimant sustain an industrial injury to his back on January 8 or January 11, 1982? Admittedly, the inconsistency in the medical reports might be due in part to a certain degree of communication difficulties between claimant and the examining physicians. As noted previously, Dr. Perry's report of February 5, 1982 indicates that claimant had discomfort while stepping on a bleacher. It does not mention a fall. Dr. Noall was under the impression that the bleacher incident took place 5 to 6 years ago. On March 1, 1982 Dr. Perry reported that claimant first told him the pain came on gradually and later informed him that he "tilted back to the left while stepping on the bleachers and had developed back pain." Dr. Parsons reported that claimant fell while repairing some bleachers and landed on his back and right elbow, but that he had no back pain until he was installing plywood floors later. Claimant testified at the hearing that he actually landed on his elbow and buttocks.

Depending on which version of the facts one accepts, claimant either tilted and experienced back pain, fell and landed on his back, or fell and did not land on his back. In any event, claimant specifically testified that he experienced no back difficulties and no problems following the January 8, 1982 incident:

> "Q. Did you have any physical problems of any kind on January 8th right after the fall?
>
> "A. No.
>
> "Q. You weren't having any problems with your back at that time?

"A. No."

Based on that testimony, we are reluctant to conclude that claimant sustained an industrial back injury on January 8, 1982.

Even accepting the more generous version of the facts, i.e., that claimant tilted to the left while on the bleachers and felt pain, we do not believe that this represented an industrial injury any more than did the pain he experienced while putting in plywood flooring on January 11, 1982. On the contrary, all of the medical reports indicate that what claimant was experiencing was an increase in pain caused by his underlying degenerative arthritic condition. Unlike the Referee, we find no reason to question Dr. Parsons' opinion that claimant's underlying condition was not affected but that he only experienced an increase in pain. Dr. Parsons performed a complete examination of claimant and on that basis was asked to render an opinion. In actuality, we believe that Dr. Perry was of the same opinion. Despite the fact that he used the term "aggravate," his report read as a whole may be construed to mean that the January 1982 occurrences increased claimant's pain, but did not worsen his underlying degenerative condition. An increase in symptomatology without a concomitant worsening of the underlying condition is not compensable. Cochell v. SAIF, 59 Or App 391 (1982); Partridge v. SAIF, 57 Or App 163 (1982); Hall v. Home Insurance Company, 59 Or App 526 (1982).

We believe that the facts of the present case are virtually identical to Hall. In that case, the claimant had a preexisting underlying degenerative back condition, as does the claimant in the present case. While lifting at work, the claimant in Hall experienced back pain. The medical evidence indicated that claimant's pain was associated with her employment, but that it did not cause any change in her underlying condition. The court stated that Florence v. SAIF, 55 Or App 467 (1981), was not applicable since there was no specific injury involved, but that claimant's back pain gradually worsened. The court concluded that, under Weller v. Union Carbide, 288 Or 27 (1979), the claim was not compensable.

Claimant cross-requested review of the Referee's order. Claimant filed no brief, but in his request for review he specifically asks that, to the extent we reverse the Referee's order, we find that claimant has sustained a compensable occupational disease. There is no evidence in the record which would support a conclusion that claimant's work activities with the school district were the major contributing cause of his degenerative arthritic condition. SAIF v. Gygi, 55 Or App 570 (1982).

ORDER

The Referee's order dated September 21, 1982 is reversed. SAIF's denial dated April 2, 1982 is reinstated and affirmed as are its "oral" denials made at the September 14, 1982 hearing.

MYRON C. SMITH, Claimant
Samuel Hall, Jr., Claimant's Attorney
Moscato & Meyers, Defense Attorneys

WCB 82-02497
June 6, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer requests review of Referee McCullough's order which awarded claimant 80% unscheduled permanent partial disability, that being an increase of 45% over and above the March 15, 1982 Determination Order. The issue is extent of claimant's disability.

Claimant, who was 43 years of age at the time of hearing, was employed as a core layer when he injured his back on October 20, 1978. A herniated disc was discovered and a right lumbar laminectomy L5, S1 with disc excision was performed on December 15, 1978 by Dr. Robertson. On May 4, 1979 a second laminectomy was performed by Dr. Golden at L5, S1 with a foramenotomy at L4, 5 and L5, S1 on the right. Claimant was thereafter referred to the Northwest Pain Center from October 30, 1979 to November 15, 1979. Dr. Seres reported on November 19, 1979 that:

> "Clearly, the patient does have the physical capacity to return to some meaningful type of employment. He does have a signficant disability with respect to his back and should avoid any form of heavy exertional work activity."

Claimant's motivation for return to work was considered poor at the time of pain center admission and fair to good at the time of discharge.

On January 25, 1980 the Field Services Division indicated that it was closing claimant's file because he had returned to work on January 21, 1980. Claimant experienced some low back and leg difficulties but was able to continue working in a light duty capacity. His work consisted mainly of putting informational stickers on short pieces of wood paneling, boxing the samples and, usually with the help of another employe, stacking the filled boxes. Claimant also rotated to other generally light-duty jobs in the plant when other employes were absent. Claimant's work in the sample room allowed him to stand or sit as needed.

On March 24, 1981 claimant underwent corrective right foot surgery (interphalangeal arthrodeses) in an attempt to correct a claw-toe problem which had developed. Dr. Robertson reported on July 24, 1981 that claimant could return to his former job as soon as a pair of special shoes arrived. Claimant apparently did return to that work and continued working until September of 1981. He testified that pain forced him to quit.

On February 15, 1981 claimant was examined by Dr. Degge, an orthopedic surgeon. Dr. Degge reported that claimant's cervical ranges of motion were 90% of normal and essentially painless. There is no visible atrophy of any extremity and muscle strength was considered "good." Lumbar ranges of motion were 50% of normal with tenderness at the extremes. Dr. Degge concluded:

> "There was mild interference from a functional standpoint during the examination manifest by refusals, inconsistencies, exaggerations. A marked degree of callosities on this patient's palms suggest that he is certainly capable of physical effort. His daily activity inventory would indicate that he is capable of light work."

Dr. Degge felt that claim closure was appropriate and that claimant could return to an occupation not requiring prolonged bending, walking or lifting. He did not believe claimant could return to his previous job as a core layer. Loss of function was considered mildly moderate. It appears that Dr. Degge was taking claimant's pain into consideration in making this impairment rating. A Determination Order issued on March 15, 1982 awarding claimant 15% scheduled right foot disability and 35% unscheduled low back disability.

Claimant was thereafter referred by the employer to Michele Nielsen of Medical Management Services for vocational assistance. Ms. Nielsen reported on April 21, 1982 that claimant was interested in working with a traveling portrait studio where his wife was employed. Claimant informed Ms. Nielsen that he felt he was physically capable of performing the job. Claimant worked with his wife for a time at the studio, but was unable to secure a regular job due to economic conditions. He testified that he was involved with the studio from May 10 through July 15, 1982, that he has not attempted to locate work since that time and had not contacted Ms. Nielsen again with regard to vocational assistance.

The Referee concluded that claimant had lost 80% of his earning capacity. As noted above, the medical evidence indicates that claimant is capable of working at a light or sedentary job, if he avoids prolonged bending, walking or lifting. In fact, following his second back surgery, claimant did work at a light duty job from January 1980 until he required foot surgery in March 1981, and for a short period of time thereafter until he quit in September 1981. Claimant did experience some continuing back and leg pain while he was working, but this does not appear to have interfered with his ability to continue working. Dr. Robertson's chart notes dating from February 1980 through January 1981 relate little in the way of back symptoms, despite the fact that claimant was working during this period of time. Exactly why claimant quit work in September 1982 is a question that has not been answered to our complete satisfaction. There are no medical reports in the record dated after Dr. Robertson's March 17, 1982 concurrence with Dr. Degge's report. It appears that Dr. Degge was the last physician to examine claimant. That examination took place in February 1982. If claimant actually quit work due to back pain, he apparently did not feel that the pain was of sufficient magnitude to justify returning to a physician.

Although it is true that the majority of claimant's work experience has been that of a core layer, that fact alone does not justify an award of 80% disability. This is especially true in

view of the fact that claimant was only 43 years of age at the time of the hearing. Additionally, core laying is not a particularly skilled occupation. The Dictionary of Occupational Titles, (Fourth edition, 1977), indicates that it is work requiring only up to thirty days to develop adequate performance skills. Core laying is considered medium work. Claimant still has the physical capacity to perform light duty work.

In summary, claimant is 43 years of age. He has had an eleventh grade education (median education in Oregon is twelfth grade). He is capable of performing both light and sedentary work. There is no evidence of emotional disturbance and the record as a whole indicates that claimant has about an average mental capacity. Claimant's impairment is mildly moderate. The American Medical Association's standards allow a range of 20% to 40% for mildly moderate impairment. Considering claimant's disabling pain, we assign a value of +35 to this factor. Claimant's age (43) yields a value of +2. His work experience is assigned a value of zero as it required only a short demonstration period. Mental and emotional factors are also assigned a value of zero. Since claimant's pre-injury work required medium exertion and he is now limited to light work, a value of +5 is assigned to the adaptability factor. As the employer correctly indicates, claimant's labor market findings yield a range of +10 to +15. Resolving all doubt in claimant's favor, we assign this factor a value of +15. The total combined value of these factors is +50. We conclude that an award of 50% unscheduled disability very adequately reflects claimant's loss of earning capacity.

ORDER

The Referee's order dated August 26, 1982 is modified. Claimant is awarded 160° for 50% unscheduled permanent partial disability, that being an increase of 15% over and above the March 15, 1982 Determination Order. This is in lieu of and not in addition to all previous awards. Claimant's attorney's fee should be adjusted accordingly.

WAYNE WELCH, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-10619
June 6, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Nichols' order which awarded claimant 10% unscheduled disability for the compensable consequences of his low back injury. We previously ruled in a prior appeal in this case that claimant's rheumatic arthritis is not a compensable consequence of the industrial injury. Wayne E. Welch, 34 Van Natta 766 (1983). On remand following our prior order, the Referee entered the order that is the subject of this review.

Claimant argues that we should take into account his preexisting rheumatic arthritis which was asymptomatic at the time of his injury but which worsened significantly shortly thereafter and find him permanently and totally disabled. We have held that

a post-injury worsening of a noncompensable condition cannot be considered in determining permanent total disability. Frank Mason, 34 Van Natta 568, aff'd 60 Or App 786 (1982).

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated December 17, 1982 is affirmed.

RONALD W. DOUD, Claimant
Bottini & Bottini, Claimant's Attorneys
Garrett et al., Defense Attorneys

WCB 82-01925
June 8, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Braverman's order which awarded claimant 30% unscheduled permanent disability, that being an increase over the 15% unscheduled permanent disability awarded by Determination Order. The issue is extent of disability. We affirm and adopt the Referee's order with the following comments.

The Referee indicated that he evaluated the extent of claimant's disability with reference to the relevant administrative rules (OAR 436-65-600 et seq.), but he did not set forth his specific findings. We cannot be sure whether our calculations are the same as the Referee's but we agree that claimant is entitled to an award of 30% permanent disability based upon the following factors: Impairment: we believe that in this case Orthopaedic Consultants' assessment of claimant's impairment at 20% loss of function is the most reliable (value of +20); age 37 years (0 value); education high school (0 value); work experience (based on job at time of injury) millwright (DOT No. 638-281.018, SVP of 7) (value of +10); adaptability -- claimant formerly was capable of heavy work and is now restricted to light to sedentary work (impact +15); mental capacity and emotional/psychological adjustment to disability, normal (no impact); and labor market findings -- based on the assumptions that claimant has a residual functional capacity for light work, an SVP potential of 7 and a GED level of 4, claimant has 41% of the labor market still open to him (impact of -25).

Combining these values and applying the formula set forth in OAR 436-65-601 results in a disability determination of 30%.

The employer strenuously argues that claimant is not entitled to an award greater than that awarded by Determination Order because he quit a job (made available by the employer) which was within his physical limitations and for reasons other than physical inability to do the job. For purposes of determining permanent partial disability, it is generally irrelevant whether the person quits a job of which he or she is physically capable. It is implicit in a finding that an injured worker is only partially disabled that there are jobs the worker can still perform. Of the jobs which a claimant is capable of performing he

or she may accept or reject them for whatever reason. This has no bearing on the determinative question in extent of permanent partial disability cases: What is claimant's loss of wage earning capacity as evidenced by the claimant's inability to perform jobs which, prior to the compensable injury, he or she was capable of performing.

Here, claimant chose to quit what he perceived as a low paying, dead-end job and return to school to pursue a career which offered him more opportunity. We assign a -25 value in the labor market findings area based on our finding that a significant portion of the labor market is still available to him because he has the general educational development and the demonstrated ability to master a high percentage of jobs in the light and sedentary category, including the one he quit.

For these reasons, we affirm the Referee's order.

ORDER

The Referee's order dated October 14, 1982 is affirmed. Claimant's counsel is awarded $600 as a reasonable attorney's fee on Board review payable by the self-insured employer.

BOBBY R. FLEMING, Claimant
Parks & Ratliff, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 80-06712 & 82-00241
June 8, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Brown's order which affirmed the Determination Order's award of 5% scheduled disability for claimant's right knee condition and, in addition, awarded 10% unscheduled disability for claimant's thoracic spine condition. Claimant contends that he is entitled to greater awards of both scheduled and unscheduled disability.

With respect to the knee condition, we agree with the Referee's findings and analysis and, therefore, affirm that portion of his order. With respect to claimant's thoracic spine condition, we adopt the Referee's recitation of facts but reach the conclusion based on those facts that claimant is entitled to an award of 25% unscheduled disability.

The facts relevant to the back condition are as follows. Claimant, now 42 years of age, was injured in December 1978 when the brakes on the log truck he was driving failed, resulting in a wreck and injuries to his thoracic spine and right knee. Claimant underwent a medial meniscectomy in May 1979 and after a recovery period made an unsuccessful attempt to return to his regular work as a log truck driver and timber faller. In March 1980 claimant began participation in a training program for marketing and management positions. In May 1980 claimant participated in additional training in preparation to take insurance exams. After completion of his insurance exams, claimant participated in a six month on-the-job training program with an insurance agency in Klamath Falls.

On May 13, 1981 claimant underwent surgery identified as an extra dural ganglionectomy and a rhizotomy (a separation of adjacent nerves to relieve pain). Following a recovery period claimant was released to return to work. In October 1981 claimant was not taking any medication other than aspirin and had a full range of back motion. However, he had chronic pain, increased pain with heavy lifting and loss of stamina. Dr. Campagna rated claimant's overall impairment due to the compensable injury as mild.

In January 1982 claimant purchased an insurance agency in Glendale, Oregon. Claimant and his wife both work in the business and together bring home about $1,200 per month. However, until 1988 a portion of the gross earnings of the agency will be devoted to retiring the purchase price of the agency. At the time of his injury, while employed in the logging industry, claimant was earning approximately $80 per day.

In rating the extent of claimant's unscheduled disability, the Referee applied the administrative rules for the evaluation of unscheduled permanent disability (OAR 436-65-600 et seq.). We differ with the Referee as to the values to be assigned to some of the factors.

With respect to impairment, claimant underwent a ganglionectomy which, according to the surgical report, necessitated laminotomies. Under OAR 536-65-615, relating to assessing impairment for injuries to the spine, a value of 1% impairment of the whole person is assigned for a laminectomy without disc removal. While the surgery here was not directed at relieving pressure from the intervertebral disc itself, we believe that the ganglionectomy and associated laminotomies are sufficiently similar to a laminectomy and discectomy to warrant assigning one point for the surgery itself. The Referee noted that claimant experiences chronic and at least mildly disabling pain, justifying an assignment of 5% impairment under OAR 436-65-675. One other residual of claimant's injury and resulting surgery has been loss of stamina which has to some extent further reduced claimant's level of functioning. If we assign up to five additional percentage points for this factor, and combine the values for the surgery, chronic pain and loss of stamina, we arrive at an overall impairment value of 11. This corresponds with claimant's treating physician's assessment of the degree of impairment in the mild range (0 to 10%).

Claimant is now age 42 whereas at the time of the hearing he was 41. However, under OAR 436-65-602 a +1 value is appropriate regardless whether claimant is age 41 or 42. Claimant obtained his graduation equivalency diploma while in the military service and he appears to have at least a normal intellectual capacity, thus the education and mental capacity factors yield zero values for disability evaluation purposes.

With respect to his emotional and psychological findings, claimant contends that he suffers chronic and at least mild depression as a result of the difficulty he has had adjusting to the disabling effects of his injury. The primary source of

support for this proposition comes from claimant's wife who testified concerning her observations of claimant's behavior. While we do not doubt Mrs. Fleming's word, there is no medical documentation for any psychological disability, and we are not sufficiently persuaded that whatever emotional reaction claimant is having to the residuals of his injury is interfering in his ability to function in his work. Accordingly, we assign no points for the emotional and psychological findings factor. See also Danny H. Sackett, 34 Van Natta 1107 (1982); Jack G. Monroe, 34 Van Natta 1106 (1982).

With respect to claimant's adaptability to strenuous work (OAR 436-65-605), the Referee found that claimant was formerly capable of heavy work and is now restricted to medium work, justifying a value of +5 for this factor. We find that prior to his injury claimant was capable of very heavy work, that is, he was capable of performing jobs rated by the Dictionary of Occupational Titles (DOT) (4th Edition, 1977) as having a strength (STR) value of 5. Given claimant's chronic pain and loss of stamina, we do not believe that claimant could engage in all forms of medium labor and that his residual functional capacity is somewhere between the medium and light range. Thus, we believe a value of +8 would be more appropriate for this factor.

With respect to the work experience factor, OAR 436-65-604, the Referee assigned a value of +3 based on his assumptions that claimant's occupation at the time of his injury was a log truck driver and that it takes 30 days to six months to become proficient in that occupation. First, our examination of the Dictionary of Occupational Titles and the accompanying print-out indicate to us that log truck driving is rated as having an SVP (specific vocational preparation period) value of 4. Furthermore, it appears that claimant engaged in both log truck driving and timber falling more or less at the same time although he was driving a truck at the time of his injury. The SVP value for a timber faller is 6 or 3, depending on the person's skill and duties. Considering the number of years claimant has been engaged in the logging industry as well as his experience at other jobs with a high SVP rating (e.g., well driller and heavy equipment operator), we think an SVP rating of 6 with a disability evaluation impact of +8 is more appropriate.

With respect to the labor market findings, we believe that claimant is restricted to light work, and considering his SVP potential of 6 and his general educational development value of 4, applying the matrices appearing in the commentary to the labor market findings rule reveals that claimant has 37% of the labor market available to him. This yields an impact of -9. The Referee apparently thought that a -25 value was required because claimant had returned to work. As we understand the provisions of OAR 436-65-608(1)(e), a -25 value is assigned for a return to work only when the claimant has been released and/or actually has returned to the occupation he had at the time of his injury. Claimant here has returned to work but at a new occupation, thus, it is inappropriate to assign a -25 value for the labor market findings factor.

Combining these values and applying the formula as provided

in OAR 436-65-601 yields a disability determination of 26% which, when rounded to the nearest five percent as required by the administrative rules results in a 25% disability award. Comparing this case to similar cases we believe an award of 25% unscheduled permanent disability will properly compensate claimant for his loss of wage earning capacity attributable to his compensable injury.

ORDER

The Referee's order dated October 28, 1982 is modified. That portion of the order affirming the award of scheduled permanent disability for claimant's right knee is affirmed. Claimant is awarded 25% unscheduled permanent disability. This award is in lieu of and not in addition to the Referee's award of unscheduled disability. Claimant's attorney is allowed 25% of the increased award of unscheduled permanent disability, not to exceed $3,000, as a reasonable attorney's fee, payable out of and not in addition to claimant's compensation.

JUAN ANFILOFIEFF, Claimant
Blair, et al., Claimant's Attorneys
Burt, et al., Defense Attorneys
Carl Davis, Attorney

WCB 78-04612
June 10, 1983
Order on Reconsideration

The Board issued its Order on Review herein on March 31, 1983. Claimant thereafter requested reconsideration of that order insofar as it failed to award claimant's attorney an attorney's fee. The Board abated its Order on Review by order of April 25, 1983, in order to allow an opportunity for response to claimant's request for reconsideration.

On reconsideration of our order and in light of claimant's request for an award of an attorney's fee, we find that claimant's attorney is entitled to an award of a reasonable attorney's fee by authority of ORS 656.262(9) and 656.382(1). We modify our Order on Review accordingly.

ORDER

The Order on Review dated March 31, 1983 is modified to award claimant's attorney a reasonable attorney's fee in the amount of $500. Except as modified, the Board adheres to its former order, which is hereby reaffirmed and republished.

RUTH A. CODDINGTON, Claimant
Emmons, Kyle et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-05848
June 10, 1983
Order on Review (Remanding)

Reviewed by Board members Ferris and Barnes.

The SAIF Corporation requests review of Referee Wilson's order which set aside its denial of claimant's aggravation claim.

Claimant is a 43-year-old school bus driver. She has a history, dating back to 1963, of low back problems unrelated to work activities. Her treating physician from 1963 until 1979, Dr. Reid, diagnosed her problems as lumbosacral sprain with periods of remission and exacerbation, with intermittent pain radiation down her right leg. In a deposition Dr. Reid testified that he suspected over the years that claimant had a disc problem, but he never actually diagnosed that condition.

In early 1980 claimant missed about two weeks of work with back pain and right leg sciatica. However, by the summer of 1980 she was able to ride on the back of her husband's motorcycle on a 3,000 mile trip. She testified that her back did not bother her at that time. She was able to work full time at her bus driving job during the entire fall semester of 1980. Claimant also testified that her back did not bother her then.

On January 13, 1981 claimant compensably injured her back when she slipped while climbing down from her bus. She initially experienced right knee pain, but began to experience low back pain a day or so later. Claimant initially saw Dr. Altizer who was her family physician but who had never previously treated her back problems. Dr. Altizer referred her to Dr. McGee, a neurological surgeon, who had previously treated the claimant's back problems. Dr. McGee diagnosed a preexisting degenerative disc disease with a paravertebral muscle strain. He referred the claimant back to Dr. Altizer for continuing care.

Claimant returned to work on March 3, 1981 with Dr. Altizer's concurrence. Dr. Altizer opined at that time that claimant's range of motion had returned to its pre-injury level. On April 10, 1982 Dr. Altizer reported that the claimant was medically stationary and that there should be no permanent residuals from her compensable injury. Dr. Altizer described range of motion findings which put claimant "back to where she was essentially prior to this acute strain which was superimposed on old disc disease . . ."

Claimant worked during the entire month of March and until April 10, 1981. She testified that she remained stiff and sore during this period and that her back pain began to increase during the latter part of March. However, during this period of time claimant was able to take two 100-to 200-mile motorcycle trips on the back of her husband's motorcycle.

Claimant left work in early April with flu which caused symptoms of nausea, diarrhea and chills. Dr. Altizer noted that the flu seemed to increase claimant's low back pain. On April 23, 1981 claimant had an involuntary twitch just as she was falling asleep; claimant immediately experienced stabbing pain radiating down her left leg. Dr. McGee subsequently discovered a bulging disc and performed a laminectomy and discectomy.

Claimant submitted an aggravation claim in connection with this surgery, which SAIF denied. The issue is whether, under Grable v. Weyerhaeuser, 291 Or 387 (1981), claimant's compensable injury of January 13, 1981 was a material cause of the bulging disc which led to claimant's surgery. The Referee found that it was. We disagree.

All of the medical reports in evidence tend to be toward the conclusory end of the spectrum. We have thus relied heavily on the depositions of Drs. Altizer and McGee. Neither deposition is a model of clarity. But we think these two principal doctors agree on some things. Both Drs. Altizer and McGee suggest that claimant's degenerative disc disease, which pre-existed her January 1981 industrial injury, was a factor in producing the bulging disc that eventually required surgery. Both seem to agree that claimant's disc did not herniate at the time of the January 1981 incident; actually, Dr. Altizer gave inconsistent answers to this question, apparently landing on the side of no herniation in January 1981. Both Drs. Altizer and McGee seem to agree that claimant's involuntary twitch while falling asleep in April 1981 caused the degree of disc bulging that necessitated surgery; actually, Dr. Altizer was again a bit inconsistent on this question.

The area of clear disagreement involves the extent of the contribution of the January 1981 injury to the disc abnormality discovered several months later. Dr. Altizer opined that the January injury was a material cause of the disc abnormality, relying on the nature and the continuity of claimant's symptoms after January. It is apparent from Dr. McGee's reports and deposition that he too initially believed that claimant's compensable January injury was a material cause of her subsequently discovered disc abnormality. However, when confronted at the time of deposition with the fact that claimant's symptoms subsided sufficiently after January for her to take relatively long motorcycle trips, Dr. McGee changed his opinion as we understand his testimony. Given those motorcycle-trip facts, Dr. McGee twice stated at his deposition that the January injury was probably not a material cause of claimant's subsequently worsened disc condition.

SAIF's consultant, Dr. Norton, after reviewing the medical records and speaking with Dr. McGee, submitted the most comprehensive report in the record. Dr. Norton opined that claimant had a degenerative disc condition and that the "influence of the job incident in causing the disc herniation appears to be of no identifiable significance."

On this record, we cannot say that we are more persuaded by Dr. Altizer's opinion. As admitted in deposition testimony, Dr. Altizer did not treat claimant's back condition before January 1981; was not, in the doctor's words, claimant's "back doctor"; and often in deposition deferred to the views of specialists, as also indicated by Dr. Altizer having first referred claimant to Dr. McGee. Moreover, the material causation opinion that Dr. Altizer expressed after claimant's disc surgery is inconsistent with the opinion that Dr. Altizer expressed earlier, in March and April 1982, to the effect that claimant had fully recovered from her January injury. Although asked to do so at deposition, we find that Dr. Altizer had no satisfactory explanation for this difference in opinions. Finally, Dr. Altizer's testimony about

claimant's continuous symptoms during early 1981 seems to us to be somewhat inconsistent with the objective and undisputed facts of claimant's return to school bus driving for about six weeks and recreational motorcycle travel during this same period.

As indicated above, Dr. Altizer also identified several other possible and probable causes of claimant's disc condition other than the January 1981 industrial injury. When pressed to explain why the January injury should be regarded as "material," Dr. Altizer responded:

> "I find I am really faced with a real [legal] dilemma, rather than a medical dilemma. Because every single episode of something that happens to somebody is a material contributing cause. But that is a [legal] term, as I understand it, rather than a medical term. I don't know where you draw the line at one episode -- affects where a person is today. Everything that happens to us has, markes its mark on the body."

We have also expressed some doubts about the meaning of "material causation." See Wilma H. Ruff, 34 Van Natta 1048 (1982). In George Brasky, 34 Van Natta 453, aff'd without opinion, 61 Or App 226 (1982), we equated "material" with "a notable portion" of the causation of a result. It is clear in this case that there were many causes of the result of a bulging disc that necessitated surgery; we are not convinced that the contribution, if any, of claimant's January 1981 industrial injury was a notable portion of the total causation.

Finally, we note that the Referee stated: "There is no question that claimant indeed had pre-existing degenerative back disease, but when an industrial trauma causes a material worsening of such a condition, as occurred in this case, the claim is properly compensable to the same extent as if the trauma was imposed on a sound back." While we disagree with the Referee's analysis and conclusion, for clarity we point out that there is absolutely no evidence that claimant's January 1981 compensable injury contributed in any way to a generalized worsening of claimant's degenerative disease; the most that can possibly be said, although we are not persuaded to so conclude, is that the January injury caused an increased bulging of the disc at the L4-5 level.

Claimant's request for hearing raised the issues of entitlement to greater temporary and permanent disability than that awarded by the May 12, 1981 Determination Order. Because he set aside SAIF's denial of claimant's aggravation claim, the Referee appropriately did not reach these issues. Because we have reversed the Referee on the aggravation claim, we remand for further proceedings on the other issues raised by claimant's request for hearing.

ORDER

The Referee's order dated August 10, 1982 is reversed. The SAIF Corporation's denial of claimant's aggravation claim dated June 5, 1981 is reinstated and affirmed. This case is remanded to the Referee for further proceedings consistent with this order.

BERNICE HARBAUGH, Claimant
Pozzi, Wilson et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Lindsay, Hart, et al., Defense Attorneys

WCB 82-04752 & 82-04753
June 10, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of that portion of Referee Shebley's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for left carpal tunnel syndrome. Although claimant's brief cites cases involving responsibility, we understand the issue to be compensability: Whether claimant's work as a cook at the Cascade Inn between June 1981 and February 1982 was the major cause of her left wrist condition.

Claimant's left carpal tunnel syndrome was mentioned - at least as a possibility - in medical reports written during her work at Cascade Inn; however, we find no evidence that any form of medical treatment was rendered for claimant's left wrist before she left her position at Cascade Inn. Nor do we find any evidence that claimant experienced any disability, i.e., time loss, because of her left wrist while employed at Cascade Inn. There was a period when claimant was unable to work due to a cervical problem and due to a right wrist problem; but once those conditions resolved, claimant was able to continue restaurant work despite her left wrist problem. We are not completely persuaded by Dr. Ordonez's rather cryptic opinion to the effect that restaurant work was the major cause of claimant's left carpal tunnel syndrome. Even more significantly, however, if we were to accept Dr. Ordonez's theory, it would necessarily follow that claimant had a subsequent injurious exposure when she worked for about two months at the Spartree Restaurant after leaving the Cascade Inn. For all of these reasons, we agree with the Referee's conclusion regarding the compensability of claimant's left wrist condition.

ORDER

The Referee's order dated October 4, 1982 is affirmed.

BETTY HEART, Claimant
Welch, Bruun & Green, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 82-0303M
June 10, 1983
Own Motion Order

Claimant, by and through her attorney, has renewed her request that the Board exercise its own motion authority and reopen her claim for payment of temporary total disability compensation in connection with her August 1, 1974 industrial injury. The Board issued an Own Motion Order herein on December 3, 1982, declining to grant own motion relief, stating:

> "The evidence before us indicates that claimant has not worked since her injury. She told the Orthopaedic Consultants that she was unable to find work in the past due to her history. No doctor has indicated, however, that she could not work due in whole, or in part, to her injury. Under

the rationale set forth in Vernon Michael, 34 Van Natta 1212 (1982), we conclude claimant has failed to show entitlement to compensation for temporary total disability."

In support of her renewed request for own motion relief, claimant has submitted a report dated March 31, 1983, from Dr. Smith, relative to whether or not surgical intervention is presently appropriate for treatment of claimant's low back.

The SAIF Corporation previously indicated to the Board that it would continue to pay claimant's reasonable and necessary medical expenses, pursuant to the provisions of ORS 656.245. Any disputed issues concerning claimant's entitlement to claimed medical services are matters concerning a claim which are subject to claimant's right to request a hearing. ORS 656.245(2). Even if claimant submits to compensable surgical treatment, we have already determined that claimant does not qualify for claim reopening pursuant to ORS 656.278 by virtue of her vocational status. See Vernon Michael, supra. In the absence of some evidence indicating a change in claimant's vocational status, the Board will not grant claimant's request for own motion relief.

ORDER

Claimant's request for own motion relief is denied.

ILAH LaROQUE, Beneficiary
(EDWARD J. LaROQUE, Deceased)
Pozzi, Wilson et al., Attorneys
Schwabe, Williamson et al., Attorneys
Keith Skelton, Attorney

WCB 81-11384 & 81-11347
June 10, 1983
Order of Abatement

The Board has received a motion for reconsideration of its Order on Review dated May 16, 1983.

In order to allow sufficient time to consider the motion, the above noted Board order is abated.

IT IS SO ORDERED.

EDWARD LIAN, Claimant
Lyle Velure, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 83-0157M
June 10, 1983
Own Motion Order

Claimant, by and through his attorney, has requested that the Board exercise its own motion authority and reopen his claim for payment of temporary disability compensation. Claimant's aggravation rights have expired. The SAIF Corporation has voluntarily accepted claimant's claim for medical services and is paying those benefits pursuant to ORS 656.245. SAIF has chosen not to voluntarily reopen the claim for payment of temporary disability benefits and has submitted the claim to the Board for a

decision on the question of claim reopening pursuant to ORS 656.278. We find that claimant is entitled to claim reopening for payment of temporary total disability compensation as of April 7, 1983, the date of his medically verified inability to work due to a worsened condition.

Claimant was injured in October 1975 while working as a timber cutter. He fell off a log and injured his low back. He was initially released to return to work, and no residual disability was anticipated. Claimant continued to experience low back problems, and in February 1976, the first in a series of low back surgeries was performed. After surgery, a hemilaminectomy of the L4 interspace on the left, claimant's back problems continued. In April 1977, a laminectomy was performed at the L4-5 level on the left, with a posterior spinal fusion from L4 to L5. Claimant thereafter continued to experience pain in his left leg, and in April 1980, he underwent a third surgical procedure, which was an exploration, bilateral decompression at L4-5 with spinal fusion of L4-5 into L5, S1, utilizing bilaternal knot rods. Claimant has continued to experience chronic pain since this third surgery, and this chronic pain syndrome, to a material extent, has necessitated psychiatric intervention for treatment of what has been diagnosed as major depression.

Claimant has not been gainfully employed since October 1979. Due to his physical limitations, he is unable to return to his pre-injury employment as a timber faller. Claimant participated in a vocational rehabilitation program in Arizona and completed a course in motorcycle mechanics in January of 1981. He has received vocational assistance in this state, with no success in obtaining employment in the field of motorcycle repair work.

There appears to be an issue concerning claimant's ability to actually perform the work of a motorcycle mechanic, due to the physical limitations resulting from his industrial injury. He has been advised by at least one physician that he should not attempt to perform such work due to his physical condition; however, after an evaluation at the Callahan Center, it was recommended that claimant attempt to pursue this type of employment goal with the assistance of vocational consultation services, in an effort to obtain such employment with job modifications suitable to claimant's physical limitations.

In November 1982, the Vocational Rehabilitation Division closed its file with claimant for the reason that he had failed to maintain contact with his rehabilitation counselor as instructed and also had failed to participate in any job search activity. The Field Services Division subsequently reinstituted a program of vocational assistance, and Direct Employment Program services were initiated in an effort to obtain modified employment as a motorcycle mechanic. This program recently has been interrupted due to claimant's enrollment in a pain center treatment program. Some question exists concerning claimant's motivation to actually return to gainful employment, as noted by the medical examiner at the Callahan Center:

"I think this man will be hard to place, as

> down deep I get the impression that he really hasn't tried hard to be active and improve his lot."

Based upon our review of the record presently before us, however, we are confident that once claimant's chronic pain syndrome is appropriately dealt with medically and psychiatrically, he will be capable of re-entering the labor market as a productive member of society.

Claimant's physician, Dr. Wichser, referred him for psychiatric treatment in March 1983. By letter of March 8, 1983, Dr. Wichser reported that he had been treating claimant for chronic low back pain, and that claimant recently had developed an apparent severe, agitated depression, "with major issues revolving around his current work injury disability and incapability of managing gainful employment in the occupation for which he was retrained."

Claimant was examined by Dr. Carter, a psychiatrist, who diagnosed major depression and chronic pain. In a form 827 dated March 14, 1983, Dr. Carter indicated that claimant's condition was not medically stationary. In a handwritten note dated April 7, 1983, addressed "To Whom It May Concern," Dr. Carter certified that claimant was too disabled to work and would remain so for over sixty (60) days. He subsequently reiterated his impression that claimant's condition was not medically stationary in a preprinted form supplied by a vocational rehabilitation organization soliciting information from Dr. Carter concerning claimant's physical limitations. A similar form also was completed by Dr. Wichser, who also indicated that claimant's condition was not medically stationary.

In a comprehensive report dated May 25, 1983, from Dr. Holland, a psychiatrist, addressed to SAIF and written after completion of a psychiatric evaluation, the following conclusions are stated:

> "This examiner is of the opinion Mr. Lian's industrial injury has played a material contributing role in the production of his current psychiatric complaints. The documentation in this case has allowed for the MMPI characterization of the unfolding of his psychiatric distress. It is now rather profound and he is in need of medical treatment * * *."

Dr. Holland also stated that it was not advisable for claimant's claim to be "held open" for psychiatric treatment in view of the secondary gain which he felt "would be risky."

Claimant is currently engaged in psychotherapy with Dr. Carter, as well as biofeedback and physical therapy treatments at the Western Pain Center in Roseburg. As previously mentioned, SAIF has acknowledged its responsibility for payment of claimant's expenses for psychiatric treatment.

The last award or arrangement of compensation entered in this claim is a Determination Order dated April 13, 1982, issued pursuant to ORS 656.268(5), upon completion of an authorized program of vocational rehabilitation. Claimant was awarded compensation for additional temporary total disability and a 40% unscheduled permanent partial disability for injury to his low back. Based upon the medical evidence of record, and particularly statements authored by claimant's treating psychiatrist, Dr. Carter, we find that claimant's condition has worsened since the last award or arrangement of compensation. Accordingly, we deem it appropriate to exercise our discretionary own motion authority in this case and reopen this claim for payment of temporary total disability compensation.

ORDER

Claimant's October 13, 1975 injury claim hereby is reopened for payment of temporary total disability compensation as of April 7, 1983, said payments to continue periodically until claim closure pursuant to ORS 656.278. Claimant's attorney is allowed a reasonable attorney's fee equal to 25% of the compensation made payable under the terms of this order, not to exceed $500, payable out of claimant's compensation and not in addition thereto.

THOMAS W. MATTHEWS, Claimant
Hansen & Wobbrock, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-10754
June 10, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Mulder's order which set aside its partial denial of claimant's gastrointestinal and psychiatric problems, thus finding these problems to be compensable consequences of claimant's accepted claim for a shoulder/back injury in February 1981.

In addition to the compensability issue, SAIF raises an issue about the Referee's having refused to admit Exhibit 37, a report written by Dr. Parvaresh. It is clear that SAIF contends that Dr. Parvaresh's report should have been admitted; it is clear that claimant believes it was properly excluded; the basis of these respective positions and of the Referee's ruling is less clear.

Apparently, the underlying issue involves that portion of ORS 656.325(1) that limits an insurer's right to medical examination of a claimant to "no more than three physicians . . . except after notification to and authorization by the director." This statute was clearly relevant when SAIF scheduled claimant for examination by Dr. Parvaresh and claimant objected on the ground that, because he had previously been examined by at least three physicians at SAIF's request, SAIF had to first obtain authorization from the Director. Apparently, that dispute was resolved by the parties stipulating to an examination by Dr. Moss. We thus do not understand there to be any issue now before us of whether claimant should have been examined by Dr. Parvaresh.

What Dr. Parvaresh did, as reflected in Exhibit 37, was to review claimant's medical records and to offer some analysis and opinions based on his review of the records. If the Referee declined to admit Exhibit 37 because of the three-physician rule stated in ORS 656.325(1), we disagree. That statute relates only to required physical examinations of a claimant; it has nothing to do with the admissibility of evidence in the form of medical opinions expressed after reviewing medical records. So far as we are aware, there is no numerical limitation on the number of doctors who may offer opinion evidence after a review of medical records, other than a Referee's inherent authority to exclude evidence that is unduly repetitious.

We believe Exhibit 37 should have been admitted. For the reasons stated in Edward Morgan, 34 Van Natta 1590 (1982), we deem it unnecessary to remand to the Referee, and we have considered Exhibit 37 in our review of this case.

On the merits, we affirm and adopt those portions of the Referee's order regarding the compensability of claimant's gastrointestinal and psychiatric problems with the following additional comments.

There are various versions of claimant's February 1981 injury. Claimant was struck on the shoulder/upper back by the branches of a falling tree while he was working in the woods. He also may have been struck on the lower back. He also may have fallen and landed on his back. Claimant's physical problems were initially believed to be relatively minor; his then treating doctor gave him a full release to return to work in the woods after about one week. Despite performance of every available diagnostic procedure, no doctor has been able to find any organic explanation for claimant's gastrointestinal problem. Despite general agreement that claimant has some form of psychiatric problem, the doctors disagree rather strongly in their diagnoses of that problem. There also appears to be general agreement that some of claimant's descriptions of some of his symptoms are exaggerated.

For all of these reasons -- minor initial injury, subsequent development of unexplainable symptoms and claimant's conscious or unconscious embellishment of those symptoms -- we agree with SAIF that there is a certain inherent implausability to claimant's position in this case. Nevertheless, the narrow issue remains whether claimant has proven that his February 1981 industrial injury was a material cause of his subsequent gastrointestinal and psychiatric difficulties -- and, on this narrow causation issue, exaggeration of symptoms would not appear to be very relevant. We agree with the Referee that the preponderance of the medical evidence does establish the required material causation link.

ORDER

Except on the evidentiary issue discussed herein, the Referee's orders dated May 20, 1982 and July 28, 1982 are affirmed. Claimant's attorney is awarded $650 for services rendered on Board review, payable by the SAIF Corporation.

JO WANDA ORMAN, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-03671
June 10, 1983
Order of Abatement

The Board has received a motion for reconsideration of its Order on Review dated May 11, 1983.

In order to allow sufficient time to consider the motion, the above-noted Board order is abated and SAIF Corporation is requested to file a response to the motion for reconsideration within ten days.

IT IS SO ORDERED.

HARRY ZERVAS, Claimant
Doblie, et al., Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 81-10471
June 10, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of Referee Johnson's order which awarded claimant 20% scheduled disability for the right forearm, that being an increase over the Determination Order which awarded no permanent disability. The issue is extent of disability.

We affirm and adopt the Referee's order subject to one comment. In his order the Referee refers to claimant having injured himself in November, 1980 while working the greenchain. In fact, he was injured while working the drychain and he did return to that or similar work after his second right carpal release surgery. Nevertheless, the fact remains that claimant must avoid repetitive activities and heavy strenuous lifting with his right hand. Considering the record as a whole, we agree with the Referee that claimant has sustained a 20% loss of wage earning capacity attributable to this 1980 injury.

ORDER

The Referee's order dated September 29, 1982 is affirmed. Claimant's counsel is awarded $350 as a reasonable attorney's fee for his services on review, payable by the employer.

JAMES C. DILL, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-11788
June 13, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of that portion of Referee Fink's order which affirmed the December 17, 1981 Determination Order that awarded claimant 25% unscheduled disability for the consequences of his April 16, 1981 back injury. Claimant contends that he is permanently and totally disabled or that he is entitled to a greater award for partial disability.

We affirm and adopt those portions of the Referee's order which found that claimant's hearing testimony was not credible and concluded that claimant is not totally disabled.

As for claimant's partial disability, it appears that there is at least one obvious error in the evaluator's worksheet that was the basis of the December 17, 1981 Determination Order. The evaluator assigned a zero value for claimant's education with the notation "in use." We do not understand the meaning of this notation; it appears to us that claimant should receive a +15 value pursuant to OAR 436-65-603 because of his third grade education. This suggests an increase in claimant's disability award.

However, we also disagree with the evaluator in an additional, albeit less quantifiable, aspect. The evaluator rated claimant's physical impairment at 24%. There are some medical reports that suggest that the extent of claimant's total impairment may be that high when all forms of impairment are taken into account, including claimant's preexisting respiratory condition. But ORS 656.214(5) limits this award of permanent disability to "the permanent loss of earning capacity due to the compensable injury." (Emphasis added.) Although the doctors involved offer little basis for separating claimant's compensable impairment from his noncompensable impairment, our best guess is that claimant's physical impairment due to the April 16, 1981 back injury is in the range of 5% to 15%; at least, we cannot say that, discounting claimant's testimony because of the Referee's and our credibility finding, the objective medical evidence proves any greater level of impairment due to the April 16, 1981 injury. This suggests that the award granted by the December 17, 1981 Determination Order was excessive.

In summary, we think the Determination Order should have been based on a higher education value and a lower impairment value. We conclude that these two changes, when factored into the formula in OAR 436-65-601, approximately cancel each other out and thus conclude that there is no persuasive basis in this record for an increased partial disability award.

ORDER

The Referee's order dated September 28, 1982 is affirmed.

KIM M.GRIFFIN, Claimant
Fallgren/McKee Associates, Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 82-00664
June 13, 1983
Order Denying Motion for Order of Dismissal

The Board, after having considered claimant's Motion for Order of Dismissal of appellant's request for review, find that the request was date stamped by the Portland office of the Board on Monday, October 4, 1982, and received by the Salem office of the Board on Tuesday, October 5, 1982. The request was, therefore, filed timely in accordance with provisions of ORS 656.289(3). The Motion for Order of Dismissal is hereby denied.

IT IS SO ORDERED.

DUANE KEARNS, Claimant
Galton, Popick & Scott, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Wolf, Griffith et al., Defense Attorneys

WCB 81-11626 & 82-05409
June 14, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Industrial Indemnity Company, the insurer providing coverage for the employer on the date of claimant's October 1, 1979 injury, requests review of Referee Williams' order which assigned to it responsibility for the current condition of claimant's low back, ordering it to accept claimant's aggravation claim, pay compensation and process the claim according to law. EBI Companies, the insurer providing coverage for the employer at the time of claimant's February 14, 1979 injury, raises two issues on review: The propriety of that portion of the Referee's order which set aside EBI's denial of claimant's aggravation claim insofar as it attempts to retroactively deny EBI's responsibility for claimant's previously accepted February 1979 injury, and the propriety of that portion of the order which directs EBI to pay interim compensation together with a 25% penalty.

Claimant was originally injured while working for the employer on May 11, 1968 when he sustained a strain to his low back. The employer was then insured by the SAIF Corporation. A Determination Order closed the claim in February 1969 with an award of 5% unscheduled permanent partial disability for injury to claimant's low back. Claimant sustained a second injury while SAIF was on the risk on June 1, 1972 when a pallet fell on his right foot. Claimant subsequently developed a recurrence of severe low back pain, and in January 1973 a herniated intervertebral disc at the L4-L5 level was excised. The claim was reclosed by Determination Order in June 1976, which awarded claimant an additional 5% unscheduled permanent partial disability.

Claimant experienced a worsening of his low back condition in November 1976 and filed a claim for reopening pursuant to ORS 656.273. This aggravation claim was initially denied by SAIF but later accepted by Stipulation in April 1977, which provided for a reopening of claimant's 1972 injury claim. The claim was reclosed by Determination Order in January 1978, awarding claimant an additional 5% unscheduled permanent partial disability. By stipulation of the parties in May 1978, claimant was awarded an additional 12.5% unscheduled low back disability.

On February 14, 1979 claimant sustained a twisting injury to his back. The employer had changed workers' compensation insurers and, on the date of this injury, was insured with EBI Companies. This injury was accepted as a nondisabling injury, and compensation for medical expenses was paid.

Claimant sustained a fourth industrial injury on October 1, 1979. This claim was initially processed by EBI Companies, and it subsequently was discovered that on the date of this injury the employer's workers' compensation coverage was no longer provided by EBI Companies but was provided by Industrial Indemnity Company. This October 1979 injury occurred while claimant was

stretching over two barrels and pushing a third when he experienced the severe onset of pain in his right leg and low back. He was released to return to work after two days with restrictions of no heavy lifting and supervising only.

In September 1981 claimant's physician petitioned EBI Companies to reopen claimant's 1979 injury claim, without specifying a February or October date of injury. This claim for reopening prompted EBI to investigate claimant's original February 1979 injury claim. As a result of this investigation, EBI discovered that, when claimant had reinjured his back in October 1979, it had accepted and paid benefits on a claim which arose on a date and time at which it no longer had provided the employer with coverage, and that Industrial Indemnity was on the risk at that time. EBI also discovered the fact, apparently for the first time, that claimant had two previous injuries with the employer while the SAIF Corporation provided coverage, and that claimant's episode on February 14, 1979 might have been a recurrence of the condition caused by claimant's earlier injuries in 1968 and 1972. On October 23, 1981 EBI issued a denial of any liability for the consequences of claimant's October 1, 1979 injury, based upon the newly discovered fact that Industrial Indemnity provided the employer with workers' compensation coverage at the time of the October 1979 injury.

Upon receipt of a copy of EBI's October 23, 1981 denial, claimant's physician corresponded with the company. By letter of November 9, 1981 claimant's physician, Dr. Hazel, "requested reconsideration" of EBI's denial, pointing out the facts that claimant had sustained an injury on February 14, 1979 which EBI had accepted and that, in fact, EBI had paid claimant's medical expenses between March 8, 1979 and March 25, 1980. The record does not reflect whether EBI responded to Dr. Hazel's letter, but it is apparent that claimant heard nothing further from EBI with respect to a claim for reopening of his February 1979 injury until some time later.

Industrial Indemnity commenced payment of interim compensation benefits as of the first day that claimant stopped working in September 1981 and until it denied claimant's aggravation claim on December 11, 1981. Industrial Indemnity's denial states the following reasons for denying reopening of claimant's October 1, 1979 injury claim:

> "1) Your present condition is not the result of your injury of October 1, 1979 nor has there been any evidence of a new and separate injury occurring at Holman Transfer Company.
>
> "2) Your condition is no worse now than at the time of the incident of October 1, 1979.
>
> "3) If your condition is worse, it is our position that it is related to your previous injury and surgery as well as the progression of an underlying degenerative process."

In December 1981 claimant filed two requests for hearing, one of which identified Industrial Indemnity as the insurer, the other of which identified EBI Companies as the insurer, and both of which identified the date of injury as October 1, 1979. By letter of January 25, 1982 claimant withdrew his request for hearing contesting EBI Companies' October 23, 1981 denial of reopening of claimant's October 1, 1979 injury claim, stating that Industrial Indemnity had acknowledged the claim for injury of that date. The hearing request apparently was dismissed, and by letter to counsel for EBI Companies, claimant's attorney advised EBI that "[t]he dispute for responsibility is between Industrial Indemnity and SAIF Corporation." Claimant's attorney also advised EBI's counsel that claimant had filed a request for own motion relief with the Board.

By an Own Motion Order issued on March 4, 1982 the Board referred claimant's request for own motion relief to the Hearings Division for consolidation with claimant's pending hearing request contesting Industrial Indemnity's denial of claimant's aggravation claim. That order states: "The Referee is to take evidence to determine whether claimant's current condition is related to his 1973 industrial injury, his [October 1,] 1979 industrial injury or neither." Upon receipt of the Board's Own Motion Order referring the request for own motion relief to the Hearings Division for a consolidated hearing, counsel for SAIF Corporation moved the Board for an order to join EBI Companies as a necessary party to the proceedings, advising that SAIF had tendered an aggravation claim to EBI Companies in behalf of claimant. The Board referred SAIF's motion to the Referee. Meanwhile, claimant filed another request for hearing identifying EBI Companies as the insurer and a February 14, 1979 date of injury. That request for hearing protests a "de facto denial" of claim reopening and requests payment of interim compensation from November 9, 1981 which was the date of Dr. Hazel's letter to EBI "requesting reconsideration" of its denial of liability for claimant's October 1, 1979 injury. This request for hearing was received by the Board on June 17, 1982, and on June 23, 1982 EBI Companies issued a denial stating that claimant's February 1979 episode was "an aggravation of the prior SAIF injury, "denying all responsibility for any back problems claimant may have had during the period that EBI provided coverage for the employer. Claimant subsequently amended his request for hearing to put in issue EBI's June 23, 1982 denial.

The hearing initially convened on July 27, 1982, and counsel for claimant and all three insurers (SAIF, EBI Companies and Industrial Indemnity) were present. During opening statements, counsel for Industrial Indemnity stated: "Industrial Indemnity is not at this juncture contending that claimant's condition is not compensable. Carrier responsibility is the only question." Counsel for EBI made no statement that would indicate EBI denied the compensability of claimant's condition in September 1981. Opening remarks made by counsel for SAIF indicate that SAIF's argument in opposition to the Board's exercise of own motion relief was twofold: Firstly, that claimant's condition in September 1981 did not result from his accepted 1968 and 1972 injuries, but rather resulted from the natural progression of a degenerative disease process; and secondly that, even if the injuries incurred by claimant while SAIF was on the risk had some

contribution to claimant's current condition, the more recent incidents in 1979 represented more recent injuries or exposures contributing to claimant's current condition, thereby relieving SAIF of any liability. It is also apparent that, in reliance upon a written opinion from its medical administrator, SAIF was attempting to create doubt concerning not only the contributing effects of claimant's 1968 and 1972 injuries to his condition in September 1981 and thereafter, but also the nature of claimant's 1968 and 1972 "injuries" and their effect upon claimant's degenerative disc disease at that time.

After counsel's opening statements were made, the hearing recessed and reconvened on August 4, 1982 at which time claimant, the only witness, testified. During cross-examination by counsel for SAIF, EBI's attorney interjected an objection to counsel's line of questioning:

> "I'm going to object to the continued line of questioning that appears at least to put compensability at issue unless I'm still unclear as to the issues which I thought were clarified earlier. * * * And these questions regarding the sudden onset of pain prior to surgery, whether or not an incident happened off work, go only to compensability, not to any issue that is before us here today."

Claimant joined in this objection which was overruled by the Referee. The propriety of the Referee's ruling has not been raised on review and is not an issue before us; however, we consider the quoted passage a fairly clear indication that counsel for EBI understood responsibility to be the issue before the Referee, not compensability.

The Referee found Industrial Indemnity responsible for claimant's 1981 aggravation claim, finding that the condition of claimant's low back, including the pain radiating into his right leg, "deteriorated from the date of the October 1, 1979 episode virtually without abatement." The Referee also relied upon a statement from claimant's treating physician, Dr. Hazel, that the condition of claimant's low back in September 1981 and thereafter was the "summation of all the forces and factors that have occurred to [claimant] since 1969."

Although we do not agree with the Referee's finding that claimant's condition progressively and unremittingly deteriorated after his October 1, 1979 injury, we are in agreement with several of his other findings, including the fact that a "fair interpretation" of all of the statements and conclusions offered by Dr. Hazel, who has been claimant's treating physician since 1969, is that the current condition of claimant's low back is the result of an accumulation of causes, one of which is claimant's October 1, 1979 injury. The conclusion that claimant's most recent injury contributed to his condition in September 1981 is supported by the fact that, after claimant's October 1979 injury, he was released to work with restrictions not previously imposed;

i.e., "supervising only -- no heavy lifting." Before the October, 1979 injury, and particularly after the February 1979 injury, claimant would only occasionally take pain medication in the form of Empirin with codeine. After the October 1979 injury, claimant was taking three to five Empirin with codeine every working day. After October 1979 claimant's symptoms of pain radiating into his right leg continued, true to Dr. Hazel's prognosis in March 1980 that claimant would continue to experience leg pain persistently or intermittently for an indefinite period of time. Claimant testified that, after October 1979, he found it necessary to take more time off from work than he previously had, which he took as vacation time.

Dr. Norton, SAIF's medical administrator, whose report appears in the record, expressed the opinion that none of claimant's industrial injuries represented true injuries but were only manifestations of degenerative disc disease. As a result of their examination of claimant in April 1982, the Orthopaedic Consultants expressed the opinion that claimant's "injuries" in 1979 did not contribute to claimant's current condition. Dr. Hazel also had made statements, primarily in response to specific inquiries made by Industrial Indemnity and its counsel, indicating that claimant's October 1979 injury did not contribute independently to his current condition, and that his condition would be the same even in the absence of the October 1979 episode. Dr. Hazel's statements, of course, are the most persuasive in our view, in view of the fact that he has been treating claimant for approximately 13 years and is in the best position to assess the various factors that have influenced claimant's low back condition. Although he has authored statements tending to indicate that claimant's October 1979 injury did not independently contribute to the current condition of claimant's low back, he also has made statements which lead to the conclusion that the October 1979 injury contributed at least slightly to the condition of claimant's low back in September 1981 and thereafter.

> "I am inclined to agree that Mr. Kearns' present condition has its genesis in degenerative disc disease, manifested as far back as 1969 and accentuated by back injuries of the early 1970's and subsequent surgery and likewise influenced by repetitive back stresses.
>
> "In summary, Mr. Kearns' current condition is a summation of all the forces and factors that have occurred to the gentleman since 1969. Any one of these factors may have been inconsequential in itself. As previously noted, his injury as described to me that occurred in October, 1979 does not appear to be in itself, an injury that substantially altered his current physical condition." (Emphasis added.)

Our holdings in Roger Ballinger, 34 Van Natta 732 (1982), and Paul S. Gill, 34 Van Natta 1471 (1982), provide that, in cases involving successive injuries to the same area of a claimant's body, where the only issue is which employer or insurer is responsible for payment of the claimant's compensation when a subsequent claim for medical services and/or disability compensation arises, the most recent employer or insurer has the burden of proving that it is not responsible for payment of claimant's compensation. We are satisfied that the only issue in this case is responsibility for claimant's current condition as between EBI Companies, which provided coverage for the employer on the date of claimant's February 14, 1979 injury, and Industrial Indemnity Company, which provided coverage for the employer on the date of claimant's most recent injury, October 1, 1979. There is no issue concerning the compensability of claimant's current condition which is the subject of his September 1981 aggravation claim. Cf. ORS 656.307.

In Wills v. Boise Cascade Corp., 58 Or App 636 (1982), the court held that the issue of employer/insurer responsibility in cases of the nature involved herein is resolved by determining whether the most recent injury sustained by claimant contributed independently to the condition currently requiring medical services or disability compensation. In Wills, the court found that the more recent of the two potentially responsible employers/insurers was not responsible for claimant's subsequent surgery because claimant's more recent injury had merely caused symptoms of the claimant's condition without independently contributing to the development of the underlying condition itself.

In considering the rule we established in Ballinger and further refined in Gill, together with the court's holding in Wills, the following rule emerges: Where there are multiple accepted injuries involving the same body part, we will assume that the last injury contributed independently to the condition now requiring further medical services or resulting in additional disability, and the employer/insurer on the risk at the time of the most recent injury has the burden of proving that some other accepted injury last contributed independently to the condition which presently gives rise to the claim for compensation; e.g., that its accepted injury caused only symptoms of the condition or involved a different condition affecting the same body part.

Applying that test to the facts of this case, we find that Dr. Hazel has issued statements which are ambivalent. Some of his statements would support a finding that the most recent injury, at which time Industrial Indemnity was on the risk, did independently contribute at least slightly to claimant's current condition and resultant disability and need for medical services. Other statements authored by Dr. Hazel would support a contrary conclusion; i.e. that claimant's current condition has developed, and would have developed, independently of his most recent injury which constituted nothing more than the symptomatology of an underlying degenerative process set in motion years before. Considering this evidence, as well as all of the other evidence bearing upon the issue of insurer responsibility, we find that

Industrial Indemnity, the insurer on the risk at the time of claimant's most recent low back injury, has failed to satisfy its burden of proving that claimant's October 1, 1979 injury did not independently contribute at least slightly to claimant's underlying degenerative disease process and the resulting current condition. Accordingly, we affirm the Referee's finding that Industrial Indemnity is the insurer responsible for payment of claimant's compensation.

The Referee found that EBI's June 23, 1982 denial attempted to retroactively deny all responsibility for claimant's February 1979 injury; and, although he found Industrial Indemnity responsible for claimant's September 1981 aggravation claim, he also set aside EBI's June 23, 1982 denial insofar as it attempted to retroactively deny responsibility for the previously accepted February 1979 injury. The Referee found, in effect, that claimant's February 1979 injury represented a new injury and not merely an aggravation of claimant's prior injuries insured by the SAIF Corporation. On review EBI appears to contend that the Referee's order was in error insofar as it did not allow EBI's June 23, 1982 "back-up" denial to stand in its entirety. We need not decide the merits of EBI's contention that it never was responsible for claimant's February 14, 1979 injury in view of the Court of Appeals' recent decision in Bauman v. SAIF, 62 Or App 323 (1983).

Our understanding of Bauman renders EBI's June 23, 1982 denial a nullity insofar as it attempts to retroactively deny claimant's previously accepted February 1979 injury. Claimant's 1979 injury was accepted as a nondisabling injury. Apparently no Determination Order closed the claim. In spite of this apparent fact, however, the principle of the holding in Bauman supports our conclusion by virtue of the passage of more than three years after the date of claimant's February 1979 nondisabling injury and before EBI's attempted retroactive denial in June 1982. The only effect of that denial, therefore, was to deny EBI's responsibility for claimant's September 1981 aggravation claim, and we have determined that EBI is not responsible for this claim, as did the Referee. Accordingly, we affirm that portion of the Referee's order which, in effect, set aside this denial insofar as it attempted to revoke EBI's prior acceptance of claimant's February 1979 injury claim.

EBI also takes issue with that portion of the Referee's order directing it to pay claimant interim compensation from the date of receipt of Dr. Hazel's November 9, 1981 letter through June 23, 1982, the date of EBI's second denial. The Referee found that Dr. Hazel's letter constituted a "consummated claim of aggravation," requiring it to commence payment of interim compensation within 14 days and accept or deny within 60 days. EBI argues that Dr. Hazel's November 9, 1981 letter was not a new claim of aggravation but was merely a request for reconsideration of its October 1981 denial; and that, since it already had denied the aggravation claim, no further action was required. We find it unnecessary to determine the true nature of Dr. Hazel's letter in deciding the issues of interim compensation and penalties.

ORS 656.273(6) requires an insurer to initiate payment of interim compensation no later than 14 days after notice or knowledge of medically verified inability to work resulting from a

worsened condition. See also Silsby v. SAIF, 39 Or App 555 (1979). Dr. Hazel's November 9, 1981 letter contains no statement which could be construed as medical verification of claimant's inability to work; therefore, no duty arose on the part of EBI to initiate interim compensation payments as a result of its receipt of this letter. Since EBI had no duty to pay interim compensation, it cannot be penalized for its failure to do so.

The Referee's imposition of a penalty appears to be based, in part, upon EBI's failure to issue a timely denial of the "renewed claim" for reopening represented by Dr. Hazel's letter. Assuming arguendo that Dr. Hazel's letter constituted a claim requiring acceptance or denial, our finding that it did not trigger a duty to commence payment of interim compensation disposes of the possible issue of a penalty for unreasonable delay in acceptance or denial since there are no amounts "then due" upon which to calculate a penalty. Gary L. Clark, 35 Van Natta 117 (1983); Laura Maitland, 34 Van Natta 1294 (1982).

ORDER

The Referee's order dated October 29, 1982 is reversed in part. That portion of the order which directs EBI Companies to pay claimant interim compensation and a penalty is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee on Board review, payable by Industrial Indemnity Company.

DUANE KEARNS, Claimant
Galton, Popick & Scott, Claimant's Attorneys
Cliff & Snarskis, Defense Attorneys
SAIF Corp Legal, Defense Attorney
Wolf, Griffith et al., Defense Attorneys

Own Motion 82-0016M
June 14, 1983
Own Motion Order

Claimant requested that the Board exercise its own motion authority pursuant to ORS 656.278 and reopen his claim for a worsening of his low back condition, allegedly resulting from injuries sustained on May 6, 1968 and June 1, 1972.

On March 4, 1982, the Board issued an Own Motion Order referring claimant's request for own motion relief to the Hearings Division for consolidation with the pending hearing request in WCB Case No. 81-11626, involving a claim of aggravation filed against the insurer on the risk at the time of an injury occurring in October, 1979 (Industrial Indemnity). Claimant subsequently filed another request for hearing raising an issue of aggravation allegedly resulting from a February, 1979 injury occurring while another insurer was on the risk (EBI Companies), which was assigned WCB Case No. 82-05409. All claims were heard by the Referee, who issued an order pursuant to ORS 656.289 in WCB Case Nos. 81-11626 and 82-05409. The Referee also made a recommendation to the Board concerning claimant's request for own motion relief in Own Motion No. 82-0016M.

The Board has considered the record of the proceedings developed before the Referee, including the transcript of

testimony, in deciding whether to exercise its own motion authority and order reopening of claimant's 1968 and/or 1972 injury claims, insured by the SAIF Corporation. The Referee's recommendation to the Board was that it not grant relief pursuant to ORS 656.278, in view of the Referee's finding that one of the two more recent insurers is responsible for the current condition of claimant's low back.

We have this day issued a separate Order on Review in WCB Case Nos. 81-11626 and 82-05409, affirming the Referee's order insofar as it finds the insurer on the risk at the time of claimant's most recent industrial injury responsible for claimant's current low back condition. We, therefore, agree with and adopt the Referee's recommendation that claimant's request for own motion relief be denied.

IT IS SO ORDERED.

HOMER LOGAN, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-10349
June 14, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Daron's order which affirmed the Determination Order dated January 7, 1982. Claimant contends he should receive additional compensation for both temporary and permanent disability.

The Determination Order awarded time loss through November 23, 1981. That decision was presumably based upon Dr. Butters' report of that date stating that claimant "should probably be released for work and considered stationary." However, Dr. Butters wrote a cryptic two-sentence letter on December 10, 1981 stating that claimant was "presently unable to work." Southern Oregon Medical Consultants found claimant to be medically stationary on December 14, 1981. Claimant argues that, because Dr. Butters "changed his mind," he should be awarded time loss through December 14, 1981, the date of the first and only unequivocal statement of medically stationary status. Resolving a lot of doubt in claimant's favor, we agree.

The Determination Order, which was affirmed by the Referee, awarded claimant compensation for 15% permanent partial disability. We agree with several of the evaluator's findings that led to this award, including 8% right shoulder and cervical impairment, age (60) +10, and average mental capacity and normal emotional/psychological findings, both thus having no impact. However, we find that claimant only has an eighth grade education and should receive a +10 under OAR 436-65-603, contrary to the evaluator's assignment of a zero to this factor.

The labor market factor under OAR 436-65-608 requires a judgment call. That rule requires assigning a value of -25 when a worker has "successfully" returned to work, and that is the value that the evaluator assigned. From all the evidence, we conclude

that claimant's return to truck driving with his right shoulder and cervical impairment more fairly should be characterized as "somewhat problematical," rather than "successful." Finding a residual functional capacity of medium, a GED factor of 2 and an SVP factor of 4, we conclude that a more appropriate labor market value would be -10.

When these modifications for education (+10, rather than 0) and labor market (-10, rather than -25) are used in the formula stated in OAR 436-65-601, the result is an award of 25% unscheduled permanent partial disability.

ORDER

The Referee's order dated May 25, 1982 is reversed. Claimant is awarded compensation for temporary total disability from November 23, 1981 to December 14, 1981; this award is in addition to, not in lieu of, the award for temporary total disability granted by the Determination Order dated January 7, 1982. Claimant is also awarded 80° for 25% unscheduled permanent partial disability for injuries to his right shoulder and neck; this award is in lieu of, not in addition to the award for permanent partial disability granted by the Determination Order dated January 7, 1982.

Claimant's attorney is allowed 25% of the increased compensation granted by this order as and for a reasonable attorney's fee.

HARRY K. AGNER, Claimant
Welch, Bruun & Green, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Schwabe, Williamson et al., Defense Attorneys

WCB 81-8632 & 81-6391
June 15, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Consolidated Freightways (Freightliners) requests review of that portion of Referee Knapp's order which assigned responsibility to Freightliners based on his findings that claimant sustained a compensable injury in May 1981 and that the injury was an aggravation rather than a new injury. The issues on review are whether claimant sustained any compensable injury in May 1981 while employed by St. Vincent de Paul (insured by SAIF) and, if so, whether the injury constitutes an aggravation of a 1976 injury for which Freightliners would be responsible or a new injury for which SAIF would be responsible.

In August 1976, at the age of 52, claimant sustained a low back strain while employed by Freightliners. Claimant filed a claim for that condition which was accepted by Freightliners. Claimant was treated conservatively by medication, exercises and use of a back brace. It does not appear that claimant consulted a physician for medical treatment after March 1977. The Evaluation Division issued a Determination Order in May 1977 establishing April 18, 1977 as a medically stationary date and awarding claimant 5% unscheduled disability.

Following unsuccessful attempts to return to work at Freightliners, in 1979 claimant completed a vocational rehabilitation program in refrigerator and air conditioner repair. In February 1980 claimant became employed with St. Vincent de Paul engaged in refrigerator repair. In June 1980, pursuant to an appeal from a Determination Order reclosing claimant's file following vocational rehabilitation, a Referee awarded claimant 20% unscheduled disability.

When claimant was hired, St. Vincent's was well aware of claimant's back condition and the lifting restrictions to which he was subject. Claimant was assigned a helper to assist in moving refrigerators as necessary. During one particular week in May 1981 claimant's helper was unavailable and the facility otherwise was short handed. During that week claimant undertook to move some refrigerators himself which involved exerting himself beyond the lifting restrictions imposed by his physician. During that week claimant gradually began to experience increased back pain, and on one particular day claimant experienced a significant increase in pain that caused him to leave work and seek medical care.

Claimant initially filed an aggravation claim with Freightliners. Freightliners denied that claim on the grounds that claimant's condition had not worsened since the last arrangement of compensation. Claimant then filed a new injury claim with St. Vincent's which was denied by SAIF on the grounds that neither claimant's work activities in general nor any specific incident while employed by St. Vincent's caused his condition in May or June 1981 or thereafter.

Examinations of claimant by the physicians who treated claimant following his 1976 injury generally indicate that claimant's condition had not changed since it became stationary in 1977. In December 1981 one of claimant's treating physicians, Dr. Walter Smith, referred claimant to Dr. John Harris for a second opinion. Dr. Harris' findings generally coincide with Dr. Smith's; however, Dr. Harris indicated, "It appears that he [claimant] will not be able to resume his previous job unless arrangements can be made so that he does not have to do any stooping or heavy lifting." In a subsequent report, Dr. Harris recommended that claimant not be required to stoop or lift any objects from the floor but that he could lift 25-30 pound objects repeatedly at counter level. In 1976 Dr. Smith had released claimant for work indicating that claimant "should be cautious regarding lifting any object over ten pounds and should avoid prolonged sitting, stooping and bending."

At hearing, counsel for SAIF attempted to elicit testimony from claimant to the effect that he had experienced continuous pain since the 1976 injury. Based on claimant's testimony and Dr. Harris' reports, the Referee found that claimant had sustained a compensable injury and that the injury constituted an aggravation of his 1976 injury.

We agree that claimant sustained a compensable injury in May 1981, but we disagree that it constitutes an aggravation of his 1976 injury. First, we believe that claimant's testimony at hearing in and of itself would support a finding of either a new injury or an

aggravation. Second, the two physicians in the best position to determine whether claimant's condition has worsened, i.e., the physicians who treated him following the 1976 claim and after May 1981, opined that there was no objective evidence that claimant's condition had changed or worsened since 1976-1977. Third, contrary to the Referee's finding, we find that claimant did not experience continuous back pain since 1976. Fourth, contrary to claimant's contentions we do not believe that the difference between Dr. Smith's lifting restrictions in 1976 and Dr. Harris' restrictions in 1981 (a difference at most whether claimant can lift ten pounds from the floor) is probative of a worsening.

It is true that the May 1981 condition is the same condition as the 1976 injury, namely, a low back strain. It is also true that the symptoms claimant experienced in 1981 as well as the treatment he received then are similar to the symptoms and treatment in 1976. These factors would tend to indicate that claimant had sustained an aggravation. The Referee, the claimant and SAIF have cited a number of cases in support of their position that these facts indicate that claimant sustained an aggravation. See, for instance, Barackman v. SAIF, 25 Or App 293 (1976), Perdue v. SAIF, 53 Or App 117 (1981), and Boise Cascade v. Starbuck, 61 Or App 631 (1983), We would add to the list, SAIF v. Brewer, 61 Or App ___ (1983), and Donald M. Drake Company v. Lundmark, 63 Or App 261 (May 25, 1983).

However, three threads running through these cases are: (1) The claimant experiencing continuing symptoms from the original injury through a subsequent injury; (2) disability or the need for medical services within a year or two after the original injury; and (3) the absence of identifiable incidents which reasonably could have caused a new injury. None of these factors are present here. Here, claimant went for a period of over four years without seeking treatment for his back. The Referee characterized claimant's testimony as indicating that claimant's symptoms "never resolved entirely but remained at a tolerable level if not agitated by increased activity." It is instructive to set forth claimant's actual testimony:

> "Q. . . . Mr. Agner, my understanding is that after your injury in 1976, with Freightliner, you had -- you have had consistent low back pain, is that correct?
>
> "A. Not -- only at first, it diminished after the first -- I mean, at the time, like I said, started in at St. Vincent's, it was down tolerably. In other words, wasn't bothering me too much except under certain conditions that it would start hurting, but not severely.
>
> * * *
>
> "Q. I understand that even in June of 1980, you had this constant low back pain, isn't that correct?

"A. It wasn't constant, no. Like I said, depending on what I did, everything, it would -- I would have it at times, like standing or movement of certain types."

Second, the period of time between the original injury and the alleged aggravation is over four years, during which time claimant sought no treatment for his back. In 1979 claimant discarded the back brace he had been wearing after the 1976 injury. Claimant went to work for St. Vincent's in February 1980, and at the time of the previous hearing in May 1980 on extent of disability, the Referee in his order commented that claimant had missed only a half day of work. There is no other evidence that claimant missed any work while employed at St. Vincent's.

Third, claimant's condition in 1981 did not come on gradually over a period of a year or more. It did not even develop over a period of a month or more. Claimant testified that he experienced a significant increase in pain as the result of about one week's work because of his need to move refrigerators around without the assistance of a helper. This constitutes an identifiable traumatic incident which likely would lead to injury. See Valtinson v. SAIF, 56 Or App 184 (1982) and Donald M. Drake Company v. Lundmark, supra.

Although no physician specifically indicated that claimant's condition in May-June 1981 constituted a new injury, we believe that the temporal relationship between claimant's work activity during the week of May 28, 1981 and the onset of disabling pain, together with the other factors present in this case, support our inference that claimant's work activities during that week contributed independently to claimant's condition and constitutes a new injury. Uris v. Compensation Department, 247 Or 420 (1967), Peterson v. Eugene Burrill Lumber Co., 294 Or 537 (1983).

Claimant's counsel successfully defended on review that portion of the Referee's order finding that claimant sustained a compensable injury in May 1981. Therefore, he is entitled to an insurer paid fee. However, claimant's counsel is not entitled to a fee for that portion of his brief devoted to arguing that claimant sustained an aggravation rather than a new injury.

ORDER

The Referee's order dated December 22, 1982 is modified. That portion of his order affirming SAIF's denial of September 14, 1981 is reversed and claimant's claim is remanded to SAIF for acceptance and payment of compensation in accordance with law, including reimbursement to Consolidated Freightliner. That portion of the Referee's order disallowing Consolidated Freightliner's denial of August 1, 1981 is reversed and Consolidated Freightway's denial is reinstated. Claimant's counsel is awarded $300 for his services on review, payable by the SAIF Corporation.

ALVAH G. BAKER, Claimant
John D. McLeod, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-11177
June 15, 1983
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Mulder's order which, in effect, affirmed the November 13, 1980 Determination Order on Reevaluation of Permanent Total Disability, as amended by the November 19, 1980 Determination Order, continuing claimant's status as permanently and totally disabled. ORS 656.206(5), 656.325(3). SAIF contends that claimant is now able to regularly engage in gainful and suitable employment in connection with his family nursery business, and that he is, therefore, no longer permanently and totally disabled.

A majority of the Board affirms and adopts the Referee's order. Claimant's attorney has filed no brief with the Board, and, therefore, no attorney's fee is awarded.

ORDER

The Referee's order dated June 1, 1982 is affirmed.

Board Member Barnes, dissenting:

The strongest argument in support of the result reached by the Referee and the Board majority is that the appellate courts have imposed such a high burden of proof on employers/insurers that, as a practical matter, it is virtually, if not literally, impossible to terminate a total disability award. See Richard Pick, 34 Van Natta 957 (1982), and cases cited therein. The appellate courts have indirectly indicated that an insurer's burden of proof simply cannot be satisfied in this context by the fact that no reported appellate court decision has allowed the termination of an award for total disability. But the appellate courts have not yet directly said that this is a burden that cannot be satisfied.

Assuming, then, that it is ever possible to terminate an award for total disability, the strongest argument to do so in this case -- and the finding I would make in reversing the Referee -- is that the SAIF Corporation has proven to my satisfaction that claimant is actually working in a gainful and suitable occupation.

Claimant is involved with several family members in the operation of a nursery business. A SAIF investigator testified that he observed claimant cultivating the nursery stock on a tractor. Three persons who had done considerable business with the nursery, Mr. Locklear, Mr. Tibbetts and Mr. Krueger, testified that claimant appeared to be operating the nursery business; that they had observed claimant doing cultivating, grafting and other nursery work; and that claimant had at times helped them load purchases. I find all of these witnesses credible. Claimant and his relatives testified to the contrary, i.e., that claimant did no work in connection with the family nursery business. The Referee concluded:

> "that claimant's credibility was substantially eroded by many significant inconsistencies in his assertions as compared to evidence of others. The balance of claimant's witnesses were not persuasive as to claimant's limitations. His participation in the business exceeds the amount attempted to be portrayed by the claimant, and to a lesser extent, by the family."

As I read the record, I think the Referee's finding was too charitable. I believe that claimant's sworn testimony about nonparticipation in the nursery business amounted to perjury.

The income from that business varied greatly. Apparently net income in the best years was about $40,000.

In summary, the evidence clearly establishes in my mind that claimant is doing physical and managerial work for a profitable family business. I understand the Referee to have so found. Since the Board majority "adopts" the Referee's analysis, I understand we are unanimous on these points.

The only possible flaw in SAIF's evidence is whether it has been proven that claimant is able to work "regularly." I submit that issue should be addressed in context. The nursery business is seasonal; there are undoubtedly more hectic times of year, followed by more tranquil times of year. It is probably a fair inference that claimant works as much as is necessary when the nursery business requires. Furthermore, I suggest that we should appreciate that all data about the "regularity" of claimant's work for a family-owned, family-operated business is going to be known only to the family members. And as the transcript in this case demonstrates to my satisfaction, it is not very realistic to expect that family members would candidly share that data at a hearing which involves the issue of possible reduction of a family income. In my opinion, this can only mean one of two things: Either (1) we should be willing to draw an inference from limited circumstantial evidence that a claimant is regularly working in a family-operated business; or (2) we might as well admit that all supposedly totally disabled claimants can work all they want in profitable family businesses without concern about possible loss of their total disability awards because, absent an unusually honest family member, there will never be direct evidence about the regularity of their work in the family business.

PAMELA S. BERNHARDT, Claimant
William M. Durr, Claimant's Attorney
Wolf, Griffith et al., Defense Attorneys
Howard Cliff, Defense Attorney

WCB 81-07893 & 81-06774
June 15, 1983
Order Denying Motion to Dismiss

The Board has received claimant's motion for dismissal of the employer's request for Board review on the grounds that the employer has not filed an appellant's brief.

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

IT IS SO ORDERED.

DARRELL GREEN, Claimant
Evohl Malagon, Claimant's Attorney
Walter & Johnson, Defense Attorneys

WCB 82-07834
June 15, 1983
Order of Dismissal

The claimant has requested review of Referee's order dated April 22, 1983. The request for review was filed with the Board on June, 10, 1983 , more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

The claimant's request for review is hereby dismissed as being untimely filed.

JOHN R. HART, Claimant
Ferder, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01353
June 15, 1983
Order on Review

The SAIF Corporation requests reconsideration of that portion of the Board's Order on Review dated May 16, 1983 which required SAIF to pay claimant a 25% penalty on interim compensation paid during the period between the sixtieth day after notice of the claim and SAIF's denial.

SAIF argues that the Board, in awarding penalties, "decided an issue which was not raised on appeal"; that claimant requested only that the Referee's order be affirmed; and cites several cases for the proposition that the Board cannot consider issues which were not raised on appeal.

It is true that we have often stated that the Board and Referees should confine themselves to issues raised and not volunteer decisions on additional or different issues. Minnie Thomas, 34 Van Natta 40 (1982); Richard L. McBee, 34 Van Natta 1119 (1982). However, in the current case, the issue of penalties was before the Referee and, although claimant did not request

cross-review of the Referee's order, he specifically states in his brief:

> "If anything, the penalty awarded by the Referee is too little. The maximum penalty to be imposed is 25 percent (25%) of the amount due claimant."

We are uncertain just how much more specifically SAIF believes is necessary.

ORDER

The Board's Order on Review dated May 16, 1983 is readopted and republished effective this date.

GARLAND ARNAUD, Claimant
Galton, Popick et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 79-10623
June 16, 1983
Order on Remand

On review of the Board's order dated December 18, 1981, the Court of Appeals affirmed the Board's order finding that claimant's myocardial infarction was not compensable, and remanded for a determination and award of an attorney's fee pursuant to ORS 656.382(1).

Now, therefore, the above-noted Board order is modified to award claimant's attorney $300 in association with the penalty imposed for the SAIF Corporation's unreasonable delay in paying interim compensation and unreasonable delay in accepting or denying the claim.

IT IS SO ORDERED.

KATHLEEN A. BALLARD, Claimant
Coons & McKeown, Claimant's Attorneys
Schwabe, Williamson et al., Defense Attorneys

WCB 81-08515
June 16, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Nichols' order awarding claimant $250 in attorney fees for overturning the insurer's denial. The propriety of an attorney's fee award is the only issue on review.

We affirm and adopt the Referee's order with the following comment: The insurer's denial was overturned by stipulation. The only issue at hearing was attorney's fees. The basis for the Referee's award of an attorney's fee is unclear. She states that "The purpose of carrier paid attorney's fees in denied matters is to encourage carriers to accept appropriate claims before a hearing is held." She also states, however, that the insurer's action in denying the claim for future medical services was unreasonable. The majority of the parties' briefs focuses on the

reasonableness of the insurer's actions.

We do not believe the reasonableness of the insurer's action is the relevant inquiry in this case. OAR 436-47-015 provides that where an attorney is "instrumental in obtaining compensation without a hearing" he may be entitled to an attorney's fee. The inquiry in this case is whether claimant's attorney was instrumental in having the denial set aside and thus in obtaining compensation for the claimant. Because the denial was set aside on the basis of a stipulation we believe it is a reasonable inference that claimant's attorney was instrumental in obtaining compensation.

ORDER

The Referee's order of January 5, 1983 is affirmed. Claimant's attorney is awarded $200 for services on Board review.

PHILLIP J. BARRETT, Claimant
Rolf Olson, Claimant's Attorney
Cheney & Kelley, Defense Attorneys

WCB 81-03112
June 16, 1983
Order on Remand

This case is before us again on remand from the Supreme Court. Barrett v. Coast Range Plywood, 294 Or 641 (1983). The Referee originally determined the claimant to be permanently and totally disabled. On review we reversed the Referee and awarded claimant 40% unscheduled permanent partial disability. Phillip J. Barrett, 34 Van Natta 450 (1982). Our order was affirmed by the Court of Appeals, Barrett v. Coast Range Plywood, 56 Or App 371 (1982), and the Supreme Court granted claimant's petition for review.

The Supreme Court accepted review to address the specific issues of:

> ". . . whether the presence of functional overlay is a subject of such a scientific or technical nature that only the testimony of psychological experts may suffice to establish the causal relationship between claimant's injury and his disability." 294 Or at 645.

and:

> ". . . what kind of expert medical testimony is necessary to prove the causal relationship between an injury and the alleged psychological components of the injury." 294 Or at 646.

The court examined the questions of qualifications of expert witnesses in general and, more specifically, of an expert's competency to offer an opinion concerning a particular specialty when the expert is engaged in the field in either another sub-specialty or the entire field in only a general manner. The court concluded:

> Accordingly, we hold that because the diagnosis of functional overlay is within the competency of medical doctors, they may express expert opinions about the disability. The fact that they are not psychotherapists may go to the weight to be accorded their testimony but that fact cannot serve as the reason to disregard the testimony entirely." 294 Or at 649.

In retrospect, we find that our initial order was inartfully worded. The court interpreted our order as indicating that we could not make a finding that claimant was affected by functional overlay because of lack of evidence from one or more psychiatrists. We accept that medical and mental health professionals other than psychiatrists are competent to express an opinion whether the source of a claimant's pain (or alleged pain) is due to physiological causes, or, by process of elimination, psychological causes. We did not mean to imply that claimant is not affected by "functional overlay," i.e., pain or discomfort resulting from non-physiological and presumably psychological causes. See Barrett v. Coast Range Plywood, 264 Or 643-644. Virtually every physician who has examined or treated claimant has opined, expressly or in so many words, that claimant exhibits "functional overlay." In that sense, there can be no doubt but that a significant part of claimant's claimed disability is the result of "functional overlay."

We believe that the real question in this case is whether the pain that claimant alleges he experiences (but which has little or no physiological basis) is the result of conscious exaggeration on claimant's part, i.e., malingering, or whether it is the result of an unconscious, presumably psychological and unexplained process, i.e., functional overlay. In our previous order we were attempting to indicate that, in our estimation, claimant was exaggerating the pain and discomfort he was feeling and that he was not as disabled as he would have us believe. On remand, we have again reviewed the entire record and reconsidered the evidence and have arrived at the conclusion that claimant is not malingering and is not exaggerating the extent of his impairment.

The record indicates that, prior to his injury, claimant, by all accounts, was a hard working, conscientious worker capable of heavy to very heavy work, in good health and with virtually no low back or leg problems. Since his industrial injury and notwithstanding the absence of evidence indicating neurological or skeletal involvement, claimant has exhibited a dramatic change in his posture, gait and physical functioning as well as his lifestyle and ability to function at home and in the market place.

Surveillance of claimant by private investigators retained by the employer revealed (1) a level of inactivity on claimant's part consistent with claimant's description of his disability and behavior when he knows he is being observed; and (2) no evidence of engaging in physical activities while not being watched, e.g., stacks of old firewood with no evidence of recent woodcutting and gradual deterioration of a previously well-kept yard.

Claimant's treating physician observed claimant in town and under circumstances when claimant did not know he was being

observed and, again, observed a level of disability consistent with observations of claimant during in-office examinations. With respect to the medical reports, functional overlay of a type suggesting malingering is frequently evidenced by reference in such reports to "inconsistencies," which we understand to mean a claimant's response to various clinical maneuvers which do not correlate with the claimant's response to other maneuvers or self-descriptions of impairment, or which are anatomically impossible. The medical reports here do not refer to such inconsistencies; they merely refer to pain behavior inconsistent with the results of x-rays and myelograms as well as claimant's musculature.

Lastly, the testimony of claimant's witnesses at hearing lend support to a finding that claimant is not consciously exaggerating the extent of his disability.

The inference which can be drawn from this evidence, and which we now make, is that claimant experiences pain, the source of which cannot be explained in physiological terms, but which is real and disabling to him. See Juanita M. DesJardins, 34 Van Natta 595 (1982). That is, we find that claimant experiences "functional overlay" of the type which should be taken into consideration in rating the extent of claimant's impairment.

Considering the effects of functional overlay on this claimant, we determine claimant's impairment level to be in the moderately severe category. In addition, claimant is precluded from returning to his former types of employment (carpenter, farmer, farm equipment operator) and is precluded from anything but sedentary work, whereas prior to his injury he was capable of heavy to very heavy work. On the other hand, claimant is relatively young (age 37 at time of hearing), has normal intellectual capacity, is a high school graduate and has demonstrated the ability to learn complex jobs. Moreover, most physicians who have examined him have recommended vocational rehabilitation. Based on this record, we find that claimant is not permanently and totally disabled. Due to factors which have nothing to do with claimant's physical disabilities, vocational rehabilitation has not been really tried. Considering the record as a whole, we conclude that claimant is entitled to an award of 70% unscheduled disability.

ORDER

On remand and reconsideration, we award 70% unscheduled permanent disability. Claimant's attorney is granted 25% of that award, not to exceed $3,000, as a reasonable attorney's fee.

Board Member Barnes, dissenting:

Much ado has been made in this case about "functional overlay." Putting aside that collateral issue for a moment, I submit that a fair overview of the record in this case is: According to the preponderance of the lay testimony, claimant is

totally disabled; according to the preponderance of the medical evidence, claimant is not totally disabled but instead (although this matter is a bit more debatable) is about 40% partially disabled, as recognized in our prior Order on Review.

For unarticulated reasons, the Board majority seems to be saying that the lay testimony is more persuasive than the medical evidence. Yet, perplexingly and again for unarticulated reasons, the majority stops short of awarding total disability. My overall position can be simply articulated: I find the preponderance of the medical evidence to be most persuasive and find that the medical evidence is most consistent with the partial disability award previously granted by the Board.

I

Our starting point on remand should be considered on the concept of "functional overlay." The Supreme Court discussed various definitions of this term from dictionaries and other appellate court decisions. 294 Or at 643-44 and 647-48. Without even mention or apparent consideration of the definitions discussed by the Supreme Court, the majority offers its own definition: Functional overlay, we are told, is an unconscious, presumably psychological and unexplained process that the majority seems to state at one point is the opposite of conscious malingering -- but at another point the majority refers to "functional overlay of a type suggesting malingering."

With due deference to the Supreme Court and the Board majority, I doubt that these definitional efforts are going to contribute anything to the Oregon workers compensation system. In my experience and opinion, Oregon doctors who treat and examine injured workers actually use the term "functional overlay" in a variety of different ways. That term is generally used, as indicated by the Supreme Court, as a shorthand reference to a patient's report of pain or other symptoms which a doctor cannot verify and for which a doctor can find no physiological explanation. I submit, however, that there is no universal medical usage of "functional overlay," standing alone, as an expression of a medical opinion about whether such unexplainable symptoms are real, or feigned, or consciously exaggerated, or unconsciously exaggerated, or permanent, or temporary (expected to resolve once workers compensation litigation is over), etc., or whether the doctor even has an opinion on the reliability/ permanency of the reported symptoms.

Moreover, a diagnosis is ordinarily just the starting point in determining causation and permanency. See, e.g., Lorrie A. Minton, 34 Van Natta 162 (1982). A physician might diagnose a fracture or a laceration or a myocardial infarction. That tells me what the condition is, but I am not aware of any dianosis that simultaneously states (in anything more than a very general sense) what caused the condition or what permanent impairment results from the condition. Cf. Bales v. SAIF, 294 Or 224 (1982).

In summary, I suggest that all the energy that has been devoted in this case to defining "functional overlay" obscures, rather than advances, disposition of the ultimate issue. It also

obscures analysis in future cases for the Board majority to both equate functional overlay with malingering and also to suggest that those concepts are opposites. The ultimate issue in this case is the extent of claimant's permanent disability caused by his March 1979 industrial injury. The starting point in assessing permanent disability is to assess permanent, injury-caused impairment. Whatever it means, I find that a diagnosis of "functional overlay," standing alone, adds little to an assessment of claimant's impairment. I return to this point in more detail in Part III, infra.

II

I believe our Order on Remand should also address the evidentiary issue discussed at length by the Supreme Court. The Supreme Court apparently interpreted our prior Order on Review to mean that the Board was completely rejecting the evidence concerning claimant's psychological condition solely because that evidence was generated, not by psychologists or psychiatrists, but by medical doctors with no particular expertise in the mental health field. In retrospect, that is a possible interpretation of the wording of our prior Order on Review; however, I am confident that was not what we intended to say.

In fact, this Board has long followed what I believe to be the exact evidentiary standards set forth in the Supreme Court's opinion. The following cases are illustrative.

In Daniel K. Bevier, 35 Van Natta 258 (1983), the Board, weighing the medical evidence accordingly, accepted evidence relating to causation of claimant's gastrointestinal problems from a physician who specialized in the field over that of the claimant's treating chiropractor who specialized in naturopathic treatment modalities. The issue in Wayne E. Welch, 34 Van Natta 766 (1982), involved the causal relation between claimant's injury and his rheumatoid arthritis condition. We stated:

> "We are impressed by the relative expertise of the doctors involved. Drs. Rosenbaum and May are specialists in rheumatology. Dr. Kenyon is an internist and the nature of Dr. Moore's practice is unknown. On the level of relative expertise, the edge has to go to Drs. Rosenbaum and May." 34 Van Natta at 768.

In Fred H. Paehler, 34 Van Natta 76 (1982), the issue was the causal relation between claimant's work activities and his spondylosis condition. Opinions were offered from claimant's treating physician and a medical consultant. We stated:

> "In weighing the respective opinions of Drs. Hopkins and Norton, we look to relative expertise, knowledge of claimant's work and the reasons given for their opinions." 34 Van Natta at 77.

In Glenn O. Hall, 34 Van Natta 1725 (1982), we stated that we gave less weight to the opinion of a psychologist on a question of brain damage because that issue was somewhat outside the

psychologist's area of expertise; we did not regard the psychologist's opinion to be incompetent or inadmissible. In Lavona Hatmaker, 34 Van Natta 950, 951 (1982), we stated: "Where there is conflict in medical opinion, we look to the relative expertise of the experts." In William E. Urton, 34 Van Natta 1263 (1982), we stated that we gave less weight to a psychologist's opinion concerning the cause of a myocardial infarction when there were opinions from cardiologists in the record. In Madonna Duman, 34 Van Natta 1642 (1982), there was a significant conflict between claimant's treating chiropractor and several orthopedists regarding the need for additional chiropractic care. Citing Creasey v. Hogan, 292 Or 156 (1981), we held:

> "We think it follows that, in appropriate cases, orthopedic surgeons are qualified to express opinions on the need for chiropractic care and it further follows that, in appropriate cases, the opinion of an orthopedic surgeon could be found to be more persuasive on that issue." 34 Van Natta at 1645 (emphasis added).

We have even held that a witness who was a graduate student in psychology was qualified to testify as to his observations concerning a claimant's dyslexia condition. James Albers, 34 Van Natta 1621 (1982). We concluded that the limited expertise of the witness only went to the weight to be accorded the testimony. A perhaps even more extreme example is David Mobley, 34 Van Natta 35 (1982), where we gave more weight to lay testimony concerning a causation issue than to the opinion of an expert medical consultant. See also Anthony J. Duman, 35 Van Natta 260 (1983); Harlan Crawford, 34 Van Natta 1010 (1982); Clea B. Carpenter, 34 Van Natta 456 (1982); James Thurston, 32 Van Natta 146 (1981), aff'd 58 Or App 568 (1982); Dianne Lopatin, 29 Van Natta 466 (1980).

There are many additional cases which I could cite for the same proposition, but I feel that the above-cited cases sufficiently indicate that our consistent policy has always been to weigh and assess expert opinions, and never to outright reject expert opinion as being beyond an expert's particular specialty. It is unfortunate in this case that a single, perhaps improperly juxtaposed, sentence in our prior order created the impression that the Board was following an improper evidentiary standard. I do not think we did in this case or have in prior cases.

III

I turn to the question of the extent of claimant's permanent disability. All doctors agree that claimant's March 1979 injury was a minor soft tissue injury. Indeed, claimant was first released to return to his pre-injury job about two months later. A subsequent myelogram was normal. A subsequent CT scan was normal. No doctor has found any neurologic or orthopedic problem. No surgery has been performed or is contemplated. Claimant is relatively young (37 at the time of hearing) and has average education (high school graduate). In literally dozens of similar cases, we have granted awards in the 10% to 20% range.

The somewhat unusual feature in this case is that claimant offers subjective complaints of disabling pain that are grossly inconsistent with all objective medical findings. For example, claimant says he is unable to walk without a cane, but the doctors find no leg muscle atrophy. That is simply inconsistent, and even the majority says it is inconsistent.

Unable to find any organic or physiological explanation for claimant's extreme complaints, the doctors involved began referring to "functional" or psychological problems. This was first mentioned in the January 4, 1980 report of Orthopaedic Consultants who diagnosed lumbar strain with leg symptoms by history and functional overlay, conversion type. Claimant was found to be medically stationary and in need of psychiatric examination. The Consultants expressed no opinion as to the cause of the claimant's functional overlay, whether it was permanent or temporary in nature or if it was disabling. Dr. Berkeley, on February 6, 1980, seemed to agree that claimant exhibited signs of functional overlay. Again, however, he expressed no opinion on causation, permanency or whether or not it would prevent claimant from returning to work. Dr. Raaf reported that he found very little in the way of physical impairment and that: "There is marked functional overlay." Dr. Raaf believed that claimant could be gainfully employed. Nothing further was said by Dr. Raaf with regard to claimant's functional problem. On March 10, 1981 Dr. Winkler reported his belief that, if claimant had a functional problem at all, it was due to the pain he was experiencing. On April 29, 1981 Dr. Berkeley reported that claimant's disability seemed "quite severe" despite negative neurological findings. He later reported on July 17, 1981: "I still maintain that his disabilities are not mild but rather moderate and I feel that given help, he should be able to work with some assistance." That is essentially the sum total of the evidence in the record with regard to claimant's functional or psychological problem.

In context, I understand these references to a functional or psychological problem to mean: (1) Although claimant's March 1979 compensable injury was initially believed to be a rather minor back strain, claimant nevertheless continues to suffer from some level of chronic and disabling pain; (2) no physician has been able to identify an organic or physiological explanation for claimant's chronic pain; therefore (3) claimant has "functional overlay" in the sense of chronic pain which is not physical in origin and which, by a process of elimination, must be psychological in origin. I do not understand any of the doctors who have mentioned psychological or functional problems to be stating that claimant has any form of permanent psychological impairment caused by his March 1979 injury, other than chronic pain.

In my opinion, however, the origin of the claimant's pain is not especially relevant. The issue is the extent of claimant's disability. The principal if not only form of impairment suggested in this record is disabling pain. The ultimate question in most cases of this type is whether the factfinder is persuaded that a claimant's reported symptoms, even if unverifiable and unexplainable, are genuine.

I think it is safe to assume that claimant has told all treating and examining doctors about the same level of symptoms he described in his hearing testimony. So assuming, with the possible exception of Dr. Winkler, no doctor finds claimant's reported symptoms completely genuine. In terms of reported symptoms, there can be no doubt that claimant is totally disabled. Yet the medical experts have rated claimant's impairment due to disabling pain from minimal (Orthopaedic Consultants) to moderate (Dr. Berkeley in his latest report).

And, with the exception of Dr. Winkler, every doctor involved has opined that claimant is capable of returning to work. I cannot believe that these doctors accept claimant's reported symptoms as completely genuine and at the same time opine that he is able to return to work.

In numbers, the opinions about impairment offered by Orthopaedic Consultants and Dr. Berkeley translate into from 1% to 60% impairment. Without apparent concern about support in the medical evidence, the majority finds claimant's impairment to be moderately severe, which means 60% to 80% impairment. This conclusion is apparently based on accepting the lay testimony as more persuasive than the medical findings (e.g., no leg atrophy) and opinions (e.g., as little as minimal impairment).

But, in my opinion, that is simply irrational. By the lay testimony, claimant is totally disabled, and I don't see how anybody can possibly conclude otherwise.

I am simply not willing to find the lay testimony to be more persuasive in the face of what I understand to be contrary medical evidence. I agree that claimant has disabling pain. The question is the magnitude of that pain. I have no reason to think that I can, with any confidence, be more precise than were the doctors who rated claimant's impairment from pain between 1% and 60%, but my best guess is that claimant's impairment is in the neighborhood of 25%-30%. Combining this level of impairment with the relevant social/vocational factors, I continue to think that the 40% permanent partial disability award we previously granted is proper and adequate. In so concluding, I have again considered the evidence that the Supreme Court remanded for us to consider. That evidence offers some explanation for the source of claimant's disabling pain, but it does not change my conclusion about the proven magnitude of claimant's disabling pain.

On remand and reconsideration, I would adhere to the findings and conclusions stated in the prior Order on Review dated April 14, 1982 and, therefore, respectfully dissent.

KENT BIRDENO, Claimant
Roll & Westmoreland, Claimant's Attorneys
Anderson, et al., Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 82-02838
June 16, 1983
Order on Reconsideration

The employer has requested reconsideration of the Board's Order on Review dated May 16, 1983.

The request is granted. On reconsideration, the Board adheres to its former order and readopts and republishes that order effective this date.

IT IS SO ORDERED.

RAY D. BROWN, Claimant
Rolf Olson, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 80-09825
June 16, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer requests review and claimant cross-review of Referee Menashe's order which, in relevant part: (1) found that an aggravation claim had been filed on claimant's behalf via a medical report received by the employer on July 23, 1981; (2) ordered temporary total disability from July 23, 1981 until the date of the hearing on account of the employer's failure to accept or deny the aggravation claim; (3) imposed penalties and an attorney's fee relating to the failure to respond to the aggravation claim; (4) found that the claimant failed to prove a worsening of his condition since the last arrangement of compensation; (5) awarded 50% unscheduled permanent disability, that being an increase over the 30% unscheduled disability awarded by Determination Order; and (6) denied claimant's request for penalties arising from the employer's failure to pay the 30% permanent disability in a lump sum. While the case was pending review by the Board, the employer filed a motion requesting the Board to consider new evidence, or in the alternative, to remand the matter to the Referee to consider newly discovered evidence.

Thus, the issues are: (1) Whether the proffered evidence should be considered by the Board directly or by remand to the Referee; (2) if not, whether a medical report filed on behalf of claimant constituted an aggravation claim; (3) if the report constituted an aggravation claim, whether and to what extent the employer is liable for penalties and attorney's fees for failing to respond to the claim; (4) whether claimant proved that his compensable condition worsened since the last award of compensation; (5) if the aggravation claim issue is decided adversely to claimant, the extent of claimant's permanent disability, including permanent total disability; and (6) whether a penalty should be imposed because of the employer's failure to pay in a lump sum an amount of permanent disability due under a Determination Order.

With one exception, we adopt the Referee's findings of fact as our own. The Referee's findings of fact could be construed to mean that Dr. N.J. Wilson's report dated May 19, 1981 and received by the employer on July 23, 1981 did not state sufficient facts from which a worsening of claimant's condition could be inferred. We find Dr. Wilson's report ambiguous concerning whether or not claimant was experiencing a worsening of his condition at that time, but that ambiguity was cured by the employer's letter to Dr. Wilson acknowledging the claim.

I.

The employer's request for consideration of newly discovered evidence is deemed to be a request for remand to the Referee and the employer must show that the evidence in the exercise of due diligence could not have been obtained prior to closure of the record at hearing. Robert A. Barnett, 31 Van Natta 172 (1981). The insurer's request for remand alleges that after the hearing claimant returned to work, that such evidence is highly relevant to the extent of disability issue (particularly since claimant contends he is permanently and totally disabled), and that the evidence could not have been obtained prior to closure of the record at hearing, in the exercise of due diligence or otherwise. We agree that the evidence could not have been obtained prior to hearing and that it is relevant to the issue of extent of disability. However, considering our disposition of the extent of disability issue, affirming the Referee's award of 50% unscheduled permanent disability, we decline the invitation to remand to receive the evidence. Our assessment of the extent of disability is based on the evidence adduced at hearing. If the employer believes that the evidence demonstrates a reduction in disability, the employer may seek a redetermination pursuant to the provisions of ORS 656.325(3) providing for periodic evaluations of a permanently disabled person's extent of disability.

II.

The medical report claimant relies on as stating an aggravation claim was prepared by Dr. N. J. Wilson who examined claimant pursuant to claimant's request for a "second opinion." The letter was addressed to Dr. Mario Campagna, claimant's treating physician, but copied to the employer. The report recited a history of claimant's industrial accident and ensuing treatment, described claimant's present symptoms, and sets forth the results of the doctor's clinical examination of claimant and interpretation of prior diagnostic tests. Dr. Wilson's report concludes as follows:

> "It is my impression that Mr. Brown has mechanical low back instability secondary to degenerative changes and the possibility of a protruded L4 disc laterally.
>
> "I feel that Mr. Brown is disabled at the present time from his ability to perform mill work. He is desirous of treatment for his low back condition. With the mechanical instability present in his lower back I would feel that if lumbar

> laminectomy is carried out, consideration of fusion should probably be given. It would be my recommendation that repeat lumbar myelography with Amipaque be carried out prior to the surgery.
>
> "I would recommend reopening of his claim and restoration of his time loss benefits."

The insurer responded to this medical report by sending a letter to Dr. Wilson advising him as follows:

> "We've received a copy of your July 16, 1981 letter to Dr. Campagna, and we appreciate your keeping us apprised on your consultation with Dr. Campagna.
>
> "We presently are not in a position to reopen Ray's claim, pay time loss or authorize surgery. We are evaluating your opinion along with those of the other physicians who have seen Ray on his claim. We anticipate being in a position to respond to a specific final recommendation by Ray's treating physician the second or third week in August."

The medical report is not a model aggravation claim. It does not use the words "worse" or "worsened conditions" or any other language comparing claimant's present condition to his condition to some point in the past. Nor is a worsening readily apparent by comparing Dr. Wilson's medical report with the medical reports antedating the last arrangement of compensation. Lastly, Dr. Wilson seems to relate claimant's condition more to claimant's pre-existing condition than the residuals of his industrial injury. On the other hand, the report clearly requests claim reopening and time loss. And, perhaps most importantly, the employer appears to have treated the report as a claim. We find this case very similar to Clark v. SAIF, 50 Or App 139 (1981) and Hewes v. SAIF, 36 Or App 91 (1978) in which the Court found aggravation claims to have been made out. Thus, we agree with the Referee that the medical report triggered an obligation on the employer's part to accept or deny the claim and to pay temporary total disability within 14 days pending a denial.

Although we affirm the award of interim compensation through the date of the hearing, we believe that under the facts of this case a reduction in the associated penalty is in order. At the time of the employer's failure to respond to the claim, a request was pending on the extent of claimant's disability. There was a legitimate basis at that time for taking the position that a formal denial was not necessary, see Vandehey v. Pumilite Glass & Bldg. Co., 35 Or App 187 (1978). We have since held, and the Court of Appeals apparently agrees, that a pending request for hearing does not obviate an insurer/employer's duty to respond to an aggravation claim. Harold Metler, 34 Van Natta 710 (1982), affirmed without opinion, Metler v. Jeld-Wen, Inc., 61 Or App 296 (1983). Considering the ambiguous nature of the report constituting the aggravation

claim and the legal uncertainty created by the Vandehey case, the amount of the penalty should be reduced from 25% to 10%.

The employer has also challenged the amount of the attorney's fee awarded in conjunction with the issue of unreasonable failure to deny or pay interim compensation. The record indicates that claimant's attorney filed an amended request for hearing relating to the time loss and associated penalties issue, the attorney called an employe of the employer as a witness at the hearing, and he argued the matter at hearing. Under these circumstances we cannot say that the $300 award of attorney's fees was excessive.

III.

We are sure that claimant is contending that he has proven a worsening of his condition justifying remanding the claim for further processing. We are considerably less sure whether claimant is also alleging premature closure: Claimant argues that he has established a worsening or, in the alternative, that when a request for claim reopening is made within one year after the Determination Order it is unnecessary to prove a worsening.

We agree with the Referee that claimant has not proven a worsening of his condition since the last arrangement of compensation. With respect to claimant's contention that he need not prove a worsening, he is only partly right. Claim reopening can be accomplished within one year of the Determination Order without proving an aggravation only by proving premature closure. Roy J. McFerran, Jr., 34 Van Natta 621 (1982), affirmed without opinion, McFerran v. SAIF, 60 Or App 786 (1982). Dr. Wilson's report tends to support a finding of premature closure more than it does an aggravation claim. In any event, Dr. Campagna, claimant's treating physician, considered Dr. Wilson's consulting report and arranged for further testing, but ultimately determined that claimant's condition would not be improved by further treatment including surgery. Thus, considering the evidence as a whole, we are not persuaded that the claim was prematurely closed, that is, we believe that claimant was medically stationary as per the last Determination Order.

IV.

Based on our de novo review of the record and applying the disability evaluation guidelines of OAR 436-65-600 et seq., we agree with the Referee that an award of 50% unscheduled permanent disability accurately compensates claimant for his loss of wage earning capacity attributable to his industrial injury.

V.

Claimant's contention that he is entitled to a penalty for the employer's failure to pay in a lump sum an award of permanent disability granted by Determination Order is based on the following sequence of events:

February 8, 1979 - Determination Order issues finding claimant to be medically stationary in 12/78.

March 14, 1980 - Referee's Order finding claim prematurely closed.

October 1, 1980 - Determination Order awarding 30% unscheduled disability.

October 24, 1980 - Order on Review reversing the Referee.

November 14, 1980 - Determination Order rescinding the 30% award because of the Order on Review.

May 11, 1981 - Court of Appeals reinstates the Referee's order.

June 29, 1981 - Determination Order reinstating the 30% permanent disability award.

Following issuance of the June 29, 1981 Determination Order, the employer began making monthly payments of permanent disability.

Claimant contends that the legal effect of the Court of Appeals' decision was to reinstate the award of 30% permanent disability and that, since that sum should have been paid out starting in November 1980, the entire sum was due and payable in a lump sum effective when the Court of Appeals entered its mandate.

First, we doubt that the legal effect of the Court of Appeals' decision was to reinstate the permanent disability award. At issue in the Court of Appeals proceeding was the correctness of the February 1979 Determination Order. The effect of the Court's decision was to affirm the Referee's finding that the claim was prematurely closed in 1979, nothing more and nothing less. The correctness of the October 1980 Determination Order was not at issue before the Court. Moreover, at the time of the court's decision, claimant had pending before the Hearings Division a request for hearing concerning the adequacy of the awards of temporary and permanent disability arising from the Determination Orders awarding 30% permanent disability.

Even if the effect of the court's decision was to reinstate the award of permanent disability under the October 1980 Determination Order, we are aware of no authority which requires the employer unilaterally to pay the award out in a lump sum. ORS 656.216 requires monthly payments. ORS 656.230 provides for lump sum payments, but only upon request of the claimant and with the approval of the Director of the Workers' Compensation Department. There is no evidence here that the Director ordered or authorized a lump sum payment to claimant. Moreover, if claimant accepted payment of the permanent disability award in a lump sum, then according to the provisions of ORS 656.230(1), he would have waived his right to challenge the sufficiency thereof, and he would not be entitled to the 20% increase in disability awarded by the Referee and affirmed by us. Absent evidence of a communication from the Director to make a lump sum payment, the insurer had no duty to make one. Absent a duty to make a lump sum payment, there can be no penalty for an unreasonable failure to pay the award of permanent disability in that fashion.

ORDER

The Referee's order dated June 18, 1982 is modified. That

portion of the order awarding penalties is modified to reduce the amount of the penalty from 25% to 10% of the temporary total disability due under the Referee's order. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee for his services on review, payable by the employer.

ALFRED M. NORBECK, Claimant
W.D. Bates, Jr., Claimant's Attorney
Moscato & Meyers, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-06775, 82-05186 & 82-06053
June 16, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review and EBI Companies cross-requests review of Referee Peterson's order which assigned liability for claimant's low back condition to SAIF as the insurer for Pitchford's, Inc.; imposed a penalty for SAIF's unreasonable failure to pay claimant interim compensation pending acceptance or denial of a claim filed with SAIF as the insurer for Central Manufacturing Corporation, in the amount of 25% of the interim compensation that SAIF should have paid from the date of notice or knowledge of the claim until the date of SAIF's denial; imposed an additional penalty for SAIF's unreasonably delayed denial of the claim, in the amount of 25% of the disability compensation to be awarded claimant by the first Determination Order closing "this SAIF claim," not to exceed $500; and awarded claimant compensation for a 15% unscheduled permanent partial disability for an "injury" claim filed with Central Manufacturing Corporation in 1979, at which time it was insured by EBI Companies.

SAIF challenges the Referee's findings that claimant's back condition (osteoarthritis) is compensable as an occupational disease, and that SAIF, as the insurer for Pitchford's Inc. (the successor to Central Manufacturing Corporation), is the insurer responsible for this condition. SAIF also challenges the Referee's imposition of two 25% penalties, claiming that it had no obligation to pay claimant interim compensation, and that its failure to do so, therefore, does not subject it to a penalty; and that, since no amount of interim compensation was "then due," no penalty can be imposed for its failure to issue a timely denial. EBI challenges the Referee's award of 15% unscheduled permanent disability, claiming that it is excessive.

We affirm and adopt the Referee's order on all issues except the issue of penalties. We agree with SAIF that the Referee erred with respect to imposition of penalties, although for reasons different than those advanced by SAIF.

Claimant filed his Central Manufacturing Corporation claim directly with SAIF in March 1982. This filing constituted the notice or knowledge contemplated by ORS 656.262(4). SAIF had an obligation either to commence payment of interim compensation within 14 days of its receipt of this claim form, which was March 23, 1982, or deny the claim. The fact that claimant apparently was retired at the time the claim was filed does not excuse SAIF's

failure to comply with this duty. Stone v. SAIF, 57 Or App 808 (1982); Anthony A. Bono, 35 Van Natta 1 (1983). SAIF, therefore, is required to pay claimant interim compensation from March 23, 1982 until the date of the denial issued in behalf of Central Manufacturing Corporation, June 28, 1982, in accordance with the terms of the Referee's order. SAIF never paid the interim compensation that was then due, and, therefore, a maximum penalty equivalent to 25% of the interim compensation is warranted. SAIF also failed to issue a timely denial of this claim, and the question remains whether any penalty in addition to that imposed for its failure to pay interim compensation can or should be imposed for failure to comply with this additional statutory duty; i.e., acceptance or denial of the claim within 60 days of notice or knowledge thereof.

We find that the late denial was unreasonably delayed. It was issued more than 30 days after expiration of the 60 day period, and during this period claimant was receiving no payments of interim compensation. Under the standards of Zelda M. Bahler, 33 Van Natta 478, 480 (1981), reversed on other grounds, 60 Or App 90 (1982), this delay was unreasonable. This violation standing alone would warrant imposition of a penalty; however, we have already determined that SAIF is subject to the maximum penalty for its failure to pay interim compensation. The Referee apparently decided it was inappropriate to impose a penalty equivalent to 50% of the interim compensation that SAIF should have paid preceding its denial, which may explain his decision to impose a penalty equivalent to 25% of an amount of future compensation that may be awarded to claimant by the Evaluation Division upon closure of the claim, as a penalty for SAIF's unreasonably delayed denial. There are certain problems with this approach.

To begin with, the statute providing for imposition of a penalty contemplates calculation of the penalty based upon a percentage of compensation "then due":

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25% of the amounts then due plus any attorney fees which may be assessed under ORS 656.382." ORS 656.262(9).

Although a delay in acceptance or denial of a claim which is ultimately found to be compensable results in a delay in processing the claim and, therefore, a delay in the worker's receipt of compensation to which he or she may be entitled upon claim closure, the compensation that the claimant receives upon closure of the claim is not compensation "then due" within the meaning of the statute, which can provide a basis for calculation of a penalty. The only compensation which can provide the basis for imposition of a penalty for unreasonable denial is compensation then due, i.e., compensation due at the time the allegedly unreasonable action has occurred. Gary L. Clark, 35 Van Natta 117 (1983).

In Clark the Board reversed a portion of the Referee's order which had imposed a 25% penalty for "unreasonable resistance" and another 25% penalty for "unreasonable refusal." Although employers and insurers have separate and distinct statutory obligations and duties to: (1) pay interim compensation benefits no later than the 14th day after notice or knowledge of a claim, ORS 656.262(4); and (2) accept or deny a claim within 60 days after notice or knowledge of the claim, ORS 656.262(6); we have determined that the statute provides a maximum penalty -- 25% of compensation then due -- for any and all forms of "unreasonable claims processing," which may be committed by a variety of means, i.e., unreasonable refusal, delay or resistance. Gary L. Clark, supra, 35 Van Natta at 119. It follows, therefore, that the maximum penalty that can be imposed in those instances in which the employer or insurer unreasonably delays payment of interim compensation and unreasonably delays acceptance or denial of the claim is 25% of the compensation "then due." Accordingly, that portion of the Referee's order imposing a penalty in excess of the maximum allowable by law is in error.

As a practical matter, a claimant may receive more than the maximum 25% penalty where more than one employer/insurer is found guilty of unreasonable claims processing and each is penalized. That situation is not present in this case, however, which involves an issue of unreasonable claims processing as against one employer/insurer.

ORDER

The Referee's order dated October 29, 1982 is reversed in part. That portion of the Referee's order directing SAIF to pay "a lump sum equal to 25 percent of the disability compensation awarded to the claimant by the first Determination Order that closes this SAIF claim, as a penalty for SAIF's unreasonable delay in denial of the claim, but not to exceed a total penalty of $500" is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $350 as a reasonable attorney's fee on Board review, payable by the SAIF Corporation as the insurer for Pitchford's, Inc.

SHAYNE EARLEY, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-04359 & 81-05958
June 17, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

SAIF Corporation requests review of that portion of Referee Howell's order which set aside SAIF's denial of claimant's bilateral carpal tunnel syndrome condition (WCB Case No. 81-05958). SAIF asserts that claimant has failed to prove that his work was the major contributing cause of his wrist problems. Claimant cross-requests review of that portion of the Referee's order which held that claimant was not entitled to temporary total disability compensation for the period April 1, 1981 to February 9, 1982 (WCB No. 81-04359). Claimant asserts that he was unable to work during the period in question due to pain from his head injury and the effects of the medication he was taking for that pain.

SAIF has moved to strike claimant's request for Board review, contending that claimant's request was not made within 30 days of the Referee's order, and that claimant's request did not bear the proper WCB case number. Both of these assertions are without merit. The request for Board review was made within the 30 day limit pursuant to OAR 436-83-700, and the description of the claim in the request for review was adequate to identify which case claimant intended to appeal. The motion to strike claimant's request for Board Review is denied.

On the merits, we affirm and adopt the Referee's order.

ORDER

The Referee's order dated November 15, 1982 as amended on December 1, 1982 is affirmed. Claimant's attorney is awarded $400 as a reasonable attorney's fee on Board review for prevailing on the issue of the compensability of claimant's carpal tunnel syndrome, to be paid by the SAIF Corporation.

ILAH LaROQUE, Beneficiary
(EDWARD J. LaROQUE, Deceased)
Pozzi, Wilson et al., Attorneys
Schwabe, Williamson et al., Attorneys
Keith Skelton, Attorney

WCB 81-11384 &81-11347
June 17, 1983
Order on Reconsideration

The Board issued its Order on Review in this matter on May 16, 1983. A request for reconsideration was filed and the Board abated its order on June 10, 1983.

The parties have stipulated that as of March 1, 1983 Ilah LaRoque, widow of Edward J. LaRoque, be substituted as the claimant of record in this matter. Accordingly, we modify our original order substituting Ilah LaRoque for Edward J. LaRoque as the claimant of record.

ORDER

It is ordered that the Board's Order on Review of May 16, 1983 is modified to substitute Ilah LaRoque as the claimant of record for Edward J. LaRoque (deceased). In all other aspects the Order on Review of May 16, 1983 is affirmed and republished.

DIXIE SCRANTON, Claimant
Emmons, Kyle et al., Claimant's Attorneys
G. Howard Cliff, Defense Attorney

WCB 81-11803
June 17, 1983
Order on Review

Reviewed by Board members Lewis and Ferris.

Claimant requests review of Referee Seifert's order which affirmed the November 19, 1981 Determination Order which had awarded no permanent disability compensation over the 15° for 10% right forearm award agreed to in a July 22, 1981 stipulation by the parties.

Claimant contends she has incurred additional permanent partial disability in her right hand, wrist and elbow.

The record shows claimant has had some right elbow pain since her injury on November 29, 1979. Elbow disability is rated as disability to the arm. ORS 656.214(2)(a).

The last arrangement of compensation was a stipulation dated July 22, 1981 in which the parties agreed claimant would receive 15° for 10% of the right forearm. Prior to the stipulation, medical reports noted the elbow ache, but said little beyond that. Subsequent to the stipulation, the medical reports have noted "moderate tenderness" present over the lateral epicondyle with a diagnosis of mild lateral epicondylitis. Claimant's testimony supports this slight increase in elbow complaints in that her elbow is now constantly tender, aches and limits her ability to maneuver and lift with her right arm.

We find that claimant has proven a mild worsening over that awarded in the July 22, 1981 stipulation. A total award of 19.2° for 10% of the right arm (which includes the elbow) scheduled disability compensation adequately compensates the claimant for her disability.

ORDER

The Referee's order dated October 26, 1982 is reversed. The claimant is awarded an additional 4.2° for a total award equal to 19.2° for 10% scheduled disability of her right arm. Claimant's attorney is allowed 25% of the increased compensation as a reasonable attorney's fee.

JOHN STORM, Claimant
Hansen & Wobbrock, Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 82-10264
June 17, 1983
Order of Dismissal

The employer requested Board review on June 10, 1983. The Referee abated his May 31, 1983 Opinion and Order on June 8, 1983; therefore, jurisdiction still remains with the Referee and the request for review is hereby dismissed as premature.

IT IS SO ORDERED.

MARIAN J. ADAMS, Claimant
Magar E. Magar, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-04245
June 21, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Menashe's order which found claimant entitled to compensation for permanent and total disability. The issue is the extent of claimant's disability.

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

SAIF argues that claimant's general refusal to seek employment and specific refusal to participate in rehabilitation efforts forecloses a finding of permanent total disability pursuant to ORS 656.206(3). However, as we noted in Jim Lafferty, 33 Van Natta 530 (1981):

> "There are exceptions to ORS 656.206(3). See Dock A. Perkins, [31 Van Natta 180 (1981)]. This case indicates another exception is warranted. Here, claimant's psychological illness, which is a compensable consequence of his industrial injury, precludes his meaningful participation in a job search or in vocational rehabilitation."

Similarly, in the current case, claimant's psychological problems are due, in major part, to her compensable injury. We conclude that her psychological difficulties have had a substantial impact on her ability to undertake a purposeful job search or to participate in rehabilitation efforts. Based on Lafferty, we affirm the order of the Referee.

ORDER

The Referee's order dated September 10, 1982 is affirmed. Claimant's attorney is awarded an attorney's fee of $550 for services before the Board, payable by the SAIF Corporation.

EDWARD E. BLUM, Claimant
Allen & Vick, Claimant's Attorney
Wolf, Griffith et al., Defense Attorney

WCB 82-10047
June 21, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Foster's order overturning its denial of claimant's low back claim. The issues on review are the propriety of the denial and whether the Referee awarded an excessive attorney's fee.

We affirm and adopt the Referee's order with the following comments. This is not a complicated case of medical causation which requires expert evidence. Lay testimony to the effect that claimant felt a sudden sharp pain while lifting and twisting is sufficient to establish that his pain and need for treatment were caused by the lifting and twisting at work. The Referee found the claimant's testimony credible and we find nothing in the record which contradicts that finding. We also note that $900 is not an excessive fee in a case in which claimant's attorney has successfully overturned a denial. See Clara M. Peoples, 31 Van Natta 134 (1981).

ORDER

The Referee's order dated January 10, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review, payable by the insurer.

ROSE L. ENGLER, Claimant
Ronald Thom, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-09672
June 21, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Thye's order which set aside its denial of claimant's occupational disease claim for left knee degenerative joint disease.

Claimant, 59 years old at the time of hearing, has worked as a kitchen assistant in a nursing home for about the past 23 years. In May 1981 she began noticing pain in her left knee, particularly after being on her feet for extended periods of time at work. She saw her treating physician, Dr. Heusch, in July 1981. He diagnosed degenerative joint disease of the medial compartment. Dr. Heusch relates claimant's left knee condition to "prolonged ambulation on hard surfaces as a cook in a nursing home."

SAIF sent claimant's file to Dr. Norton for an opinion. Dr. Norton concluded that claimant's knee condition was caused by a variety of factors including heredity, diet, hormones and immunology:

> "The concept of hard usage or 'wear and tear' as the major factor appears to be an obsolete theory and probably not a significant factor in most joints as is evidenced by the wrist, elbow, and ankle joints, which hardly ever show naturally developing degenerative arthritis, but yet enjoy some of the hardest usage of any joints in the body. Prolonged weight bearing likewise does not appear to be a critical factor. . . . The knee joints are thought to develop osteoarthritis changes in response to abnormal biomechanical stress as the most significant factor."

He specifically stated that claimant's knee condition was not caused or worsened by her occupational exposure.

Claimant was then sent to Dr. Duff by SAIF. Dr. Duff concurred with Dr. Norton's opinion. He opined:

> "There is nothing to indicate that her left knee condition is a result of any work injury or any activity at work peculiar to her job."

Claimant testified that her job consisted of walking and standing all day on a hard floor. She was required to lift heavy pans, load and unload carts, bend, squat, stoop and reach. The Referee found the claim compensable because he felt that claimant's job activities constituted the type of "abnormal biomechanical stress" which Dr. Norton considered the primary etiology of such knee problems.

We disagree with the Referee's analysis. Both Dr. Norton and

Dr. Duff knew that claimant worked in a kitchen and spent much of each day on her feet. Nevertheless, both concluded that her work exposure was not the major cause of her knee problem. While we are not certain what Dr. Norton meant by "abnormal biomechanical stress," in context with the balance of his detailed report it is clear that he had in mind something other than claimant's kitchen work. Claimant, of course, has the burden of proving that her work activity was the major cause of her degenerative joint disease. In order for claimant to sustain that burden, we would have to be able to affirmatively say that we find Dr. Huesch's opinion more persuasive than the opinions of Drs. Norton and Duff. Having considered the entire record, we are simply not persuaded by Dr. Huesch's opinion to that degree.

ORDER

The Referee's order dated December 8, 1982 is reversed. The SAIF Corporation's denial dated October 9, 1981 is reinstated and affirmed.

PATRICK R. JEFFERIES, Claimant
Lyle C. Velure, Claimant's Attorney
David Horne, Defense Attorney

WCB 80-10577
June 21, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The employer/insurer requests review of Referee Menashe's order which awarded claimant 15% unscheduled permanent partial low back disability. The issue for review is the extent of claimant's disability. The employer contends that claimant is entitled to no additional award of unscheduled disability and that he has already been adequately compensated by previous awards of scheduled and unscheduled disability.

Claimant, who was 37 years of age at the time of the hearing, was employed as a timber faller when he sustained injuries to his right foot and right wrist when a tree that was being felled struck a previously felled tree on which he was standing. In addition to the foot and wrist injuries, claimant sustained a lumbosacral sprain as well as more minor injuries to his right knee and right shoulder. The claim was eventually closed by Determination Order of February 2, 1977 which awarded claimant 5% scheduled disability for loss of the right foot. This award was increased to 30% scheduled disability for loss of right leg, 15% scheduled disability for loss of right forearm and 10% unscheduled disability for loss of the right shoulder as a result of a hearing before Referee Mulder on October 19, 1977. Referee Mulder stated that claimant had not proven entitlement to an award of permanent disability for his back. This order was affirmed on review by the Board with the additional notation that claimant's back condition was compensable even though he had not established entitlement to an award of permanent disability for the back. 26 Van Natta 623 (1983).

Subsequent to the hearing, the claim was reopened for additional surgery to claimant's right foot. On February 11, 1980 Dr. Lilly reported that claimant was complaining of "some pain of the thoracic and lumbar spines when he works hard; for example at his usual occupation as a timber faller." This is the first time

claimant had complained of back problems since his claim was reopened. Dr. Lilly felt that no treatment was necessary for the back other than perhaps some activity restriction.

Claimant was examined by the Orthopaedic Consultants on May 28, 1980 and presented a variety of complaints concerning numerous areas of his body, including his right hand, arm, shoulder, foot, knee, as well as his back. The Consultants concluded that claimant had actually improved since the time of their last examination of him but that he could not return to his occupation of timber faller due to inability to use a chainsaw as a result of his partial loss of right hand function. On November 19, 1980 a Determination Order issued closing the claim and allowing claimant benefits for temporary total disability only.

On November 25, 1980 claimant was examined by Dr. Laubengayer who took x-rays of his lumbosacral spine. Dr. Laubengayer found a Grade I spondylolisthesis of L-5 on S-1 with a forward slippage of approximately 6 millimeters and a bilateral spondylolysis on the pars interarticularis of L-5 with some minor disc space narrowing at L-5, S-1. On February 17, 1981 Dr. Rosenbaum reported that the spondylolisthesis was so minimal that it could hardly be classified as Grade I, and that this was usually a congenital condition, and that as a cause of disability, it was minimal in this case.

On March 27, 1981 Dr. Lilly reported that he did not previously note the spondylolysis or spondylolisthesis and that he had either missed it in the past, or that it was a more recent development. He believed the latter to be the more likely and stated that he believed that the claimant had a moderate amount of disability referrable to the low back. Dr. Rosenbaum reported on April 13, 1981 that he believed claimant's spondylolisthesis was a congenital condition and did not result from the compensable injury since Dr. Lilly had not reported it in any of his previous x-ray interpretations.

Dr. Lilly was deposed on June 26, 1981. He stated that claimant had a full and completely normal range of motion in his back. Although he felt it possible that the original injury caused the minor degeneration of the L-5, S-1 disc interspace, he did not believe that this could, within a reasonable medical probability be related to the compensable injury. He was unable to render an opinion as to whether the spondylolysis and spondylolisthesis were the result of the original injury. He stated that he felt claimant had some residual scarring as a result of the back sprain, but could not objectively verify this. We, therefore, understand this opinion to be based on claimant's subjective complaints.

Subsequent to the 1975 injury, claimant returned to work as a timber faller and continued to work as such until 1979. Claimant leases approximately 50 acres of land near Klamath Falls. He is an experienced horseman and has been actively involved in working with horses for many years, and was doing so at the time of the hearing. Claimant trains, rides, stalls, shoes, transports and, at times, has raced horses. He testified at the April 14, 1981 hearing that he was again looking for work as a timber faller. Claimant transported several horses to Colorado sometime in the spring of 1981 and worked driving a log truck for approximately two and one-half

months on a short-term job near the end of 1981. When the continued hearing reconvened on January 21, 1981 claimant had obtained employment as an equipment operator on an oil rig in Wyoming.

The employer offered as evidence at the hearing three reels of surveillance film it had taken of claimant. These films depict a well-tanned muscular individual engaging in heavy and vigorous farm work over a two day period. They show claimant driving tractor while he rakes and bales hay, and unloading and stacking bales of hay with no apparent physical difficulty. The films also show claimant working with several horses, training and riding them with no distress noted to either his upper and lower right extremity or his back. As the Referee apparently noted, these films are contradictory to certain portions of claimant's and his wife's testimony.

Dr. Rosenbaum was deposed twice. Prior to the taking of his second deposition, he reviewed the films which the employer offered at the hearing. After viewing these films, and comparing what was actually seen on the films with Dr. Laubengayer's findings, Dr. Rosenbaum was of the opinion that "one could reasonably conclude that this is strong objective evidence that this patient has no disabilities."

The Referee acknowledged that the films showed claimant performing physical tasks with little apparent difficulty, but stated that it must be recognized that what claimant could do on a regular sustained basis in an employment setting is a different question.

While we agree with that general proposition, it must also be remembered that it is the claimant who must shoulder the burden of proof in establishing a loss of wage earning capacity. Riutta v. Mayflower Farms, Inc., 19 Or App 278 (1974). Speculation concerning what claimant could or could not do in an employment setting is not adequate to sustain that burden and the films do not aid his contention that he is entitled to additional permanent disability. Contrary to the Referee, we believe that the films do establish that claimant is capable of working on a sustained basis at reasonably strenuous labor.

In finding claimant entitled to additional unscheduled disability, the Referee also relied in part on certain testimony taken from Dr. Lilly when he was deposed:

> "Q. He testified that he can reach; he can bend down and pick up a hoof of each horse and pick it out, if you know what that is. He uses a pitchfork. He said he uses a hammer once in a while. He's fixed a fence once in a while. He used a chain saw to cut up about half a pickup load of wood. He's thinking about going into some type of horse business. Did he tell you those kind of things; that type of activity.
>
> * * *

"Do you think he can do those types of things that I mentioned?

"A. Well, I don't think that some of these things he could do for any long period of time. He couldn't do them steadily. Probably, occasionally, he could do most of those things."

We believe that the films depict claimant engaging in substantially heavier and more sustained physical activities than those which were outlined to Dr. Lilly. It was also subsequent to Dr. Lilly's deposition that claimant was employed driving a log truck and as an equipment operator on an oil rig. It is also not clear whether Dr. Lilly was considering claimant's right extremity difficulties, for which he has already been compensated, his alleged back difficulty, or both. Dr. Rosenbaum, on the other hand, did review the films. We believe that to be a significant factor in determining whether claimant suffers from an additional unscheduled disability.

The Referee also stated:

"The preponderance of recent medical evidence is that the low back impairment probably limits claimant's ability to obtain and hold employment. He engaged in hard, vigorous work before the injury. Claimant still appears to be an active individual but the low back condition precludes high-paid logging and other heavy work." (Emphasis added.)

We disagree with that conclusion. The evidence does not establish that it is claimant's back condition which precludes him from high paid work in the logging field. A complete examination of the medical evidence indicates that the reason claimant is precluded from such work is, as noted by the Orthopaedic Consultants, due to the disability suffered in the right arm and leg, not the back.

We conclude that claimant has not established by a preponderance of the evidence that he has suffered a loss of wage earning capacity as a result of his low back injury. In fact, a comparison of the medical reports in evidence at the hearing before Referee Mulder on October 19, 1977 and those subsequent to that hearing, indicate that claimant's injury-related back condition (this does not include the spondylolysis and/or spondylolisthesis) is little different now than it was at that time.

ORDER

The Referee's order dated June 21, 1982 is reversed.

TRACY FRANCIS NEWTON, Claimant
B. DOUGLAS PRATT, Employer
Lindsay, et al., Claimant's Attorney
Becker, et al., Employer's Attorney
SAIF Corp Legal, Defense Attorney
Carl Davis, Attorney

WCB 82-02522
June 21, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

The noncomplying employer requests review of Referee Knapp's order which affirmed the Compliance Division's proposed and final order which found that claimant was a subject employe when injured on November 12, 1981. The employer contends that the Referee erred in finding claimant to be a subject employe when injured and, alternatively, even if he was a subject employe, that claimant was not injured in the course of his employment with Pratt Mortuary Service.

We agree completely with the Referee's well-reasoned order and, therefore, we affirm and adopt it.

Subsequent to the issuance of the Referee's order, claimant's attorney submitted a petition for an attorney's fee to the Referee. Before the Referee could consider the matter, the employer filed its request for review, thus divesting the Referee of jurisdiction. OAR 436-83-480. Claimant then requested the Board to consider his petition and correctly cites Kelly P. Britt, 34 Van Natta 1182 (1982), as authority for the proposition that he is entitled to an attorney's fee. We agree that claimant's attorney is entitled to an attorney's fee for services before the Referee as well as the Board.

Counsel's affidavit reflects that a total of 63.5 hours was expended on this claim. Counsel has requested a fee of $6,350, based on the hourly rate of $100. OAR 438-47-020(1)(a) states:

> "In a proceeding before a referee, the referee shall allow a reasonable fee, not to exceed $3,000. . . [w]hen a claim previously denied is ordered accepted by the referee, whether the proceeding is on a claim of aggravation or on the original claim of injury. . ."

Amounts in excess of the maximum indicated are allowable when "extraordinary services" are rendered by counsel. OAR 438-47-010(2).

We cannot say that "extraordinary services" were rendered in the current case, which would be necessary in order to justify a fee in the range which counsel requests. The only issue involved in this case by the time of the hearing was the issue of compensability raised by the noncomplying employer. SAIF had accepted the claim and provided benefits. Even if fees were awarded on an hourly basis, there are a number of items listed in counsel's affidavit which do not appear to have been performed on behalf of claimant in the prosecution of the compensability issue in this case. We recognize the fact, however, that this case did require

efforts on the part of counsel that were in excess of those generally required in cases involving compensability issues, and our award reflects our recognition of those efforts. Considering all of the factors noted above, we conclude that a fee of $2,000 is appropriate for services rendered at hearing.

ORDER

The Referee's order dated December 21, 1982 is affirmed. Claimant's attorney is awarded an attorney's fee of $2,750 for services before the Referee and Board, payable by the SAIF Corporation and collectable from the noncomplying employer.

DARRYL G. WARNER, Claimant
Pozzi, et al., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-00631
June 21, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Shebley's order which set aside SAIF's denial of claimant's knee injury claim. SAIF contends that claimant did not suffer a compensable injury to his knee.

We affirm and adopt those portions of the Referee's order on the compensability issue with the following qualification and comment.

Subsequent to the Referee's order in this case, the Court of Appeals issued its opinion in Bauman v. SAIF, 62 Or App 323 (1983). We understand that opinion to allow backup denials of compensability while extent of disability is still under administrative or judicial review.

This claim was originally accepted as compensable by SAIF in 1976 and a Determination Order was issued on February 25, 1980. A Referee's order increased claimant's disability award on October 23, 1981. On January 8, 1982 SAIF issued the backup denial in issue in this proceeding. At that time, the extent issue in the prior proceeding was pending on appeal to the Board. We reduced the award of disability on May 14, 1982. The Court of Appeals affirmed the Board's order on May 25, 1983. Thus, in the present case, the backup denial was timely under Bauman because the question of extent of claimant's disability was still in litigation at the time the backup denial was issued.

Moreover, the Referee may have approached this case with the understanding that claimant had the burden of proof. However, since the Referee's decision, the Board has concluded that the burden of proof in proceedings involving backup denials is on the employer/insurer. Patricia G. Davis, 35 Van Natta 635 (1983).

ORDER

The Referee's order dated August 26, 1982 is affirmed. Claimant's attorney is awarded $300 as a reasonable attorney's fee for services rendered on Board review, payable by the SAIF Corporation.

MICHAEL V. BARR, Claimant
Roy Dwyer, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-09541 & 79-02685
June 23, 1983
Order of Dismissal (Remanding)

Claimant requests review of Referee Seifert's order which dismissed the proceedings before him for lack of jurisdiction. The procedural history of this claim is rather complicated and confusing. The basis for the Referee's Order of Dismissal was an Own Motion Determination issued by the Board on March 24, 1982 closing claimant's 1971 injury claim. After issuance of Referee Seifert's order dismissing the proceedings, dated November 3, 1982, the Board withdrew its previous Own Motion Determination by order of November 24, 1982.

The Board's rescission of its previous Own Motion Determination renders moot the proceedings presently on review of Referee Seifert's November 3, 1982 order. Claimant's request for review, therefore, is dismissed, and the claim is remanded to the Referee for further proceedings. The parties and the Referee should cooperate to the fullest extent possible to obtain an early setting for hearing, in view of the fact that this proceeding has been sufficiently delayed and prolonged.

IT IS SO ORDERED.

PAULA E. BEYER, Claimant
Ferris Boothe, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05964
June 23, 1983
Order of Abatement

The Board issued an Order on Review herein on May 24, 1983, affirming the Presiding Referee's order dismissing claimant's request for hearing.

Claimant has requested reconsideration and abatement of the Board's Order on Review. In order to allow an opportunity for further consideration of claimant's request, the Board's May 24, 1983 Order on Review hereby is abated.

Within twenty (20) days of the date of this order, claimant shall submit written argument in support of her request. The SAIF Corporation shall submit its argument within fifteen (15) days of receipt of claimant's submissions, and claimant will be allowed ten (10) days thereafter for reply.

IT IS SO ORDERED.

DEWEY A. LOGUE, Claimant
Waring, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-04671
June 23, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Seifert's order which affirmed the Evaluation Division's award of 67.5° for 45% scheduled disability arising from an industrial injury to claimant's left hand.

In June 1981 while working as a hook tender for a logging operation, the fingers of claimant's left hand were partially amputated when he caught his hand on a cable which was then drawn into a pulley block. Following four surgeries, claimant's hand became medically stationary and was evaluated by the Eugene Hand Rehabilitation Center. The evaluation record from the Center together with other evidence demonstrates as follows: (1) That claimant's index finger was amputated below the proximal interphalangeal joint (PIP joint), that his middle finger and ring fingers were amputated adjacent to the PIP joint, and that his little finger was amputated below the distal interphalangeal joint; (2) that claimant has sustained a sensory loss in all of the fingers of his left hand; (3) that claimant has sustained a loss of range of motion at the remaining PIP joint of the little finger and in all of the metacarpophalangeal joints (MP joints), including the thumb; (4) that claimant has sustained 5° loss of palmar flexion; and (5) that claimant has sustained a loss of grip strength and pinch strength in his left hand. In addition, claimant testified that the palm of his hand occasionally becomes numb, that his arm aches at the elbow, that intermittently he has pain that shoots from the index finger up into the forearm, that with activity his arm may ache up to the elbow, and that the strength of his left arm varies from day to day.

Applying the disability evaluation rules, OAR 436-65-502(2) (relating to finger amputations), 436-65-505 and 510 (relating to loss of range of motion in the thumb and fingers, and 436-65-530 (relating to sensory losses), and converting multiple finger values to hand values as provided in OAR 436-83-515, we arrive at the following impairment ratings for those factors:

Digit	Amputation	Loss of ROM[1]	Sensory Loss[2]	Combined	Converted To Hand %
Thumb		19%		19%	8%
Index F.	75%	17%	25%	84%	19%
Middle F.	70%	15%	25%	81%	16%
Ring F.	70%	30%	25%	84%	6%
Little F.	50%	24%	5%	64%	6%
				TOTAL:	55%

[1]The Eugene Hand Rehabilitation Center uses a somewhat different scoring method for measuring loss of range of motion than that used in the administrative rules but those measures can be converted

into measures recognized by the rules. For instance, with respect to the MP finger joints, a finger held straight out from the hand is at a 180° angle. A normal finger range of motion at that joint would be the ability to move the finger down to a 90° angle. Based upon the measures of claimant's uninjured right hand, his fingers can flex only down to 95°. Thus, a score of MP 95°/120° (right/left) indicates a loss for this claimant of 25° of range of motion at the MP joint of the index finger of the left hand.

[2]Loss of sensory perception is measured pursuant to what is referred to as a two-point discrimination test. As we understand the 2-point discrimination test, it measures the ability of a person with eyes closed to distinguish whether the surface of the skin at a particular site on the body (in this case, at the ends of claimant's amputated fingers) is being pressed with a two-pronged object approximately the size of an unfolded paper clip with the ends placed at varying widths apart. With respect to the fingers, the inability to distinguish the two prongs at 7 millimeters to 15 millimeters is considered a moderate loss of sensory perception. The ability to perceive two prongs at 6 mm or less would be considered normal and the inability to perceive two prongs at 15 mm or more would be considered a severe loss of sensory perception.

Thus, based on the amputations, loss of range of motion and sensory losses, claimant has impairment equal to 55% impairment of the hand. Although claimant has sustained a loss of grip and pinch strength as well as the ability to oppose his fingers with his thumb, the rules provide that amputation and sensory ratings and conversion of finger/thumb values to hand values compensate for loss of grip and pinch strength as well as loss of opposition. Therefore, no additional points are added for those losses. In addition, claimant has sustained a 5° loss of range of motion in palmer flexion which, under OAR 436-65-520(3), is equivalent to 1% impairment of the forearm, and some disabling pain and variable loss of strength in the forearm, altogether amounting to no more than 5% impairment.

Combining the 55% hand impairment rating arising from the finger and thumb injuries to the maximum of 5% impairment to the forearm yields an overall disability rating of 57% which, when rounded off to the nearest 5% results in a 55% impairment rating. Considering the record as a whole and comparing claimant's case to other cases involving hand injuries, we believe a 55% scheduled permanent disability award accurately compensates claimant for the residual effects of his industrial injury.

ORDER

The Referee's order dated May 13, 1982 is reversed. Claimant is awarded 82.5 degrees for 55% scheduled disability for the (left) hand/forearm. This award is in lieu of and not in addition to the award made by Determination Order and affirmed by the Referee. Claimant's attorney is allowed 25% of the increase in compensation as an attorney's fee for his services on behalf of claimant.

CLARENCE POOLE, Claimant
Karol Wyatt Kersh, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-08408
June 23, 1983
Order on Review

Reviewed by Board members Barnes and Ferris.

The SAIF Corporation requests review and claimant cross-requests review of Referee Quillinan's order which set aside SAIF's denial of compensation in the form of additional medical services. SAIF argues that the medical services in question are not causally related to claimant's accepted 1978 back injury. Claimant argues that penalties and attorney fees should be assessed.

Claimant suffered a compensable low back injury in March 1978. Most contemporaneous medical reports describe that injury as involving a strain or sprain; however, in the course of diagnosing and treating the strain or sprain, doctors discovered and mentioned that claimant had some form of degenerative spinal disease. The extent of claimant's permanent disability as a result of the 1978 injury was the subject of a Referee's order issued on August 12, 1980.

The present dispute, which arose in 1981, involves continuing chiropractic treatment. Claimant has been receiving such treatment from Dr. Nickila apparently about twice a month, occassionally more often. Beginning in March 1981 SAIF sent Dr. Nickila several requests asking for clarification of the relationship between his treatments and claimant's 1978 industrial injury. Dr. Nickila did not send any reply to SAIF until about one year later in March 1982.

Earlier, in January 1982, Dr. Nickila had corresponded with claimant's attorney, stating: "The treatments are necessary to treat the partial permanent residuals from [claimant's] 1978 work injury."

The balance of the record makes it clear to us that the present issue is far more complex than this conclusory sentence would indicate. We think Dr. Tiley's most recent letter to SAIF accurately describes the problem:

> "Mr. Poole continues to receive chiropractic care for his degenerative disc disease which gives him temporary palliative symptomatic relief but is in no way curative. As can be seen in our clinic note, x-rays have shown progression of his degenerative disc disease and this is to be expected and natural and unrelated to any specific injury. I think the big dilemma for you is going to be a question of whether your acceptance of the original claim was related to his back strain or whether it was related to his disc degeneration. If you [sic] responsibility is a back strain episode then the current problem is not related to that at all. However, if you are responsible for some

> disc degeneration when the claim was originally opened then that presents a major problem for you.
>
> "In summary, Mr. Poole is currently under chiropractic care with some evidence of at least transient episodic symptom relief for his degenerative disc disease which is not related to any specific injury, but instead can be viewed to be a degenerative process that is quite commonly encountered by all human beings."

The other relevant assessment comes from Dr. Fechtel. In one report he states:

> "The present complaints do not correlate with the mechanism of injury. Mechanism of injury is suggestive of acute lumbar sprain which would have resolved within two to three, or possibly four months. With his previous history of 'slipped disc,' some 25 years previously would suggest that a recurrence of lumbosacral disc problem was possible."

In a chart note he states:

> "X-rays . . . suggest a chronic progressive disorder in the lumbar spine. This patient may very well seek further manipulative treatments; these will probably alleviate some low back discomfort. However, the need for treatment would be consistent with the progressive underlying disorder and not a strain type injury in the lumbar spine some years prior."

We are persuaded by the distinction drawn by Drs. Tiley and Fechtel: It is medically probable that claimant's current (and contested) treatment is for symptoms of degenerative spinal disease and not for treatment of a strain/sprain type injury. The question thus becomes whether, as stated by Dr. Tiley, claimant's 1978 claim involved only a strain/sprain or, instead, whether it also involved some material contribution to the progression of claimant's degenerative condition.

We approach that question very differently than the Referee did. The Referee reasoned: "[I]t has not been shown that claimant's problems are not the result of his 1978 injury or that they are, as defense contends, the result of underlying spondylosis or degenerative disc disease." We think this turns the burden of proof on its head. It is claimant's burden to prove that contested medical services are compensable, not the burden of the employer/insurer to prove the contrary.

And based on our finding stated above, that the treatment here in issue is for the symptoms of claimant's degenerative disease,

the ultimate question becomes whether claimant has proven that his degenerative disease is a compensable consequence of his accepted 1978 injury claim.

It is often difficult to determine precisely what physical conditions have been accepted (or ordered accepted) and what physical conditions have been denied. In this case, for example, claimant's degenerative condition has been mentioned (or mentioned in passing might be a better way to put it) often since his March 1978 injury; but no doctor has ever really offered what we understand to be an opinion, one way or the other, on the relationship between the injury and the disease. On the other hand, claimant has reported generally continuous low back symptoms since his 1978 injury, symptoms that suggest something more may have been involved than an expected-to-resolve strain/sprain, as discussed by Drs. Tiley and Fechtel.

As noted above, the extent of claimant's disability was the subject of prior litigation. We think the Referee's order from that prior case offers what is probably the best insight into the current situation:

> "The medical reports . . . establish that [claimant] has virtually no physical impairment on an organic basis. * * * The essence of this case, however, is claimant's conversion reaction. * * * The physical problem itself is minimal and does not prevent a return to work. The conversion reaction, on the other hand, is a substantial factor hindering claimant's return to work. * * * [A] back strain is the only physical manifestation of claimant's injury. The degenerative changes are the result of age. A strain, such as that suffered by claimant in his industrial injury, normally resolves in time. Here, claimant has focused upon his strain and his conversion reaction has incapacitated him to some degree." (Emphasis added.)

We do not think that the findings in the prior proceeding are necessarily in the nature of res judicata, law of the case, or anything of that sort. We only conclude that the finding that the "degenerative changes are the result of age" is correct and applicable in this case; or, stated differently and more accurately, that claimant has not proven in this case that the degenerative condition for which he is currently being treated has any material relationship to his 1978 injury.

In view of our conclusion on the merits, there is no need to consider the penalty issue raised by claimant. Compare Gary L. Clark, 35 Van Natta 117 (1983), with Richard Kirkwood, 35 Van Natta 140 (1983). We only note that SAIF's failure to advise claimant of its position on the disputed medical services was inconsistent with the requirement we have since established in Billy J. Eubanks, 35 Van Natta 131 (1983).

ORDER

The Referee's orders dated June 2, 1980 and July 20, 1980 are reversed.

JOANNE E. RUSSELL, Claimant
Emmons, Kyle et al., Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB 82-06915
June 23, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Williver's order which determined that claimant was not medically stationary, that her claim had been prematurely closed and that she was entitled to additional temporary total disability benefits. The difficulty is that the issue litigated at hearing was extent of permanent disability; claimant did not contend at hearing that she was medically unstationary. It was error for the Referee to decide an issue not presented or litigated at hearing. See Dorotha Lorraine Oyler, 34 Van Natta 1129 (1982), and the cases cited therein.

With respect to the extent of claimant's permanent disability, the Determination Order awarded 15% unscheduled disability for claimant's back injury. Applying the disability evaluation guidelines for unscheduled conditions set forth in OAR 436-65-600, et seq., we assess the extent of claimant's disability as follows.

Claimant sustained low back and shoulder injuries. Her residual impairment in the back is limited to a slight loss of extension due to pain at the extreme, equal to 2% of the whole person. With respect to the shoulder, again because of acute pain at certain levels of motion, claimant has the following impairment: abduction, pain at 45°, equal to 6% impairment of whole person, external rotation, pain at 45°, equal to 5% impairment, and internal rotation, pain at 90°, equal to 1% impairment. In addition, claimant has chronic and mildly disabling pain, equal to 5% impairment of the whole person. Adding and combining these values in the manner provided by administrative rule yields an overall impairment rating of 18%.

With respect to social and vocational factors, claimant is 33 years old (-2 value), she has a high school education (0 value), she was employed as a grocery store checker-stocker at the time of the injury (SVP of 3, +3 value), formerly she was capable of medium work and now is restricted to light work (value of +5), her mental capacity and emotional/psychological reaction to her injury are normal (0 value for those factors), and her labor market findings yield a -9 value, based on the assumption that claimant is capable of light work, has a vocational preparation potential value of 6 (based on the fact that she attended hairdresser school for 13 months and worked as a hairdresser for four or five years), and a general education development level of 4.

Combining these factors and applying the formula for computation of disability in the manner provided in OAR 435-65-601, yields a disability rating of 21%, which is rounded to 20%. Considering the record as a whole and comparing this claimant's disability with similar cases, we believe that an award of 20% unscheduled permanent disability properly compensates claimant for her loss of wage earning capacity attributable to her compensable injuries.

At the outset of the hearing before the Referee, SAIF requested authorization to assert an overpayment of temporary total

disability paid to claimant between the dates she became medically stationary and the issuance of the Determination Order. Because of his disposition of the case, the Referee did not reach that issue. On review SAIF has renewed its request for leave to assert the overpayment. We see no reason for disallowing the offset.

ORDER

The Referee's order dated November 19, 1982 is reversed. The Determination Order of July 23, 1982 is reinstated but modified as to the award of permanent disability. Claimant is awarded 20% unscheduled permanent disability. This award is in lieu of and not in addition to previous awards of disability arising from this claim. Claimant's attorney is allowed 25% of the increase in compensation over that awarded by Determination Order for his services on behalf of claimant at hearing and on review. The SAIF Corporation may offset against the award of permanent disability the overpayment of temporary total disability arising between the medically stationary date established by the Determination Order and the date the Determination Order issued.

CARLTON A. SPOONER, Claimant
Goldberg & Mechanic, Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 80-11400
June 23, 1983
Order of Correction

The Board issued its Order on Review herein on September 3, 1982. 34 Van Natta 1444 (1982). That order was thereafter abated, and the Board issued an Order on Reconsideration, reaffirming and republishing the Order on Review. 34 Van Natta 1594 (1982). It since has come to the attention of the Board that the Order on Review contains an error in designating Employers of Wausau as the party responsible for payment of a reasonable attorney's fee to claimant's attorney, pursuant to ORS 656.382(2). The employer Diamond International initiated the proceeding on Board review, and the Board found that employer responsible for payment of claimant's compensation. The designation of Employers of Wausau as the party responsible for payment of claimant's attorney's fee was, therefore, a clerical error which we now will correct.

ORDER

The Order on Review and Order on Reconsideration issued herein hereby are corrected to reflect that claimant's attorney is awarded $300 as and for a reasonable attorney's fee, payable by the employer Diamond International.

JAMES M. WOODWARD, Claimant
Steven C. Yates, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 81-04244
June 23, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Baker's order which upheld the SAIF Corporation's denial of claimant's aggravation claim and affirmed the Determination Order with respect to both the medically stationary date and the award of 10% unscheduled disability for claimant's low back injury.

In his opening brief claimant first states that the issues on review are whether his condition compensably worsened, or in the alternative, extent of permanent disability. Claimant then goes on to state that his primary contention is that he is medically unstationary and/or that his condition has worsened. There is no argument concerning the extent of claimant's permanent disability. In his reply brief claimant states the issue as being whether his condition was stationary at the time his claim was closed but goes on to argue that his condition has worsened, and in his request for relief asks that the denial of his aggravation claim be reversed.

We adopt the Referee's findings of fact and affirm his conclusion with the following comments. There is no basis in the record for a finding that claimant was other than medically stationary at the time his claim was initially closed by the April 13, 1981 Determination Order. Claimant submits no argument that the extent of his permanent disability is greater than that awarded by Determination Order. There is evidence in the record that claimant may have sustained a worsening which may be related to his accepted injury/condition, but on this record claimant has not proven to our satisfaction that in fact there was a worsening, or that, if he has sustained a worsening, it is related to the compensable injury/condition.

ORDER

The Referee's order dated December 30, 1982 is affirmed.

JOHN R. BLACKMAN, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB # TP-83001
June 24, 1983
Third Party Distribution Order

This matter is before the Board on application of the SAIF Corporation for resolution of a dispute concerning the proper distribution of the proceeds of a third party recovery obtained by claimant. ORS 656.154, 656.593. The Board previously issued an Order of Disbursement of Third Party Funds, which was reversed and remanded for further proceedings by the Court of Appeals. 60 Or App 446 (1982).

Pursuant to the Board's request, the parties have submitted additional materials and argument in support of their respective positions. The only issue is the extent of SAIF's lien for expenditures for compensation, with no claim being made for expected future expenditures.

The dispute concerns the amount of SAIF's expenditures for compensation paid to date. A tender of $1,852.91 was previously made by claimant and apparently accepted by SAIF in partial satisfaction of SAIF's lien for expenditures. SAIF claims a remaining balance due of $587, $423 of which represents the cost of an examination and narrative report by the Orthopaedic Consultants. The additional sum of $164 represents the amount of a medical bill paid by SAIF in July 1981, after claimant tendered the aforementioned sum to SAIF in December 1980.

The $164 medical bill paid by SAIF represents an expenditure for compensation and is, therefore, an amount properly included as

part of its lien. The cost of the examination and report by the Orthopaedic Consultants, however, is not. In Shawn Cutsforth, 35 Van Natta 515 (1983), we held that the cost of a narrative medical report solicited by SAIF from claimant's treating physician was not an expenditure for "compensation, first aid or other medical, surgical or hospital service", and therefore, was not an expense that could be recovered from the proceeds of claimant's third party recovery. SAIF's request for reimbursement for this expenditure, therefore, is denied.

ORDER

The SAIF Corporation shall be paid and retain the sum of $2,016.91, less amounts previously paid, from the proceeds of claimant's third party recovery herein in full and final satisfaction of its lien for expenditures for compensation. The remaining balance of the third party recovery shall be retained by claimant.

KEITH McINTOSH, Claimant
Roll & Westmoreland, Claimant's Attorneys
Mitchell, Lang & Smith, Defense Attorneys

WCB 81-04987 & 81-05192
June 24, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review and claimant cross-requests review of Referee St. Martin's order which: (1) Set aside the Determination Order dated October 6, 1981 as premature; (2) found that claimant was entitled to additional time loss benefits from September 9, 1981 to November 2, 1981; and (3) awarded claimant a penalty and attorney's fee, apparently on the grounds of premature claim closure.

Claimant raises numerous issues on review, some of which appear to go beyond the issues presented at hearing. In any event, all of claimant's arguments and the Referee's analysis presume that claimant has separate and distinct claims here in issue, one for injury to his left leg and one for injury to his back. As matters now stand, we find that premise to be factually incorrect.

The history of these claims is as follows:

April 18, 1979: Claimant injured his left leg. This claim was accepted and was assigned EBI Claim No. C-7907700. This claim was processed to closure by Determination Orders in February and June of 1980.

December 19, 1980: Claimant, having returned to work after the prior closure of his left leg injury claim, sustained another injury. This claim also was accepted and was assigned EBI Claim No. C-8022756. It is this December 1980 claim that is referred to in claimant's arguments and the Referee's order as "the back injury claim." We disagree with that characterization. At some point -- certainly by the time an Evaluation Division supervisor wrote Exhibit 64A -- it must have been apparent to everybody that claimant reinjured his left leg at the time of the December 1980 accident. As Exhibit 64A explains:

> "After the original closures of the left leg claim in February and June of 1980, Mr. McIntosh apparently got along well regarding the left leg until the incident of December 18, 1980 when he apparently reinjured the leg at the same time that he injured his back. The initial medical reports following the December 18, 1980 incident indicate that he had increased difficulty with the left leg due to the work activities on or about December 18, 1980.
>
> "Therefore, since it appeared that the worker reinjured his knee on December 18, 1980 and since we felt his condition was worse at the time of the October 6, 1981 Determination Order, we awarded 15% loss of the left leg due to reinjury in the back claim. EBI did not provide any documentation as to which claim they were accepting the aggravated left leg condition in so we applied it to the back claim based on reinjury."

September 19, 1981: Dr. Martens, a consulting orthopedist, wrote a comprehensive, three and a half page report in which he concluded that claimant's knee and back conditions were medically stationary. Relying on Dr. Martens' report, the insurer submitted the December 1980 claim for closure on September 17, 1981. Approximately simultaneously, the insurer sent copies of Dr. Martens' report to Drs. Larson, Cronk and Schmidt asking for any additional comments these treating doctors cared to make.

Late September, 1981: When Drs. Larson and Cronk expressed agreement with Dr. Martens' findings, the insurer promptly forwarded these additional documents to the Evaluation Division where its request for claim closure was then pending.

September 23, 1981: Dr. Schmidt sent a letter to claimant's

In summary: (1) Claimant's December 1980 claim (C-8022756) involved both injury to his left leg and his back; (2) possibly the left leg component of the December 1980 injury has been processed by the insurer as an aggravation of the April 1979 claim (C-7907700) -- or possibly the left leg component of the December 1980 claim has been processed by the insurer as a new injury and properly part of claim number C-8022756 -- nobody seems to now know, and we do not think it makes any practical difference; (3) although some aspects of the insurer's processing of this claim seem to have been a bit precipitous in late September 1981, we find no evidence that when the ultimate (October 16, 1981) Determination Order issued, the Evaluation Division had been furnished with anything less than all medical information in the insurer's possession.

Against this background, the issues presented are less complex. Claimant concedes that his knee condition was medically stationary, as found by Dr. Martens, in September 1981. Claimant first argues only that his back condition was not then stationary. There may be two prongs to claimant's argument. First, that Dr. Schmidt was the only doctor treating claimant's back condition and that, as a matter of law, claim closure without the concurrence of a treating doctor is inappropriate. We have previously rejected that argument. Lavona Hatmaker, 34 Van Natta 950 (1982). Second, claimant may be contending that he has proven his back condition was not stationary in September 1981 as a factual matter. As indicated above, the evidence on this point is Dr. Martens' comprehensive report, finding claimant was stationary, versus Dr. Schmidt's one sentence report to the contrary. We generally defer to a treating physician's opinion about whether a claimant is medically stationary, e.g., Hatmaker, supra. Nevertheless, we here conclude that, even with the aid of some deference to Dr. Schmidt, claimant has not proven that he was other than medically stationary on September 9, 1981. Dr. Schmidt does not state any reasons for his opinion; nor does he state in what way his treatments after September 9 were expected to improve claimant's condition -- or even what

the Evaluation Division then had in its possession all medical reports. There is no basis for penalties or attorney fees in this case.

The final issue involves a claimed setoff of a stipulated overpayment of $1,156.62. This overpayment resulted from the insurer having continued to pay time loss benefits from claimant's stationary date, September 9, until the Determination Order was issued on October 6. Pursuant to OAR 436-54-320, the insurer deducted its overpayment of time loss benefits from the award for 15% loss of the left leg granted by that Determination Order. Claimant's argument that this setoff was impermissible is based on the same premises that we have found faulty: That he had separate and distinct back and leg claims; that he was entitled to time loss beyond September 9 because his back condition was not then stationary; and that, for reasons that are not completely clear, there is something wrong with deducting an overpayment of compensation paid for one body part against additional compensation awarded for another body part.

Claimant's argument carves the reality of claims administration too thinly. As we have found, claimant injured both his back and his left leg on December 19, 1980. These were not separate claims just because two body parts were involved. Instead, claimant was entitled to compensation for temporary disability until all injured body parts were medically stationary; claimant was then entitled to compensation for permanent disability for all body parts in which there was permanent disability. Under this unitary view of what claims typically involve and what we think this claim involved, any overpayment of temporary disability can then be setoff against any award of permanent disability pursuant to OAR 436-54-320.

ORDER

The Referee's order dated June 7, 1982 is reversed. It is recognized that claimant's December 19, 1980 injury involved both injury to his back and injury to his left leg; it is recognized that the October 6, 1981 and October 16, 1981 Determination Orders closed all aspects of claimant's claim for injuries sustained on December 19, 1980. As so interpreted, the Determination Orders dated October 6, 1981 and October 16, 1981 are reinstated and affirmed as timely closure of claimant's claim for injuries sustained on December 19, 1980. The insurer is authorized to setoff its overpayment of $1,156.62 against the permanent disability awarded by the October 6, 1980 Determination Order.

JAMES G. THOMAS, Claimant
Hansen, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-07390
June 24, 1983
Order on Reconsideration

Claimant requests that the Board reconsider its Order on Review dated May 26, 1983 which found him entitled to no additional unscheduled permanent partial disability beyond the 15% received by all prior awards and arrangements of compensation.

Claimant contends that the Board failed to address the correct issue in the case. He argues that there was no dispute that he had some permanent partial disability, that the correct issue in the case was the extent of that disability, and that the Board incorrectly viewed the issue as being reliance on lay testimony to establish the existence of any permanent partial disability, rather than the extent thereof. Claimant misinterprets our Order and we disagree with his contentions.

On page of one of our Order on Review, we phrased the issues as follows:

> "The issues are penalties/attorney fees and the extent of claimant's disability." (Emphasis added.)

We obviously recognized the fact that claimant had some permanent disability when we noted that he had received a total of 15% disability by prior Determination Order and stipulation. The specific question we had to address, however, was whether claimant had any greater permanent disability following his June 1980 aggravation than the 15% he had received prior to that aggravation. We concluded that the evidence failed to support an award of increased permanent partial disability over and above that which claimant already had received. Contrary to claimant's assertions, we find that we addressed the exact issues raised on review, and we adhere to our conclusion that claimant failed to establish entitlement to any additional permanent partial disability.

ORDER

On reconsideration, the Board adheres to its Order on Review dated May 26, 1983.

TOMMY L. COMBS, Claimant
James C. Lynch, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-00755
June 27, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of those portions of Referee Menashe's order which awarded claimant additional temporary total disability compensation, increased the award of unscheduled permanent partial disability for claimant's low back injury and awarded claimant's counsel an attorney's fee for services rendered prior to the hearing. SAIF argues that claimant is not entitled to any temporary or permanent disability compensation beyond that granted by the Determination Order and that claimant's attorney should not have been awarded a fee for services rendered prior to the hearing. SAIF has also asserted on Board review that the Referee erred in allowing the issue of premature claim closure to be litigated at the hearing because claimant did not specifically state this issue in his request for hearing. Claimant cross-requests review of the Referee's award of permanent partial disability. Claimant asserts that the award should be increased.

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

SAIF contends the Referee erred in hearing the premature claim closure issue because it had not been properly raised in claimant's request for hearing. Claimant's request for hearing states:

> "The issues to be presented for resolution are as follows:
>
> "1. Claimant is entitled to more temporary disability payments than were ordered in the above determination order.
>
> "2. Claimant is entitled to further medical care and treatment.
>
> "3. Claimant is entitled to a greater award for permanent unscheduled disability than was ordered in the above described determination order."

We believe that it is reasonable to expect that a request for more temporary total disability compensation and further medical treatment includes the question whether the claim had been prematurely closed. If SAIF was surprised at the hearing, it was not due to oversight or error by claimant or the Referee.

ORDER

The Referee's order dated December 10, 1982 is affirmed. Claimant's attorney is awarded $450 as a reasonable attorney's fee for services rendered on Board review, payable by the SAIF Corporation.

LEONARD F. LARSON, JR., Claimant
Richard Nesting, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 79-05266 & 81-01012
June 27, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review and claimant cross-requests review of Referee St. Martin's order which: (1) Awarded claimant 50% unscheduled permanent partial disability for injury to his low back, in lieu of the 15% granted by the January 14, 1981 Determination Order; (2) found that the Determination Order did not prematurely close claimant's claim; and (3) affirmed SAIF's March 31, 1981 denial of reopening. SAIF raises only the extent issue on review, arguing claimant has not experienced a loss of earning capacity greater than recognized by the January 1981 Determination Order. Claimant argues his claim was prematurely closed on the basis of his treating chiropractor's statement that claimant was not medically stationary until the end of May 1981.

After our review of the evidence, we affirm and adopt those portions of the Referee's order regarding premature claim closure and reopening. We modify the Referee's order regarding extent, based on our analysis of the factors contained in OAR 436-65-600, et seq.

Claimant's age is 53, resulting in an impact of +8. He

completed the tenth grade and later received a GED; therefore, his education factor results in an impact of 0. His job at the time of his low back injury was that of school building maintenance, groundsman and educational supplyman, resulting in an SVP (Specific Vocational Preparation) of 3, with an impact of +3. He was performing work requiring heavy exertion but is now limited to light work, resulting in an adaptability factor of +10. His mental capacity and emotional/psychological findings both result in a 0 impact. Using claimant's highest SVP rating of 4 (determined after looking all the jobs he has performed), a GED rating of 4 and his restriction to light work, we conclude claimant has 25% of the labor market left open to him, resulting in an impact of 0.

Regarding impairment, the latest medical report which rated claimant's spinal ranges of motion, that of the Orthopaedic Consultants, results in an impairment rating of +8. Claimant's hearing testimony paints a picture of considerably greater impairment. However, our analysis of claimant's testimony is substantially the same as the Referee's -- that claimant has painted the bleakest possible picture, viewing or portraying his impairment as greater than any doctor involved assesses it, with the possible exception of Dr. Chekal, whose conclusory assessment likewise seems extreme. Moreover, even if claimant's injury-related impairment is somewhat greater than reflected just in the range-of-motion findings, we do not think it is sufficiently greater to change the result under the formula stated in OAR 436-65-601.

Combining all the above factors, we find claimant would be appropriately compensated with an award equal to 80° for 25% unscheduled permanent partial disability, rather than the 15% awarded by the January 1981 Determination Order or the 50% awarded by the Referee.

ORDER

The Referee's order dated November 4, 1982 is modified. Claimant is awarded 80° for 25% unscheduled permanent partial disability for injury to his low back. This award is in lieu of all prior awards. Claimant's attorney's fee should be adjusted accordingly.

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

WCB 82-05555
June 27, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Shebley's order which affirmed Wausau Insurance Companies' denial of responsibility for proposed surgery and declined to award penalties and attorney fees for unreasonable delay in processing the claim. We agree with the Referee that Wausau is not responsible for the proposed surgery, but on different grounds. The insurer denied responsibility for the surgery on the grounds that it was not reasonable and necessary, and that it was unrelated to the injury for which Wausau is on the risk. The Referee affirmed the denial based on his finding

that the surgery was not reasonable and necessary under the circumstances; we believe that it is more appropriate to rely on the lack of a causal relationship to the injury for which Wausau is liable.

I.

In 1968 claimant, now 43 years old, injured her low back while moving furniture. Claimant experienced back pain that radiated into her left leg. Claimant was noted to have a depressed left ankle reflex and straight leg testing on the left elicited a positive response. Ultimately, a herniated disc at L5-S1 was diagnosed which led to a partial laminectomy and discectomy performed by Dr. Bachhuber in July 1969. After the surgery claimant's straight leg testing was negative, but the left ankle reflex remained depressed. Claimant returned to work in September 1969. A September 1969 chart note indicated that claimant had experienced some back pain and left leg pain. However, the neurological exam was normal, and Dr. Bachhuber indicated that he suspected scarring at the disc surgery site was causing claimant's discomfort. October 1969 chart notes indicate that claimant had no back or leg complaints.

In August 1970 in the course of her employment as the manager of a service station, claimant lifted a case of oil at work and experienced some back and left leg pain. Claimant was hospitalized briefly for conservative treatment. September 1970 chart notes indicate that claimant continued to experience back and left leg pain but that the straight leg test was negative and ankle reflexes were present. The hospital discharge summary indicates that social, marital and employment factors figured into claimant's back complaints more than physical problems.

In January 1972 claimant reported to Dr. Bachhuber that her left leg had begun to "go dead." Chart notes indicate that Dr. Bachhuber believed claimant's discomfort was related to scarring at the surgery site rather than any lifting at work. In May 1972, for the first time, there is mention in Dr. Bachhuber's chart notes of pain in the right hip. X-rays revealed slight degenerative changes but her neurological exam revealed that her condition was unchanged.

There is a gap in Dr. Bachhuber's charts notes from August 1972 until December 1975 at which time claimant consulted Dr. Bachhuber complaining again of pain in her back and right hip. At that time it was noted that in the interim claimant had been hospitalized for abdominal surgery, that after the surgery she walked about in a flexed position, that she continued to list and that the forward list was causing or aggravating a lumbar strain. In January 1976, claimant reported that she was not much better, and the doctor noted that she was still walking with a list. Dr. Bachhuber also noted that the straight leg test was negative, that claimant had no sign of a herniated disc, and that he attributed her strain to continued poor posture.

In May and June 1976 claimant had a recurrence of right low back and left thigh pain. Dr. Bachhuber related her current problems to the 1968 injury and 1969 surgery as well as emotional factors. Claimant was hospitalized for low back pain in November 1976. A myelogram done at that time revealed no disc abnormalities

and minimal changes in the spine regarded as insufficient to be causing nerve root compression. Claimant received an injection in her right hip and had a severe reaction to it manifested by very painful muscle spasms in her right hip down into the leg. Neurological testing proved to be normal. There was a suggestion at that time that claimant's back and leg problems may be related to "lateral recess syndrome," that is, scarring at the disc surgery site.

There is another gap in Dr. Bachhuber's chart notes from January 1977 when it was noted that claimant's low back was better and that she was seeking psychological assistance, until February 1980 when claimant sought care for an unrelated arm condition. A June 1980 chart note indicates that claimant recently had been discharged from Holladay Park Hospital where claimant had been treated for psychiatric problems, that she had fallen when she was being picked up by her husband, thereby sustaining a lumbar strain. This was the last time claimant consulted Dr. Bachhuber for treatment.

Claimant was admitted to Holladay Park Hospital in June 1980 for depression associated with chronic low back and leg pain. The treating physician was Dr. Hughes who obtained a consultation from orthopedist Dr. Silver. Upon admittance, claimant gave a history of having had low back and right hip and leg pain going back for 13 years and that she never had any problems with her left leg. She reported the back surgery in 1970 (sic, 1969), that she had good relief from the pain for about five years thereafter, that about five years ago her back pain began to recur, and that for the past three years it had gotten progressively worse to the point that she was rendered temporarily disabled by it. Straight leg testing on June 1, 1980 elicited a positive response at 70° on the right and 90° on the left. However, that same test was normal bilaterally when repeated on June 3, 1980 except for some tightness in the right posterior thigh. The orthopedic impression at that time was chronic low back strain with probable facet joint syndrome. Psychologically, claimant was diagnosed to have chronic and severe depressive reaction to her back pain and a "mixed" personality disorder. In addition to antidepressant medications, claimant was administered electroshock treatments.

Claimant apparently was pain-free and did not seek medical attention from June 1980 until November 1981 when, in the course of her employment with Plaid Pantry Market (insured by Wausau), claimant fell through a milk crate and landed on her buttocks while stocking a walk-in cooler. Claimant felt immediate pain in her low back and left leg but continued working. On December 3, 1981 claimant experienced pain in her neck, left hip and leg while lifting 70 pound cases of soda pop and beer at work. The following day Dr. Dennis, a chiropractor, diagnosed a left sacroiliac strain. Claimant was hospitalized in December 1981 for back pain. X-rays taken at that time revealed narrowing at L5-S1 with suspected vacuum phenomenon suggesting degenerative disc disease. In January 1982 claimant was seen in consultation by Dr. Borman, D.O. Claimant was complaining at that time of left lower back pain radiating into the thigh, calf and foot. Claimant again reported that she had back surgery in 1970 for removal of a disc protrusion on the right side. Based on his examination and claimant's response to

various clinical maneuvers, Dr. Borman diagnosed left sciatic neuralgia due to a herniated lumboscacral intervertebral disk and indicated that claimant should have a myelogram and might need a discectomy.

Also in January 1982 claimant was seen in consultation by Dr. Aversano, neurological osteopath. Claimant again reported a history of 1970 surgery for low back pain that radiated into her right leg and recurring right hip pain post-surgery. Based on his examination and neurological tests, Dr. Aversano diagnosed lumbosacral radiculopathy on the left, suggested that claimant either had a residual disk or new disk or impingement upon the nerve from scar tissue formation, and recommended a myelogram.

Dr. Borman's January 1982 admitting report indicates that claimant was reporting pain in her hip and low back that went down into her left leg and paresthesia as well as pain in the right leg to a lesser degree. Straight leg testing was postive bilaterally at 50° on the left and 70° on the right. The left ankle reflex was absent on the left and the Babinksi reflex was absent bilaterally. The myelogram done at that time was interpreted by Dr. Borman as indicating compresssion of the left lumbosacral nerve root due to a herniated disc at L5-S1. Dr. Borman recommended conservative treatment with the possibility that claimant may require a laminectomy in view of the clinical, neurological and myelographic evidence of a herniated disc on the left.

Dr. Borman opined that the claimant's injury of December 3, 1981 while in the employ of Plaid Pantry was a new condition, based on claimant's reported history that her "1970" surgery was to correct right side complaints whereas now claimant's symptoms were predominantly on the left.

Claimant came under the care of Dr. Berselli in February 1982. Claimant reported to him that her previous back surgery accomplished complete resolution of then-right hip/leg pain. Dr. Berselli also interpreted the 1982 myelogram as indicating a disc protrusion at L5-S1 on the left as manifested by amputated nerve roots at that level. Since at that point claimant had had two months of conservative care without relief of symptoms, he recommended a laminectomy and discectomy. He requested authorization from Wausau Insurance.

Wausau referred claimant to Dr. Rosenbaum for an independent medical exam. Based on his initial examination of claimant and her reported history of previous back surgery for right leg pain, Dr. Rosenbaum initially reported as follows:

> "Ms. Parmer now presents with left leg and hip pain, a positive straight leg test on the left, and a depressed left ankle jerk. The findings are suggestive of a left S1 radiculopathy. I would like to review her myelogram to see if there is anatomical evidence consistent with this clinical location.
>
> "The current issue is appropriate

> treatment. If she does have a well documented defect on myelogram I feel that surgical therapy would be appropriate now. She has had ten weeks of conservative therapy without relief of her pain, and she has objective signs to correlate with her symptoms.
>
> "Another issue is the relationship of her current symptoms to her previous back problems during the 70's. By her report, all her previous back problems were related to the right leg, and this is the first time the left leg has been involved. I think it would be helpful to obtain her records from Holladay Park Hospital, and from Dr. Bachhuber."

Upon receiving and reviewing the prior medical reports, Dr. Rosenbaum became aware that claimant's previous symptoms were on the left and that the earlier back surgery was for removal of a protruding disc on the left, not on the right as reported by claimant, and that the depressed left ankle reflex had been present since 1969-1970. He then opined that claimant was not a candidate for surgery because of the chronicity of her problem and the lack of new objective neurological signs. However, he indicated that he wished to review the most recent myelograms with those done by Dr. Bachhuber before rendering a final opinion. After receiving the complete medical file, including the myelogram reports, and reexamining claimant, in June 1982 Dr. Rosenbaum noted that the 1976 myelogram revealed a nerve root filling defect at L5-S1 and he opined as follows:

> "I do not feel that Ms. Parmer's current symptoms are clearly attributable to her injury of November 1981. In particular, her own history is unreliable, and the medical records document that the pain has been a chronic problem. I do not feel that surgical therapy for her pain is currently indicated. There is not evidence of progressive neurological deficit, and her mild abnormalities on myelogram and of depressed ankle jerk are clearly chronic. Any decision for surgery would be based not upon these findings, but solely upon her complaints of pain, and given her unreliability, I think it would be an error to make a decision for surgery based solely upon her subjective complaints."

Dr. Rosenbaum recommended psychiatric consultation.

Another physician, Dr. McDougall, reviewed the November 1976 and January 1982 myelograms and stated as follows:

> "The lumbar myelogram study of 1976 and 1982 demonstrate essentially the same findings with no evidence of any localized

> extradural defect or any well demarcated amputation of the nerve rootlets.... Comparison of lumbar myelography with Metrizamide performed in 1976 and again in 1982 has not demonstrated any definite evidence of herniated disc material causing any extradural defect. There is asymmetry of the thecal sac and unequal filling of the nerve rootlets at L5-S1 as described."

Based on this information, Wausau issued a denial denying authorization for the proposed surgery.

On June 18, 1982, at Dr. Berselli's request, Dr. Silver again examined claimant. He repeated the history recited by claimant of right leg pain going back several years. He found straight leg testing positive on the left at 45° and pain in the left leg in the sciatic distribution upon flexion at the waist. Claimant could walk on her heels and toes without difficulty. Upon reviewing the myelograms, Dr. Silver agreed that there was no essential change from 1976. He opined as follows:

> "Mrs. Parmer had a fairly good result from her first lumbar disc operation. However, she still had significant right hip pain requiring repeated treatment. A repeat myelogram in 1976 showed a defect at the left lumbosacral level. Her neurological examination in 1980 showed a diminished left ankle jerk which is unchanged today.
>
> "The patient has symptoms that could well be related to a herniated left lumbosacral disc. She has fairly good mechanical signs, but no new neurological signs consistent with this condition. In view of her failure to improve with conservative treatment and reduced activity over the past several months, I agree with Dr. Berselli's recommendation to explore the S1 nerve root. I would expect this patient to achieve some relief, but her history suggests that the likelihood of residual symptoms is high."

At hearing, Drs. Bachhuber, Rosenbaum, and Berselli testified. Dr. Bachhuber had been subpoened, but prior to the hearing he did not have an opportunity to review the medical file other than his own charts and reports generated prior to June 1980. During a half hour recess he did review, apparently, the remainder of the medical file. He then testified that the signs and symptoms which Dr. Berselli was relying upon as indicating a need for surgery now were the same ones present at times since 1969 and 1970. He further opined as follows:

> "I would feel that surgery is not indicated for one of the following reasons: Number one, her neurologic changes are essentially

> the same changes as were present after the surgery in 1969; number two, she does not have myelographic evidence of pathology at L5-S1, except that which can be attributed to prior surgery at that level; number three, she has had similar episodes of pain in the past, from which she has recovered without surgical treatment."

Dr. Bachhuber conceded that he had not personally reviewed the myelograms taken in 1976 and 1982, and that there was a period of at least three years (1977 to 1980) during which claimant sought no treatment from him for back or leg complaints. Dr. Bachhuber further conceded that the only time claimant had back and leg pain which persisted as long as this most recent recurrence was in 1976-1977 when claimant was complaining of right as well as left back and leg or hip pain. Dr. Bachhuber further indicated that in rendering his opinion, he was relying on the fact that claimant had positive leg-raising tests prior to the 1981 injuries. Based on our review of the record, the only time a positive straight leg test response was reported was on June 1, 1980, and that report was contradicted by a June 3, 1980 report which indicated no positive response to the straight leg raising test. Otherwise, it does not appear that claimant had a positive straight leg raising response at any time after the 1969 surgery until after the 1981 injuries. That and other weaknesses in Dr. Bachhuber's testimony renders his opinion less persuasive on the issue of whether the proposed surgery is reasonable and necessary.

However, Dr. Rosenbaum also testified to the effect that he believed that the proposed surgery was ill-advised for essentially the same reasons given by Dr. Bachhuber. He also emphasized that when there has been no significant change in neurological findings and the myelograms show no significant change, then the physician is forced to rely on the patient's reporting of symptoms. Although he initially found claimant's straight leg raising test to be positive, at hearing he testified that claimant's report of pain was due to functional interference. In this case, because of the incorrect reporting of her history and functional interference in the examination he conducted, Dr. Rosenbaum felt that claimant was not reliable and that one should not proceed to surgery on the basis of subjective reports of pain. He also opined that with each successive surgery to the same part of the back the likelihood of achieving relief from pain decreases and the chances of actually making the patient worse increases. Lastly, Dr. Rosenbaum reiterated that he would recommend psychiatric care.

Dr. Berselli also testified at hearing. In recommending surgery, Dr. Berselli indicated that straight leg testing was positive at all times after the 1981 injuries and that all modalities of conservative treatment, including traction and injections, had been tried and had failed to afford claimant any significant relief. Initially, Dr. Berselli relied in part on his belief that claimant's 1969 surgery was for a right herniated disc whereas the presenting symptoms in 1981-1982, being on the left side, indicated a new herniation on the left. However, he also acknowledged that

scar tissue from the previous surgery could be impinging on the nerve roots. After becoming fully aware that claimant's 1969 surgery was for a herniated disc on the left side of the L5-S1 disc arising from low back and left leg pain, Dr. Berselli was more inclined to believe that claimant's present problems were due to scarring rather than to a new herniated disc. He further testified that it was possible that the 1981 injuries caused bleeding at the site of the previous surgery which led to further scarring and increased pain, and that the injuries in general caused the preexisting scarring condition to become symptomatic.

II.

Based on a thorough review of the record, including close attention to chart notes, medical reports, and the testimony of the three physicians who testified at hearing, we are unwilling to decide the medical services question in this case on the ground that the proposed surgery is not necessary. At the time of hearing, claimant had been in disabling pain for a period of eight to nine months. Every form of conservative treatment had been tried, to no avail. While the treating orthopedic surgeon who recommended the surgery concedes that the proposed surgery is controversial, he believes that there is a 60% to 70% chance that the surgery will afford claimant significant relief, i.e., relief that will enable her to resume relatively normal vocational and avocational activities. He persisted in this opinion even after coming to the realization that claimant had given him an incorrect history; indeed, the corrected history reinforced his opinion that claimant needed the surgery. Likewise, Dr. Silver, after being apprised of the correct history, continued to believe in the need for the surgery.

Dr. Rosenbaum relied heavily on what he characterized as claimant's "chronic" back problems as contraindicating surgery at this time. It appears to us that claimant's back problems were not that chronic. Indeed, there was a period of three and a half years between claimant reporting that her "low back is feeling better" in January 1977 and a lumbar strain being reported in June 1980. Moreover, between June 1980 and the injuries in November and December 1981 claimant was symptom free. It is also of some significance that Drs. Borman, Aversano and Rosenbaum elicited positive responses from clinical maneuvers for determining neurological deficits indicating impingement on the sacroiliac nerve root. The only person to note functional interference in the exam was Dr. Rosenbaum.

Unfortunately for claimant, the primary reason that militates in favor of a finding that the surgery is reasonable leads to the conclusion that the surgery is not related to the 1981 injuries for which Wausau is on the risk. Dr. Berselli testified that the fact that the 1969 surgery was for a disc herniation on the left side of L5-S1 and the fact that claimant's present symptoms consist of pain in the low back radiating into the left leg indicated to him that there is scar tissue resulting from the surgery impinging on the nerve root. He believes that the scar tissue can be partially removed and a foraminotomy carried out to accomodate any new scarring, thereby relieving the pressure on the nerve root. It follows that the need for the surgery arises from the 1968 injury and ensuing surgery rather than the 1981 injuries.

In so holding, we are aware that Dr. Berselli also testified that the 1981 injuries materially contributed to claimant's present condition. However, he also made it clear that the contribution was in the form of making symptomatic the nerve impingement already existing as a result of the scarring. Dr. Berselli testified that it was possible that the 1981 injuries caused bleeding and further scarring at the site of the previous surgery and/or caused a small disc herniation at the same site. However, he could not testify that these events probably happened; they were at best contingencies until such time as claimant undergoes surgery and it can be determined what actually has happened internally to the nerve roots at L5-S1.

Since the scarring condition is an underlying preexisting condition, claimant is required to prove that the injuries of November and December 1981 caused a pathological worsening of that underlying condition. Weller v. Union Carbide, 288 Or 27 (1979), Cooper v. SAIF, 54 Or App 659 (1981), Cochell v. SAIF, 59 Or App 391 (1982), but see Florence v. SAIF, 55 Or App 467 (1982) and Lorena Iles, 30 Van Natta 666 (1981). Dr. Berselli's testimony is too weak to enable us to make such a finding; therefore, we agree with the Referee that the insurer's denial must be upheld.

We admit to considerable frustration in this case. It is difficult enough to determine compensability when the issue is whether a particular condition is related to employment and there are competing medical opinions. In medical services cases, our task is even more difficult when we are forced to make a determination whether particular medical services, as here, surgery, is "reasonable and necessary." All of the physicians here are experts in their field and all of them advance cogent reasons for their respective positions. More frustrating, however, is that if the second surgery is never done, no one may ever know whether claimant's recurrence of back and leg pain is due to nerve impingement from scarring from the first surgery, a new herniation on the left side from the 1981 injuries, or a nonphysical cause. It is possible that the proposed surgery would fulfill the criteria of diagnostic surgery compensable under the rationale expressed in Brooks v. D & R Timber, 55 Or App 688 (1982) and Jimmy Layton, 35 Van Natta 253 (1983), but that ground has not been advanced or briefed by the parties; therefore, we decline to decide the case on that basis. Russell v. A & D Terminals, 50 Or App 27 (1981), Brooks v. D & R Timber, 55 Or App 688 (1982), Edwin L. Mustoe, 34 Van Natta 659 (1982), affirmed without opinion, Mustoe v. International Papers, 61 Or App 296 (1983).

Since claimant's present need for surgery appears to be related to her 1968 injury and 1969 surgery, claimant may be entitled to relief under the Board's own motion jurisdiction if the 1968 injury was a compensable event. ORS 656.278. The record does not indicate whether the 1968 incident occured in the course of employment, thus we express no opinion and merely point out that own motion relief may be available to the claimant.

III.

Claimant contends that she is entitled to a penalty and attorney's fee because of the insurer's failure to comply with OAR

436-69-130(2) (in effect at the time of the 1981 injuries) or OAR 436-69-130(3) (adopted effective March 1, 1982). Although the language used in the two rules differs somewhat, the same basic requirements are present: When the treating physician and the insurer's consulting physician disagree concerning whether a proposed medical service is needed, the claimant shall be referred to a third physician agreed upon by the consulting physician and the treating physician.

The Referee declined to impose a penalty because he was of the view that the law did not allow a penalty in this type of situation and that the matter was one for the Workers' Compensation Department to regulate. We agree that a penalty is not warranted under the facts of this case. First, unfortunately, both the old and new version of the administrative rule are phrased in the passive voice, that is, neither prescribes who should refer the claimant to the third physician for an independent opinion. The implication is that the insurer should assume that responsibility, but the rule is not clear and we are disinclined to award a penalty where the alleged duty to act is not clear.

Moreover, Dr. Berselli, who had requested authorization for the surgery in the first place, upon learning of Dr. Rosenbaum's negative opinion concerning the need for surgery, promptly referred claimant to Dr. Silver for a third opinion. Dr. Silver was, in fact, considered a qualified independent consultant by Dr. Rosenbaum as well as Dr. Berselli. Dr. Silver agreed with Dr. Berselli concerning the need for surgery. Even though Dr. Silver agreed with the need for the proposed surgery, we do not understand the administrative rules to require that the insurer is bound to accept that opinion. It is still free to deny authorization for the proposed surgery just as claimant is free to request a hearing if the third physician agreed with the insurer that the surgery was not necessary. Thus, there was substantial compliance with the requirements of the administrative rules.

Claimant's argument seems to be that a penalty is warranted for unreasonable delay in payment of compensation because the insurer issued a denial prematurely, i.e., before obtaining the third opinion. As odd as this sounds, there might be some merit to it if the only issue was whether the proposed surgery was reasonable and necessary. Here, however, the proposed surgery also was denied on the ground that it was unrelated to the injury for which Wausau was on the risk. The administrative rules claimant relies on do not require a third opinion where the insurer is contesting the causation aspect of the compensability determination.

For all these reasons, we agree that the Referee correctly declined to impose a penalty and award related attorney's fees.

ORDER

The Referee's order dated October 4, 1982 is affirmed.

GUADALUPE RIVERA, Claimant
Raul Soto-Seelig, Claimant's Attorney
Schwabe, Williamson et al., Defense Attorneys

WCB 82-02812
June 27, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Menashe's order which found that claimant did not establish that Argonaut, as insurer for R & S Nursery & Merchandising, Inc., failed to comply with the October 20, 1981 Determination Order which awarded claimant 10% permanent partial scheduled disability for loss of leg, found that claimant failed to establish that he did not receive the proceeds from the permanent partial disability award and refused claimant's request for penalties and attorney fees.

Claimant, who is a Mexican national, was employed by R & S Nursery near Hillsboro when, on May 31, 1980 he suffered a compensable fractured left femur. The Form 801 indicates claimant's address as being 2875 SW 214th, Aloha, Oregon 97006. The claim was accepted and claimant was treated at Tuality Community Hospital. A Form 827 signed by Dr. Fry on August 5, 1980 lists claimant's address as being 2845 SW 214th, Aloha, Oregon 97006. Beginning in December 1980 claimant's attorney wrote a series of letters to the insurer informing the insurer of his representative status and requesting that the insurer direct all communications to him as claimant's command of English was minimal at best. The insurer did not respond to any of these letters.

Since claimant was unable to speak English he was referred to a vocational rehabilitation consultant firm. The November 28, 1980 vocational report indicates that claimant was planning to return to Mexico as soon as his physician released him to travel. Another vocational report dated January 2, 1981 indicates that claimant's attorney had informed the vocational consultants that claimant was still residing in the Aloha area. A Field Services report dated July 11, 1980 (received by the insurer on July 14, 1980 and read into the record at the hearing) indicated that someone at Field Services phoned the insurer and informed it that claimant was moving to Mexico and that all of his future checks should be sent to Calli Donato Guerra, Domisilio #30, Tototlan, Jalisco, Mexico. However, an Argonaut memorandum dated July 14, 1980 indicates that claimant (or someone on his behalf) informed the insurer that he was planning to stay in Oregon after all as he was medically unable to travel. On August 24, 1981 Dr. Fry reported that claimant could be returned to full work with minimal disability. Dr. Fry added as a "P.S." that "His new address in Mexico will be Calli Donato Guerra, #30 Tototlan Jal Mexico." (Emphasis added.)

On October 20, 1981 a Determination Order issued awarding claimant 10% scheduled permanent partial disability. The value of the award was $1,500. On October 29, 1981 the insurer issued a check in claimant's name for the amount of the award. The check indicates claimant's address as being 2905 SW 214th, Apt. 23, Aloha, Oregon 97005. At some point in time, which is not clear in the record, but presumably before the check was issued, claimant moved to Mexico. Sometime in December 1981 claimant's attorney

telephoned the insurer and informed it that claimant had not received his check. The insurer subsequently issued a "stop payment" order on the check, but this was apparently too late as the check had already been cashed at a bank other than the drawee bank on November 16, 1981. Expert testimony presented at the hearing was to the effect that the signature on the check was not that of claimant.

Subsequent to the issuance of the "stop payment" order, the insurer sent out what it termed a "payee statement" (declaration of forgery). The insurer requested claimant fill out the document in his own handwriting and have it notarized. Upon receipt of the completed form, the insurer indicated it would immediately issue another check payable to claimant (this was still the insurer's position at the hearing). The document was returned to the insurer filled out and signed by claimant, but not notarized. Testimony at the hearing indicated that the bank refused to accept the document without notarization and the insurer in turn refused to issue another check until a properly notarized document was completed.

Claimant's attorney filed a request for hearing indicating the issues as being refusal of the insurer to comply with the October 20, 1981 Determination Order and penalties and attorney fees for unreasonable resistance or delay in payment of compensation. There is no attorney retainer agreement signed by claimant in the file. See OAR 438-47-010(3). Hearing convened on July 1 and December 1, 1982. Claimant did not appear at the hearing and was represented by his attorney.

The Referee concluded that, "Considering all the facts, mailing the check to the Aloha address was not unreasonable," and that while there was evidence presented that claimant did not endorse the check, there was no evidence establishing that he did not receive the proceeds from that check since, "The check was mailed to an address where claimant resided with friends for over a year." The Referee also noted that although insurers have a duty to process claims, that injured workers also have certain concomitant obligations (such as keeping an insurer informed of a proper mailing address).

Claimant sets forth numerous assignments of error in the brief. These are that the Referee erred by: (1) Requiring claimant to prove nonpayment of his award when the law requires proof of payment since it is an affirmative defense; (2) concluding that the declaration of forgery must be completed by the claimant before the insurer could be reimbursed by the bank; (3) finding claimant failed to prove non-receipt when "the only issue raised by the pleadings was the award of penalties and attorney fees;" (4) "holding against claimant" for his failure to testify at the hearing; (5) concluding that mailing the check to the Aloha address was not unreasonable; (6) holding that the claimant returned to Mexico "probably before or just after the check was issued;" (7) holding that, "In hindsight, what occurred may have been unfortunate, but did not constitute culpable conduct or a breach of duty by the carrier;" (8) in "relying" on ORS 293.475(2); and (9) failing to impose penalties. We are not certain that we should attempt to address all of these assignments of error. Indeed, we are not certain that all of these in actuality constitute "assignments of error." Nevertheless, it is our statutory charge to do so.

With regard to claimant's first assignment, that the Referee erred in requiring claimant to prove nonpayment when the law "requires" a debtor to prove payment as an affirmative defense, we quote OAR 436-54-310(1):

> "Benefits shall be deemed paid when deposited in the U.S. Mail addressed to the last known address of the worker or beneficiary."

Whatever the appropriate law may be in fields other than workers' compensation, the above quoted rule provides that deposits of the payment in the mail, at claimant's last known address, constitutes payment of benefits. The insurer thus need only establish that the check was mailed and that it was mailed to claimant's last known address. Claimant is thus correct to the extent he terms this an affirmative defense. However, testimony was presented at the hearing from Millicent Crites, claims examiner for the insurer, that the check was indeed deposited in the mail and that it was mailed to the last known address which was in the claims file. Under the rule, the insurer thus established payment and the burden of going forward with evidence then shifted to claimant. Although there was testimony to the effect that claimant's signature was in fact a forgery, as the Referee noted, no evidence was presented establishing that claimant did not in fact receive the proceeds from that check or that the check was not signed by someone in his behalf.

At this point we shift to claimant's fifth assignment of error, that being that the Referee erred in holding that mailing the check to claimant's Aloha address was not unreasonable. In Jeri Putnam, 34 Van Natta 744 (1982) and Kathie Cross, 34 Van Natta 1064 (1982), we noted (as did the Referee in the current case) that although insurers have a duty to process claims, an injured worker also has certain minimal duties associated with claims for benefits. It seems that keeping the insurer informed as to an appropriate mailing address is the least onerous and most minimal of such responsibilities. There is a considerable amount of confusion in the record concerning claimant's address. As noted, testimony indicated that the check was indeed mailed to claimant's last known address. The insurer had received no information at the time the check was issued that claimant was residing at any other address. The notation in Dr. Fry's report of August 24, 1981 is phrased in terms of futurity and it would not be reasonable to conclude, based on that notation alone, that claimant was living in Mexico at the time of the issuance of the check. Claimant argues that "claimant was only 23 years old and had a wife in Mexico. (Exhibit 27.) It was only reasonable for him to return to Mexico as soon as the doctor let him travel after being away from his family for 20 months." Suffice it to say that this is hardly an adequate basis upon which to build an argument that the insurer was unreasonable in not mailing the check to Mexico. We agree with the Referee that the insurer did not act unreasonably in mailing the check to claimant's Aloha address.

Claimant argues as his second assignment of error that the Referee erred in believing that in order for the insurer to be

reimbursed by the bank, that the bank must be supplied with a notarized declaration of forgery signed by claimant. Whether claimant is correct or not on this matter is immaterial. This agency's jurisdiction extends only to "matters concerning a claim," ORS 656.704(3), and we are not concerned with any issues relating to reimbursement between an insurer and its bank for cashing checks with forged signatures. Although it may have some peripheral bearing on the case, we find it to be too remote and we refuse to involve ourselves in that dispute.

The claimant's third assignment of error is that the Referee erred in holding that claimant failed to establish he had not received the proceeds from the check in payment of the permanent partial disability award as the "only issue raised by the pleadings was the award of penalties and attorney's fees." We are baffled by this contention. The request for hearing specifically raised the issue of nonpayment of the permanent partial disability award as well as penalties and attorney fees. When the insurer established payment under OAR 436-54-310(1), the burden of going forward with evidence shifted to claimant. Obviously it was not error for the Referee to reach that issue since it was "part and parcel" of the issue of nonpayment.

Claimant's fourth assignment of error states that the Referee erred in holding "against claimant" his failure to testify at the hearing. We express some puzzlement at this contention also. Nowhere in the Referee's order does it appear that based on his failure to testify, he ruled against claimant. In fact, it appears the Referee made every effort to allow claimant to present his case though his attorney and disallowed numerous motions to dismiss on the part of the insurer. We understand the Referee's order only to have held that as the insurer presented proof of payment, claimant had not met his burden of going forward with rebuttal evidence. The record indicates the Referee only held claimant's failure to testify against him to the extent that it went to the weight of the evidence. Again, we find no error.

Claimant argues for his sixth assignment of error that the Referee erred in holding that claimant returned to Mexico either just before or just after the check was issued. We believe that this was a reasonable inference to draw based on this record. Claimant argues that Exhibits 17 and 18 indicate that he was in Mexico as of September 1, 1981. Exhibits 17 and 18 are copies of letters written in Spanish from claimant and addressed to claimant's attorney. Claimant states that, although the postmark on these copied letters is illegible, that the originals indicate the letters were mailed from Mexico in September 1981. Claimant did not submit the originals as exhibits at the hearing. Claimant does not explain how the Referee is expected to be able to read illegible copies of date stamps in Spanish. In any event, it is irrelevant to the main issue as we already have indicated that the insurer acted reasonably in mailing the disability award check to the last known address of the claimant, of which it was aware.

Claimant's seventh assignment of error relates to the Referee's finding that the insurer's action of mailing the check to claimant's Aloha address was unfortunate, but not culpable, conduct. This is basically a repetition of claimant's fifth assignment of error, with which we already have dealt.

Claimant's next assignment of error relates to the Referee's reference to ORS 293.475(2). The Referee noted that the insurer's request for the notarized declaration of forgery was similar to that required by the state before it is authorized to issue duplicate instruments to payees. We do not believe the Referee's order indicated that he was directly relying on ORS 293.475(2) as authority for anything, or that he even believed it had any bearing on the case. Rather, he only appeared to be drawing an analogy between the statute and the insurer's request for a notarized declaration of forgery.

Claimant's final assignment of error is that the Referee erred in failing to find the insurer's conduct justified the imposition of penalties under ORS 656.262(9). This assignment of error is also somewhat repetitious of others previously addressed. We find no conduct on the part of the insurer which would justify the imposition of penalties. This entire matter could have been avoided had claimant simply informed the insurer of his change of address before he returned to Mexico, or possibly even seen to it that his mail was forwarded. The insurer has expressed its willingness to issue another check upon being furnished with a completed declaration of forgery. Claimant has raised some issues in regard to Mexican law in relation to acknowledgments. We have no desire and see no need to attempt to wade into that morass. In short, we find no error in the Referee's order whatsoever and we, therefore, affirm.

ORDER

The Referee's order dated December 28, 1982 is affirmed.

JOSEPH F. COLLINSON, Claimant
Pozzi, Wilson et al., Claimant's Attorneys
Moscato & Meyers, Defense Attorneys

WCB 80-07310
June 28, 1983
Order on Review

Reviewed by Board members Ferris and Lewis.

The insurer requests review of Referee Neal's order awarding claimant permanent total disability. The issues on review are: 1) Whether the Referee properly considered extent of disability; and 2) in the alternative, extent of disability including whether the claimant is permanently and totally disabled. We find that the Referee properly considered extent of disability, but that the claimant has failed to prove permanent total disability.

FACTS

Claimant, a 62-year-old air conditioning and refrigeration repairman, suffered a compensable myocardial infarction on January 12, 1976. The claim was accepted by North Pacific Insurance Company, the insurer for the employer at that time. The claim was closed with an award of 20% unscheduled disability on August 24, 1977. The claimant returned to work at his regular job; however, he slowed his pace considerably and stopped working overtime.

August 8, 1978 was a rare summer day for Portland. The temperature reached 100°. As claimant was driving home that day he

received an emergency call. The cooler at a health food wholesaler, one of his biggest clients, had stopped working. He then drove back across town to the health food warehouse. He took a large aluminum ladder off the top of his service van and climbed to the roof of the warehouse, carrying his tool belt and a CO2 cannister weighing between 30 and 50 pounds. Claimant worked on the compressor for about 20 minutes in the 115° to 120° heat on the roof. As he was getting down from the roof he began to feel weak. He felt nauseated as he drove home. Shortly after returning home, the claimant was taken by his wife to an emergency room where he was diagnosed as having a second myocardial infarction.

EBI Companies, the employer's present insurer, initially accepted the second myocardial infarction as a disabling injury. The claim was closed by a Determination Order on July 28, 1980, which awarded claimant an additional 45% unscheduled disability. Claimant requested a hearing, alleging, among other things, that the amount of his permanent disability exceeded that awarded by the Determination Order.

Several months after his second heart attack, claimant returned to work for a different employer, doing significantly lighter work. He quit that job in August 1980 in order to retire in Baker, Oregon.

In January 1981 Dr. Hattenhauer, a cardiologist, examined claimant at the insurer's request. Claimant performed very poorly on a stress test. Dr. Hattenhauer opined that claimant "is not capable of performing light to sedentary work. . . . In essence . . . he has a very serious condition."

In July 1981, after inquiries by the insurer, Dr. Hattenhauer opined that claimant's second heart attack was not causally related to his work but was the result of the natural progression of his preexisting heart disease. On the basis of this report, the insurer issued a denial specifically denying both the heart attack and the pre-existing heart disease. The claimant requested a hearing protesting the denial. A hearing was held on January 13, 1982.

The Referee upheld the denial of the heart disease but found the second heart attack compensable. Neither party contests those findings.

I. JURISDICTION TO HEAR EXTENT ISSUE

The insurer moved to dismiss the issue of extent or, in the alternative, for a continuation of the hearing to present additional evidence on the question of extent. The Referee denied the motions but left the record open for the deposition of Dr. Hattenhauer. Dr. Hattenhauer's deposition was taken and was considered by the Referee.

The insurer now argues that the Referee did not have jurisdiction to entertain the issue of extent of disability and that the proper course was to remand the claim to the Evaluation Division once the denial issues were decided. The insurer cites no authority in support of its assertions. It merely argues that the Determination Order was based on erroneous assumptions concerning the compensability as well as the permanency of the heart attack and

the preexisting heart disease. The insurer urges that because it is the function of the Evaluation Division to make the preliminary decision on extent of disability, the Board should remand the claim to Evaluation to make a second preliminary decision based on newly developed evidence.

We reject the insurer's argument. The Evaluation Division has made a preliminary decision on extent of disability. The claimant almost immediately protested that determination, and the insurer has been aware of the claimant's disagreement with that determination since the original request for a hearing. Furthermore, the Referee allowed the insurer to develop its evidence on extent by holding the record open for the deposition of Dr. Hattenhauer. The insurer has certainly not been prejudiced by litigating the issue of extent.

We believe it would fly in the face of administrative economy to remand the case back to the Evaluation Division after both sides had ample time to develop evidence, merely because the insurer has issued a back-up denial. The Referee and the Board are quite capable of deciding compensability issues and then rating extent of disability based on those conditions found to be compensable.

II. PERMANENT TOTAL DISABILITY

The Referee awarded claimant permanent total disability based on the opinions of claimant's treating physician, Dr. Grover, and the insurer's consultant, Dr. Hattenhauer, that the claimant at the time of hearing was not able to do regular work. The Referee made the specific finding that the second heart attack had not contributed to the underlying heart disease, but that it had contributed to the claimant's permanent impairment and found that claimant was permanently and totally disabled.

We agree with the Referee that claimant's second heart attack did not contribute to the worsening of claimant's pre-existing heart disease but did contribute to his permanent impairment. The Referee found Dr. Grover's opinion on this issue more convincing than Dr. Hattenhauer's contrary opinion because the evidence indicates that following the second heart attack claimant's ability to work was immediately and permanently affected. He was, thereafter, only able to do much lighter work.

We do not agree, however, that claimant is permanently and totally disabled. The Referee erred in considering claimant's heart disease as it existed at the time of the hearing:

> "[W]hen a claimant is affected by a pre-existing condition that continues to worsen after the date of the compensable injury, and that worsening is not related to the compensable injury, it is appropriate to consider the state of the claimant's pre-existing condition only as it existed at the time of the most recent compensable injury, when determining whether a claimant is permanently and totally disabled." Frank Mason, 34 Van Natta 568, 569 (1982).

We conclude that, considering the state of claimant's preexisting heart disease as it existed at the time of his second heart attack, he is not permanently and totally disabled.

Dr. Grover testified that in his opinion claimant's preexisting heart disease had not significantly worsened since the time of his second heart attack. However, Dr. Hattenhauer described claimant's heart disease as "progressive." Furthermore, claimant was able to work at a significantly lighter job for approximately one year following his second heart attack. According to both doctors, by the time of the hearing, claimant was unable to work at all. Dr. Grover conceded that claimant was capable of working shortly after the second heart attack but later became incapable. Claimant's total inability to work occurred after his second heart attack claim was closed, so presumably he was then medically stationary from that condition. We can only conclude that he became unable to work because his pre-existing condition worsened following his second heart attack. Accordingly, we hold that claimant has failed to prove permanent total disability.

III. EXTENT OF DISABILITY

As noted earlier, we agree with the Referee's conclusion that claimant's second heart attack contributed to his permanent impairment. The only issue, then, is extent of disability related to claimant's second heart attack. The Determination Order awarded claimant 45% unscheduled disability. We believe, in view of the modified work to which claimant returned, that 45% is an appropriate award for the disability attributable to his second heart attack. Accordingly, we affirm the Determination Order.

ORDER

The Referee's order dated November 16, 1982 is reversed in part. That portion of the order awarding claimant permanent total disability is reversed, and the Determination Order dated July 28, 1980 is affirmed. The remainder of the Referee's order is affirmed.

ARCHIE DEAN, Claimant
Merten & Saltveit, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 82-02057 & 81-11100
June 28, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer, FMC, requests review of Referee Mulder's order which found FMC responsible for claimant's December 3, 1981 low back injury. The issue on review is whether the December 3 "injury," incurred while claimant was working for another employer, Bingham-Willamette, insured by the SAIF Corporation, constitutes a new injury for which Bingham-Willamette would be responsible, or whether such is an aggravation of prior injuries sustained at FMC, for which FMC would be responsible. Claimant testified that back pain commenced while working on a sand hopper at Bingham-Willamette; he developed spasms and while painting one day was unable to straighten up.

FMC asserts that the SAIF Corporation's insured,

Bingham-Willamette, is the responsible employer under the rule of Smith v. Ed's Pancake House, 27 Or App 361 (1976). FMC states that, in accordance with this rule, claimant's December 3 injury was not merely a recurrence of the prior injuries, but contributed independently to the injury. SAIF is thus solely liable, FMC argues, "even if the injury would have been much less severe in the absence of the prior condition, and even if the prior injury contributed the major part to the final condition." Smith v. Ed's Pancake House, supra, 27 Or App at 365.

FMC offers the following facts in support of its argument: (1) Claimant had reported a full recovery after his last injury at FMC; (2) the report of Dr. Puziss, who initially treated claimant for the December 3 injury, confirmed that claimant's back was stationary and relatively asymptomatic prior to the December 3 injury and that such "contributed substantially to his present condition"; (3) Dr. Thompson, claimant's treating physician ultimately opined that claimant sustained a new injury on December 3 and that his work activities at Bingham-Willamette were the "prime contributory factor to the underlying back problems" and the "main contributory cause of his present symptoms"; (4) claimant testified that the symptomatology he experienced following the December 3 injury was different than that experienced after his prior injuries and that such caused him more discomfort than the prior injuries; (5) Dr. Norton, SAIF's consulting doctor, who opined that the December 3 incident was an aggravation of the prior FMC injuries, never even saw claimant; and (6) the Orthopaedic Consultants, who also opined that the December 3 incident was an aggravation, only saw claimant once. FMC, therefore, concludes that both Dr. Norton and the Orthopaedic Consultants are less qualified to make a judgment than Drs. Thompson and Puziss.

SAIF, on the other hand, asserts that: (1) The Board should give the opinions of Dr. Norton and the Orthopaedic Consultants more weight, arguing that a treating doctor has no particular advantage in this kind of case involving expert analysis; (2) Dr. Norton's opinion is more reliable because Dr. Thompson based his opinion on incomplete information regarding claimant's history and work activity; and (3) claimant's work at Bingham-Willamette merely made his degenerative disc disease symptomatic; therefore, his back difficulty was only a continuation of his prior problems.

The evidentiary conflict in this case reduces to a difference of opinion between Drs. Puziss and Thompson, on the one hand, who opine that claimant sustained a new injury on December 3; and Dr. Norton and the Orthopaedic Consultants, on the other hand, who opine that claimant sustained an aggravation of his prior FMC injuries. We are more persuaded by Drs. Puziss and Thompson, because of their firsthand exposure and knowledge of claimant's condition. Givens v. SAIF, 61 Or App 490 (1983); Hamlin v. Roseburg Lumber Co., 30 Or App 615, 619 (1977). Although Dr. Thompson initially opined that claimant had sustained an aggravation, upon acquiring a more complete history he stated that the December 3 incident constituted a new injury and did not thereafter waiver from that opinion. Furthermore, the Referee found claimant to be credible and we defer to that finding. Anfiliofieff v. SAIF, 52 Or App 127, 131 (1981). We, therefore, reverse the Referee's finding that claimant sustained an aggravation of his prior FMC

injuries, based on the weight of the medical evidence and claimant's credible testimony.

Claimant's attorney is not entitled to an attorney's fee on Board review. Robert Heilman, 34 Van Natta 1487 (1982).

ORDER

The Referee's order dated September 10, 1982 is reversed. The Referee's award of a $1,600 FMC-paid attorney's fee is reversed and the SAIF Corporation is ordered to pay claimant's attorney the $1,600 attorney's fee, not to be paid from claimant's compensation.

HOWARD W. LAKIN, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01234
June 28, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Nichols' order overturning SAIF's denial of claimant's occupational disease claim for coronary artery disease. The issues on review are whether claimant's claim is barred by application of the doctrine of res judicata and, if not, whether claimant has proven by a preponderance of the evidence that his on the job exposure was the major contributing cause of his coronary artery disease.

FACTS

Claimant is a 53 year old man who worked for the City of Coburg from 1968 until December 1981 with the exception of a one year period around 1974. Claimant was the Police Chief as well as the Director of Public Works for the City of Coburg for most of this time. However, during the last years of his employment he was relieved of his Chief of Police duties at his doctor's request and became City Purchasing Agent.

In 1970 claimant first began to experience chest pains radiating into his left arm. It is not clear from the record whether he suffered a heart attack then or not. He filed a workers' compensation claim which was denied by SAIF on the alternative grounds that he had failed to prove a work related injury or occupational disease. Claimant did not contest that denial.

In 1974 claimant left his job with the City of Coburg to take up truck driving. He returned to work with the City of Coburg in 1975. However, in 1975 while attempting to quell a domestic disturbance he again experienced severe chest pains. He then underwent a two vessel coronary bypass operation. He was asymptomatic following that operation for about three years.

In 1978 claimant saw Dr. Jacobsen for heart problems. Dr. Jacobsen felt that his problems were related to stress on the job and consequently wrote a letter to the Mayor of Coburg requesting that claimant be relieved of his duties as Chief of Police.

In 1981 claimant's heart problems became severe. An angiogram

was performed by Dr. Robinhold who noted that while the right coronary artery was not well visualized, it appeared that the right coronary artery was occluded. He also noted that the vein graft site from the ascending aorta was totally occluded just beyond its origin.

Claimant left his job at that time at Dr. Jacobsen's direction and has not returned to work since. He filed a workers' compensation claim for occupational disease on December 2, 1981.

RES JUDICATA

SAIF argues that claimant's occupational disease claim is barred by application of the doctrine of res judicata because claimant never contested SAIF's 1970 denial which rested in part on the assertion that he had failed to prove an occupational disease. The Referee reasoned that the uncontested denial only served to bar further litigation concerning the compensability of claimant's heart disease as it existed in 1970. She held that it did not bar litigation of any contribution his on the job exposure may have had to the worsening or development of the heart condition following the 1970 denial. We agree.

COMPENSABILITY

Because this is an occupational disease claim, claimant bears the burden of proving by a preponderance of the evidence that his on the job exposure was the major contributing cause of his heart disease. SAIF v. Gygi, 55 Or App 570 (1982). There are essentially two conflicting medical opinions upon which resolution of the compensability question depends.

Claimant's treating physician, Dr. Jacobsen, articulately argues in favor of the compensability of claimant's heart disease. Dr. Jacobsen is an internist whose practice includes patients with heart disease. Dr. Jacobsen opines that the only significant risk factor which claimant has for coronary artery disease is labile hypertension. He testified that he has observed that claimant's blood pressure increases under stress. He further testified that he believed the hypertension contributed to the coronary artery disease. He was able to offer a hypothetical explanation of how stress-related high blood pressure contributed to the coronary artery disease. In essence, his explanation is that under high pressure the blood in the arteries does not effectively exchange nutrients with the arteries which causes tissue in the arteries to die. This dead tissue he described as scarring. He said scarring is precisely what arteriosclerotic disease is.

The opposing point of view was voiced by Dr. Romm, a cardiologist who examined claimant. He stated that he did not believe that claimant's heart disease was work related. He rested his opinion on the fact that:

> "[T]here is no firm proof that long-term stress like Mr. Lakin claims he has been subjected to has any deleterious effect on the atherosclerotic process."

The Referee found Dr. Jacobsen more persuasive. We disagree. Dr. Romm's specialty is cardiology, while Dr. Jacobsen's specialty merely includes cardiology among other internal problems. Based on Dr. Romm's presumed expertise, we find him more persuasive. Accordingly, we find that claimant has failed to sustain his burden of proving that his on the job exposure was the major contributing cause of his heart disease.

ORDER

The Referee's order dated September 8, 1982 is reversed and the SAIF Corporation's denial of February 2, 1982 is reinstated and affirmed.

DAVID M. LINDAMOOD, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-04069
June 28, 1983
Order on Review (Remanding)

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Presiding Referee Daughtry's order which dismissed his request for hearing due to lack of jurisdiction.

The issues generally involve the problems that have arisen in the implementation and execution of a disputed claim settlement that resolved a prior proceeding, WCB Case No. 81-07973. A Referee approved that disputed claim settlement on April 27, 1982. Subsequent events -- and some procedural confusion that has resulted -- can best be described chronologically.

May 10, 1982: The Board received a request for hearing from claimant which was assigned WCB Case No. 82-04069. That request stated the issue to be: "Failure to abide by disputed claim settlement of 4-27-82. Attempt to collect an overpayment not provided for." Subsequent correspondence makes it fairly clear that the issue raised by this hearing request involved a dispute between claimant and his health insurance carrier, known as SelectCare. While claimant's claim that was the subject of the earlier proceeding, WCB Case No. 81-07973, was in denied status, SelectCare had paid for claimant's medical treatment pursuant to ORS 656.313(3). After the prior proceeding was resolved on a disputed claim basis, SelectCare invoked a provision of its policy with claimant to assert a claim for reimbursement against the settlement proceeds. Claimant's May 10, 1982 hearing request in WCB Case No. 82-04069 sought a decision on the propriety of SelectCare asserting any kind of lien against the proceeds of the disputed claim settlement.

July 2, 1982: The Board received another hearing request from claimant which was assigned WCB Case No. 82-05940. That request stated the issue to be: "Attempt by Springfield Utility Board and SelectCare to interfere with and become a party to stipulated settlement approved by Board." Subsequent correspondence makes it fairly clear that the additional issue raised by this hearing request involved a dispute between claimant and his employer, the

Springfield Utility Board (SUB). Apparently, although this is far from certain based on the present limited record: (1) while claimant was off work with what he was then claiming was a compensable injury, SUB did not make any deductions from claimant's previously accrued sick leave; but (2) following execution of the disputed claim settlement which resolved claimant's claim, SUB then deducted the time claimant had missed from work from claimant's accrued sick leave.

July 22, 1982: In an order that is not in this record but which we officially notice, Dennis Fraser, 35 Van Natta 271 (1983), Presiding Referee Daughtry dismissed claimant's hearing request in WCB Case No. 82-05940 because:

> ". . . we received a supplemental request for hearing, which was erroneously construed as a separate hearing request and assigned WCB Case No. 82-05940. Due to clerical error two files have been established on the same claim.
>
> "IT IS THEREFORE ORDERED WCB CASE NO. 82-05940 be and hereby is dismissed; all documents are now combined under WCB Case No. 82-04069."

November 8, 1982: Presiding Referee Daughtry dismissed claimant's hearing request in WCB Case No. 82-04069, the case and order now before us for review. Consistent with our above summary of the issue originally raised in that case, the Presiding Referee concluded only that this agency lacks jurisdiction over a dispute between claimant and his or her health insurance carrier. Apparently the Presiding Referee overlooked the fact that the additional issue raised in what had originally been assigned WCB Case No. 82-05940 (the dispute between claimant and his employer) had been merged into WCB Case No. 82-04069 by virtue of the Presiding Referee's July order; in any event, the Presiding Referee's Order of Dismissal now before us does not mention that additional issue.

Claimant argues in his brief:

> "The Order of Dismissal of Referee Daughtry was perhaps correct insofar as it refers to the dispute between the Claimant and SelectCare. That dispute is now before the District Court for Lane County Oregon. Therefore, the Claimant does not wish to have the Order of Dismissal reversed with respect to that. Claimant, however, clearly complained of the conduct of the Springfield Utility Board as well as the conduct of SelectCare and clearly indicated that Springfield Utility Board was interfering with the Referee's order. Claimant is clearly entitled to adduce evidence with regard to this complaint. Failure to obey an order of the Workers' Compensation Board or any of its referees with regard to matters concerning a claim (temporary total

disability in this case) is clearly within the jurisdiction and the duty of the Workers' Compensation Board and its referees to resolve."

Claimant correctly summarizes the record as far as he goes: His dispute with SelectCare is separate and distinct from his dispute with SUB. Claimant does not, however, acknowledge that these separate disputes were initially processed as separate cases; were then ordered merged into a single case; and that the Presiding Referee apparently overlooked claimant's dispute with SUB when he ruled there was no jurisdiction over claimant's separate dispute with SelectCare.

We reach that additional issue. At the risk of being repetitious, but for the sake of clarity, we understand claimant to be contending that SUB's act of debiting his sick leave account after execution of the disputed claim settlement is inconsistent with the terms of the disputed claim settlement. So understood, but without expressing any view whatsoever on the merits, we conclude that there is jurisdiction to request a hearing on that issue. Claimant's employer and its industrial insurer are, of course, separate parties to proceedings before this agency. ORS 656.005(19). And since a disputed claim settlement is somewhat in the nature of an order of this agency, this agency in turn has authority to police compliance with a disputed claim settlement. Mary Lou Claypool, 34 Van Natta 943 (1982). Claimant is entitled to a hearing on his contention that SUB's actions since approval of the disputed claim settlement are in derogation of that settlement.

ORDER

The Referee's order dated November 8, 1982 is reversed and this case is remanded to the Hearings Division for further proceedings consistent with this order.

JERRY M. RASMUSSEN, Claimant
Gatti & Gatti, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 82-00319
June 28, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer/insurer requests review of Referee Foster's order and Order on Reconsideration which set aside the employer's January 5, 1981 aggravation claim denial. Claimant cross-requests review of those portions of the Referee's orders which refused to award penalties for failure to accept or deny the claim within sixty days. ORS 656.262(6), 656.262(9).

Claimant sustained an injury to his low back on July 23, 1979 while employed by Applegate Dairy. Prior to the injury, claimant experienced no previous difficulties with his back. The claim was accepted. On September 4, 1979 Dr. Fax diagnosed a probable herniated disc resulting in low back pain along with a possibility of ankylosing spondylitis. Dr. Fax did not feel that ankylosing spondylitis was likely, however, as claimant had experienced no previous symptomatology of that nature. He further indicated that if claimant had ankylosing spondylitis, it would not be work

related. Claimant was treated conservatively and eventually released to return to work on October 13, 1979. A Determination Order dated March 20, 1980 awarded claimant 5% unscheduled permanent partial low back disability.

Claimant returned to work at Applegate Dairy. He testified, however, that he continued to experience difficulties with his back. On May 29, 1980 claimant was examined by Dr. Grewe, a neurosurgeon. Dr. Grewe reported that the findings of his examination were "highly suspicious for anklylosing spondylitis," and he also suspected possible lumbar nerve root compression at L4-5. A myelogram was performed on June 4, 1980 and a CT scan on June 6, 1980. The myelogram was somewhat inconclusive but the CT scan revealed what appeared to be a minimal disc herniation between L5 and S1. A discogram was performed on June 12, 1980. The impression was a degenerated disc. On June 13, 1980 Dr. Grewe performed a lumbar laminectomy with nerve root decompression L4-5, L5-S1. No herniated disc was discovered upon surgery and Dr. Grewe's operative report indicates that, "I think the patient has a degenerated disk without herniation and I think the settling of the interspace is responsible for the encroachment on the nerve." Dr. Grewe found a very thin and degenerated disc interspace.

There is a certain degree of confusion in the record concerning the insurer's position regarding the surgery. It appears that the claim was initially put in deferred status on June 12, 1980, but accepted by the insurer on June 30, 1980, and benefits paid accordingly.

Claimant initially experienced a good result from the surgery, but gradually began experiencing a recurrence of pain. By January 1981 claimant reported the pain as being 80% as severe as it was preoperatively. Claimant did not return to work following the surgery.

On July 8, 1981 Dr. Grewe performed a second myelogram. The myelogram was essentially normal with a suggestion of edema of the L5 nerve roots. Claimant was thereafter referred to Dr. Waldram, an orthopedic surgeon. Dr. Waldram reported on September 15, 1981 that his diagnosis was severe degenerative disc disease, L5-S1. Drs. Grewe and Waldram agreed to treat claimant conservatively.

On December 7, 1981 Dr. Grewe reported that it was his opinion that claimant's thin disc space at L5-S1 was related to his industrial injury. He stated:

> "Injury either causes or augments the degenerative changes in the disc. * * * It would appear that re-exploring the nerve root to establish adequate decompression and fusing of the joint to provide immobilization are right and proper treatments for his industrial injury. * * * The proposed treatment in my estimation should be included under his industrial claim."

On December 16, 1981 Dr. Waldram reported that claimant had experi-

enced no difficulty with his back prior to the 1979 injury, that symptoms developed immediatly thereafter, and that claimant had initially experienced a good result from his surgery. It was Dr. Waldram's opinion that the first surgery resulted in further narrowing of claimant's disc space causing additional collapse at the L5-S1 level, thus necessitating a second surgery.

On January 5, 1982 the insurer issued a denial. The denial is somewhat confusing as to whether the insurer intended to deny the entire claim, or the second surgery only. The insurer's apparent position at the hearing was that although the orignal injury had been accepted, the January 5, 1982 denial effectively served to deny that any treatment which claimant received subsequent to the issuance of the March 20, 1980 Determination Order was related to the compensable 1979 injury. In other words, it served to deny the aggravation claim which was initially accepted by the insurer on June 30, 1982. Since there had been no arrangement of compensation in relation to claimant's aggravation claim which "was not challenged by a request for hearing or otherwise," it would appear that the insurer was not legally prohibited from denying the aggravation claim at that point in time. See Bauman v. SAIF, 62 Or App 323, 328 (1983).

Claimant's second surgery proceeded on January 15, 1982 with Drs. Grewe and Waldram performing an L4-5, L5-S1 laminectomy with removal of an osteophyte and the intervertebral disc at L5-S1 with an interbody L5-S1 posterolateral fusion. A foreign body such as a bone chip or disc fragment was removed from the body of L5. On April 20, 1982 Dr. Grewe reported that:

> "In my estimation, the need for treatment is related to his industrial injury for which this claim was established. His symptoms date from that event of July 23, 1979. All of the treatment has been aimed at restoring him to a level of function that would once again make him self-sufficient. * * * Whether he had arthritis, a congenitally thin lumbosacral interspace, an acquired previously asymptomatic degenerated disc or some other underlying condition at the time of injury, the sequence of events speaks for itself and justifies the treatment on a causal relationship basis."

He indicated further that this was not a unique or even unusual industrial injury related problem.

Claimant was referred by the insurer for examination by Dr. Raaf. Dr. Raaf examined claimant and performed an impressively comprehensive review of all prior medical records. Despite the insurer's arguments to the contrary, Dr. Raaf's final opinion was not totally unequivocal. He stated:

> "The incident on July 23, 1979 seemed to be the factor which produced pain which finally led to the operation on June 13, 1980. However, there were no findings at

> operation which indicate that the incident . . . caused an operable lesion to be present. If his symptoms were due to degenerative disc disease at L5-S1 or to ankylosing spondylitis as originally was thought by Dr. Fax, the incident on July 23, 1979 was not the cause of his symptoms." (Emphasis added.)

Dr. Raaf thus seems to exhibit a certain degree of uncertainty as to the cause of claimant's difficulties, and is, to a degree, somewhat contradictory.

The insurer thereafter requested an opinion from Dr. Rosenbaum, a specialist in rheumatology. Dr. Rosenbaum reported on July 22, 1982 that he was of the opinion that claimant did have ankylosing spondylitis, that the disease was certainly present before claimant's injury, and that "it is very probable that many of his symptoms were due to ankylosing spondylitis, and not the injury." (Emphasis added.) Thus Dr. Rosenbaum also renders a somewhat equivocal opinion. There is, however, no dispute among any of the physicians that claimant's second surgery was necessitated by the first surgery.

Hearing convened on November 1, 1982. Dr. Rosenbaum testified on behalf of the insurer. Dr. Rosenbaum stated that he was of the opinion that claimant suffered either a back strain or sprain in 1979, that he did not have a herniated disc but did have ankylosing spondylitis, that the strain or sprain did not affect the degenerative condition and that it was simply a coincidence that claimant experienced his first onset of symptoms of the disease on the same day he suffered his back strain/sprain.

The Referee stated that although he found Dr. Rosenbaum to be a very impressive witness, he concluded that when the medical evidence was viewed as a whole, it supported compensability. We also find it to be a very close question, and we otherwise agree with the Referee.

The medical reports generated subsequent to claimant's 1979 injury are not supportive of Dr. Rosenbaum's opinion that claimant suffered only a back strain/sprain. This does not appear to have been a possible diagnosis by any of the physicians who examined the claimant at the time of the 1979 injury. Rather, the general consensus was that claimant suffered from ankylosing spondylitis and a herniated disc. The herniated disc theory subsequently proved to be incorrect. Dr. Grewe, claimant's treating physician and the doctor who actually performed the surgeries, was apparently not in agreement with Dr. Rosenbaum that claimant's L5-S1 problem was caused by ankylosing spondylitis. He believed that it could have been due either to a congenitally degenerated disc, arthritis or another underlying condition. He nevertheless felt that the 1979 injury did serve to aggravate the L5-S1 problem and that it was the injury which actually caused claimant's need for treatment.

As the Referee noted, claimant experienced no back difficulties prior to his 1979 injury. Although this in and of itself is certainly not conclusive, it does become another factor in claim-

ant's favor when combined with Dr. Grewe's opinion. We additionally have some difficulty in this instance, accepting Dr. Rosenbaum's conclusion that it was merely a coincidence that claimant's ankylosing spondylitis symptoms appeared at the same time as what he felt was a back strain/sprain. Dr. Grewe's opinion is more consistent with the facts of this case.

We agree with the Referee that Dr. Rosenbaum presented credible and impressive testimony. We agree with the insurer that we have on other occasions accepted the opinions of Dr. Rosenbaum over and above those of other physicians. However, we disagree with the insurer that this necessarily means that we will always defer to Dr. Rosenbaum's opinion in different factual situations.

With regard to Dr. Raaf, as we noted above, his opinion in this instance is somewhat equivocal and seems to be neither pro nor con on the issue of compensability. In summary, although we find it to be a close question, the facts of this case make deference to the opinion of claimant's treating physician appropriate. We do so and, therefore, agree with the Referee's conclusion.

With regard to claimant's cross-request on the penalties issue, we agree with the Referee's determination on this matter also.

ORDER

The Referee's order dated November 30, 1982 is affirmed. Claimant's attorney is awarded $400 as a reasonable attorney's fee before the Board, payable by the insurer.

GEORGE B. WASSON, Claimant
W.D. Bates, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-00176
June 28, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee McCullough's order which set aside its denial of claimant's occupational disease claim for headaches. SAIF contends that claimant's claim was not timely filed and is not compensable on the merits.

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

We agree with the Referee that claimant has proven that the employer was specifically aware of claimant's headaches and was at least generally aware of the connection with his job stress. Both claimant's testimony and the information supplied by the employer on the 801 form support that conclusion.

The nature of claimant's problems are unclear. He may have stress-related headaches or he may have psychophysiological headaches as an unconscious means of obtaining medication originally prescribed to cure stress-related headaches.

His treating physician, Dr. Anderson, notes that claimant had headaches in his previous occupations but that these had cleared

up by the time he went to work as a counselor at the University of Oregon. He states that work stress was extreme in 1974 when claimant first began experiencing headaches. Claimant has treated with Dr. Anderson since then, primarily for his headaches. Dr. Anderson has consistently prescribed Valium and Codeine to treat his headaches. Dr. Anderson says that the stress of claimant's work again increased significantly in 1980. He advised a one year layoff to deal with the headaches.

Dr. Henderson, a psychiatrist, examined claimant and opined that in 1974 claimant's job caused him to suffer from extreme headaches. He felt that claimant is not now experiencing a great deal of stress from his work, but that he has become dependent upon the medications prescribed for his prior work-related headaches.

These two physicians supply the only evidence on causation in this case. Dr. Anderson draws a direct link with claimant's work. Dr. Henderson draws an indirect link with claimant's work. No matter which of them is correct, the result is the same.

ORDER

The Referee's order dated November 22, 1982 is affirmed. Claimant's attorney is awarded $200 as a reasonable attorney's fee on Board review, payable by the SAIF Corporation.

WILLARD B. EVANS, Claimant
Evohl F. Malagon, Claimant's Attorney
Minturn, Van Voorhees et al., Defense Attorneys

WCB 80-11378
June 29, 1983
Order on Remand

On review of the Board's order dated April 27, 1982, the Court of Appeals reversed the Board's order and remanded for an order directing the SAIF Corporation to provide claimant medical services pursuant to ORS 656.245 and to "pay claimant a penalty based on the cost of medical services to date, together with reasonable attorney fees for prevailing on the medical service issue." Evans v. SAIF, 62 Or App 182, 187 (1983).

The court's final order herein has now issued, and claimant has been awarded costs and disbursements on appeal and a further sum as attorney fees for services rendered before the Board as well as the Court of Appeals. Accordingly, it is unnecessary for the Board to award claimant's attorney any further attorney's fee for prevailing on the medical services issue. Cf Hubble v. SAIF, Or App 513, 520 (1982).

Claimant has moved the Board to remand this case for a hearing in order to develop a fuller evidentiary record on the issue of penalties for SAIF's unreasonable denial of the claim for medical services. The court found that a report from Dr. Friesen, received by SAIF on January 20, 1981, constituted a "prima facie valid claim for medical services," which had not been "rebutted" by SAIF. 62 Or App at 186.

We find it unnecessary to remand for taking further evidence on the issue of the unreasonableness of SAIF's conduct. We find the maximum allowable penalty appropriate, according to the facts of this case and the resultant conclusions reached by the Court of

Appeals, by which we are bound. The penalty is to be calculated based upon the medical bills incurred and unpaid at the time of the hearing, which was September 3, 1981. Any claim for allegedly unreasonable conduct related to facts and circumstances arising subsequent to the date of the hearing in this case may be raised by a new request for hearing.

ORDER

The Board's order dated April 27, 1982 is vacated, and this claim for medical services is remanded to the SAIF Corporation for acceptance and payment of benefits in accordance with law. SAIF shall pay claimant 25% of the outstanding medical bills as of the time of the hearing herein as and for a penalty for SAIF's unreasonable refusal to pay claimant compensation.

GERALD HERRINGTON, Claimant — WCB TP-83003
Anderson, Fulton et al., Claimant's Attorneys — June 29, 1983
Macdonald, McCallister & Snow, Defense Attorneys — Third Party Distribution Order

Claimant has petitioned the Board for resolution of a dispute concerning the proper distribution of the proceeds of a third party recovery. See ORS 656.154, 656.593. Claimant initially requested a hearing on this issue, which was consolidated with other matters pending in the Hearings Division. The Referee who heard the case properly concluded that she was without jurisdiction to resolve the dispute concerning the distribution of claimant's third party recovery, and the matter eventually was brought before the Board. The primary issue involves the extent of the industrial insurer's lien for anticipated future expenditures.

Claimant was involved in a motor vehicle accident in December 1978 while acting within the course of his employment. He filed a workers' compensation claim and also elected to pursue his civil remedies against the allegedly negligent third party. A Determination Order closed claimant's workers' compensation claim on July 19, 1979, awarding compensation for temporary total disability only. Claimant requested a hearing seeking compensation for permanent disability.

Claimant negotiated a settlement of his civil action against the third party defendant in June 1980. This settlement was approved by the SAIF Corporation, the industrial insurer. ORS 656.587. A partial distribution of the proceeds of claimant's third party recovery was made: The costs of litigation and claimant's attorney's fee were paid; claimant received 25% of the balance of the recovery; and SAIF received reimbursement for its then-current expenditures paid to date. A balance remained in the approximate amount of $12,700, which was retained by SAIF in anticipation of future expenditures.

After a hearing, a Referee awarded claimant 35° of scheduled permanent partial disability for a 35% loss of vision in his left eye. SAIF deducted this award from the funds it was retaining in its "advance refund account," which reduced the remaining balance of claimant's third party recovery to approximately $9,500.

Claimant requested Board review of the Referee's order, seeking additional compensation for permanent disability. The Board affirmed the Referee's order by Order on Review dated September 3, 1982.

Claimant has raised a procedural issue and contends that it was improper for SAIF to retain the entire balance of his third party recovery which, at the time claimant's civil action was settled in June 1980, amounted to over $12,000. Claimant bases this contention on the fact that the July 1979 Determination Order awarded no compensation for permanent disability. Claimant seems to argue that the status of his claim in June 1980 was that he sustained no permanent disability as a result of his industrial injury, and, thus, that SAIF was not entitled to retain any portion of the balance of the third party recovery in order to preserve its claim for reasonably-to-be-expected future expenditures for compensation. Claimant, however, had requested a hearing in August 1979, claiming compensation for a permanent disability, and at the time of the partial distribution of the settlement proceeds, claimant's hearing request was pending.

An industrial insurer has a lien against the proceeds of a claimant's third party recovery for its expenditures for compensation paid to the claimant, including reasonably-to-be-anticipated future expenditures. ORS 656.593(1)(c). In order to preserve its lien for anticipated future expenditures, the paying agency is required to withhold from the proceeds of the third party recovery an amount sufficient to satisfy its lien for future expenditures. Robert A. Parker, 32 Van Natta 259 (1981), affirmed 61 Or App 47 (1982). When a dispute arises concerning the amount that may be retained by the paying agency in satisfaction of its statutory lien, the dispute is to be resolved by the Board. ORS 656.593(1)(d). In order to establish its claim of a lien for anticipated future expenditures, the paying agency is required to adduce evidence that it is reasonably certain to incur future expenditures and what the amount of those expenditures will be. Leroy R. Schlecht, 32 Van Natta 261 (1981), reversed in part on other grounds, 60 Or App 449 (1982); Larry Campuzano, 34 Van Natta 734 (1982). Where there is litigation pending concerning the extent of a claimant's permanent disability, the Board will generally defer ruling on a claim for anticipated future expenditures in a related third party proceeding until such time as the extent of permanent disability is finally adjudicated. John J. O'Halloran, 34 Van Natta 1504 (1982).

Since SAIF was required to retain from the proceeds of claimant's third party recovery sufficient amounts to satisfy its lien for anticipated future expenditures, it was proper to withhold the remaining balance of the third party recovery after partial distribution was made in accordance with the statutory distribution formula. ORS 656.593(1). Since there was litigation pending concerning the extent of claimant's permanent disability, SAIF could not anticipate its potential liability for future expenditures; therefore, it was not improper for SAIF to retain the remaining balance in its entirety.

We turn to the merits. SAIF's claim for future expenditures relates to the partial loss of vision in claimant's left eye.

Claimant's eye condition was not identified and diagnosed until several months after his 1978 injury. Dr. Banholzer, claimant's attending ophthalmologist, first examined claimant in February 1979, at which time he diagnosed hyperopia (far-sightedness) and an "early cataract." Dr. Banholzer believed that the cataract was secondary to trauma to the eye sustained in claimant's motor vehicle accident. He again examined claimant in March 1979, and found that the cataract had not progressed. In a report to claimant's attorney, dated April 24, 1979, Dr. Banholzer stated:

> "The prognosis for the left eye is not entirely clear. Occasionally this type cataract will remain stationary for long periods but more likely it will become more dense and eventually require cataract surgery. Vision after successful cataract surgery may well be 20/20 but it is never as good as normal vision prior to a cataract."

In response to an inquiry from SAIF, Dr. Banholzer stated on August 16, 1979, that claimant's condition had not changed since his original report in February 1979. Dr. Banholzer reported on March 10, 1980 that claimant's left eye cataract appeared "about the same." On May 6, 1980, Dr. Banholzer reiterated his prior opinion that claimant's left eye cataract would eventually require surgery.

The above-referenced medical reports from Dr. Banholzer were part of the record before the Referee, who found claimant entitled to an award of permanent disability for loss of vision. After issuance of the Referee's order, and while claimant's request for Board review was pending, SAIF solicited a report from Dr. Banholzer specifically requesting information concerning possible future costs related to claimant's eye injury claim. In a report dated August 31, 1982, Dr. Banholzer responded:

> "I would suspect that Mr. Herrington will eventually need cataract surgery on the left eye and would probably best be served by an intraocular lens implant. For this he would also need an ultrasonic scan to determine the correct lens. Present day costs are: A scan * * * $ 140.00; cataract surgery with intraocular lens * * * $1,775.00; assistant surgeon * * * $355.00.
>
> "He would not be able to work for one month following surgery and limited work to a second month. I would suspect no further loss of vision and in fact restoration of vision barring any complication."

We find it is reasonably certain that claimant eventually will require the cataract surgery contemplated by Dr. Banholzer. SAIF has presented sufficient evidence to establish this as a prospective expenditure, including evidence of what the surgery is likely to cost. Claimant has submitted no evidence in opposition.

In defining the extent of the paying agency's lien for reasonably-to-be-expected future expenditures for compensation and other claim costs, the legislature has specifically excluded payment of compensation that might become payable to the claimant in the future under the terms of ORS 656.273, the aggravation statute, or ORS 656.278, the own motion statute. Under ORS 656.273, a claimant is entitled to additional compensation, including medical services, for worsened conditions resulting from the claimant's original injury. Medical services such as the cataract surgery anticipated by Dr. Banholzer might be considered compensation payable for a worsened condition under ORS 656.273, and thus excluded from the paying agency's lien for anticipated future expenditures. We have held, however, that the substantive right to medical services is governed by ORS 656.245, and that the reference to medical services in ORS 656.273 governs the procedure for requesting compensation in the form of medical services during the five-year aggravation period. Willard B. Evans, 34 Van Natta 490 (1982). See also Mary Ann Hall, 31 Van Natta 56 (1981), and Evans v. SAIF, 62 Or App 182 (1983), in which the court reversed the Board's determination that the claimant in Willard Evans, supra, had failed to establish a claim for compensable medical services, also noting the apparent ambiguity between ORS 656.245 and 656.273. 62 Or App at 185-186.

Because the right to continuing medical services arises under ORS 656.245, and compensation which may become payable under that provision is not excluded from the paying agency's lien for anticipated future expenditures, the anticipated cost of the cataract surgery contemplated by Dr. Banholzer is a future expenditure here recoverable by SAIF as part of its lien. In reaching this conclusion, we have considered the purposes underlying the third party recovery statutes, which are the payment of claimant's damages by the ultimate wrongdoer and the avoidance of a double recovery by the claimant. John J. O'Halloran, supra; John Galanopoulos, 34 Van Natta 615, 616 (1982).

Although the anticipated medical services are part of SAIF's lien for future expenditures, the compensation for temporary disability that may be incurred in association with the cataract surgery is not a future expenditure recoverable by SAIF. Whereas the anticipated surgical procedure would be payable under ORS 656.245, the associated temporary disability compensation would be payable under ORS 656.273, and, therefore, is excluded from SAIF's lien. ORS 656.593(1)(c). Claimant may incur future surgery, which we find has been established to a reasonable certainty, and SAIF is entitled to recover from the proceeds of claimant's third party recovery the presently identified costs of that surgery; however, any temporary disability compensation that may become payable in association with this surgery is not a factor in determining the proper distribution of the third party recovery.

Claimant requests that the Board order SAIF to pay interest at a rate of 12% per annum on the balance of claimant's third party recovery which is payable to claimant under the terms of this order, in view of SAIF's retention of this money since claimant's settlement with the third party in June of 1980. Even if claimant might be entitled to this relief, we lack authority to grant it under the existing provisions of the third party recovery statutes.

ORDER

The SAIF Corporation shall be paid and retain from the proceeds of claimant's third party recovery $2,270 in full and final satisfaction of its lien for reasonably-to-be-expected future expenditures for compensation and other costs of this claim. The remaining balance of the third party recovery shall be paid to claimant.

DARRELL C. JOHNSON, Claimant
Ringo, Walton & Eves, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-02883
June 29, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Danner's order which found claimant to be permanently and totally disabled. Extent of disability is the only issue.

Claimant is 61 years old. He formerly did automobile body repair work and painted automobiles. He compensably injured his low back in 1976 while closing a paint room door. He was diagnosed at that time as having a muscle strain superimposed on preexisting degenerative arthritis and mild osteoporosis. He received conservative treatment. On May 18, 1977 the claim was closed by a Determination Order awarding him 15% unscheduled disability. In October 1977 a stipulation was approved which increased his total unscheduled disability award to 35%.

Thereafter claimant returned to the same automobile work, but his work consisted mostly of painting and warranty work which were the lighter jobs in the shop. In early 1979 claimant was laid off by the employer. Shortly thereafter he filed an aggravation claim. The Court of Appeals ultimately set aside SAIF's denial of that aggravation claim. Johnson v. SAIF, 54 Or App 179 (1981). Two Determination Orders have issued since, awarding time loss but no increased permanent disability. Claimant suffered a heart attack in July 1979.

Claimant suffers from a number of medical problems, many of which are not compensable, although the wording of the prior decision of the Court of Appeals involving this claim leaves us uncertain about the compensability of some of claimant's problems. The noncompensable problems include coronary artery disease, diabetes mellitus, chronic obstructive pulmonary disease and peripheral vascular disease. We do not understand claimant to be contending that these problems of preexisting disability, i.e., existing before his 1976 injury, should be taken into account pursuant to ORS 656.206(1)(a). See Emmons v. SAIF, 34 Or App 603 (1978); Glen O. Hall, 34 Van Natta 1725 (1982). Nor do we understand claimant to be contending that post-1976 worsening of these noncompensable conditions is relevant to the present determination. See Frank Mason, 34 Van Natta 568, aff'd, 60 Or App 786 (1982).

The compensable condition started in 1976 as a low back strain superimposed on arthritis and osteoperosis. Even after extensive

prior litigation and on the record in this case, it is far from clear whether and to what extent claimant's arthritis and osteoperosis have been established to be or are here claimed to be compensable consequences of his 1976 injury. The 1981 decision of the Court of Appeals did not specifically address these conditions, but rather identified two other compensable consequences of claimant's 1976 injury: "weakness of the plantar flexion of the left foot, and . . . a sensory dermatoma of L5 and S1 on the left side." 54 Or App at 183. We assume the court's reference was to a dermatome, i.e., the area of the skin supplied with nerve fibers by a single spinal nerve root, which can be diagnostically signficant in indicating the existence and probable location of nerve root impairment. Stated differently, a certain dermatome pattern can indicate nerve root sensory impairment at L5-S1. Plantar flexion weakness would possibly be indicative of nerve root motor impairment.

Since the court's decision, the suggestion of possible nerve root involvement has not been followed up with a myelogram, surgery or, so far as we can tell from this record, any other form of treatment. Dr. Tsai reiterates his impression of herniated L5-S1 disc in reports dated April 2, 1982, May 4, 1982 and in answers to interrogatories dated July 9, 1982. An Orthopaedic Consultants' report dated February 2, 1982 and Dr. Halls' report dated April 27, 1982 seemingly disagree with that diagnosis. In answers to interrogatories, both Drs. Tsai and Hall state that they are not claimant's treating doctor. Indeed, so far as this record reflects, claimant currently has no treating doctor. In our experience, it is certainly strange for a claimant who supposedly experiences significant back pain and who has received a possible herniated disc diagnosis to not follow up with further diagnostic investigation (such as myelogram) and treatment.

The reports of Dr. Hall and Orthopaedic Consultants also mention that claimant suffers from lumbar degenerative joint disease and lumbar osteoporosis. While no doctor has specifically so stated since Dr. Tsai's April 18, 1980 deposition, it would appear that these conditions are worsening as claimant ages. Circumstantial evidence to that effect is that claimant was able to return to modified work for about 2 1/2 years between 1976 and 1979, but has apparently been unable to work since 1979. If claimant is contending that his degenerative conditions are compensable consequences of this 1976 industrial injury, we find no evidence in this record to support any such contention.

The current medical opinions concerning the extent of claimant's disability have to be interpreted in the context of the above-discussed ambiguities about exactly what is compensable.

Dr. Tsai reported the following findings in 1979:

> "Straight leg raising 90 degrees on the right side with no discomfort with 70 degrees on the left side with cause of left side of low back pain without radiation. Tenderness L5-S1 on the left side upon digital pressure without radiation. Left sciatic notch tenderness upon pressure

> without radiation. Plantar flexion of the left foot demonstrate upon tiptoe exercises only. Sensory dermatome L5 and S1 on the left side. No sacral sensory denervation noted. No reflex asymmetry noted at this time including ankle jerks. . . . X-ray of lumbosacral spine taken on 9-7-76 and 12-16-77 reviewed revealing lumbar scoliosis and osteoporosis."

Dr. Tsai's 1982 reports state there has been no change in claimant's condition since 1979.

Orthopaedic Consultants' findings are generally consistent with Dr. Tsai's although somewhat more severe. However, their conclusion is in marked contrast to Dr. Tsai's:

> "We do not believe that he is employable largely because of his cardiac and pulmonary disease, diabetes and because of his low back problem. We do not believe that orthopedic and neurological treatment would be of benefit to him.
>
> "We believe the total loss of function of the low back as it exists today is in the lower limits of moderate, and the loss of function due to this injury is in the mildly moderate category."

Dr. Hall opined that none of claimant's medical problems totally incapacitated him as of April 1982. He said:

> "[H]is medical problems singly and taken in combination, do not provide a sufficient impairment of exercise ability to lead to a marked restriction of activity and ultimate disability. It is my medical opinion that the patient's primary problem leading to limitation of activity is his chronic low back disease."

In context, we understand Dr. Hall's reference to "low back disease" to more likely be a reference to claimant's degenerative joint disease and osteoporosis, conditions which we do not think have been proven to be compensable.

The Referee concluded that claimant is totally disabled because he thought that all the physicians who had voiced an opinion concluded that claimant is totally disabled. We do not so read the medical evidence. Dr. Hall's opinion is that all of claimant's problems combined do not render him totally disabled. Furthermore, while Orthopaedic Consultants do believe that claimant is totally disabled, they only attribute a moderately mild disability to his compensable injury and a moderate disability to his entire low back condition. Only Dr. Tsai concludes that claimant is totally disabled because of his back condition, and his opinions are consistently phrased in terms of current inability to work, rather than permanent inability to work.

Claimant testified at hearing to severe and disabling pain in his low back and legs. Aside from being mystified about why claimant has apparently not sought treatment for a possible herniated disc, we have no reason to doubt his testimony. Nevertheless, the fact remains that the medical evidence documents numerous possible explanations for claimant's disabling pain, not all of which would be compensable consequences of his 1976 back strain injury.

Under all of these circumstances, we cannot say we are persuaded by Dr. Tsai's opinion that claimant is permanently and totally disabled -- if that is Dr. Tsai's opinion -- in the face of the contrary opinions of Dr. Hall and Orthopaedic Consultants. Dr. Tsai does not articulate any basis for his apparent conclusion, yet his objective findings of claimant's condition (which probably includes both compensable and noncompensable problems) are less severe than those of Orthopaedic Consultants who rate claimant's overall disability as moderate and compensable disability as mildly moderate.

As for claimant's partial disability, a strong case can be made that claimant has not proven that his compensable disability is greater than previously awarded (35%). However, resolving considerable doubt in claimant's favor, considering Orthopaedic Consultants' mildly moderate impairment rating and considering the relevant social/vocational factors, we conclude that an additional award of 15% unscheduled disability would be appropriate.

ORDER

The Referee's order dated November 8, 1982 is reversed. Claimant is awarded 48° for an additional 15% unscheduled disability, for a total permanent disability award to date of 50%. Claimant's attorney is allowed 25% of the increased compensation granted by this order as and for a reasonable attorney's fee, in lieu of the fee allowed by the Referee, to be paid out of claimant's compensation and not in addition thereto.

CHARLES JONES, Claimant
Powers & Dorman, Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB TP-83002
June 29, 1983
Third Party Distribution Order

Claimant has petitioned the Board for resolution of a dispute concerning the proper distribution of the proceeds of a third party recovery. See ORS 656.154, 656.593.

Claimant was injured in a motor vehicle accident in June 1980 while working in the course of his employment. He filed a workers' compensation claim with the employer's insurer, the SAIF Corporation, and also elected to pursue his civil remedies by filing an action against the allegedly negligent third party. The civil action was settled with the approval of SAIF in June 1982. Claimant's litigation costs and attorney fees were paid from the settlement proceeds, claimant received his minimum statutory percentage of the settlement proceeds, and SAIF was paid its current expenditures for compensation that had been paid to claimant. After this partial distribution of the proceeds of claimant's third party recovery, there remained a balance of approximately

$9,000. The dispute in this case concerns the proper distribution of this remaining balance. ORS 656.593(1)(d).

SAIF claims the entire remaining balance for reasonably-to-be-expected future expenditures for compensation that will become payable to claimant or claimant's beneficiaries. Claimant is a 75-year-old man who sustained injuries rendering him permanently and totally disabled. In support of its claim that it is entitled to retain the entire remaining balance, SAIF has submitted actuarial estimates based upon claimant's life expectancy, as well as that of claimant's wife, who apparently is also 75 years of age, and who will be entitled to receive death benefits if claimant predeceases her. The actuarial estimate is that workers' compensation benefits payable to claimant or his wife will exceed $70,000.

Claimant contends that the actuarial estimate submitted by SAIF overstates the present value of its reasonably-to-be-expected future expenditures for the costs of this claim. Claimant also contends that, in the event of his demise prior to SAIF's expenditure of that portion of the proceeds which the Board determines SAIF is entitled to retain for anticipated expenditures, any unexpended sum should be refunded to claimant's estate.

ORS 656.593 requires the paying agency, in this case SAIF, to determine and withhold from the proceeds of a third party recovery sufficient amounts to satisfy the paying agency's statutory lien, including any expenditures the paying agency will incur in the future. Robert A. Parker, 32 Van Natta 259 (1981), affirmed 61 Or App 47 (1982). In order to establish its claim for reasonably-to-be-expected future expenditures, the paying agency must establish to a reasonable certainty that it will incur the claimed costs and what the amount of those costs will be. Leroy R. Schlecht, 32 Van Natta 261 (1981), reversed in part on other grounds, 60 Or App 449 (1982).

The future costs that SAIF claims it will incur in connection with this claim are permanent total disability benefits payable to claimant and his wife during claimant's life, and survivor benefits that may become payable to claimant's wife in the event that claimant predeceases his spouse. Claimant has been adjudged permanently and totally disabled as a result of his industrial injury. The actuary who estimated SAIF's projected costs computed claimant's statutory permanent total disability benefits at $233.34 per month for twelve months per year for 7.526 years (NCCI factor age 75), arriving at an estimate of SAIF's projected costs for payment of statutory permanent total disability benefits alone in an amount exceeding $21,000. The balance of the third party settlement proceeds remaining after the partial distribution discussed above was approximately $9,000. Since the dispute was initially submitted to the Board for resolution, SAIF has undoubtedly incurred additional costs in paying claimant's monthly permanent total disability benefits, and possibly additional medical expenditures. Our computations indicate that on the basis of a monthly statutory benefit of $233.34, the $9,000 that SAIF claims in partial satisfaction of its anticipated future claim costs would be expended within a period of

3.3 years. The actuarial figures estimate claimant's remaining life expectancy to be 7.5 years, with an additional period during which claimant's spouse would be entitled to receive a survivor's benefit, based on the apparent actuarial prediction that claimant's wife will outlive claimant. Claimant has not submitted any actuarial estimates to rebut those submitted by SAIF, stating only that the actuarial estimate submitted by SAIF is excessive.

Considering the available evidence, we find that SAIF has satisfied its burden of proving that it is reasonably certain to incur future expenditures in connection with this claim and that these expenditures are reasonably certain to amount to, if not significantly exceed, the remaining balance of the proceeds of claimant's third party recovery. Accordingly, SAIF is entitled to be paid and retain any remaining balance pursuant to ORS 656.593(1)(c).

We think the fact that claimant's wife would continue to receive a form of workers' compensation benefits after claimant's death is sufficient for present purposes to dispose of claimant's contention that we should now order some possible contingent distribution of the third party settlement balance to claimant's estate. If both claimant and his wife were to die before workers' compensation benefits equal to the presently remaining balance of claimant's third party recovery had been paid out, it would then be appropriate to consider possible estate claims against the then remaining balance.

ORDER

The remaining balance of the proceeds of claimant's third party recovery shall be paid to and retained by the SAIF Corporation in satisfaction of its lien for reasonably to be expected future expenditures for compensation and other costs of this claim.

HARRY K. AGNER, Claimant
Welch, Bruun & Green, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorney

WCB 81-08632 & 81-06391
June 30, 1983
Order on Reconsideration

The Board issued its Order on Review herein on June 15, 1983. Claimant has requested reconsideration and clarification of the Board's order as it relates to responsibility as between the two employers/insurers herein for payment of claimant's attorney's fee for services rendered before the Referee.

The Board reversed the Referee's finding that Consolidated Freightways (Freightliners) was responsible for claimant's condition as an aggravation of his 1976 injury, finding instead that the SAIF Corporation, as insurer for St. Vincent de Paul, was responsible for claimant's condition as a new injury. The Board remanded claimant's claim to SAIF "for acceptance and payment of compensation in accordance with law, including reimbursement to Consolidated Freightliner."

The Referee awarded claimant's attorney $900 as a reasonable

attorney's fee pursuant to ORS 656.386(1), to be paid by Consolidated Freightliner. In ordering SAIF to reimburse Consolidated Freightliner for compensation previously paid, the Board inadvertently neglected to direct SAIF to pay the attorney's fee awarded by the Referee. We modify our order accordingly.

ORDER

The Board's Order on Review dated June 15, 1983 is modified to provide that the SAIF Corporation, rather than Consolidated Freightways (Freightliners), shall pay claimant's attorney $900 as a reasonable attorney's fee for services before the Referee, as awarded by the Referee. Except as modified, the Board adheres to its former order which hereby is republished and reaffirmed.

DONALD AMENT, Claimant
Flaxel, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 80-09477
June 30, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Peterson's orders which: (1) Upheld the SAIF Corporation's denial of claimant's claim for his December 9, 1979 myocardial infarction and; (2) found that, although the insurer unreasonably delayed the denial for many months, there was no penalty that could be imposed for that delay under ORS 656.262(9) because there was no compensation "then due" between the date of the claim and the date of the denial.

The Board affirms and adopts the orders of the Referee. As regards the penalty issue, we note that SAIF did pay claimant interim compensation for the period of time he was hospitalized and unable to work in December 1979. However, claimant did return to work after his hospitalization and continued to work up through the September 1980 denial. Since claimant was working, SAIF was under no obligation to pay him interim compensation. Anthony A. Bono, 35 Van Natta 1 (1983).

ORDER

The Referee's orders dated November 30, 1982 and December 8, 1982 are affirmed.

PHILLIP A. BERTRAND, Claimant
Doblie & Francesconi, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-11065
June 30, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Williams' order which set aside its partial denial, ordered it to continue paying temporary total disability compensation to claimant until his claim is closed and awarded a penalty and an attorney's fee. SAIF contends that it followed the insurer's closure procedures under ORS 656.268(3) and that its denial of the claim was proper and done in a reasonable manner.

On July 21 1981, claimant suffered a compensable injury to his left wrist which was diagnosed as a strain and tenosynovitis.

This injury was accepted by SAIF which began paying temporary total disability compensation. Claimant had suffered several nonindustrial injuries to the same wrist and hand over the course of the previous six years including a fracture, two crush injuries, a human bite and multiple lacerations.

Claimant was examined, at SAIF's request, by Dr. Button in November of 1981. At the time of this examination, claimant had not been released to return to work by his treating physician, Dr. Rusch. On November 20, 1981, Dr. Button reported to SAIF:

> "In relation to his present problem, this appears to be a strain and tenosynovitis, which has now resolved. I would not consider the incident of July 21, 1981 to be a material or significant worsening of his pre-existing condition and may be considered stationary. There is no permanent impairment of function of the left wrist, relative to the incident of July 21, 1981. Impairment of function relates to his previous injury years ago."

Upon receipt of Dr. Button's report, SAIF ceased payment of temporary total disability compensation and issued a partial denial. The denial reaffirmed SAIF's acceptance of the July injury but stated that the injury had healed and was not a material factor in his loss of wrist function. SAIF therefore denied the compensability of his continuing wrist problems. Claimant requested a hearing on the denial, asserting that his wrist problems were still related to the accepted injury and that SAIF should not have terminated his temporary disability payments before the claim was properly closed.

This case raises a basic question as to whether the issuance of a partial denial permits an insurer or self-insured employer to terminate temporary disability payments. We do not question the legitimacy of partial denials per se, nor do we wish to discourage their use when appropriate. See Ohlig v. FMC Rail & Marine Equip.'t Divn., 291 Or 586 (1981), and OAR 436-83-125. Nevertheless, the present case and several others currently before this Board involve the same claims handling issue. An insurer's duty to pay temporary disability compensation, following a partial denial of compensability due to an underlying preexisting condition or because of a supervening new injury, has not been clearly articulated by the Legislature, this Board or the courts.

When an insurer denies a claim in its entirety, there is no doubt that, pursuant to ORS 656.262(2), the insurer may immediately cease making temporary disability payments. It is equally clear that, except for a few specific exceptions, when a claim has not been denied the insurer must continue to pay compensation until the claim is closed. ORS 656.268 and ORS 656.325. However, an insurer enters a claims processing twilight zone when it partially accepts and partially denies different components of a single claim. Allowing insurers to discontinue benefits soley because a partial denial has been issued would require us to view the claim with acute tunnel vision. The other

portion of the claim is still in an accepted, open status. We can find no compelling reason to hold that a claimant who has had only a portion of his or her claim accepted should not be afforded the rights and protections provided by formal claim closure.

There is no clear statutory guidance as to whether an insurer may terminate temporary disability payments when only a portion of a claim has been denied. In fact, the statutes seem to be in conflict. ORS 656.262(2) states:

> "The compensation due under this chapter shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except where the right to compensation is denied by the insurer or self-insured employer."

This provision can be read so as to relieve the insurer from the duty to pay compensation for a claim if the insurer believes the claimant's residual problems were never or are no longer related to an accepted injury and thus it denies the compensability of that component of the claim.

On the other hand, ORS 656.268 provides:

> "Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary . . ."
>
> * * *
>
> "When the injured worker's condition resulting from a disabling injury has become medically stationary . . . the insurer or self-insured employer shall so notify the Evaluation Division, the worker and employer, if any, and request the claim be examined and further compensation, if any, be determined . . . If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section."

This section states that when a claim has not been denied, temporary disability payments are not to be discontinued unilaterally by the employer prior to closure of the claim. The logical corollary is that when a portion of a claim has not been denied and the claimant has been receiving temporary disability compensation for that portion of the claim, such compensation cannot be terminated without first closing the open portion of the claim.

Standing alone, both of the above statutory interpretations seem plausible. However, when the question is placed in context with the purposes for temporary total disability compensation and the general policies expressed by the Legislature and the courts, the latter interpretation is more persuasive than the former.

Temporary disability payments are "compensation for loss of income until claimant's condition becomes stationary in order to enable a claimant to support self and family during that period." Taylor v. SAIF, 40 Or App 437, 440 (1979); Hedlund v. SAIF, 55 Or App 313, 317 (1981). Thus, temporary disability compensation is designed to continue until the worker's injury is medically stationary and a determination of permanent disability can be made. Allowing insurers to stop temporary disability payments by issuing a partial denial without closing the accepted portion of the claim would frustrate the purpose of avoiding economic hardship for the claimant.

The Court of Appeals in Jackson v. SAIF, 7 Or App 109 (1971), said that only through the process set forth in ORS 656.268 can the injured worker avoid possible hardship from wrongful termination of temporary disability compensation. If an insurer may terminate temporary disability payments without closing the accepted portion of the claim, the worker would be deprived of the right to have his or her disability properly evaluated by the Evaluation Division. If a partial denial is treated the same as a full denial, the insurer is relieved from the risk of penalties for unreasonable refusal or delay in payment of compensation even if the denial is ultimately found to have been wrong, so long as the insurer's action was reasonably founded. In contrast, if the entire claim was still in an open, accepted status, a unilateral cutoff of time loss payments would be unreasonable per se. Mark L. Side, 34 Van Natta 661 (1982); Jackson v. SAIF, supra. We can find no logical reason to treat a partially accepted claim differently from one that has been accepted in its entirety.

We, therefore, hold that SAIF's unilateral termination of the claimant's benefits because it had issued a partial denial relating to a portion of the claim was improper. If SAIF wished to make a partial denial, it should not have simply ignored the portion of the claim left in an open, accepted status. The accepted portion should have been simultaneously processed through claim closure pursuant to ORS 656.268 and SAIF should have continued to pay benefits just as it would with any other accepted claim.

This decision does not in any way alter an insurer's or employer's right to properly terminate benefits in situations where there is an accompanying justification to do so, such as in those situations set forth in ORS 656.325.

SAIF has asserted in its brief on review that it did not unreasonably terminate claimant's benefits because it closed the claim pursuant to the insurer-closure procedure in ORS 656.268(3). SAIF's assertion that it closed this claim is unsupported by the record. If such a closure was attempted by SAIF, it is obvious that the notice requirements of ORS 656.268(3) were not complied with and, thus, a penalty is warranted. However, due to the statutory haze that permeates the claims-

processing issue in this case, we believe that an award of less than the maximum penalty would be more appropriate.

The Referee set aside SAIF's denial and remanded the case back to SAIF for proper processing. Although we agree with the Referee's conclusion that the unilateral termination of time loss payments was improper, we do not believe the denial should have been set aside. SAIF's error was not in making the partial denial; it was in terminating benefits without properly closing the accepted portion of the claim. Thus, the Referee should have addressed the substantive merits of the denial in his order. Since the compensability issue was litigated at the hearing and the record before us is adaquate to resolve the question, we need not remand the case for further proceedings.

SAIF has only denied that the 1981 compensable injury caused any permanent impairment of claimant's left wrist. The question of whether claimant's continuing symptoms are related to the 1981 injury is one which we believe requires expert medical evidence.

Dr. Button's report of November 20, 1981 indicates that claimant's continuing symptoms are related to his prior non-industrial injuries. Claimant's treating physician, Dr. Rusch, stated on October 20, 1981 that although claimant's symptoms following the July 1981 injury were probabably an aggravation of his preexisting injuries, it was "improbable" that claimant had sustained "a significant and material worsening of his preexisting hand condition . . ."

However, Dr. Rusch also checked-off a box on a rehabilitation counselor's form which states that Mr. Bertrand has suffered some permanent impairment as a result of "a job injury." There is no further explanation of this statement from Dr. Rusch. Claimant suffered a crush injury to his hand in 1978 which he originally claimed occurred on the job and then another left hand injury on the job in 1979. Thus, we are not sure which "job injury" Dr. Rusch may have been referring to and accordingly give the statment little weight.

In light of the multiple prior injuries to claimant's left wrist and hand, the opinion of Dr. Button and the lack of evidence supporting claimant's position, we find that claimant has failed to prove that the July 21, 1981 injury contributed to his current hand and wrist symptoms or that it resulted in any permanent disability. See Phillip A. Bertrand, 35 Van Natta 874 WCB Case No. 82-03525 (decided this date).

ORDER

The Referee's order dated February 10, 1982 is reversed in part. The SAIF Corporation's denial of December 3, 1981 is reinstated and affirmed. The remainder of the Referee's order is affirmed.

Claimant's attorney is awarded $450 as a reasonable attorney's for prevailing on the unilateral termination of time loss issue on Board review.

PHILLIP A. BERTRAND, Claimant
Doblie & Francesconi, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-03525
June 30, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Pferdner's order which upheld the Determination Order awarding no permanent disability. Claimant contends that he is entitled to an award of permanent partial disability compensation for his July 21, 1981 wrist injury.

Subsequent to the hearing on the extent of disability in this case, the compensability portion of the claim was appealed to the Board. Our opinion reviewing the compensability of the claimant's wrist condition is decided this same date. See Phillip A. Bertrand, 35 Van Natta 869 WCB Case No. 81-11065 (decided this date). The Board reinstated the SAIF Corporation's partial denial and found that none of claimant's symptoms after November 20, 1981 were related to the 1981 injury.

The Referee in the first hearing remanded the entire claim, the accepted portion and the portion which we have ultimately found to be not compensable, to SAIF. The claim was processed to closure and a Determination Order issued on April 1, 1982. The Determination Order awarded temporary total disabiltiy from the date of the injury through November 20, 1981, the date that Dr. Button opined that claimant's continuing problems were related to his prior injuries and not the July 21, 1981 on-the-job injury. Since this period of temporary disability has never been disputed by SAIF, the Determination Order properly closed the accepted portion of the claim.

Although the Referee did not have the benefit of the Board's order on the compensability portion of the claim, and thus, reviewed the merits of the extent claim, he arrived at the same conclusion. Claimant is not entitled to any permanent disability as a result of the 1981 injury. We therefore affirm the Referee's order.

ORDER

The Referee's order dated August 5, 1982 is affirmed.

HAROLD R. CHESTER, Claimant
John D. McLeod, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-11793
June 30, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Menashe's order which set aside its denial of claimant's claim related to coronary problems. It is clear that the principal issue is the compensability of claimant's September 20, 1981 myocardial infarction. SAIF's denial also refers to claimant's other coronary conditions, diagnosed as arteriosclerotic artery disease and angina pectoris; apparently the compensability of these conditions is also in issue, although that is far from clear.

SAIF asserts that claimant's work activities did not cause his heart disease or heart attack. Rather, SAIF contends claimant's heart disease caused the September 20 heart attack, and that the disease developed because of several factors unrelated to claimant's work: Claimant's smoking for 20 years, obesity, family history of heart disease, high animal fat intake and borderline hypertension. Finally, SAIF asserts that claimant's claim is one for an occupational disease, not an injury as the Referee found, because the facts claimant alleges point to job stress over a long period of time. This latter point depends largely on whether the issue is the compensability of claimant's coronary artery disease, or the compensability of claimant's myocardial infarction or both, a point on which we have already confessed some confusion; we approach this case as primarily a claim for a myocardial infarction, which we view as being primarily in the nature of an injury claim.

Claimant has not filed a brief on review, but apparently contended at the hearing that the anxiety and pressure of his job caused him to be exhausted, thereby causing his heart attack.

Claimant, 43 years old at the time of hearing, was originally employed as a counselor by the Klamath Alcohol and Drug Abuse Program in February 1981. A few months later he was promoted to Administrative Assistant and performed budgetary duties during a time when the agency was experiencing funding cuts.

Claimant was to attend a regional meeting in Seattle on Friday, September 18, 1981 to discuss funding issues. He planned to leave Thursday morning, September 17. On his way to the Seattle meeting, he was to drop off a client at a Portland in-patient facility. The night before they were to leave, the client called claimant three or four times, interrupting his sleep. At 7:30 the next morning (Thursday), claimant, his wife and the client left Klamath Falls to drive to Portland. Claimant had to stop several times to calm down the client. When they arrived in Portland there was some trouble checking the client into the facility, but ultimately that was accomplished. Claimant and his wife then drove to Seattle. Upon arriving, claimant was unable to locate the motel at which he was to stay; he and his wife ended up staying at another motel.

The next morning, Friday, September 18, when claimant arrived at the meeting place, he discovered the meeting had been cancelled. To salvage something from the trip, he called and met with several people about the agency's funding problems. Claimant and his wife left Seattle that evening around 5:30, stopped in Portland for dinner and arrived between 11 p.m. and 1 a.m. in Salem, where they spent the night. He slept late Saturday morning, September 19. He spent Saturday shopping and doing personal errands. About 8:30 p.m. claimant experienced a brief dull ache in his left precordium. After going to bed Saturday evening, claimant awoke with intense pain about 12:30 a.m., September 20, and upon arriving at the hospital was found to have suffered a myocardial infarction. On October 13, 1981 he underwent bypass surgery.

In sum, claimant clearly experienced considerable stress and frustration in connection with a business trip on Thursday and Friday, September 17-18. He then devoted his time on Saturday, September 19, to relatively restful personal matters unrelated to his work. While in bed that night, he suffered a myocardial infarction.

Claimant must establish both legal and medical causation to prove a compensable heart attack. Coday v. Willamette Tug and Barge, 250 Or 39, 49 (1968); Ginter v. Woodburn United Methodist Church, 62 Or App 118 (1983); Batdorf v. SAIF, 54 Or App 496 (1981). Legal causation requires a showing of work connectedness; medical causation requires expert medical evidence that the work exertion was, within the range of medical probability, a precipitating factor of the heart attack.

Looking at all the appellate court and Board decisions in which legal causation has been found, there appears to be an almost universal, if not literally universal, common denominator: That the heart attack probably occurred during the course of, or followed soon after, allegedly precipitating work activity. That element is missing in this case. Claimant returned from his frustrating Seattle trip very late on Friday, September 18 or very early Saturday, September 19. His heart attack was very late on Saturday or very early on Sunday, September 20. He spent the intervening approximately 24 hours resting and attending to personal matters. We conclude that claimant has not proven that his heart attack occurred sufficiently close in time to his Seattle trip or any other work activity to satisfy the legal causation element of his burden of proof.

We also find the preponderance of the evidence fails to establish medical causation. Dr. Bigelow, a cardiovascular surgeon who treated claimant after his heart attack, opined that the "etiology of his current heart condition is arteriosclerotic coronary artery disease. The exact cause of this . . . is undetermined." Dr. Wasenmiller, a cardiologist who reviewed the medical records, opined that "the etiology of Mr. Chester's heart condition is arteriosclerotic heart disease . . . The factors that initiate this process in certain individuals, however, is, at the present time, highly speculative and subject to revision." He then listed the risk factors present in claimant's case, "smoking cigarettes, a questionably positive family history for coronary artery disease, exogenous obesity with hypercholesterolemia;" and stated that, "No single factor can be implicated as the major contributing factor that led to his myocardial infarction."

Dr. Berven testified that it was his medical opinion that claimant "was a candidate at some point in time for a heart attack." He testified further that the circumstances prior to the heart attack "would be equivalent to maximal stress, sleep deprivation, anxiety and frustration, and . . . I think that the increased cardiac workload, increased by mental stress, was a marked factor to this event." He then testified that, in fact, the almost clogged artery was the major cause of claimant's myocardial infarction.

In the course of cross-examination, it developed that Dr. Berven had formed his opinion without knowing that claimant had pre-existing heart problems and had taken nitroglycerin in 1980 for such problems. After being confronted with this additional information, Dr. Berven's opinion seemed to vacillate somewhat. Dr. Berven also seemed to vacillate in his reactions to the opinions expressed by other doctors. He first testified that he could not disagree with Dr. Wasenmiller's statement that no single factor was the major cause of claimant's infarction; he then stated flatly that he agreed with that statement. Dr. Berven next indicated general agreement with Dr. Bigelow's opinions, which were contrary to his own. More specifically, commenting on Dr. Bigelow's statement that "a person working in the counseling business works with a high stress population, but the exact interrelationship of this with coronary disease is still to be directly shown," Dr. Berven testified: "I think that is probably a very honest statement."

Although, to repeat again, we are unsure whether this is a claim for all of claimant's coronary problems or only for his infarction, and are thus unsure whether this claim is for injury or disease, we are not persuaded that claimant's work activities were a material cause or the major cause of any of his coronary problems.

ORDER

The Referee's order dated November 26, 1982 is reversed. The SAIF Corporation's denial dated November 25, 1981 is reinstated and affirmed.

MARIE A. CURWICK, Claimant
Hansen & Wobbrock, Claimant's Attorneys
Lindsay, Hart, et al., Defense Attorneys

WCB 82-02195
June 30, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Pferdner's order which upheld the insurer's denials of compensability for claimant's low back, neck and right shoulder problems and also upheld the award of temporary total disability granted by the Determination Order for claimant's compensable left hand injury. Claimant contends that her back, neck and shoulder problems were caused by the same fall at work that injured her hand. Claimant also asserts that she is entitled to a greater award of temporary total disability than that granted by the Determination Order.

We affirm and adopt the Referee's order with one comment. The Referee's order did not address whether claimant was entitled to an additional award of temporary total disability. The Determination Order awarded temporary disability from the time of the injury through February 12, 1982, the date claimant's treating physician, Dr. Silver, found claimant's hand condition to be medically stationary. Claimant asserts that she was not stationary until August 10, 1982 when Dr. Gill indicated that no

further treatment was indicated. Orthopaedic Consultants examined claimant on March 16, 1982. They stated that they did not think claimant's hand was stationary at that time but did not recommend any further treatment.

We find Dr. Silver's opinion to be the most persuasive. He performed the carpal tunnel release surgery on claimant and followed the condition for the longest period of time and, thus, was in the best position to judge when she was medically stationary. We affirm the award of temporary disability granted by the Determination Order.

ORDER

The Referee's order dated January 13, 1983 is affirmed.

ELMER S. DIRKS, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Macdonald, et al., Defense Attorneys

WCB 81-04414
June 30, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Gemmell's order which increased claimant's award of unscheduled permanent partial disability from the 25% awarded by Determination Order to 75%. SAIF contends that an award of about 30% would be more appropriate. Claimant argues the award should be increased to 100%.

Claimant injured his low back in March 1980 when he fell while walking on a ramp in the course of his employment as a bartender. That fall resulted in a herniated disc and led to a discectomy and fusion at L5-S1. Prior to this 1980 injury and surgery, claimant had two laminectomies and partial disc removals arising from two previous noncompensable injuries. The Orthopaedic Consultants rated claimant's overall back impairment as moderate and the amount of impairment attributable to the compensable injury as mild, i.e., in the 10% to 20% range. Applying the administrative rules for the evaluation of back surgeries and loss of range of motion, OAR 436-65-615 and 446-65-620(2), we arrive at a rating of 20% impairment of the whole person, which generally corresponds with the Consultants' assessment of impairment attributable to this injury.

In addition, the record documents that claimant has a nervous condition which may have been exacerbated by the compensable injury and which causes a rash and occasional hand tremors. When present, the hand tremors are sufficiently severe that they interfere with claimant's ability to engage in such activities as using tools to repair appliances. We have some doubts about the causal relationship of this condition to claimant's March 1980 injury and some doubts about the permanence of this condition, but we resolve these doubts in claimant's favor and add an additional 4% impairment for this condition. Combining the orthopedic and psychological aspects of claimant's impairment results in an overall impairment rating of 23% attributable to this injury.

Claimant is 43 years old, which yields a +2 value for the age factor. He completed nine years of school, which yields a +7 value for the education factor.

With respect to the work experience factor, claimant was injured in the course of his employment as a bartender. Because of standing limitations arising from the compensable injury and surgery, claimant is unable to return to tending bar; thus, it is appropriate to assign a positive value for the work experience factor. In the course of his work history, claimant has achieved proficiency at a wide variety of occupations with widely varying proficiency achievement periods, including working in a sawmill, carrying mail, tending bar and managing a variety store. His employment at the time of the injury (tending bar) has a specific vocational preparation (SVP) value of 3, indicating a proficiency period of 30 days to six months. Applying OAR 436-65-604 results in a work experience impact value of +3. Considering claimant's work history and the fact that, post-injury, claimant successfully completed a training course in refrigeration and air condition repair, an impact value of +3 is appropriate if not somewhat high, considering claimant's demonstrated ability to adjust to new occupations.

With respect to the adaptability factor, we infer from the record that prior to the 1980 compensable injury claimant was limited to medium to heavy work because of his previous back surgeries. Since the 1980 injury claimant appears to be limited to light to sedentary work. Accordingly, an impact value of +12 is appropriate.

The labor market factor is somewhat difficult to evaluate because claimant's residual functional capacity attributable to the injury probably falls somewhere between light and sedentary. Accordingly, we have computed the percentage of labor market twice -- once based on an assumed RFC for light work, and once based on an assumed RFC for sedentary work -- and averaged the results. We have also assumed a specific vocational preparation ability value of 6 and a general educational development value of 4 based on claimant's experience as a manager of a small variety store. These calculations indicate that claimant has about 15% of the labor market left open to him, which yields an impact value of +1.

Combining these values in the manner provided in OAR 436-65-601 results in a determination that claimant has sustained a 40% loss of wage earning capacity attributable to the compensable injury.

In arriving at a significantly higher disability rating, the Referee may have been impressed with the fact that claimant probably cannot return to any of his previous occupations and by the fact that claimant may not be capable of working a regular 40-hour work schedule. We emphasize "may" because claimant is presently successfully engaged as the assistant manager and maintenance person for an apartment building wherein he sets his own hours and is able to rest when his back bothers him. However, following completion of his refrigeration and air conditioning repair training, claimant was employed and self-employed in that line of work, and he left that work for reasons other than physical inability to maintain a regular work week. Moreover, claimant's inability to return to some of his previous occupations is attributable to his pre-1980 noncompensable injuries and back surgeries.

ORDER

The Referee's order dated September 1, 1982 is modified. Claimant is awarded 128° for 40% unscheduled permanent partial disability. This award is in lieu of all previous awards of permanent disability arising from this claim. Claimant's attorney's fee shall be adjusted accordingly.

WILLIAM A. GAMEL, Claimant
Paul H. Gunderson, Claimant's Attorney
Wolf, Griffith et al., Defense Attorneys

WCB 82-01821
June 30, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer, Skutt Ceramics, and its insurer, EBI Companies, request review of Referee Leahy's orders which (1) reversed EBI's denial of claimant's low back condition and remanded it for rating by the Evaluation Division; (2) modified the Determination Order by specifying a later medically stationary date and awarding additional temporary disability; and (3) increasing the award of permanent disability for claimant's right foot condition from 5% scheduled disability to 15%. The employer contends that the Referee erred in finding claimant's present back condition to be a compensable consequence of the accepted injury, and further erred in modifying the medically stationary date and awarding additional time loss. In his responding brief, claimant defends the Referee's order and, in addition, contends that penalties should be imposed because of the insurer's unreasonable denial of claimant's back condition claim.

The issues are whether the claim was prematurely closed, whether claimant's back condition is compensable, and entitlement to penalties and attorney fees for unreasonable denial. No issue has been raised on review concerning the award of permanent disability for claimant's right foot condition.

I.

In May 1980 claimant was moving a cart and barrel containing pulleys and weighing approximately 400-500 pounds when they tipped over and fell onto claimant's leg and foot. The 801 claim form indicates that claimant sustained injuries to his leg and foot and twisted his back. The focus of treatment initially was on the foot where claimant had sustained a comminuted fracture of the lateral sesamoid bone. Claimant was treated conservatively with injections, pads and other measures until April 1981 when surgery was performed on the foot to excise the fragmented bone.

Claimant was released to regular work in August 1981 based upon an examination in June 1981. The surgery was only partially successful in relieving the pain claimant experienced in his foot. In September 1981 claimant sought treatment because of an increase in foot pain. Claimant's treating physician, Dr. LaGasse, authorized time loss. Further injections and a custom made orthosis were prescribed. When the foot pain failed to respond to these measures, claimant was referred to another physician who tried immobilizing the foot in a cast.

In December 1981 Dr. LaGasse noted that claimant had not responded to treatment sufficiently to enable him to return to normal gainful occupation and that, at that point, the problem seemed unresolvable except for the possibility of further surgery. Apparently in response to Dr. LaGasse's request for further orthopedic consultation, in December 1981 claimant was referred to the Oregon Orthopaedic Clinic. Dr. Noall, of that Clinic, opined as follows:

> "The cause of his persistent pain, despite all modes of conservative management, is not apparent.
>
> "There does not appear to be any causalgic component.
>
> "With regard to treatment, a hard arch support could be tried but I am not optimistic that this would be helpful because he does have pain in the medial arch as well as in the region of the sesamoid. Similarly, anti-inflammatories could be tried, but again, for this type of aching pain, I don't think they are going to have a dramatic effect, but he might realize some improvement from them.
>
> "Basically, I don't see any further medical treatment that can be done for him. I don't see any surgical treatment in the absence of any clear objective localized findings.
>
> "* * * I think that it would be best to consider him medically stationary with permanent impairment related to inability to do work which requires standing for more than a few minutes at a time and very little walking."

On January 12, 1982 claimant's treating physician indicated that he concurred with Dr. Noall's report. However, on January 19, 1982 by checking the appropriate box on a form 828, Dr. LaGasse indicated that claimant was not released to work and was not medically stationary.

Apparently based on these report, the claim was submitted for closure, and on February 5, 1982 a Determination Order issued finding claimant to be medically stationary as of December 22, 1981.

On February 10, 1982, claimant sought treatment from Dr. Hurd, D.C., for upper and lower back pain, and signed a claim form naming EBI as the liable insurer and giving May 1, 1980 as the date of injury. In his report Dr. Hurd noted that when claimant fell in the May 1980 accident he twisted his back and, therefore, Dr. Hurd related claimant's present back pain to that incident. He also indicated that claimant was not medically stationary and

not released for work. Dr. Hurd's treatment was directed at both the back and the foot conditions. On February 22, 1982 Dr. Hurd opined, "Some portion of his foot pain may also be related to the low back condition and this is already showing some noticeable improvement."

Dr. LaGasse reported, "I have no record of [claimant] complaining about symptoms during that time severe enough to require medical treatment." On March 1, 1982 the insurer denied liability for claimant's back condition claim.

Meanwhile, a February 16, 1982 chart note by Dr. LaGasse indicated that claimant had a new longitudinal arch support, that it was making a "little bit of a difference," and that claimant was going to see a new orthopedic surgeon. In March 1982 claimant began treating with orthopedist Dr. Marble concerning his foot problems. After examining claimant and reviewing his x-rays, Dr. Marble suggested that claimant may have minor causalgia and may respond to "differential spinal blocking and or a pair of lumbar parasympathetic block" to be administered "in the near future." Dr. Marble noted that claimant was not working at that time and that a change to sedentary work would be appropriate. In a report dated March 30, 1982, Dr. Marble clarified that the spinal blocks were done more as a diagnostic than a therapeutic measure, that claimant did not respond well to them and that he had no other mode of treatment to offer claimant.

Notwithstanding his March 30, 1982 report, on April 13, 1982, Dr. Marble suggested that claimant might have a "compartment syndrome" and referred claimant to the University of Washington for consideration for reconstructive surgery. Dr. Marble requested authorization from the insurer for the consultive examination. On April 11, 1982 claimant returned to Dr. LaGasse who injected two medications into claimant's foot and suggested possible removal of claimant's other sesamoid and clean out any bone fragments from the flexor tendons. In May 1982 Dr. LaGasse suggested awaiting the University of Washington consultation before administering any further treatment.

On May 16, 1982, after receiving authorization from the insurer, claimant was examined by an orthopedic physician at the University of Washington. That physician described surgical procedures that could be tried to alleviate claimant's discomfort. The consensus of medical opinion is that the proposed surgery had about a 50% chance of improving claimant's foot condition. On June 15, 1982 Dr. Marble discussed with claimant the University of Washington consulation report, the suggestions of surgery and that, with or without the surgery, claimant would have some residual impairment in both his foot and back. At that time claimant indicated he was uncertain whether to go through with the surgery.

Meanwhile, on March 24, 1982 claimant began evaluation for vocational rehabilitation and in April 1982 the vocational consultant inquired of Dr. LaGasse whether claimant was physically capable of handling a machine operator position. Dr. LaGasse indicated that while he could understand having reservations about

such a position, with good incentive and psychological attitude, claimant could perform satisfactorily. However, in light of the suggestions of further surgery from the University of Washington, vocational rehabilitation efforts were discontinued in June 1982 pending clarification of claimant's intent to proceed with surgery.

In July 1982 claimant found seasonal work operating a forklift for a cold storage warehouse. He worked there approximately two months before the job ended.

In August 1982 claimant consulted Dr. John Thompson, an orthopedist who had treated claimant as a child. As a teenager claimant sought treatment for back pain and Dr. Thompson diagnosed congenital spondylolisthesis and spina bifida. At that time Dr. Thompson prescribed exercises and use of a back brace. Claimant wore the back brace until he graduated from high school and went to work, at which time he discontinued use of the brace. Dr. Thompson had not seen claimant until August 1982 at which time, after examining claimant and obtaining a history from him, the doctor opined that claimant's abnormal gait caused by the foot injury had aggravated his pre-existing spondylolisthesis and had led to a chronic lumbosacral strain. Dr. Thompson further indicated that before proceeding to surgery he would like to try other conservative measures such as fitting claimant with an anterior heel to transmit weight bearing away from the site of the pain.

On September 7, 1982 Dr. Thompson indicated that he assumed that claimant was not medically stationary in June 1982 when claimant first consulted him. As to whether claimant was presently medically stationary and had sustained any permanent impairment, Dr. Thompson reported first that if claimant continued in the job he currently was in (forklift driver) he probably could be determined medically stationary. However, Dr. Thompson also said:

> "If his symptoms subside in his foot and thus his back symptoms subside, then he would not have a permanent partial impairment relative to his back. However, if over a period of 2 to 3 months his back symptoms continue, certainly to the point he requires more medical attention, i.e., a spinal fusion, his degree of impairment will be significantly different."

In September 1982, Dr. Hurd reported that he treated claimant on an irregular basis from February 1982 and continuing into September 1982, and that improvements were evident through May when reinjury to the S-1 joint caused by claimant's gait and activities destabilized him. Dr. Hurd further indicated that claimant was again stabilized in June and remained in that condition until August when he again became destabilized due to "reinjury."

II

From this morass of inconsistent and ambivalent information the Referee found that Dr. Noall's December 1981 statement that

"it would be best to consider [claimant] medically stationary" suggested that claimant perhaps was not medically stationary which was confirmed by subsequent examinations of claimant by other physicians.

ORS 656.005(17) defines "medically stationary" in terms of "no further material improvement would reasonably be expected from medical treatment, or the passage of time." Here, in late 1981 Drs. LaGasse and Noall apparently felt that no further improvement could be expected in claimant's condition, but in February 1982 Dr. LaGasse prescribed a new arch support, and in April 1982 he prescribed further injections into claimant's foot as well as suggesting the possibility of surgery. Dr. Hurd began treating claimant's foot (and back) in February 1982 apparently in the expectation of providing more than palliative care. In March 1982, Dr. Marble unsuccessfully tried sympathetic blocks, reported that he had little else to offer claimant, then shortly later suggested the possibility of reconstructive surgery and referred claimant for evaluation to the University of Washington.

Given the evidence in this case the question is indeed a close one whether claimant's foot condition was medically stationary in December 1981. Certainly it cannot be said that claimant's condition improved on more than a temporary basis in response to the various measures tried thereafter. Although a number of physicians tried other conservative measures after that date, those measures appear to us to be either diagnostic or palliative. To the extent that the treatment could be considered curative, it appears that the physicians at most "hoped" those measures might improve claimant's condition; it does not appear that they actually expected material improvement. Accordingly, we find claimant's foot condition to have been medically stationary in December 1981.

III.

We agree with the Referee that claimant's back condition is a compensable consequence of the May 1980 industrial injury. Claimant's antalgic gait is a direct consequence of the surgery resulting from the initial injury. Claimant's gait combined with his pre-existing condition to produce a third condition, a chronic lumbosacral strain. Whether the strain is considered a worsening of the underlying spondylolisthesis and spina bifida or a separate condition, the sequelae of the injury materially contributed to its development, therefore, it is compensable. Hoffman v. Bumble Bee Seafoods, 15 Or App 253 (1973); Gilbert v. SAIF, 63 Or App 320 (1983).

There is insufficient indication that claimant's back required medical services until after the Determination Order issued closing the case. Accordingly, claimant's February 1981 back condition claim should be considered an aggravation claim at that time rather than an indication that claimant was not medically stationary in December 1981. The Referee found claimant's back condition to be medically stationary as of September 6, 1982, presumably based upon Dr. Thompson's report of that date. While that report is even more ambivalent than Dr. Noall's concerning the certainty with which he felt that claimant was medically stationary, for lack of better evidence we concur

that claimant's back condition was medically stationary as of that date. There is insufficient evidence that claimant sustained any time loss because of his basic condition; therefore, we do not order any temporary disability in addition to that awarded by the Determination Order.

IV

Claimant contends that in light of the reports of Dr. Hurd and Dr. Thompson relating claimant's back condition to his injury and no contrary medical opinions, the insurer should be assessed a penalty for unreasonable denial. First, Dr. Thompson's report was not generated until several months after the insurer already had denied the claim. Second, the lapse of time between the injury and the onset of disability/need for medical services for the back condition together with Dr. LaGasse's statement that claimant had never complained of back symptoms sufficient to warrant medical treatment raised sufficient doubt concerning the validity of the claim to justify the denial.

ORDER

The Referee's orders dated November 12, 1982 are reversed in part and affirmed in part. Those portions of part three of the Referee's orders relating to awards of temporary disability and modifying the medically stationary date are reversed and the Determination Order of February 5, 1982 is reinstated with respect to the medically stationary date and the award of temporary disability. The insurer is entitled to an offset for any overpayment of temporary disability arising from the Referee's order together with the overpayment of $334.61 claimed by the insurer at hearing. The remainder of the Referee's orders are affirmed.

Claimant's attorney is awarded $450 as a reasonable attorney's fee on Board review, to be paid by the employer/insurer.

WALTER L. HOSKINS, Claimant
Dwight Gerber, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-07238
June 30, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review and the SAIF Corporation cross-requests review of that portion of Referee Howell's order which awarded claimant 40% unscheduled permanent disability. Claimant contends his impairment is greater than that recognized by the Referee, including permanent total disability. SAIF contends that claimant's disability is no greater than 10%.

The primary issue on review is extent of disability. However, there is a preliminary evidentiary question. The Referee refused to admit an exhibit offered by claimant, apparently on the grounds that a copy of it was not furnished to the assigned Referee at least 10 days prior to the hearing as required by OAR 436-83-400(3). The exhibit in question is a report from the Orthopaedic Consultants which was prepared following an independent

medical exam conducted at SAIF's request. The report was furnished by SAIF to claimant in a timely manner along with other evidence. When SAIF submitted to the Referee its list and packet of exhibits it intended to rely on at hearing, it excluded the Orthopaedic Consultants' report as well as a report from a Dr. Matteri, one of claimant's treating physicians.

Claimant offered both exhibits at hearing contending that both exhibits were admissible notwithstanding that they were not submitted to the Referee at least 10 days before hearing. Claimant pointed out that SAIF had copies of both documents well in advance of the hearing and that one report (from the Orthopaedic Consultants) arose from an independent medical examination arranged at SAIF's request, and argued that SAIF was not surprised by the documents being offered. SAIF's only objection to admitting the exhibits was that they were not furnished to the Referee in a timely manner as required by OAR 436-83-400(3). SAIF did not dispute claimant's contention that it was not surprised by the documents being offered, nor did it allege prejudice in going forward with the hearing at that time or indicate that a post-hearing deposition, independent medical examination or other activities would be necessary to respond to the exhibits in question. The Referee admitted Dr. Matteri's report on the grounds that another exhibit timely furnished to the Referee, and not objected to, referred to Dr. Matteri's report, but excluded the Orthopaedic Consultants' report. On review, the insurer has not renewed its objection to admitting Dr. Matteri's report. However, claimant contends that the Referee erred in failing to admit the Consultants' report and contends that the Board should consider the report.

In Donald Young, 35 Van Natta 143 (1983), we stated that:

> ". . . [A]s a general rule, the provisions of OAR 436-83-400(3) should be strictly applied by the Referees, subject to limited exceptions where it appears that, in the exercise of due diligence, the late submission could not reasonably have been made available at an earlier date, or was not timely filed with the Hearings Division and provided to opposing counsel due to forces beyond the control of the party offering the exhibit."

On the other hand, claimant argues that:

> "The purpose of the ten-day rule is to prevent surprise and to allow adequate preparation. The carrier's attorney was unable to call [the] referee's attention to any surprise, was unable to advise the Referee of any need for further preparations or additional post hearing activities that would result from admitting this [exhibit]. In view of the fact that . . . the purpose of Workers'

> Compensation hearings is to obtain substantial justice, it was error to deny admitting the report, and the report should have been so admitted, absent some showing of prejudice, or a showing that admitting the report would additionally delay the proceeding in progress."

Claimant here does not contend that the exhibits in question could not have been furnished to the Referee in a timely manner or that the failure to do so was attributable to forces beyond his control. In his brief on review claimant's counsel contends that he had not taken note of the insurer's failure to include the exhibits in question in the insurer's list of exhibits furnished to the Referee. We have searched the record and do not find that representation was made at the hearing. For the reasons that follow we find that omission critical to our determination concerning the admissibility of the document in question and affirm the Referee's action in refusing to admit the document.

This case appears to fall squarely within the rule quoted above from the Young case. In deciding Young, we considered a number of other recent Board cases interpreting the 10-day rule, including Minnie Thomas, 34 Van Natta 40 (1982), Ronald Bronski, 34 Van Natta 612 (1982), Darryl G. Warner, 34 Van Natta 634 (1982), and Fred Hanna, 34 Van Natta 1271 (1982). In Thomas and Warner the party objecting to the admissibility of proffered exhibits had not been furnished with copies of the exhibits prior to the hearing. Likewise, in Bronski the Referee distinguished between the admissibility of numerous exhibits offered in violation of the 10-day rule based upon whether the adverse party had been furnished copies of the exhibits prior to the hearing; he admitted those exhibits which previously had been furnished to the claimant and excluded those which had not. Also, in Warner the claimant on review sought remand to the Referee for consideration of the proffered evidence. A remand in that case would have involved the scheduling of another hearing and occupying the Referee's time reconsidering the case in light of the additional evidence. We pointed out that what may be substantial justice for the claimant involved in the remanded case creates injustice for other claimants awaiting their hearing.

In Hanna, exhibits in question had been in the possession of the other party well in advance of the hearing but due to inadvertence, had not been furnished to the Referee in a timely manner. In Hanna we noted that the forum has an interest that transcends the strategic interests of the litigants in having proposed exhibits furnished to the Referee in a timely manner. Timely provision of proposed exhibits to the forum enables the Referee to be prepared for a hearing which in turn facilitates his or her ability to be familiar with the issues and nature of the evidence, rule on objections and otherwise maintain control of the hearing process and decide the case in a timely manner.

The latter was a critical factor in Donald Young because no exhibits whatsoever had been furnished to the Referee prior to the hearing. Obviously, the Referee was seriously prejudiced in his ability to be acquainted with the issues and the nature of the evidence. Moreover, had the parties gone forward with the hearing,

a substantial amount of time would have been devoted to arranging and marking exhibits.

Thus, in each of these cases, the factors relied upon in the course of determining the admissibility of evidence offered in violation of OAR 436-83-400(3) were: (1) The presence or absence of an element of strategy on the part of the parties, (2) surprise and prejudice to the party objecting to the proposed exhibits, or (3) prejudice to the Referee and/or potential prejudice to other litigants. Although this case appears to fall within the Young interpretation of OAR 436-83-400(3), most of the factors relied upon in Young and the other cases are not present here: SAIF, the party objecting to admission of the evidence, did not dispute claimant's contention that SAIF was not surprised or prejudiced in the presentation of its case at hearing; it does not appear that it would have been necessary to leave the record open for post-hearing depositions or other litigation; and, the Referee's ability to control the hearing or decide the case in a timely manner was not impaired. We believe that it is implicit in the Young interpretation of the 10-day rule that there be some underlying actual or potential prejudice to somebody.

However, claimant offered no excuse or explanation for his own failure to comply with the 10-day rule. Had he done so, there would have been a basis for the Referee to determine whether claimant's failure to comply with the rule was a matter of inadvertence or an attempt to gain a strategic advantage. In his brief before the Board claimant offers the explanation to the effect that he did not note SAIF's failure to include two medical reports in its submission of documents to the Referee; in effect, inadvertence in the preparation of claimant's case. Had we been able to make such a finding based on the representations of counsel at hearing and the record before the Referee we would be inclined to reverse the Referee's ruling on the evidentiary question. However, on the record before us (as distinguished from claimant's representations in his brief) claimant's failure to submit the exhibits in question may have been a matter of strategy rather than mere inadvertence. Under such circumstances even if in retrospect no one was prejudiced by the claimant's failure to abide by the rule, we cannot say that the Referee erred in excluding the proffered exhibit.

In deciding this issue as we have, we want to emphasize that the thrust of Young is to the effect that a party offering an exhibit in violation of the 10-day rule has the burden of showing good cause for admitting the exhibit. Young purports to recognize certain fact situations as constituting good cause for a failure to comply with the 10-day rule, without considering the possibility that there may be other factual situations that would also constitute good cause for failing to comply with the rule. We have discussed at some length our reasons for affirming the Referee in this case because of concern that the phraseology of the rule in Young is overly restrictive in that it emphasizes certain factual situations which will always constitute good cause for not complying with the rule (i.e., the party's reason for failing to comply with the rule) without considering the possibility of other factual situations that also would constitute good cause. We continue to favor strict enforcement of the exclusionary rule where a party offering an exhibit in violation of the 10-day rule is unable to

satisfy the burden of proving good cause for admitting the exhibit into the record. We are suggesting the possibility, however, that where the record reveals mere inadvertence on the part of the party offering an exhibit together with the absence of prejudice to the adverse party, the Referee or other litigants, good cause may exist for admitting an exhibit notwithstanding a technical failure to comply with the rule.

In this case we believe the claimant articulated a partially adequate reason for admitting the Orthopaedic Consultants' report; namely, the absence of prejudice to the adverse party, the Referee or other litigants. However, claimant failed to provide an adequate explanation at hearing for his failure to comply with the 10-day rule. Under these circumstances, the Referee correctly refused to admit the exhibit offered by claimant.

II.

Even if we considered the Consultants' report, it would not change our assessment of the extent of claimant's impairment or disability. Based on our de novo review of the record, exclusive of the Orthopaedic Consultants' report, we are satisfied that claimant is not permanently and totally disabled for purposes of workers' compensation. The most that the Consultants' report does is to relate part of claimant's present condition to the compensable injury and indicate that the level of impairment is in the "lower limits of the mildly moderate category." It is apparent from the rest of the record that a great deal of claimant's present impairment is due to the natural and post-injury progression of his dorsal spondylosis. A mildly moderate impairment as suggested by the Consultants' report would be in the 20% to 40% impairment range. Based on the record other than the Consultants' report, we believe that the extent of claimant's impairment is greater than that allowed by the Referee (less than 10%) but less than the 20% to 40% characterized by the Consultants' report.

We rate claimant's impairment at 15%. This impairment rating is based on the evidence indicating that claimant has a chronic back strain, that claimant's osteoarthritis which was asymptomatic prior to the traumatic injury was worsened to a minimal degree by the injury, and that much of claimant's present impairment is attributable to the post-injury progression of an underlying and noncompensable condition.

We rate the social/vocational factors as follows: age (+10), education (+10), work experience (0), adaptability (+12) (our rating here is based on the fact that claimant's functional capacity went from heavy work to somewhere between light and sedentary work), mental capacity and emotional/psychological factors (0), and labor market findings (+15, based on a residual functional capacity for light to sedentary work, a vocational preparation potential of 2 and a general education development level of 1 to 2). Combining these values in the manner provided in OAR 436-56-601 yields a 50% disability figure. Comparing this case to similar cases, we believe a 50% disability award accurately represents the amount of disability claimant has experienced attributable to the compensable portion of his condition.

SAIF argues that claimant's failure to accept a position

offered to him means that claimant is lacking in motivation and that claimant is, therefore, entitled to substantially less permanent disability. SAIF also argues that claimant, a 56-year-old man who has worked as a hod carrier virtually his entire working life, failed to make a reasonable work search apart from his failure to accept proffered employment. Before claimant became medically stationary, the employer offered to take him back scraping mortar off the walls and further represented that claimant would not have to bend or stoop below two or three feet from the ground because someone else would get the lower levels. We are satisfied that no such job exists generally in the labor market.

With respect to claimant's job search, SAIF's brief misstates the evidence. Claimant introduced a notebook indicating the jobs claimant had applied for since being released to return to work. The notebook starts only about two months prior to the hearing. SAIF characterizes this evidence as indicating that claimant did not begin looking for work until his attorney advised him that motivation would be an issue at the hearing. In fact, the evidence is that claimant was looking for work prior to starting the journal but was not keeping a record until being advised that he would have to furnish proof of his work search. SAIF also criticizes claimant for applying for work which the claimant did not think he could handle, such as working in a filling station. We have taken the position that, where the claimant is not disabled based solely on medical and social/vocational factors, in order to establish entitlement to permanent and total disability the claimant should at least try to work, inasmuch as attempting to perform light and sedentary work is the acid test of disability. Keith Phillips, 35 Van Natta 388 (1983). Claimant should not be faulted for seeking work which he may or may not be able to perform, particularly when the vocational expert also was not able to identify any jobs the claimant could perform considering both his compensable and noncompensable conditions.

ORDER

The Referee's order dated September 7, 1982 is modified. Claimant is awarded 160° for 50% unscheduled permanent disability in lieu of all previous awards arising from this claim. Claimant's counsel is allowed 25% of the disability award as an attorney's fee, up to a maximum of $3,000, in lieu of the Referee's allowance of attorney's fees.

Board Member Barnes Concurring in Part:

OAR 436-83-400(3), which the Board majority here interprets but interestingly does not quote, requires that "not less than 10 days prior to the hearing each party shall file with the assigned Referee and provide all other parties with legible copies of all medical reports and other documentary evidence upon which the party will rely. . . ." In Minnie Thomas, 34 Van Natta 40, 41 (1982), we referred to OAR 436-83-400(3) as "a simple, unambigous rule which is designed to effectuate the entire hearing process." The Board has not amended OAR 436-83-400(3) since we made that statement in

Thomas. But our Referees, reading the rambling essay my Board colleagues have signed today, might reasonably think the simplicity of OAR 436-83-400(3) is gone.

However, I believe it is important to point out that this Board remains unanimous on a few basic points about our administrative rule:

(1) OAR 436-83-400(3) is a general rule of exclusion: When a party seeks to have an exhibit admitted into evidence without having complied with the pre-hearing submission requirements of OAR 436-83-400(3), generally the exhibit will not be admitted.

(2) The general rule of exclusion is subject to a good-cause exception: When a party seeks to have an exhibit admitted into evidence without having complied with the pre-hearing submission requirements of OAR 436-83-400(3) and the party in noncompliance with that rule offers some cogent and reasonable explanation for noncompliance with that rule, the exhibit will be admitted.

(3) It is important to keep straight what is the general rule and what is the exception, and to interpret and apply the good-cause exception sparingly so that it does not eventually consume the general rule of exclusion.

Of course, it is probably easier to agree on abstractions -- and I think we do -- than to agree on specific applications. I may be on a collision course with my Board colleagues about one specific application of the good-cause exception to the requirements of OAR 436-83-400(3). By way of dicta in this case, the majority hints that, in some not-very-clearly-defined circumstances, attorney "inadvertence" might be good cause for noncompliance with OAR 436-83-400(3). I lean the other way. As we have often concluded in the context of questions about reopening the record or remanding for introduction of additional evidence, attorneys for both sides are expected to marshal the evidence pre-hearing. E.g. Ruth M. Case, 33 Van Natta 490 (1981). Given this conceptualization, I am unsure what an attorney's "inadvertent" preparation for hearing would be -- and I think pre-hearing preparation includes pre-hearing submission of proposed exhibits as required by OAR 436-83-400(3). Rather than belabor this point in additional dicta, I await the specific facts of future specific cases to learn more about how an attorney's hearing preparation could be "inadvertent" and then to decide whether all of the circumstances indicate good cause for noncompliance with OAR 436-83-400(3).

I express no view on the extent of claimant's disability.

DENNIS M. KELLEY, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05784
June 30, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Seymour's order awarding claimant 25% unscheduled permanent partial disability for injury to his low back. SAIF contends the Determination Order, which granted no permanent disability should be reinstated.

Claimant is a former diesel mechanic who was 34 years old at the time of hearing. He suffered a compensable low back injury on March 21, 1979 when he slipped while changing a tire. An earlier Referee's order found his low back condition compensable. That order was not appealed, so the compensability of his low back condition is res judicata.

The Referee found, and we agree, that claimant's low back impairment is minimal. We base that conclusion on the Orthopeadic Consultants' report which states: "The total loss of function as it exists today is felt to be minimal."

The Referee stated that he applied the rules for rating unscheduled disability found in OAR 436-65-600, et seq. We, too, apply those rules; however, our calculations yield a disability rating of 15% rather than the 25% awarded by the Referee.

We assign a +5 figure based on claimant's minimal impairment. We assign a -1 figure based on claimants age of 34 at the time of the hearing. We assign a +10 figure based on his previous work experience as a diesel mechanic which takes a significant amount of time to learn. We assign a +5 figure for adaptability because he was capable of doing heavy work prior to his injury but is now only capable of doing medium work. We assign a -25 figure for labor market findings because, according to the guidelines in OAR 436-65-608, a claimant with his education, experience and physical capacity has 78% of the labor market open to him. Combining those figures according to the chart which accompanies the rules we arrive at a figure of 13.26. After rounding that figure to the nearest 5, we arrive at a 15% unscheduled disability rating. We find 15% to be in accordance with similar cases with comparable injuries.

ORDER

The Referee's order dated November 8, 1982 is modified. Claimant is awarded 48° for 15% unscheduled permanent partial disability for his low back condition in lieu of all other awards of compensation for his low back. Claimant's attorney's fee should be adjusted accordingly.

JENNETTE B. LEHMAN, Claimant
Allen & Vick, Claimant's Attorneys
Wolf, Griffith, et al., Defense Attorneys

WCB 82-02352
June 30, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review and the insurer cross-requests review of Referee Braverman's order which: (1) Awarded claimant benefits for temporary disability in addition to such benefits awarded by the December 10, 1981 Determination Order; and (2) awarded claimant 15% permanent partial disability, the Determination Order not having awarded any compensation for permanent disability. Claimant contends that the Referee's permanent disability award is inadequate. The insurer argues that the award is excessive and also challenges the Referee's award of additional compensation for temporary disability.

We affirm and adopt those portions of the Referee's order relating to the extent of claimant's permanent disability.

We disagree with the Referee's conclusion regarding the proper period of temporary disability. The Determination Order granted claimant temporary total disability from November 2, 1981 through December 10, 1981, the date her treating physician released her to modified work, and temporary partial disability from December 11, 1981 through December 31, 1981, the date her treating physician found her to be medically stationary. The Referee ordered that claimant be paid compensation for temporary total disability to February 7, 1982.

There is no issue about the difference between temporary total and temporary partial disability. Since claimant did not actually return to work until February 8, 1982, under OAR 436-54-222 her benefits for temporary total and temporary partial disability were the same.

The Referee's initial order that more benefits for temporary disability be paid explained:

> "Dr. Hendricks authorized claimant to return to her . . . job . . . in December of 1981 but required modification of the job duties to accommodate claimant's impairment and restrictions. These work modifications were not completed until approximately February 8, 1982 when claimant did return to work. Therefore, claimant is entitled to temporary total disability benefits to February 7, 1982."

We are not aware of any legal doctrine under which the Referee's third sentence, starting, "[t]herefore," follows from the prior two sentences.

In denying reconsideration on this issue, the Referee elaborated:

"The term 'medically stationary' is not talismatic . . . . The evidence, I concluded, demonstrated that claimant became stationary for temporary total disability benefits purposes on February 7, 1982, when she returned to modified work."

We do recognize that doctrine: An injured worker has a right to benefits for temporary disability until he or she becomes medically stationary.

The only evidence we find on that point in this record is the statement of claimant's treating doctor that claimant was medically stationary on December 31, 1981. The Referee does not cite, nor can we find, any evidence in this record that supports any other conclusion.

Since claimant has not proven she was other than medically stationary on December 31, 1981, it follows that the insurer is entitled to setoff its overpayment of $475.97 pursuant to OAR 436-54-320.

ORDER

The Referee's order dated August 31, 1982 is affirmed in part and reversed in part. That portion of the Referee's order which awarded benefits for temporary disability in addition to those granted by the January 25, 1982 Determination Order is reversed. The remainder of the Referee's order is affirmed.

DAVID H. McNAMARA, Claimant
Galton, et al., Claimant's Attorneys
William Beers, Defense Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-03552 & 82-03553
June 30, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Mulder's order affirming the denials of the SAIF Corporation and Western Insurance for his low back condition which required treatment in early 1982. The Referee refused to award interim compensation or a penalty for Western's alleged failure to accept or deny a claim as required by statute.

We agree with the Referee that claimant has failed to prove that he has a compensable condition attributable to either employment. Accordingly, we affirm and adopt those portions of the Referee's order relevant to the propriety of the two denials.

We disagree, however, with the Referee on the issue of failure to pay interim compensation. The uncontroverted evidence is that claimant submitted an 801 claim form to his employer on January 20, 1982. The employer misguidedly relied on the advice of an investigator for SAIF and, therefore, failed to submit the 801 form to his workers' compensation insurer, Western, until March 10, 1982. Western did not issue a denial until April 23, 1982.

ORS 656.262 requires an employer to begin paying interim compensation "no later than the 14th day after the subject employer has notice or knowledge of the claim." Interim compensation is to be paid pending acceptance or denial of the claim. The Referee found that "the evidence did not show that communication between claimant and the employer was sufficient to charge the employer with 'effective' knowledge." We disagree. The employer's receipt of the 801 form was certainly sufficient to charge him with knowledge that the claimant not only had filed but was filing a workers' compensation claim. His misplaced reliance on the investigator for another insurance company does not excuse failure to pay interim compensation. Accordingly, we find that the insurer was obligated to pay interim compensation after receipt of the 801 form on January 20, 1982 until his doctor verified he was able to return to work on March 15, 1982. We also assess a 25% penalty for failure to pay interim compensation as required by statute.

ORDER

The Referee's orders dated January 4, 1983 and January 14, 1983 are affirmed in part and reversed in part. Those portions of the Referee's order affirming the denials of SAIF and Western Insurance are affirmed. Those portions of the Referee's order relating to the issue of interim compensation are reversed. Western is ordered to pay claimant interim compensation consistent with this order plus a 25% penalty calculated on those amounts. Claimant's attorney is awarded $300 as an insurer-paid attorney's fee pursuant to ORS 656.382(1); and further is allowed a reasonable attorney's fee equal to 25% of the interim compensation made payable to claimant under the terms of this order, not to exceed $300, payable out of and not in addition to claimant's interim compensation.

GARY S. MEYER, Claimant
Robert Johnstone, Claimant's Attorney
Schwabe, Williamson et al., Defense Attorneys

WCB 82-04237
June 30, 1983
Order Denying Motion to Dismiss

The Board has received respondent's motion for dismissal of claimant's request for Board review on the grounds that claimant has not filed an appellant's brief.

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

Respondent is granted 20 days from the date of this order in which to file a brief.

IT IS SO ORDERED.

ERNEST R. MURDOCK, Claimant
Karol Wyatt Kersh, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-08300 & 81-08301
June 30, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Danner's order which affirmed the Determination Orders of April 17 and August 4, 1981 which awarded claimant no benefits for permanent partial disability for injury to his low back and right shoulder. The issue for review is extent of disability.

SAIF, as "cross-appellant," contends that the Referee erred in admitting Exhibit A-11 (p2) in violation of OAR 436-83-400(3). However, despite the SAIF Corporation's contention that it is a "cross-appellant," there is nothing in the record which indicates that SAIF ever filed a request for Board review of the Referee's order. Even assuming that the Referee did err in admitting the document, it is immaterial, for we find that he reached the correct conclusion in this case, and we would so conclude with or without benefit of Exhibit A-11 (p2). We, therefore, affirm and adopt his order.

ORDER

The Referee's order dated January 21, 1983 is affirmed.

CHARLES E. PARR, Claimant
Kenneth M. Montgomery, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07106
June 30, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of that portion of Referee Pferdner's Order on Reconsideration that declined to reopen the evidentiary record for receipt of additional evidence submitted after the hearing. Claimant does not contest the merits of the issues decided in the Referee's original order dated September 17, 1982; claimant challenges only the Referee's Order on Reconsideration dated October 12, 1982.

On August 9, 1982 the Board received claimant's Application to Presiding Referee to Schedule Hearing which certified: "The claimant is ready for hearing and is prepared with all medical reports and other evidence." Pursuant to claimant's request, an expedited hearing was scheduled and held September 8, 1982. The Referee's order, that was issued promptly on September 17, 1982, was adverse to claimant's position that he was entitled to additional compensation for permanent disability. After receipt of that order, and contrary to claimant's prior certification that he was "prepared with all medical reports and other evidence," claimant moved to reopen the record for the introduction of reports from Dr. Gritzka dated October 4, 1982 and October 20, 1982.

We agree with the Referee's decision not to reopen the record. As the Referee put it: "After having the benefit of the

[Referee's] comments [in his original order] on the evidentiary deficiency, claimant sought a new physician and now asks the trier of fact to give him a second chance." As the SAIF Corporation's brief puts it:

> "Indeed, claimant requested and received an expedited hearing. Claimant must be presumed to have understood that an accelerated gathering of evidence attends such scheduling."

See also Ora M. Conley, 34 Van Natta 1698 (1982); Robert A. Barnett, 31 Van Natta 172 (1981).

ORDER

The Referee's orders dated September 17, 1982 and October 12, 1982 are affirmed.

JESUS RIVERA, Claimant
Philip Nelson, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 81-08534
June 30, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Knapp's order which approved the employer's September 3, 1981 denial of compensability, and found claimant entitled to no benefits for interim compensation, nor to penalties and attorney fees.

Claimant contends that on November 7, 1979, while working for a seafood cannery, his back was injured when three or four fish fell on him while he was working in the hold of a boat that was docked and being unloaded. At some subsequent point the employer understood that claimant was alleging an on-the-job injury. The employer first processed that claim under the Federal Longshoreman's and Harbor Workers Compensation Act (LHWCA). A form of interim compensation benefits were paid to claimant under LHWCA from December 10, 1979 to January 27, 1980. On the latter date the employer denied the LHWCA claim.

On April 16, 1980 a claims examiner from the United States Department of Labor presided over some type of informal conference in connection with the LHWCA claim. Claimant and the employer were represented by counsel at that conference. The examiner took the position that claimant's claim did not properly arise under the LHWCA because claimant's work activities did not meet the definition of maritime employment. Claimant did not thereafter pursue a LHWCA claim through whatever administrative processes were available.

Apparently some time in August 1981 claimant's attorney advised the employer or the employer's attorney that benefits were being claimed under the Oregon Workers' Compensation Law. The employer issued a denial of claimant's state claim on September 3, 1981. No issue is raised concerning the informality of that denial, probably because claimant obviously understood what was

intended sufficiently to promptly request a hearing on September 10, 1981. The matter proceeded to hearing on June 24, 1982 and, as previously stated, the Referee denied claimant all relief requested.

Claimant apparently does not dispute the Referee's finding on the issue of compensability. The Referee, with good reason, found claimant to be somewhat less than credible. Rather, the claimant only contends that he is entitled to interim compensation benefits from January 28, 1980, at which time his claim was controverted under the LHWCA, until the employer's September 3, 1981 denial of benefits under the Oregon Workers' Compensation Law.

The Referee concluded that claimant had elected to take advantage of the more beneficial aspects of the LHWCA. Claimant argues that it was the employer who decided to treat his claim as one arising under the LHWCA, that he at no time asked that his claim be treated under that Act, that he had no idea when he reported his injury whether it was a federal or state claim and that it is not his obligation to make that decision. That being the case, claimant contends that the employer is responsible for interim compensation benefits from the time benefits were terminated under the LHWCA until the September 3, 1981 denial under the state law.

We basically agree with claimant's thesis. While we do not know or particularly care to know the procedural details of other compensation programs, Oregon law only requires a worker to give notice of a claim to his or her employer. ORS 656.262, 656.265. After receipt of such notice, it is the responsibility of the employer to process the claim or forward the claim to the responsible entity (insurer) for processing. ORS 656.262. Thus, at least as a matter of Oregon law, it is not the responsibility of a worker who is subject to possible concurrent or alternative coverage for an on-the-job injury to determine which coverage his claim properly falls under.

The employer in this case responds, however: (1) Any worker can specifically determine on his or her own or through counsel that a claim will be pursued only under one benefit program and that any possible alternative claims will be waived; and (2) the claimant in this case did just that, i.e., elected to pursue a LHWCA claim and thus waived a state compensation claim. We find it unnecessary to reach the employer's first/legal proposition because we disagree with the employer's second/factual proposition. There are, admittedly, indications in the testimony that claimant elected to pursue his claim under the LHWCA and only under the LHWCA. There are also indications to the contrary. On this record we are unwilling to find that there was any election of remedies that constituted a waiver of a possible state compensation claim (assuming arguendo that such waiver is legally possible under state law).

The facts, then, are that claimant notified his employer that he was claiming an on-the-job injury in November or December 1979; that no denial under state law was issued until September 1980; and that no state interim compensation was paid between those dates.

As we understand his position, claimant does not contend that he should receive state interim compensation for the same period of time during which he received LHWCA compensation; rather, claimant apparently asks only for state interim compensation from January 28, 1980 to September 3, 1980.

For reasons already indicated, we agree claimant should receive state interim compensation starting on January 28, 1980. We do not agree, however, that the interim compensation should run until September. In Anna M. Scheidemantel, 35 Van Natta 740 (May 31, 1983), we concluded that interim compensation need not be paid beyond an injured worker's full release to return to regular work. In the current case, Dr. Cottrell reported on June 12, 1980 that he had last seen claimant on April 14, 1980, at which time:

> ". . . I authorized him to return to work. I also advised him that I was not willing to treat him any further, since I felt there was no further medical treatment that I could offer him which would do any good."

Therefore, under Scheidemantel, claimant is entitled to interim compensation from January 28, 1980 to April 14, 1980.

Claimant raises no issue before the Board with regard to penalties and attorney's fees. Even if such issues were raised, we do not feel that this would have been an appropriate case for such sanctions considering the vagueness of the record and the general confusion that seems to have surrounded this matter.

ORDER

The Referee's order dated July 21, 1982 is affirmed in part and reversed in part. The employer is ordered to provide claimant with benefits for interim compensation from January 28, 1980 through April 14, 1980. Claimant's attorney is allowed an attorney's fee of 25% of such compensation, not to exceed $750. The remainder of the Referee's order is affirmed.

GARY P. ROSE, Claimant
Evohl F. Malagon, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 80-06067
June 30, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of those portions of Referee Baker's orders requiring the insurer to pay interim compensation and a penalty and attorney's fee for failing to pay interim compensation.

Claimant sustained a compensable low back injury on April 27, 1979. The claim has been closed with a total of 25% unscheduled disability. On October 21, 1981 claimant was evaluated by Dr. Wichser. Dr. Wichser wrote a letter to the insurer on October 29, 1981 in which he noted that he agreed with the other doctors that an operation would not help claimant's condition. However, he opined that a rheumatologist might be able to treat claimant's muscle spasms and thus alleviate his pain. He then stated:

"Therefore, I would urgently request that Mr. Rose's medical case be reopened for medical treatment by rheumatologists and physical therapists....

"If Mr. Rose is willing to participate in further medical treatments, there are some logistical problems involved....I would estimate that his rehabilitation would require some three to six months....Therefore, for the initial period of rehabilitation (or at least evaluation) some time loss benefits should be allowed, presumably starting when medical treatments resume."

Dr. Wichser's report is clearly an aggravation claim which triggers an obligation on the part of the insurer to accept or deny within 60 days pursuant to ORS 656.262(6). However, the duty to pay interim compensation within fourteen days is only triggered on an aggravation claim if there is "medically verified inability to work resulting from the worsened condition." ORS 656.273(6).

Dr. Wichser's report does not provide medical verification of claimant's inability to work. Rather, it states that claimant will (or might) become unable to work once he begins the suggested treatments. It even states specifically that time loss should not begin until claimant submits to the suggested treatments. Consequently, we conclude that the insurer was under no obligation to pay interim compensation to claimant based on Dr. Wichser's report.

Accordingly, we reverse the Referee on the question of the insurer's duty to pay interim compensation. Because the insurer was under no obligation to pay interim compensation, imposition of a penalty and attorney's fee for failure to pay interim compensation is, of course, inappropriate. We, therefore, reverse the Referee on those issues also.

Although the insurer failed to accept or deny the aggravation claim within 60 days in violation of ORS 656.262(6), the Referee found the aggravation claim to be noncompensable. That finding is not challenged on review. There is thus nothing due upon which to base a penalty.

ORDER

The Referee's orders dated September 22, 1982 and December 9, 1982 are affirmed in part and reversed in part. Those portions which awarded interim compensation, penalties and attorney fees are reversed. The balance of the Referee's orders is affirmed.

DARRELL L. ROTHENFLUCH, Claimant
Pozzi, et al., Claimant's Attorneys
Wolf, Griffith, et al., Defense Attorneys

WCB 81-09620 & 81-04234
June 30, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Williams' order which: (1) Affirmed the August 6, 1981 Determination Order which had awarded claimant 15% unscheduled permanent shoulder disability as a result of his compensable injury of July 9, 1980; and (2) upheld the insurer's denial of claimant's low back aggravation claim. The issues are extent of disability and the compensability of claimant's low back aggravation claim.

The Referee did an excellent job of summarizing the conflicting (and often confusing) facts in this record. We thus adopt the Referee's findings of fact as our own.

With regard to the issue of extent of disability, we affirm. We agree with the insurer that the only body areas in which claimant has proven any possible impairment due to the July 1980 injury are the neck and right shoulder areas. However, there is a dearth of medical evidence indicating that claimant has any permanent impairment in these areas. Claimant's treating physician, Dr. Hazel, reported on May 20, 1982 that claimant's July 1980 shoulder injury did not cause claimant's degenerative disc disease but may have contributed some to the symptomatology. He indicated that this was only transient and that there were no permanent effects on the underlying condition. Additionally, Dr. Hazel specifically stated that, with regard to claimant's right shoulder, "[H]e does not have any limitation of motion referrable to his shoulder from his July 1980 injury." On this record, we agree with the Referee that claimant has not proven entitlement to greater disability than the 15% award granted by the Determination Order.

The question of claimant's low back aggravation claim is more difficult. Claimant suffered a compensable injury on January 22, 1980, apparently diagnosed as a low back strain. The medical evidence surrounding this event is extremely sketchy; it appears that claimant received only chiropractic treatment for the injury and returned to work approximately two weeks later, on February 15, 1980, with no permanent impairment as a result of that injury.

In 1952 claimant sustained a back injury and has experienced approximately 30 episodes of back pain of varying intensity over the years subsequent to that injury. The medical reports subsequent to claimant's July 1980 shoulder injury are somewhat confusing and contain various histories and report numerous and varied complaints concerning nearly every part of claimant's body. It seems clear, however, that claimant did not injure his back in July of 1980. It also seems clear that claimant has degenerative disc disease at several levels in his back. There is no medical report which relates claimant's current low back problems to either his January 1980 or July 1980 industrial injuries. We believe the Referee was correct in analogizing the facts of this case to the situation presented in Hall v. Home Insurance & American Motorists, 59 Or App 526 (1982). But see Boise Cascade Corp. v. Starbuck, 61 Or App 631 (1983). We, therefore, also affirm the denial portion

of the Referee's order.

ORDER

The Referee's order dated October 6, 1982 is affirmed.

ROSALIE SHELDON, Claimant
Cash Perrine, Claimant's Attorney
J.W. McCracken, Jr., Defense Attorney

WCB 82-06484
June 30, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The self-insured employer requests review of Referee Williver's order which set aside its partial denial to the effect that claimant's spondylolisthesis, congenital hip condition and "underlying degenerative changes" were neither caused nor aggravated by claimant's December 6, 1979 industrial injury. We reverse the Referee's order and reinstate the employer's partial denial.

Claimant, who was 28 years of age at the time of the hearing, had been employed by the Weyerhaeuser Company in the shipping department of its Springfield plant. On December 6, 1979 claimant twisted her hip when she slipped on some grease and noticed hip pain later in the day after she jumped five to eight feet from a catwalk and landed on her feet. The claim was accepted by the employer on a nondisabling basis. Claimant was examined by Dr. Bre Miller on December 11, 1979. Dr. Bre Miller noted that claimant had a rather peculiar femoral neck and femoral head orientation. He diagnosed cervical, lumbar and right hip pain due to the injury and recommended light work for a short period of time.

On March 25, 1980 claimant was examined by Dr. Collis, who also noted that claimant had a slightly deformed femoral head, bilaterally, and that there was some slight degenerative change with mild spurring present. He diagnosed a hip strain which would gradually improve, but he cautioned that claimant's degenerative condition might eventually require surgery and recommended no activities which would be strenuous to her hips.

In September 1980 claimant became employed by Diamond International as a clean-up person. She was not seen by any physician again for hip pain until she was examined by Dr. Sulkosky on May 22, 1981. Dr. Sulkosky reported that claimant was experiencing hip pain and he diagnosed possible spondylolysis, L5-S1, mild coccyvalga deformity with femoral neck changes. He informed claimant that he did not feel she had any injury of significance and that no treatment was recommended.

On September 8, 1981 claimant presented herself to Dr. Kendrick, a neurosurgeon, complaining of low back, hip and leg pain of a very generalized nature. He noted that there were no previous indications that she had experienced leg pain, and:

> "In any event, she is now approximately seven months pregnant and continues to have pain in the back, which she states pre-dated

her pregnancy and continues to have the same hip pain, together with leg pain radiating . . . ."

Claimant thereafter treated with Dr. Lang, a chiropractor, for her low back pain. Dr. Lang reported on January 12, 1982 that there was no doubt that claimant's pregnancy did contribute to her back pain, but that he did not believe it was the cause of all of her low back problems. Claimant also continued to treat with Dr. Kendrick, who reported on January 12, 1982:

> "Therefore, I would say that her current problems are possibly related to her injury, but I cannot definitely say that they are with any degree of certainty at all. With regard to whether or not her pregnancy is contributing to her current back problems, yes, indeed, I would think that whether she had or did not have an industrial injury, her back problems could easily be aggravated by pregnancy and, of course, nothing further should be done until that is concluded. I certainly don't think that any present disability would be on the basis of her back as much as on the basis of the pregnancy in its advanced state."

Dr. Kendrick also speculated that claimant could have injured a disc in December 1979. However, on March 12, 1982 he reported that x-rays revealed a slight spondylolisthesis at L5-S1. Following the birth of her child, claimant returned to work at Diamond International.

On June 22, 1982 Weyerhaeuser issued the partial denial here in issue, which states:

> "Weyerhaeuser Company accepts responsibility for the strain sustained to your right hip and leg on 12-6-79, but hereby denies responsibility for the treatment of the following conditions:
>
> 1) Spondylolisthesis
>
> 2) Congenital hip condition
>
> 3) Underlying degenerative changes"

On August 9, 1982 Dr. Lang reported that the 1979 injury to the right hip did cause a lumbosacral and sacroiliac strain which required treatment on April 27, June 7 and June 14, 1982.

Following a hearing on the matter, the Referee ordered that this partial denial be set aside. The basis for the Referee's conclusion is somewhat obscure. He stated only that claimant had no difficulties prior to the injury and that subsequent to the injury all of her underlying conditions became symptomatic.

Although the issue is not well developed in the record, we do not understand the employer to be contending that claimant's back strain is not a compensable consequence of her December 1979 injury. Claimant's back strain has required some minor chiropractic treatment, as noted by Dr. Lang, which the employer has apparently paid for pursuant to ORS 656.245. It thus appears that claimant's low back strain remains a part of the accepted nondisabling hip/leg injury claim.

The employer only denied responsibility for claimant's underlying back and hip conditions. We conclude that the partial denial was proper because there is absolutely no evidence which indicates that these conditions were either caused or aggravated by the 1979 injury. Neither Dr. Collis nor Dr. Kendrick diagnosed anything other than a strain as a result of the 1979 injury. Even Dr. Altrocchi, who examined claimant at the request of her attorney, did not believe that claimant's underlying hip and back condition had anything to do with her current problems. In short, the record is completely devoid of any evidence which would indicate that claimant's 1979 injury had any effect on her underlying conditions whatsoever.

ORDER

The Referee's order dated November 2, 1982 is reversed. The employer's partial denial dated June 22, 1982 is reinstated and affirmed.

JUNE M. SMITH, Claimant
Evohl F. Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-05682
June 30, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Danner's order affirming a Determination Order awarding 10% scheduled disability for the left forearm and 15% scheduled disability for the right forearm. Extent of disability is the only issue on review.

After a review of the record it appears that neither the Determination Order nor the Referee considered claimant's marked loss of grip strength. OAR 436-65-530 provides that loss of grip strength due to neurological problems should be considered in awarding scheduled forearm disability. Claimant's loss of grip strength due to bilateral carpal tunnel syndrome is neurological.

We, therefore, find claimant is entitled to an additional 25% scheduled disability to her left forearm for a total scheduled disability award of 35% to her left forearm; and an additional 30% scheduled disability to the right forearm for a total scheduled disability award of 45% to her right forearm.

ORDER

The Referee's order dated November 12, 1982 is reversed. Claimant is awarded 25% scheduled disability to her left forearm in addition to previous awards. Claimant is awarded 30% scheduled disability to her right forearm in addition to previous awards. Claimant's attorney is allowed 25% of the increased compensation not to exceed $3000

TERRY VATLAND, Claimant
Coons & McKeown, Claimant's Attorneys
Brian Pocock, Defense Attorney
SAIF Corp Legal, Defense Attorney
David O. Horne, Defense Attorney

WCB 81-04425, 81-05605 & 81-07692
June 30, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Wausau Insurance Company and its insured, Roseburg Lumber Company, request review of those portions of Referee Danner's order which found that claimant had sustained an aggravation of a prior compensable injury and assigned responsibility to Wausau. Wausau contends that the claimant's condition as of February or March 1981 is a new condition arising from claimant's employment with Silver King Mines, insured at the material time by the SAIF Corporation. In the alternative, Wausau requests that this case be remanded to the Referee for consideration of new evidence.

I.

In February 1976, at the age of 21, claimant sustained a low back injury while working for Roseburg Lumber Company. The condition was diagnosed as a lumbosacral strain with some element of degenerative disc disease. Claimant was released to return to work in April 1976 and did return to work. In August 1976 claimant injured his low back while riding a motorcycle. Claimant's treating physician, Dr. Young, opined that claimant's condition following the motorcycle accident significantly worsened, that there may have been some progression of the February 1976 industrial injury but that the motorcycle incident was a new injury and necessitated surgery to repair a protruding disc. Wausau denied further responsibility for claimant's low back condition after the motorcycle incident. After hearing in a prior proceeding, a Referee set aside that denial, finding in effect that claimant's back condition remained compensable, notwithstanding the intervening motorcycle accident, because the original injury remained a material cause of the post-accident condition.

The 1976 claim was closed in 1978. Dr. Young in his closing examination opined that claimant:

> "(H)as recovered well and is asymptomatic. He has no permanent impairment. He requires no further treatment."

The Determination Order nevertheless awarded claimant 5% unscheduled disability which was increased by stipulation to 10% unscheduled disability.

After the motorcycle injury and surgery, claimant returned to work at Roseburg Lumber Company until late 1977. Claimant then began working at a variety of jobs for a series of construction companies. Subsequent to those jobs, claimant moved to Wyoming where he was employed as a miner's helper. This job included lifting and positioning a 130-pound drill and considerable bending and stooping while mining ore.

In November 1980 claimant moved back to Oregon and began working as a miner for Silver King Mining. In February 1981 claimant was assigned to work laying railroad track. This work involved lifting pieces of rail weighing about 450 pounds. Throughout the

period following claimant's return to work post-surgery in 1977, and including the eight months he worked as a miner's helper in Wyoming, claimant experienced occasional back spasms and pulled muscles consistent with the type of heavy labor he was performing; but apparently he did not miss any work because of back problems. In February 1981, however, there was a specific incident claimant described as follows:

> "Then one day we put in a frog, which is a track switch, and that's the day I noticed I started having problems; they weigh something like 450 to 500 pounds. A lot of manhandling to get them in there and setting right.
>
> * * *
>
> "(T)he track is long, it's easier to use its own weight to get it in the right place. The frog, you just have to grunt and groan to get it lined up right."

Claimant experienced difficulty straightening up the next morning. By March the discomfort was sufficient enough that claimant sought medical care from a physician in La Grande. That physician authorized three weeks of time loss and provided conservative treatment. Three days before being released to work, in April 1981, claimant was involved in an automobile accident and sustained various injuries, none of which apparently involved or affected his low back. Claimant returned to work in May 1981, but after three days on the job he was unable to continue working and quit. Claimant returned to Roseburg and resumed treating with Dr. Young.

II.

With respect to medical evidence whether the above facts constituted an aggravation of the 1976 injury or a new condition, only Dr. Young rendered an opinion one way or the other. Dr. Young consistently opined that claimant's condition in March 1981 was an exacerbation of the 1976 injury and surgery. Dr. Young explained that the symptoms claimant was experiencing in 1981 were similar to those experienced in 1976, and that the same nerve root was involved. Dr. Young is a medical board certified orthopedist. He was claimant's treating physician for both the 1976 injury and, at least by May 1981, for the 1981 condition. Normally under such circumstances, absent compelling reasons, we would defer to the sole medical opinion. However, we find compelling reasons to disregard his opinion on the ultimate issue of aggravation versus new injury.

Dr. Young was questioned concerning the significance of claimant's ankle jerk reflex. Dr. Young conceded that claimant had the ankle jerk reflex following the 1977 surgery but that claimant had lost that reflex by the time of his May 1981 examination. Dr. Young explained that while loss of the ankle jerk reflex does not impair a person in any way, it is diagnostically significant. Furthermore, Dr. Young conceded that there was "something pathological going on in [claimant's] spine" which was not present previously. Counsel for one of the insurers posed a hypothetical question containing a description of the track switch incident

substantially similar to what we have found to have occurred. The following then ensued:

> Q. Okay....[Is it] more probable than not that a significant...element of the pathology that is confronting Terry presently is related to his 1977 [sic, 1976] injury?
>
> A. Yes.
>
> Q. And it's also true that a significant portion of his pathology is related to his work at the mine?
>
> A. If everybody would accept what he just read me from the standpoint of that episode -- in other words, if that fact is correct, I believe yes, I believe that's significant. I was talking about "probable" and "possible" but I believe that's significant, it changes my feeling considerably.
>
> Q. Okay.
>
> A. I believe what he described there represents an injury almost."

III.

Based on his understanding that claimant experienced a gradual onset of discomfort and pain, Dr. Young consistently opined that claimant had sustained an exacerbation of the 1976 injury/1977 surgery. Perhaps, medically, that is a correct position to take. However, given the legal standard set forth in Smith v. Ed's Pancake House, 27 Or App 163 (1976), and the evidence in this case, there is little doubt in our minds but that claimant's condition in February/March 1981 and thereafter was a new condition.

First, it is res judicata that claimant's 1976 motorcycle injury and the surgery that followed were compensable events because of the continuing material contribution from the 1976 industrial injury. However, in light of the additional contribution from the motorcycle accident together with the particular lifting episode while employed with Silver King Mines, we believe that the degree of contribution from the 1976 compensable injury has been reduced to a de minimus level, or less. Second, claimant returned to work in October 1977 and worked at a variety of heavy to very heavy work for almost three and a half years experiencing no more back pain than would be expected considering the nature of his work. Third, there was an identifiable traumatic incident in the course of claimant's employment with Silver King Mines that is consistent with a new injury and precipitated a period of increased back pain that culminated in an extended period of total disability. Fourth, there is evidence of new neurological involvement following the 1981 incident that was not present previously,

namely, the loss of the ankle jerk reflex. Fifth, Dr. Young's concessions at deposition, particularly those in response to the hypothetical question postulating a specific strenuous incident, substantially undercut his opinion (based on the facts as he previously understood them) on the ultimate issue of aggravation versus new injury.

For all these reasons, we conclude that claimant's work activities or the specific track switch incident while employed at Silver King Mining contributed independently and materially to his subsequent condition and that responsibility should be assigned to SAIF, insurer for Silver King Mines at that time.

IV.

In view of our disposition of the aggravation versus new injury issue, we conclude it is unnecessary to consider remanding this matter to the Referee to consider the new evidence proffered by Wausau.

ORDER

The Referee's order dated January 28, 1982 is affirmed in part and reversed in part.

With respect to WCB Case No. 81-05605, the Referee's order is reversed, the SAIF Corporation's denial dated July 1, 1981 is set aside, and claimant's claim is remanded to SAIF to be processed as an accepted new injury claim.

With respect to WCB Case No. 81-04425, the Referee's order is reversed and Wausau's denial of claimant's aggravation claim is affirmed.

The SAIF Corporation shall reimburse Wausau Insurance Company for all claim costs incurred pursuant to the Referee's order.

That portion of the Referee's order relating to an agreement between Wausau and claimant regarding payment of attorney's fees is vacated. In lieu thereof, claimant's counsel is awarded $1,300 for his services at hearing and on review, payable by SAIF.

The remainder of the Referee's order is affirmed.

WORKERS' COMPENSATION CASES

Decided in the Oregon Court of Appeals:

(Jameson v. SAIF, Chiapuzio v. SAIF, Adams v. SAIF, and Kociemba v. SAIF will appear in the next volume.)

Decided in the Oregon Supreme Court:

IN THE COURT OF APPEALS:
HOFFMAN CONSTRUCTION CO. v. McALLISTER and SAIF

Kevin J. McAllister, Claimant
J.P. Graff, Petitioner's Attorney
Robert K. Udziela, Respondent's Attorney
Emil R. Berg, Respondent's Attorney
WCB 80-08117 & 80-08118
March 30, 1983
CA A24001
Before Gillette, Presiding Judge, and Warden and Young, Judges

YOUNG, J.

The issues in this workers' compensation case are whether claimant suffered a second injury and, if so, whether the employer at the time of the original injury or the employer at the time of the second injury is responsible for compensation. We review *de novo,* ORS 656.298(6), and affirm the decision of the Workers' Compensation Board.

Claimant was injured on the job January 5, 1979, suffering a severe muscle injury to his neck and to a lesser extent muscle strain and interscapular pain in the thoracic region of his back. Claimant's symptoms continued (although intermittently) throughout 1979. He ultimately received an unscheduled permanent partial disability award for his upper back condition. Claimant was cautioned that heavy labor could cause a recurrence of symptoms.

On July 1, 1980, claimant began work for a new employer, using a pick, shovel and wheelbarrow. After one day's labor he did not return to work. The next day, his treating physician diagnosed a thoracic back strain in the same interscapular region as before. The doctor said:

> "* * * Examination revealed well-localized tenderness at approximately the 7th thoracic spinous process. Bilateral paravertebral muscle and interscapular spasm was present."

We find that claimant did suffer a worsened condition and that the worsened condition was an aggravation of the prior injury on January 5, 1979. The second incident caused a recurrence of some of the prior symptoms but was not a new injury that contributed to the cause of the worsened condition. The first employer is responsible for compensation. *Smith v. Ed's Pancake House,* 27 Or App 361, 556 P2d 158 (1976); *Calder v. Hughes & Ladd,* 23 Or App 66, 541 P2d 152 (1975).[1]

Affirmed.

[1] In view of our disposition, respondent's cross-petition is moot.

IN THE COURT OF APPEALS:
SPORE v. CAMAC VENEER, INC.

James B. Ehrlich, Appellant's Attorney
Richard A. Roseta, Respondent's Attorney

WCB 78-3734
CA A25300
April 13, 1983

Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges

RICHARDSON, P. J.

The plaintiff in this personal injury action is employed by Pinkerton, Inc. He sustained an on-the-job injury at defendant's plant, to which he was assigned as a security guard by Pinkerton. Plaintiff's action was dismissed by the trial court, which made special findings and concluded that defendant was a "mutual employer" of plaintiff and, as such, was immune from the action under the Workers' Compensation Law. *See* ORS 656.018. Plaintiff appeals, and we affirm.

Plaintiff's arguments on appeal relate to the trial court's findings and conclusions that defendant, together with Pinkerton, had the "right of control" over plaintiff's services. Plaintiff argues that there was insufficient evidence to support the findings. We disagree. *Robinson v. Omark Industries,* 46 Or App 263, 611 P2d 665, *rev allowed* 289 Or 741 (1980), *rev dismissed* 291 Or 5, 627 P2d 1263 (1981).

Plaintiff also argues:

> "Defendant contracted with Pinkerton to provide a service. It had imput into the makeup of the OJI's [written instructions] because Pinkerton shaped its service to meet the needs of its customers. This is not the sort of control which the court found in *Robinson,* where it found that
>
> " 'While plaintiff was on defendant's premises, defendant had the right to control all aspects of plaintiff's work.' *Robinson v. Omark Industries, supra,* at 46 Or App 266.
>
> "The point must be reiterated that Pinkerton, through its own supervisory personnel and through the OJI manual which it produced, had the right to place and assign plaintiff his tasks at defendant's plant.
>
> "* * * * *
>
> "Classifications aside, the only actual examples of interaction between plaintiff and defendant involved information concerning danger areas, visitors, suggestions regarding safety measures, personnel phone numbers, and items of this nature. Regardless of how this interaction is characterized (i.e., 'orders' or 'information'), there is simply not the degree of control in the present instance that existed in *Robinson v. Omark Industries, Inc., supra.* At the risk of reiterating, the court in *Robinson* emphasized

> such elements as control of hours, breaks, physical placement, and specific assignment of tasks. The extent of defendant's control over plaintiff regarding these factors is non-existent, as set forth above."

To the extent that that argument is not a continuation in a new guise of plaintiff's quarrel with the trial court's findings, it posits that, as a matter of law, the right of control must be plenary or must extend to particular terms of employment in order to make the person exercising the control an "employer" under ORS 656.005(14).[1] We said in *Robinson:*

> "* * * An employe can have more than one employer for workers' compensation purposes. * * * It follows that an employe can be subject to the right of control by more than one employer." 46 Or App at 266. (Citations omitted.)

It also follows that, where there is mutual control, neither of the two employers can singly control *everything* the employe does. There may be cases in which the incidents of control are so minimal that the person exercising that control, as a matter of law, is not an employer, but in light of the facts found by the trial court, this is not such a case.

Affirmed.

[1] ORS 656.005(14):

> "'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 supplied.)

IN THE COURT OF APPEALS:
GRIFFIN v. TIME, DC, INC. et al

Donald W. Griffin, Claimant (Deceased) WCB 81-02495
Robert L. Engle, Petitioner's Attorney April 13, 1983
Allan M. Muir, Respondent's Attorney CA A25877
Before Buttler, Presiding Judge, and Warren and Rossman, Judges

BUTTLER, P. J.

Claimant appeals from a Workers' Compensation Board order denying her widow's benefits under ORS 656.204.[1] We affirm.

Claimant's husband, now deceased, had a history of coronary heart disease. In 1971, he had aneurysm surgery. While at work in January, 1975, he inhaled diesel fumes, which caused an acute coronary insufficiency. He suffered a myocardial infarction the next day. He was then determined to be permanently and totally disabled by Determination Order on March 11, 1976. In 1978, he had chest pains diagnosed as a possible thoracic aortic aneurysm. Dr. Olson, his treating physician at that time, did not believe

[1] ORS 656.204 (*amended by* Or Laws 1981, ch 874, § 15), provided, in pertinent part:

> "If death results from the accidental injury, payments shall be made as follows:
>
> "(1) The cost of burial shall be paid, not to exceed $1,000 in any case.
>
> "(2) If the worker is survived by a spouse, monthly benefits shall be paid * * * to the surviving spouse until remarriage."

Claimant has abandoned her claim below that she is eligible for benefits under ORS 656.108; she concedes that she does not come within that statute, because she did not marry deceased until more than two years after his work-related injury.

that his symptoms were related to the aneurysm and did not recommend any surgical intervention. He stated that that surgery "is very high risk and would be of particular risk to a patient who has sustained an arterial lateral myocardial infarction" and who smokes 45 packs of cigarettes per year.

By 1980, deceased's coronary heart disease had worsened to the degree that he could not exert himself at all. He was hospitalized again that fall and released. In January, 1981, he was hospitalized with a diagnosis of coronary artery disease. It was determined that a large thoracic aortic aneurysm was displacing his esophagus. Surgery (a gastrostomy) was performed to relieve the esophagus obstruction caused by the thoracic aortic aneurysm. On February 10, 1981, he died. The death certificate listed the cause of death as respiratory arrest due to encroachment on the trachia by a thoracic aneurysm.

Claimant contends that she is entitled to benefits under ORS 656.204:

> "If death results from the accidental injury, payments shall be made as follows:
>
> "* * * * *."

She contends that the work injury in 1975 worsened deceased's heart disease to such an extent that surgery to repair the aneurysm was impossible, contributing to his ultimate death in 1981. Accordingly, she argues, death resulted from the accidental injury.

The burden is on claimant to demonstrate that death resulted from the 1975 work injury. *Youngren v. SAIF,* 6 Or App 297, 299, 487 P2d 107, *rev den* (1971). The referee found that she had not met her burden and denied her claim; the Board affirmed.

The reports of three doctors are pertinent. Dr. O'Dell, speaking of the decedent in 1980, said that

> "* * * he will never be a candidate for surgery because of the extremely poor left ventrical function due to his recurrent myocardial infarctions."

It was he who filled out the death certificate stating that the aneurysm was the cause of death. Dr. Olson, at claimant's request, wrote a letter shortly prior to the hearing stating his opinion that the thoracic aneurysm was first found in 1978

> "* * * and he [decedent] was felt not to be an operative candidate for the thoracic aneurysm, because of his cardiovascular status. The fact that he was not an operative candidate for the vascular surgery because of his cardiac disease allowed the aneurysm to progress and eventually was directly responsible for his death."

That report, however, is not consistent with his earlier report[2] of September, 1978, when he wrote that

[2] The dissent ignores Dr. Olson's earlier opinion. The inconsistency between the two reports is part of the conflicting medical evidence.

"* * * I would not recommend any surgical intervention at this time. This surgery is very high risk and would be of particular risk to a patient who has sustained an anteral lateral myocardial infarction and has a 45 pack per year smoking history."

In February, 1981, Dr. Olson wrote that Mr. Griffin entered the hospital with problems clearly related to the aneurysm and that he could not associate those problems with the myocardial infarction that had occurred in 1975.

Dr. Rogers, who had treated the deceased after the 1975 work-related incident, stated in two separate reports after decedent's death that he felt death was due to the advanced nature of the deceased's coronary heart disease with chronic failure.[3] However, it was his opinion that if deceased had died of a rupture of the thoracic aneurysm as the death certificate stated,

"* * * then I would not attribute death in any way to his coronary disease because the resection of aortic arch aneurysms is largely experimental and very high risk and would not be attempted probably in a man of 65 with chronic obstructive pulmonary disease, even if his heart were of average health."

He concluded that death was

"* * * due to the very advanced nature of his coronary heart disease with chronic failure or low output state, perhaps aggravated by the debilitating effects of the tube gastrostomy done 2/5/81, with his death coming 2/10/81."

Claimant, however, does not rely on that conclusion of Dr. Rogers; she concedes that decedent's death was caused by the aortic aneurysm.

There was no autopsy performed, and we are not convinced by the medical evidence that the death "resulted from" deceased's 1975 injury at work, because the preponderance of that evidence is that death resulted from the aortic aneurysm, which did not "result from" the 1975 injury or from the coronary condition that rendered the decedent totally disabled in 1976. The medical evidence also convinces us that the surgical procedure to accomplish the resection of the aortic arch aneurysm is very high risk surgery that would not have been performed on the decedent in 1978, regardless of the 1975 compensable injury.[4]

Affirmed.

ROSSMAN, J., dissenting.

The wife of the deceased must demonstrate by a preponderance of the evidence that the death of her husband resulted from a 1975 work injury. The majority, citing what it interprets to be conflicting medical reports,

[3] Claimant does not contend that the decedent died as a result of his coronary heart disease, but concedes he died as a result of the aneurysm.

[4] We do not agree with the dissent that claimant would "probably" recover if the decedent had undergone the surgery to correct the aneurysm and had died during surgery (slip opinion at 3). Given the reports of both Drs. Olson and Rogers that it was a "very high risk" procedure, that statement is doubtful.

finds she did not meet her burden of proof. However, in my opinion, claimant has convincingly demonstrated that all of the links in the chain of causation are present, proving that, *but for* her husband's 1975 work injury resulting in the myocardial infarction, he would have been able to have the life-saving corrective surgery on the aneurysm that eventually resulted in his death.

Claimant's case is largely based on the findings made by her husband's doctor, Dr. Olson. His letter, written soon after her husband died, outlines the causal connection this way: "The fact that he was not an operative candidate for the vascular surgery because of his cardiac disease allowed the aneurysm to progress and eventually was *directly* responsible for his death." The majority speaks of "conflicting medical evidence." A close look at Dr. Rogers' reports, on which the majority relies, however, reveals that he felt death was due to the "advanced nature of [the deceased's] coronary heart disease with chronic failure or low output state, perhaps aggravated by the debilitating effects of the tube gastrostomy * * *." I would ask, how did the coronary heart disease become so advanced? In 1975, Dr. Rogers reported that the deceased had no past history of any cardiovascular disease. The 1975 incident was, in his opinion, "a clearcut instance of work-aggravated coronary heart disease that led repeatedly to angina pectoris and finally on January 8th, to a substantial anterior myocardial infarction." It is undisputed that the 1975 work injury causing the deceased's myocardial infarction caused him to be totally and permanently disabled. The medical evidence reveals that after 1975 he could not exert himself at all, nor was it possible for him to withstand surgical repair to restore proper left ventrical function. Gradually his condition deteriorated so much that, when the aneurysm was discovered, surgical treatment could not be considered an option. Dr. O'Dell in 1980 stated that, because of the

extremely poor left ventrical function, due to his recurrent myocardial infarctions, he would *never* be a candidate for surgery.

The evidence presented by all or any one of these doctors shows that a causal connection clearly exists between the work-caused heart disease and claimant's husband's death. The myocardial infarction caused his heart disease to become so severe that he was permanently and totally disabled. This, in turn, caused him to be an unfit candidate for corrective surgery for a later discovered aneurysm, which Dr. Olson stated caused his death only because aortic surgery, was not done. Thus, he was forced to take his chances without surgery and three years later he was dead. It is ironic that claimant would probably recover if her husband had undergone the surgery to correct the aneurysm and had died during it but cannot recover here, even though he died as a result of an aneurysm that could not be corrected because of his weakened condition. The majority's approach presents those in husband's predicament with a second Hobson's choice:[1] have the aneurysm surgery, die as a result and, perhaps, thereby

insure recovery for the survivor *or* forego the surgery and die as a result a few years later, guaranteeing that there will be no recovery.

I do not see the conflict in the medical evidence that so troubles the majority. The evidence is consistent on the crucial issue of causation. No matter how you cut it, the trail leads back to the 1975 on-the-job injury. Whether claimant's husband in fact died from the heart disease itself (as Dr. Rogers concluded) or from the aneurysm that was inoperable because of the disease (as Dr. Olson concluded), his death was a direct result of the 1975 injury. There should be a recovery in either case. I believe that claimant has clearly demonstrated by a preponderance of the evidence that her husband's death was the result of his 1975 myocardial infarction due to a work injury, and therefore should recover under ORS 656.204. I would reverse.

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[1] Thomas Hobson was an English liveryman, who required every customer to take the horse nearest the door.

IN THE COURT OF APPEALS:
MILBRADT v. SAIF CORPORATION

Donald Milbradt, Claimant — WCB 81-05138
Michael N. Gutzler, Petitioner's Attorney — CA A25293
Darrell E. Bewley, Respondent's Attorney — April 13, 1983
Before Buttler, Presiding Judge, and Warren and Rossman, Judges

BUTTLER, P. J.

Claimant appeals from an order of the Workers' Compensation Board affirming SAIF's denial of payment for continued chiropractic care for claimant's back. We reverse.

Claimant suffered a compensable injury in 1976. He experienced chronic pain, and, on the advice of his doctor, he quit his job as a plumber to avoid heavy lifting and became a truck driver. In November, 1980, he was awarded 64 degrees for unscheduled disability; by stipulation, the award was increased by an additional 24 degrees on January 6, 1981.

Although claimant's condition had remained static, he had continued to experience pain, for which he received chiropractic treatments. In May, 1981, SAIF denied responsibility for any further chiropractic treatment. The denial was affirmed by the referee and by the Board, because there was no medical evidence that continued chiropractic treatments were reasonable and necessary.

Both parties rely on *Wetzel v. Goodwin Brothers,* 50 Or App 101, 622 P2d 750 (1981), in which we stated:

> "* * * Medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in the treatment of an injury for which permanent partial disability has been awarded. * * *" 50 Or App at 108.

In *Wetzel,* the claimant testified that chiropractic treatments temporarily alleviated his pain and made it possible for him to function. Claimant so testified here. He stated that each time he received the treatment he felt better for a few days and was able to continue full-time work. He also testified that he stopped the treatments when SAIF refused to pay for them, that his symptoms have worsened since then and that he had developed leg cramps and twitching in his toes, symptoms he did not have while he was receiving treatment. He testified that the treatments were helping him to an "increased extent" during the time he received them.

The only difference between this case and *Wetzel* is that the chiropractor in *Wetzel* actually testified that the treatments were necessary and reasonably performed. In

both cases the treatment was palliative, not curative. Here, the doctor did not state that the treatments were reasonable and necessary; however, he reported that he had instructed claimant to come in for them on an "as needed basis" and that he relied on claimant's statements to him that the treatments "help him get by" on the job. The doctor also said that claimant "should be sent to the Portland Pain Clinic if you are not going to allow him to come to my office on an as needed basis." We conclude that the doctor's statements, together with claimant's testimony, are sufficient to support a finding that the treatments are reasonable and necessary to relieve claimant's pain and permit him to work full-time.

Reversed and remanded.

ROSSMAN, J., dissenting.

On the basis of claimant's testimony that he feels better when he receives chiropractic treatments and worse when he does not and the chiropractor's testimony that he had instructed claimant to come in for the treatments and his suggestion that claimant be sent to a pain clinic if not to him, the majority holds that there is enough evidence to sustain a finding that the treatments are reasonable and necessary. I do not agree.

It is probable that all of us would feel better after a weekly rubdown; however, more than a showing of beneficial results are required to sustain a workers' compensation claim for such expenses and more than that is required here. The medical costs of palliative procedures are recoverable when they are "necessary and reasonably incurred." *Wetzel v. Goodwin Brothers,* 50 Or App 101, 108, 622 P2d 750 (1981). That a particular treatment "works" does not, without more, establish that it is reasonable and necessary. Thus, it is surprising that the majority notes, but apparently attributes no significance to the fact that "the only difference between this case and *Wetzel* is that the chiropractor in *Wetzel* testified that the treatments were necessary and reasonably performed." On this record, that distinction is crucial. Although I am by no means a stickler for the presence of "magic words," I believe that the *Wetzel* requirement must have some content, and I am convinced that the majority's holding leaves it with none. The order of the Workers' Compensation Board should be affirmed.

IN THE COURT OF APPEALS:
CASCADE STEEL ROLLING MILLS v. MADRIL

Ralph S. Madril, Claimant — WCB 78-05798 & 79-08024
Dennis R. VavRosky, Petitioner's Attorney — CA A25670
Quintin B. Estell, Respondent's Attorney — April 13, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newmand, Judges

VAN HOOMISSEN, J.

Employer appeals from an order of the Workers' Compensation Board on remand. It contends that the Board erred in not considering the combined effect of claimant's prior injuries and his past receipt of compensation for those injuries in making its award.

In a prior appeal in this case, we recognized that ORS 656.222 requires that, when a worker has been paid compensation for a permanent disability, his award of compensation for future accidents must be made with regard to the combined effect of his injuries and his past receipt of money for such disabilities.[1] *Cascade Steel Rolling Mills v. Madril,* 57 Or App 398, 402, 644 P2d 655 (1982). Because we were unable to determine the basis of the Board's order on review, we remanded to the Board with instructions that it clarify whether its award was made in accordance with ORS 656.222.

On remand, the Board apparently decided to take us at our literal word. The Board's order on remand states:

> "The answer is: The Board's award of 25 percent unscheduled low back disability was *not* made with regard to the combined effect of claimant's injuries and his past receipt of money for such disabilities."

In view of that statement, we are at a loss to understand why the Board declined the opportunity to review the record and to reexamine the award. This case is before us again on *de novo* review.

We initially discard employer's contention that it is entitled to an offset against claimant's previous injury due to an overpayment. OAR 436-54-320 provides:

> "Insurers and self-insured employers may recover overpayment of benefits paid to a worker on an accepted claim from benefits which are or may become payable on *that* claim. * * *" (Emphasis supplied.)

The previous overpayments which employer attempts to recover were made by a different insurer on a *prior* claim. Employer is not entitled to an offset in this claim.

[1] 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, his award of compensation for such further incident shall be made with regard to the combined effect of his injuries and his past receipt of money for such disabilities."

On the merits, and without indulging in a lengthy recitation of the medical evidence, *see Bowman v. Oregon Transfer Co.,* 33 Or App 241, 576 P2d 27 (1978), we find that after the first award claimant had recovered significantly from the effects of his earlier injuries. We conclude that the Board's award of 25 percent (80 degrees) permanent partial disability appropriately compensates him for the new or additional disability that resulted from the latest injury and that was not compensated for by the first award. *See Cascade Steel Rolling Mills, supra,* 57 Or App at 402; *Green v. State Ind. Acc. Com.,* 197 Or 160, 251 P2d 437, 252 P2d 545 (1953).

Affirmed.

IN THE COURT OF APPEALS:
TEKTRONIX CORPORATION v. TWIST

Louis Twist, Claimant — WCB 80-07811
David O. Horne, Petitioner's Attorney — CA A24401
Robert K. Udziela, Respondent's Attorney — April 13, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges

VAN HOOMISSEN, J.

Employer appeals from an order on reconsideration of the Workers' Compensation Board that remanded claimant's aggravation claim for acceptance and payment of benefits. The issues are the jurisdiction of this court to consider employer's appeal and compensability. We affirm.

In 1977, claimant sustained a compensable back injury, which was processed to closure by determination order. In 1980, he filed an aggravation claim. Employer denied the claim, and a referee sustained that denial. On January 26, 1982, the Board reversed the referee and remanded the claim to the carrier for acceptance. On February 5, 1982, employer petitioned the Board for reconsideration. Claimant moved to dismiss on the ground that the Board lacked authority to reconsider. He contended that there was no authority for the Board to reconsider its order on review and that the only way employer could contest that order was to petition for review in this court. ORS 656.298.

On February 8, 1982, the Board "abated" [1] its January 26 order, and on March 31 it issued its order on reconsideration, which is the subject of this appeal. In that order, the Board readopted and republished its January 26 order on review.

Claimant moves to dismiss the appeal, contending that we lack jurisdiction because the Board had no authority to enter its order on reconsideration and, therefore, that

[1] Claimant has not specifically challenged the Board's power to "abate" its order on review pending reconsideration. He only contests the Board's authority to reconsider its order.

order is a nullity. The Board specifically rejected that contention, reasoning:

> "* * * [C]laimant challenges our authority to reconsider an Order on Review as we have done in this case. Claimant argues that the sole remedy of a party dissatisfied by an Order on Review is to appeal to the Court of Appeals. We disagree with claimant's argument. ORS 183.482(6) permits an agency to withdraw an order for reconsideration even after an appeal is filed in the Court of Appeals. While ORS 183.315(1) states that certain parts of ORS Chapter

> 183 do not apply to this Board, ORS 183.482(6) is not one of the sections enumerated as inapplicable. If we can reconsider an order even after an appeal to the Court of Appeals, it is even more obvious that we can reconsider an order before an appeal to the Court of Appeals is filed."

We agree.

On the merits, no useful purpose will be served by reciting the medical evidence. *See Bowman v. Oregon Transfer Co.,* 33 Or App 241, 576 P2d 27 (1978). On *de novo* review, we agree with the Board that claimant's condition worsened since the last arrangement of compensation and that his 1980 aggravation claim should have been accepted.

Affirmed.

IN THE COURT OF APPEALS:
PETSHOW v. PORTLAND BOTTLING CO., PETSHOW

David R. Petshow, Claimant — WCB 80-08903 & 81-00263
Alan Scott, Petitioner's Attorney — CA A24529
Katherine H. O'Neil, Attorney — April 13, 1983
Larry Dawson, Attorney
Before Gillette, Presiding Judge, and Warden and Young, Judges

YOUNG, J.

This is a workers' compensation case involving successive injuries, a dispute between two insurers as to which is responsible for compensation and an order directing that any future award for permanent partial disability be reduced by the amount of excess benefits for temporary total disability paid by Liberty Mutual Insurance Company (Liberty). Claimant seeks judicial review, and Liberty, one of the insurers, cross-appeals. We review *de novo,* ORS 656.298(6), and reverse.

Claimant injured his left hand on September 7, 1976, while working for Portland Bottling Company. Liberty, the insurer, accepted the claim. In October, 1977, medical treatment involved the removal of a nerve from claimant's left ankle area and grafting of the nerve into the injured hand. Claimant experienced difficulty with his leg following the nerve transplant. Another surgery was performed on the leg in December, 1979, but some problems

persisted. On July 17, 1980, while working for a new employer, J. D. Petshow (claimant's brother), claimant was helping herd a bull when his Achilles tendon ruptured.

Claimant sought compensation from each employer on the basis that his condition was either a new injury or an aggravation of the original injury. Liberty commenced payment of temporary total disability (TTD). Farm Bureau Insurance Co. (Farm Bureau), the insurer for J. D. Petshow, did not accept or deny the claim and made no TTD payments. *See* ORS 656.262(6) (60 days to accept or deny); 656.262(4) (14 days to begin paying compensation after notice or knowledge of claim). On September 30, 1980, claimant requested a hearing concerning Farm Bureau's failure and sought compensation, penalties and attorney fees.

On November 6, 1980, Farm Bureau made its first payment for TTD or "interim compensation" covering the period roughly from the time of the injury to that date. Farm Bureau then sought a designation pursuant to ORS 656.307 as to which insurer should pay compensation. On January 5, 1981, the Compliance Division of the Workers' Compensation Department designated Farm Bureau the "interim" paying party and "referred * * * the issue of

responsibility, including any necessary and monetary adjustments between the parties," to the Hearings Division of the Board. On January 9, 1981, claimant filed a request for hearing on his aggravation claim against Liberty. On January 26, Liberty denied the claim, and on February 26, Farm Bureau denied the new injury claim.

The referee found claimant's condition to be an aggravation for which Liberty was responsible. He also found that Farm Bureau had neglected its statutory duty to pay "interim compensation," ordered that Farm Bureau pay compensation for the period of July 17 through December 26, 1980, and assessed a 25 percent penalty. He ordered that Liberty receive an offset of the amount of TTD that Liberty had paid between July 17 and December 26 against any eventual award of permanent partial disability.[1] On July 17, 1981, the referee issued an order on reconsideration declaring that he had jurisdiction to order the TTD offset against claimant's future disability award. On review, the Board affirmed the referee.

Claimant contends that the Hearings Division and the Board lack "subject matter jurisdiction" at this stage of the claim to order that Liberty can offset TTD against any future award of permanent disability. We do not agree.

The Board and its Hearings Division are authorized to decide disputes and controversies involving

[1] The referee also ordered Liberty to reimburse Farm Bureau for any TTD it may have paid after December 27, 1980. *But see Renolds-Croft v. Morrison*, 55 Or App 487, 638 P2d 495 (1982).

claims. ORS 656.708(3); 656.726(2). The Board is authorized to determine those matters concerning a claim in which "a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3). The central issue before the referee was whether the claim was compensable as an aggravation claim or a new injury. Both insurers had denied compensation, and one had sought an offset against claimant's future disability award. Because these questions were controversies involving claimant's "right to compensation [and] the amount thereof," the referee and the Board were acting within their authority to decide "claims." *See SAIF v. Broadway Cab,* 52 Or App 689, 693 n 2, 629 P2d 829, *rev den* 291 Or 662 (1981).

Ordinarily, a credit or offset against a final disability award is initiated by the Evaluation Division when issuing a determination order. ORS 656.268(4).[2] The offset in this case was ordered in the early stages of the claim before claimant had become medically stationary and a determination order could be issued. Nevertheless, the issue of the offset was fully contested at the hearing, and claimant was a participant in those proceedings. The offset involved the extent of compensation and was, therefore, an issue "concerning a claim" within the authority of the Board and referee to decide. *See* ORS 656.708(3); 656.726(2); 656.704(3). We find no error.

Claimant argues that each insurer had an independent statutory obligation to make what may be generally termed "time loss" payments. Claimant emphasizes a distinction between Liberty's temporary total disablity payments (TTD) made as part of an accepted claim and Farm Bureau's "interim compensation" payments made while Farm Bureau remained undecided whether to accept or deny the claim. *See Jones v. Emanuel Hospital,* 280 Or 147, 570 P2d 70 (1977) (TTD termed "interim compensation"). Claimant concludes that he is entitled to "time loss" payments by both insurers during the same time period.

Each insurer has the statutory obligation to make "time loss" payments when claims are filed against each

[2] ORS 656.268(4) provides:

"Within 10 working days after the Evaluation Division receives the medical and vocational reports relating to a disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the director's supervision. If necessary the Evaluation Division may require additional medical or other information with respect to the claim, and may postpone the determination for not more than 65 additional days. *Any determination under this subsection may include necessary adjustments in compensation paid or payable prior to the determination, including* disallowance of permanent disability payments prematurely made, *crediting temporary disability payments against permanent disability awards* and payment of temporary disability payments which were payable but not paid. The Evaluation Division shall reconsider determinations made pursuant to this subsection whenever one of the parties makes request therefor and presents medical information regarding the claim that was not available at the time the original determination was made. However, any such request for reconsideration must be made piror to the time a request for hearing is made pursuant to ORS 656.283. The time from request for reconsideration until decision on reconsideration shall not be counted in any limitation on the time allowed for requesting a hearing pursuant to ORS 656.283." (Emphasis supplied.)

insurer and neither has denied compensation. ORS 656.262 (responsibility to pay compensation); *Jones v. Emanuel Hospital, supra* (claimant entitled to time loss when insurer has not yet denied claim even if claim later found noncompensable.) For purposes of determining whether the "time loss" payments were excessive, however, there is little difference between TTD on an accepted claim and "interim compensation" paid by an undecided insurer. Both are derived from the same statute: ORS 656.210. That section entitles an injured worker to a fixed percentage of the workers' lost wages according to a formula. The worker is not entitled to recover double the statutory sums simply due to uncertainty as to which insurer is responsible for compensation. ORS 656.210(1) provides in part:

> "When the total disability is only temporary, the workers shall receive during the period of that total disability compensation *equal to 66 2/3 percent of wages, but not more than 100 percent of the average weekly wage* nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser. * * *" (Emphasis supplied.)

See Jackson v. SAIF, 7 Or App 109, 117, 490 P2d 507 (1971).[3] Claimant's retention of "time loss" payments from both insurers for the same time period would result in compensation greater than that provided by ORS 656.210(1). It was not error, therefore, to require that an eventual determination order awarding permanent partial disability include an offset for excessive TTD benefits. ORS 656.268(4).

Liberty cross-appeals, challenging the Board's determination that claimant's ruptured tendon is an aggravation of the original injury. Liberty contends that the worsened condition is a new injury, for which Farm Bureau

would be responsible, because the bull-herding incident at least "slightly contributed" to the worsened condition. Liberty emphasizes that claimant had been helping to herd the bull for twenty to thirty minutes and was moving over uneven ground when the tendon ruptured.

Farm Bureau contends that the ruptured tendon was only a direct and natural progression of the first injury and that, therefore, Liberty is responsible. Farm Bureau relies on a report written by Dr. North, claimant's treating physician, the day after the second injury:

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[3] In *Jackson v. SAIF, supra,* we said:

> "Under the unique facts of this case, the claimant sustained two separate injuries, each of which resulted in temporary total disability, covered by different insurers. The Workmen's Compensation Law establishes the amounts payable for temporary total disability in ORS 656.210. The statute not only sets out how much the employer has to pay, *but it also sets out how much the workman can receive." Jackson v. SAIF, supra,* 7 Or App at 117. (Emphasis supplied.)

We then concluded that it was proper to split the responsibility equally between the insurers.

"The patient felt a snap in the calf that sounded like a bullet going off when he was twisting and putting weight on his leg. * * * The patient has previously had nerve grafting with seral [sic] nerve and also developed some nodules on his tendon which have been excised previously. * * *

"COMMENT: The patient's Achilles tendon has ruptured and was probably predestined to this by his previous industrial injury and nerve grafting with Achilles nodules. This weakness in the tendon has now contributed significantly to the likelihood of his reason for tendon ruptured [sic] and therefore I feel it should be covered under the industrial claim. * * *"

A hospital record made at the same time indicated that the accident happened while claimant was "at home walking." When viewed in context, it becomes apparent that the doctor was concerned with compensability, not with responsibility.[4] He stressed the part that the prior injury and the surgeries played in claimant's current condition, but he did not address the question whether the second injury *also* contributed to the disabling condition.

In *Smith v. Ed's Pancake House,* 27 Or App 361, 364-65, 556 P2d 158 (1976) this court declared:

"The 'last injurious exposure' rule in successive-injury cases places full liability upon the carrier covering the risk

at the time of the most recent injury that bears a causal relation to the disability.

"* * * * *

"* * * [I]f the second incident contributes independently to the injury, the second insurer is solely liable, even if the injury would have been much less severe in the absence of the prior condition, and *even if the prior injury contributed the major part to the final condition.* * * *" (Emphasis supplied.)

We conclude that claimant's second injury contributed independently to cause the rupture of the tendon. Prior to July 17, 1980, claimant's symptoms did not include a ruptured Achilles tendon. On July 17th, however, claimant moved rapidly over uneven ground; he was "twisting and putting weight on his leg" when he suffered a sudden rupture of the tendon. The physical stress of the effort was an actual and independent contribution to the ruptured tendon,[5] and therefore Farm Bureau is responsible for

[4] The doctor stated that the prior surgery resulted in a "weakness" in the tendon that "contributed significantly" to the "likelihood" of tendon rupture and, therefore, the injury should be "covered." We understand the statement to indicate that claimant was *predisposed* to a tendon rupture but not that the rupture was necessarily inevitable. The doctor's emphasis on the role of the prior surgery for purpose of compensability does not resolve the question of the causative effect of the second injury for purposes of responsibility.

[5] This case is distinguishable from those cases in which subsequent exertion or stress merely causes a recurrence of prior symptoms, such as a recurrence of back strain. *See, e.g., Calder v. Hughes & Ladd,* 23 Or App 66, 541 P2d 152 (1975). In the present case the ruptured tendon was not a preexisting condition; neither was it an inevitable result of the prior surgeries.

compensation.[6] *Gilroy v. General Distributors,* 35 Or App 361, 582 P2d 428 (1978);[7] *Smith v. Ed's Pancake House, supra; see also Boise Cascade Corp. v. Starbuck,* 61 Or App 631, 639, 659 P2d 424 (1983).

Liberty also contends that the Board erred in affirming the referee's order that Liberty pay claimant an attorney fee. Liberty argues that the award was excessive

for an "ORS 656.307 proceeding." In light of our determination that Farm Bureau is the responsible insurer, the order awarding fees is reversed.

Reversed and remanded to the Board for further proceedings consistent with this opinion.

[6] This finding may warrant restructuring the offset against claimant's eventual permanent partial disability award. For example, Farm Bureau now might receive the offset and Liberty be reimbursed for its excess time loss payments. In any event, Liberty's reimbursement should be accomplished consistent with *Renolds-Croft v. Morrison, supra* n 1.

[7] In *Gilroy,* the claimant suffered a compensable shoulder injury in March, 1974. His shoulder dislocated repeatedly over the next two years. On April 21, 1976, he fell on a flight of stairs at work and reinjured the shoulder. The claimant testified that for the first time his fingers started to swell and he suffered more pain than before. A treating physician attributed most of the condition to the initial injury but also credited the fall as contributing. The physician said that the claimant's fall caused additional permanent damage. This court held that, although the fall was not the sole cause of the claimant's condition, the fall was a contributing factor and was thus a new injury for which the second carrier was responsible. *Gilroy v. General Distributors, supra,* 35 Or App at 363-67.

IN THE COURT OF APPEALS:
FITZPATRICK v. FREIGHTLINER CORPORATION

Dixie Fitzpatrick, Claimant WCB 80-07316
Janet A. Metcalf, Petitioner's Attorney CA A25354
Scott M. Kelley, Respondent's Attorney April 27, 1983
Before Buttler, Presiding Judge, and Warren and Rossman, Judges

WARREN, J.

Claimant appeals from an order of the Workers' Compensation Board reversing the referee's award of permanent total disability and awarding her 80 degrees for 25 percent permanent partial disability in addition to that granted by all prior determination orders. We reverse and reinstate the referee's award.

Claimant was injured in 1972 when she was attempting to free a jammed punch press. The die fell, cutting off most of her left hand. Claimant is naturally left-handed. She had undergone seven operations on the hand by 1975. In June, 1975, she began experiencing right-hand pain. By late 1977, she had developed colitis, and in 1978 the referee found, that that condition was causally related to the hand injury, finding employer responsible. In August, 1980, claimant also received an award for right arm disability.

In all, claimant has received: an award equal to 90 percent for the left forearm and 10 percent unscheduled disability to the back (1974); 5 percent unscheduled disability for injury to the "thorax" (1977); and a 10 percent unscheduled disability award for psychological disability and a 5 percent award for the right arm (1980). All of the awards are causally related to the 1972 injury.

At the hearing, claimant testified that she has right and left-shoulder pain and cannot use her left hand because of pain, swelling and cramps. Her right hand is swollen and painful. She cannot eat by herself, write letters, wash her own hair or clean her house. She has difficulty holding onto objects. Because of her colitis, she must make frequent trips to the bathroom. As a result, she cannot travel or engage in long-term activities. Her colitis also makes it difficult for her to entertain friends in her home. Other problems include screaming nightmares, pain in her chest and back and swelling in her legs. She is depressed and potentially suicidal.

The referee found that claimant was permanently totally disabled. The Board reduced this award to 50 percent of the maximum for unscheduled disability in addition to her previous awards, noting that claimant had not looked for work since her injury.

Claimant contends that her physical and psychological disabilities combine to leave her permanently totally disabled. Any attempt to seek work, she claims, would be futile and psychologically impossible and therefore she should be exempt from the requirement that she seek work.

The statute governing this case, ORS 656.206(1), provides:

> "'Permanent total disability' means the loss, including preexisting disability, of both feet and hands, or one foot and one hand, total loss of eyesight or such paralysis or *other condition permanently incapacitating the workman from regularly performing any work at a gainful and suitable occupation.*" (Emphasis supplied.)[1]

The Board concluded that claimant is subject to the seek-work requirement of ORS 656.206(3)[2] and that, because she has made no job search since at least 1975, she is not permanently and totally disabled. The burden of establishing permanent total disability is upon claimant. *Wilson*

[1] ORS 656.206(1)(a), the present statute, provides:

> "'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a suitable occupation is one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation."

[2] ORS 656.206(3) was not in effect in 1972 when claimant was first injured. It reads:

> "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."

v. Weyerhaeuser, 30 Or App 403, 567 P2d 567 (1977).

The issue then is whether, under the circumstances, it would have been futile for claimant to have attempted to find employment. As this court stated in *Wilson v. Weyerhaeuser, supra,* 30 Or App at 412:

> "'A broken body can cause a broken spirit,' *Seaberry v. SAIF,* 19 Or App 676, 683, 528 P2d 1103 (1974), and the point on the spectrum between psychopathological and attitudinal breakage at which each case falls is a question of degree which the fact finder must infer from all the evidence. * * *

> "* * * [E]vidence of the existence or absence of motivation is not essential to the establishment or disproof of a claim of permanent total disability. Rather, when odd-lot status is in issue and such evidence is offered, it is to be weighed by the fact finder, free from talismanic significance and procedural consequences, along with all other evidence from either party which reflects on the existence, nature and scope of disability."

It is obvious that claimant experiences severe difficulties in her day-to-day life. She is in constant pain, must be close to a bathroom at all times and suffers acute depression, according to her psychiatrist.

The record indicates that claimant did attempt to reenter the job market shortly after the 1972 accident. However, vocational rehabilitation was not successful, primarily due to her constant pain. She has a sixth-grade education and went to school in an attempt to pass the GED tests. Because of the loss of use of her writing hand and the constant pain she has endured, she has never passed the final test. Her experiences in vocational rehabilitation have not been pleasant or successful, and this has depressed her to the point that she feels it is useless to try anything. A psychologist at the Callahan Center concluded that claimant was an extremely unlikely candidate for return to gainful employment. Her psychiatrist, Dr. Janzer, has been treating her since 1977, counseling her to prepare her to reenter the job market and to pursue vocational rehabilitation. His testimony was that such preparation has not occurred because of her many disabilities and that it is unlikely that he can prepare her to seek work. Janzer concluded that she is permanently and totally disabled.

The referee concluded that claimant is so physically and mentally disabled that it would be a useless act for her to apply for work. We agree. The record, in its entirety, clearly indicates that this is a person whose physical injuries have resulted in her broken spirit, making her unemployable at any gainful and suitable occupation. *See Seaberry v. SAIF,* 19 Or App 676, 528 P2d 103 (1974); *Morris v. Denny's,* 50 Or App 533, 623 P2d 1118 (1981). We reverse the Board and find that claimant has met her burden of proof that she is permanently totally disabled.

Claimant next contends that her disability was

permanent and total as of August 5, 1980. On that date, a determination order was signed granting claimant temporary total disability from February 18, 1978, through January 15, 1979, and from February 16, 1979, through July 6, 1980, and 32 degrees for 10 percent unscheduled disability resulting from psychological injury and 19.2 degrees for 10 percent loss of her right arm. This was in addition to previous awards. Claimant requested a hearing, claiming she was permanently totally disabled. This appeal is the result of many subsequent proceedings. Her condition has not changed since August 5, 1980.

The general rule for determining the date on which permanent total disability benefits should be paid in cases where permanent total disability is based on the combination of a physical condition and psychological problems that follow was set out in *Wilke v. SAIF,* 49 Or App 427, 619 P2d 950 (1980). In *Morris v. Denny's,* 53 Or App 863, 867, 633 P2d 827 (1981), the court summarized the *Wilke* rule:

> "* * * When an award has been modified, the effective date of that modification is the earliest date that claimant's permanent total disability is proved to have existed."

This can be pinpointed by a doctor's report.

In his letter dated July 16, 1980, Dr. Janzer reported that he had determined that claimant's mental status had "now reached the same level as her physical condition and should be regarded as stationary." Although claimant requested a slightly later date, a review of the record indicates that claimant was permanently totally disabled as of July 16, 1980.

Reversed and remanded with instructions to award claimant permanent total disability as of July 16, 1980.

IN THE COURT OF APPEALS:
SAIF CORPORATION v. BRANNON

Beneficiaries of Robert G. Brannon (Deceased) WCB 77-8011
Donna M. Parton, Petitioner's Attorney CA A24129
Kathryn H. Clarke, Respondent's Attorney April 27, 1983
Before Richardson, P.J., Joseph, Chief Judge, and Van Hoomisen, Judge

VAN HOOMISSEN, J.

SAIF appeals from an order of the Workers' Compensation Board that ordered SAIF to pay benefits based on the deceased worker's status as "married" on the day of his injury, pursuant to ORS 656.206.[1] SAIF contends that,

[1] In 1965, ORS 656.206 provided:

"(1) 'Permanent total disability' means the loss, including preexisting disability, of both feet or hands, or one foot and one hand, total loss of eyesight or such paralysis or other condition permanently incapacitating the workman from regularly performing any work at a gainful and suitable occupation.

"(2) When permanent total disability results from the injury, the workman shall receive monthly during the period of that disability:

"(a) If unmarried at the time of injury, $155.

"(b) If the workman has a wife or invalid husband, but no child under the age of 18 years, $185. If the husband is not an invalid, the monthly payment shall be reduced by $30."

because the worker was separated from his wife on the day of his injury and was divorced several months later, he should have been compensated as a "single" worker. The worker's second wife and widow cross-appeals. She contends that the Board erred in failing to consider in its award the worker's minor child of his second marriage and in failing to award her attorney fees for represention before the Board.

The threshold issue is the proper rate of compensation during the worker's life.[2] He was injured in 1965. At the time of his injury, he was separated from his wife. Their divorce was finalized several months later. He then remarried. In 1970, while the worker was receiving permanent partial disability benefits, he and his second wife had a child. He was found to be permanently totally disabled in 1975. He died in 1978 as a result of complications from his 1965 injury.

SAIF contends that at the time of the injury the presumption of a dependency relationship under the workers' compensation law had ceased, and that the evidence does not establish that a dependency relationship continued thereafter; that the worker was not adjudged permanently and totally disabled until nine years after his

divorce; and that calculation of his temporary disability benefits and permanent total disability benefits based on his status as married would result in a windfall to him. SAIF argues that, considering the strong policy against allowing double recovery in workers' compensation cases together with the evidence in the case, proper calculation of the worker's benefits requires that he be considered unmarried on the date of his 1965 injury.[3]

We reject SAIF's contention and agree with the Board that SAIF erred in computing the worker's benefits on the basis of his being single. Oregon's statutory system does not require a showing of actual dependency by a spouse or minor child.

On cross-appeal, the worker's widow contends that the Board erred in ordering that benefits should not include compensation for the minor child. We find no error. The date of injury is the date on which a worker's status conclusively determines his rate of compensation. ORS 656.202(2); *see also Bradley v. SAIF,* 38 Or App 559, 590 P2d 784, *rev den* 287 Or 123 (1979).

The worker's widow also assigns as error the Board's failure to award her attorney fees for representation before the Board. Attorney fees in workers' compensation cases may be awarded only when expressly authorized

[2] The amount of survivor death benefits is not in issue. SAIF had admitted liability for death benefits under ORS 656.208.

[3] SAIF concedes that a *literal* reading of ORS 656.206 requires that the worker be compensated on the basis of his status as married. It contends, however, that we should not read the statute literally. We conclude that the statute is unambiguous.

by statute. *Van DerZanden v. SAIF,* 60 Or App 316, 653 P2d 558 (1982). In an insurer-initiated appeal, claimant is not entitled to attorney fees if compensation is reduced by the Board. Here, SAIF prevailed at the Board level on the issue of computation of permanent total disability benefits. Therefore, no attorney fees were authorized. ORS 656.382(2); *Korter v. EBI Companies, Inc.,* 46 Or App 43, 52, 610 P2d 312 (1980), *remanded* 51 Or App 206, 625 P2d 667 (1981).

Affirmed.

IN THE COURT OF APPEALS:
REED v. SAIF CORPORATION

Wallace Reed, Claimant — WCB 78-10329
N. Thomas Wilson, IV, Petitioner's Attorney — CA A24665
Darrell E. Bewley, Respondent's Attorney — May 11, 1983
In Banc

JOSEPH, C. J.

The issue in this workers' compensation case is the amount of claimant's permanent total disability benefits. The parties stipulated to the facts underlying the award.

Claimant worked full time as a draftsman. He worked 40 hours per week on that job and approximately 8 hours per week overtime. He also worked as a service station attendant about 15 hours per week. He was injured while working at the service station, and it is agreed that he is entitled to permanent total disability benefits. The referee and the Workers' Compensation Board held that his benefits, calculated pursuant to ORS 656.206, are to be based only on his wages from the part-time employment. Claimant appeals, contending that his benefits should be based on his total wages from both jobs.

Permanent total disability benefits are based on a percentage of wages. ORS 656.206(2). That statute provides that: " 'Wages' means wages as determined under ORS 656.210." The latter statute, relating to temporary total disability benefits, provides:

> "(2) For the purposes of this section, the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving at the time of the injury."

The statute then includes a formula for determining the weekly wage by multiplying the daily wage by the days the worker is "regularly employed" during a week. The section concludes:

> "As used in this subsection, 'regularly employed' means actual employment or availability for such employment."

The Board noted that the term "wage" is not separately defined in either ORS 656.206 or 656.210, and it applied the general definition of that term found in former ORS 656.005(30):[1]

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[1] Subsequent to claimant's injury the same definition of wages was renumbered and is presently found in ORS 656.005(27). Or Laws 1981, ch 723, §3; Or Laws 1981, ch 854, §2.

" 'Wages' means the money rate at which *the service rendered* is recompensed *under the contract of hiring in force at the time of the accident,* including reasonable value of board, rent, housing, lodging or similar advantage received from the employer. * * *" (Emphasis supplied.)

The Board concluded that that definition "could hardly be more clear in its terms" and held that "when calculating a claimant's permanent total disability benefits, he will receive benefits based on his wages on the job he was working when injured."

We concur in the Board's analysis. ORS 656.005(30) expressly addresses the point in time when wages are to be determined and what is included in that calculation. It does not expressly address whether different wage contracts with different employers should be combined to determine the total wages for benefit calculation. Prior to 1965, permanent total disability benefits were determined on a flat rate based on the number of dependents of an injured worker and were not related to wages earned. The definition of wages in former ORS 656.005(30) has been in effect at least since 1959. *See* Or Laws 1959, ch 448, §1. The survival of that definition after the wage base formulation was adopted, Or Laws 1965, ch 285, §22A, is not necessarily a legislative determination that wages from concurrent employment are not the appropriate wage base for benefits, but the referee noted and claimant concedes that the past practice of the agency has been to award disability benefits based only on wages from the injury-producing employment if more than one employment contract is involved.[2] The practice reflects a fundamental policy of the compensation system that employers should bear directly or through insurance the cost of injuries to their employes incurred in their service.

Although that policy can indeed involve difficult problems of allocation of responsibility under some circumstances, *see Bracke v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982), this is not such an instance. This employer was required only to protect this employe against the risk of industrial injury incurred in its employ, and that is all the insurance it was required to buy or that SAIF was required to sell.

Affirmed.

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[2] After the claim was filed in this case, the department adopted OAR 436-54-212(2)(f), respecting dual employment:

"(2) The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined in the following manner:

"* * * * *

"(f) Employed two jobs, two employers: Use only wage of job on which injury occurred if worker unable to work either job. * * *"

The Board correctly concluded that the regulation did not apply retroactively and instead based its decision on a construction of the statute.

RICHARDSON, J., dissenting.

One of the expressed purposes of the Workers' Compensation Act is

"[t]o provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents * * *." ORS 656.012(2)(a).

The humanitarian purposes of the Act are geared to providing compensation to the injured worker according to the extent of his disability. If he is permanently and totally disabled, by definition (ORS 656.206(1)(a)) he has lost his total wage earning capacity, and the purpose of the Act is to replace the lost employability with monthly benefits to enable him and his dependents to survive. In short, the focus of the Act is on compensation for the worker's industrial injury. The majority focuses the humanitarian aspects of the Act to the benefit of the employer. The majority says:

"This employer was required only to protect this employe against the risk of industrial injury incurred in its employ, and that is all the insurance it was required to buy or that SAIF was required to sell." ____ Or App at ____ (slip opinion at 3).

The risk of any employment is that a worker will be injured and may be entitled to permanent total disability benefits. The carriers do not insure the worker; they insure the employers. In this instance, the injury has permanently incapacitated the claimant from working in any employment, not just a 15-hour per week part-time job. Were it not for the Act (ORS 656.018) the claimant could proceed in a common law action against the employer and could seek damages related to his loss of earning power. One expressed policy of the Act is to replace the rigors of common law based litigation with a system to fairly and expeditiously to compensate the injured worker for his loss. ORS 656.012. The statute should be construed in light of the expressed policies and purposes of the Act in favor of the injured worker, and doubts in statutory construction should be resolved in favor of full compensation.

The Workers' Compensation Board and the majority depend on the definition of wages found in former ORS 656.005(30):

" 'Wages' means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer. * * *"

This definition provides what is to be included in wages and the time when that calculation is to be made. It was adopted prior to the time when total disability benefits were based on wages earned and does not directly address whether the wages earned from concurrent employment is to be included in the benefit base calculation.

ORS 656.003 provides:

"Except where the context otherwise requires, the definitions given in this chapter govern its construction."

In the context of the policies of the Act and the wording of ORS 656.205 and 656.210, I conclude that wages from

concurrent employment should be included in the benefit base determination. ORS 656.210(2) provides the formula for calculating permanent disability benefits.

> "For the purposes of this section, the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving at the time of his injury. * * *"

There follows a series of formulae which in essence provide that the above described daily wage is to be multiplied by the number of days "the worker was regularly employed during a week." The subsection concludes: "As used in this subsection 'regularly employed' means actual employment or availability for such employment." Consequently the days worked for the daily wage do not necessarily mean the actual time regularly on the job. Nowhere in these sections is the wage base restricted to the single employment which produced the injury. The objective is to replace partially the income lost by the results of the industrial injury. Because the statutes, when read together, do not base the benefits on a single employment, the doubt should be resolved in favor of the worker. Such a construction is consistent with the expressed and preceived purposes of the Act.

I would reverse and remand to the Board for recalculation of benefits based on claimant's wages from both employments. Therefore, I dissent.

IN THE COURT OF APPEALS:
FIREMAN'S FUND INS. CO. v. OREGON PORTLAND CEMENT CO. et al

Robin F. Robinette, Claimant — WCB 79-04246
Emil R. Berg, Petitioner's Attorney — CA A22204
James N. Westwood, Attorney — May 11, 1983
John D. Peterson, Claimant's Attorney
Before Buttler, Presiding Judge, and Warden and Warren, Judges

BUTTLER, P. J.

Fireman's Fund, the former insurer of employer Oregon Portland Cement Company (OPC), seeks judicial review of a determination by the Workers' Compensation Board that it is responsible for an aggravation of claimant's low-back problems. The Board reversed the order of the referee holding OPC responsible. Because some of the language in *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982), appeared to affect the outcome of this case, we withheld our opinion pending our decision in *Boise Cascade Corp. v. Starbuck*, 61 Or App 631, 659 P2d 424 (1983), in which we undertook to interpret the Supreme Court's *Bracke* opinion. On the basis of what we said in *Starbuck*, we now conclude that *Bracke* affects neither the rationale nor the result in this case and agree that Fireman's Fund is the responsible insurer.

In 1976, claimant was working for OPC when he injured his back in May and July while shoveling wet cement. He filed claims for each injury, and by a determination order in April, 1977, he was awarded temporary total disability and permanent unscheduled disability of 5 percent. OPC became

self-insured subsequent to the July, 1976, injury and Fred S. James (James) was its servicing agent.

Claimant continued to experience back pain both at work and at home. In September, 1978, while driving a Bobcat at work in a "pretty bouncy ride" over uneven ground, he experienced low-back pain. He was diagnosed as having myofibrositis and lumbosacral strain. His claim for that incident, filed with James, resulted in an award in January, 1979, for temporary total disability but no permanent disability. While that claim was pending, on October 3, 1978, claimant developed back pain when he bent over to tie his shoe and again while he was hunting during the weekend. In February, 1979, while claimant was at home, he hurt his back when he pulled on a "come along." In April, 1979, his doctor requested Fireman's Fund to reopen the 1976 claim because of an off-the-job injury on February 19, 1979, which, the doctor said, occurred while claimant was under treatment for his July, 1976, on-the-job injury. That request was denied.

On April 19, 1979, the doctor advised Fireman's Fund that he considered the February injury to be an aggravation of

previous injuries. While that matter was being pursued, claimant sustained another possibly job-related back strain on May 9, 1979, and then twisted his back on May 21 when he reached for a lever at work. A new injury claim for the May 21 incident was filed with James. Claimant's attorney notified Fireman's Fund that he was making a "second notice of claim" for aggravation of the July, 1976, injury "arising on or about May 21." In September, 1979, Fireman's Fund denied the claim for aggravation of the July, 1976, injury. James deferred acceptance or denial of the new injury claim but paid temporary total disability compensation.[1]

The referee found that claimant had suffered a new injury on May 21, 1979, and that OPC was responsible as a self-insured employer. The Board reversed, concluding that claimant's condition was the result of an aggravation of the July, 1976, injury, for which Fireman's Fund was responsible.

Fireman's Fund argues that, under the rule of *Smith v. Ed's Pancake House,* 27 Or App 361, 556 P2d 158 (1978), OPC is responsible, because the May 21 incident was a new injury that independently contributed to claimant's disability and that it was off the risk at that time. That position is strengthened by language in *Bracke v. Baza'r, supra,* to the effect that the "last injurious exposure" rule is applicable in injury cases as well as in those involving occupational disease, and that if the last on-the-job exposure *could* have caused the disability, the last employer is liable. That language, although *dicta,* is part of what concerned us in *Boise Cascade Corp. v. Starbuck, supra;* we concluded, however, that the court did not mean to change the rule enunciated in *Smith.* That is, if the original disability was the result of an injury, liability is not imposed on

[1] Pursuant to ORS 656.307, James requested the Compliance Division to issue an order designating a paying agent. On September 26, 1979, an order was issued designating Fireman's Fund as the paying agent until the responsible party was determined after a hearing.

the last employer unless a new incident contributed independently to the injury. *See Peterson v. Eugene F. Burrill Lumber,* 294 Or 537, ___ P2d ___ (1983).[2]

There is no question here but that claimant's July, 1976, disability was the result of an injury. The issue, then, is whether the May 21, 1979, incident was an independent material contributing cause of his worsened condition —not whether the working conditions at OPC at that time could have caused his disability. The medical and lay evidence in this case reveals that after his 1976 injury claimant constantly complained of back pain and sought treatment. His work record reveals many absences because of his pain. He testified that he always experienced pain while doing his job and that when it "built up" and got unbearable he would report to his supervisor and leave work, or he would call in to report that he was unable to report for his shift.

There are numerous medical reports in the record, and without detailing them it is sufficient to state that the preponderance of that evidence supports the conclusion that the May 21 incident did not contribute independently to claimant's disability. It may be summed up by the opinion of Dr. Hall, one of claimant's treating doctors, who stated that the original injury probably "never completely cleared" and that the subsequent injuries were aggravations of the original one. Accordingly, Fireman's Fund is responsible.

One further question remains. The Board assessed a penalty against Fireman's Fund and awarded claimant attorney fees. It is conceded here that if Fireman's Fund is held responsible, no penalty is assessable, although the award of attorney fees is proper, because claimant will have prevailed on a denied claim. ORS 656.382(2). We accept those concessions.

Affirmed as to the liability of Fireman's Fund and the award of attorney fees; reversed on assessment of a penalty.

[2] In *Peterson v. Eugene F. Burrill Lumber, supra,* the court dealt with a job-related back condition that worsened after claimant became self-employed. We had held, 57 Or App at 476, that the situation was analogous to that where the claimant's last injury was off-the-job and that the test was whether the *original* injury was a material contributing cause of the claimant's worsened condition. *See Grable v. Weyerhaeuser Company,* 291 Or 387, 631 P2d 768 (1981). That test is the reverse of the one enunciated in *Smith v. Ed's Pancake House, supra:* whether the *last* injury was a material contribution to the disability. In *Peterson,* the court declined to decide the question we decided, because the record did not show that the second employment contributed materially to the disability; accordingly the claim was for an aggravation similar to that involved in *Starbuck.* 294 Or at 543 n 6.

IN THE COURT OF APPEALS:
SAIF CORPORATION v. CAREY

Richard J. Carey, Claimant
Donna M. Parton, Petitioner's Attorney

WCB 79-01602
CA A24713
May 11, 1983

Before Buttler, Presiding Judge, and Warren and Rossman, Judges

BUTTLER, P. J.

SAIF petitions for reconsideration of this court's prior decision affirming without opinion a determination by the Workers' Compensation Board that SAIF is responsible for claimant's hearing loss claim. 61 Or App 296, 656 P2d 964 (1983). We grant the petition to explain our choice of the date of disability, and again affirm.

All of the medical reports in this case establish that claimant has a substantial hearing loss and strongly indicate that it is attributable to "continuous noise exposure in an employment field." Accordingly, the only issue is whether SAIF, as the insurer of the last employer, Beaver Creek, is responsible under the last injurious exposure rule as elaborated by the Supreme Court in *Bracke v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982).

Under the Supreme Court's ruling in *Bracke,* the onset of disability is the triggering date for determination of which employer is the "last potentially causal employer." In this case, claimant never became disabled from work as a result of his hearing loss. Therefore, some other date must be used as the "critical event" in assessing responsibility. Two alternative dates are suggested by the briefs: the date symptoms first appeared, which occurred while claimant was employed by Safeway, or the date on which he first sought medical attention, which occurred while he was employed by Beaver Creek. We believe, as suggested by the Supreme Court in *Bracke,* that the most logical triggering event in the case of a non-disabling injury or disease is the date when medical treatment is first sought. 293 Or at 244.

SAIF contends that the use of that date permits the claimant to control which employer will be liable for his condition by controlling the date on which he first seeks medical treatment. However, if a claimant desires to choose his target, he would have at least as much control over his testimony as to when he first began to have symptoms. The date when a claimant first sought medical treatment, at least in most cases, has some objective relationship to the date when the claimant's condition became a disability, because it is usually documented. We hold, therefore, that, because claimant first sought medical treatment while in its employ, Beaver Creek is the last potentially causal employer. Under the last injurious exposure

rule, claimant can recover against Beaver Creek if he has proven that the working conditions at Beaver Creek could have caused or exacerbated his hearing loss. *Bracke v. Baza'r, supra.* Here, claimant, through testimony, noise tests and the most recent report of Dr. Camp, has met his burden of proving that

his employment at Beaver Creek "could have caused" his hearing loss. *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1980).

Petition for reconsideration granted; reaffirmed.

IN THE COURT OF APPEALS:
U.S. PLYWOOD v. CLARK

Beneficiaries of George Clark (Deceased) WCB 76-06736
Keith Skelton, Petitioner's Attorney CA A23834
Benton Flaxel, Respondent's Attorney May 11, 1983
Before Buttler, Presiding Judge, and Warren and Rossman, Judges

BUTTLER, P. J.

Employer appeals from an order of the Workers' Compensation Board allowing a widow's claim for death benefits. The deceased employe (Clark) was fatally injured when he attempted to retrieve his lunch from the top of a hot glue press where he had placed it for heating earlier in his shift. The sole issue is whether employes' heating their lunches on the press was impliedly allowed by the employer; if it was, then Clark's widow is entitled to death benefits.

This case is before us for the second time. In the initial proceeding, the referee denied compensation; the Board reversed. On appeal, we reversed the Board. *Clark v. U.S. Plywood*, 38 Or App 381, 590 P2d 281 (1979). The Supreme Court granted review to consider the extent to which personal comfort activities of a worker, such as Clark's conduct, are deemed to arise out of and within the course of employment. ORS 656.005(8)(a). It held that the test is whether the conduct is expressly or impliedly allowed by the employer. *Clark v. U.S. Plywood*, 288 Or 255, 266, 605 P2d 265 (1980). The contention here is that the conduct was impliedly allowed, and in that connection the court said:

> "* * * Similarly, where an employer impliedly allows conduct, compensation should be provided for injuries sustained in that activity. For example, where an employer acquiesces in a course of on-premises conduct, compensation is payable for injuries which might be sustained from that activity. Acquiescence could be shown by showing common practice or custom in the work place." 288 Or at 267.

The court remanded the case to us for reconsideration in the light of that test. We remanded to the Board, which remanded to the referee, who held a second hearing. The Board accepted the referee's recommendation that the claim be allowed.

Clark worked in employer's plywood manufacturing plant on the 11 p.m. to 7 a.m. (graveyard) shift. He was allowed a 20-minute meal period. Many employes brought lunches from home, and a substantial number brought meals that required heating. The employer provided a lunchroom, but there were no facilities for heating food. However, the workplace was filled with heat-producing equipment, such as steam pipes, and employes would set their lunches on or beside the

equipment for heating a couple of hours before their meal period. Although there were numerous locations suitable for heating cans of soup, heating pans of food and TV dinners was more of a problem. The most convenient location and, until about one year before Clark's accident, the most popular one for heating such containers was a ledge on top of hot glue press number 1. That practice was well known to employes and supervisors and was not expressly disapproved; the plant superintendent testified that he was aware of the practice.

About one year before Clark's accident, however, a charger was added to the press. In our first opinion we described the press with charger as follows:

> "The machine consists of two large units, the press and the carriage, each about 20 feet high and 15 feet square. When the units are separated, there is a gap approximately three feet wide between them. Chains on each end of the gap prevent one from entering the gap while the machine is in operation. The chains are connected to a fail-safe device; when either of the chains is unhooked, the machine is inoperable. The press is capable of bonding about 25 sheets of plywood at a time, the sheets lying parallel to the floor. The carriage is mounted on tracks which connect it to the press. The major component of the carriage is the charger. It mechanically feeds the press with the wood to be bonded into sheets and is loaded by the operator and his assistant. It is activated by a switch on the operator's control panel. When activated, the carriage moves along the tracks to the press, closing the gap. The charger nests with the shelves of the press. The wood is pushed from the charger into the press by a device which sweeps from the back of the charger to the end nested with the press. Part of that feeding device is a beam which sweeps across the top of the charger. * * *" 38 Or App at 383 n 1.

The addition of the charger made the press dangerous. From each of the chains that barred entry into the area between the carriage and the press hung a sign warning, "DANGER-Keep out," and operators of the machine were instructed to unhook one of the safety chains (which would disable the machine) before entering the gap between the press and the carriage. Clark was crushed by the beam which swept across the top of the charger after he climbed a maintenance ladder onto the top of the charger to retrieve his lunch without unhooking the chain first. When he placed his lunch on the

press, he had unhooked the chain after being instructed to do so by the assistant operator.

Most of the testimony at the second hearing concerned the effect of the addition of the charger on the practice of heating meals on top of the press. All witnesses agreed that the practice dropped off substantially. Supervisors testified that they understood that the practice had stopped completely and that they saw no lunches heated on the press after the charger was added. The plant superintendent testified that he instructed the foremen and the day stock rustler to see that the

practice was discontinued. However, he did not follow up to determine whether the practice was, in fact, stopped, and there was uncontradicted testimony by employes on the graveyard shift that they were not informed that they should no longer heat their lunches on the press.

We agree with, and adopt, the Board majority's summary of the evidence:

> "The sum of the carrier's evidence is that management in the employer's plant was under directions to inform all employees that use of the hot press for heating lunches was forbidden. Management conveyed the directive to the supervisors of each shift, whose duty it was to inform the employees of each shift. Day and swing shifts received the message. Evidence of a communication of the prohibition to the workers on decedent's shift is lacking. The carrier urges us to make a logical inference: Surely if a directive was clearly communicated to two out of three shifts, there exists a compelling inference that the prohibition was in some manner conveyed to the third.
>
> "In view of the testimony of the witnesses who were employed on the graveyard shift, however, that no such prohibition was, in fact, communicated to their shift to the best of their knowledge, the majority of the Board declines to draw the inference urged by the carrier.
>
> "Although management knew of the express prohibition, the workers on the decedent's shift apparently did not. During decedent's shift, the practice continued with varying frequency. This is plausible because, under the mores of the mill, discipline and supervision are most likely to break down first on graveyard shift. When a lunch was placed on top of the press, it could be seen from the floor merely by looking up. For

> this reason, one witness believed that the supervisors of graveyard shift were aware of the fact that the workers were continually using the press to heat their lunches."

We add that by all accounts a substantial number of lunches were heated on the press before the charger was added and that management knew it. With the addition of the charger, management considered the practice to be unsafe[1] but did not take adequate steps to insure that all of its employes were instructed to discontinue it. As a result, the practice continued on the graveyard shift. The lunches were visible, and there was no attempt to conceal them. Although supervisors were in the area often, they did not check the ledge for lunches, despite their knowledge of how widespread the practice had been, because they assumed that no one would use it. Because the employer acquiesced in the practice before the charger was added, that acquiescence continued after the addition of the charger in the absence of the employer's communication to the graveyard shift of the new prohibition.

[1] Because unhooking a safety chain renders the machine inoperable and therefore safe for operators to go between the press and the charger to adjust loads, unhooking a chain presumably renders the machine safe for purposes of placing lunches on the ledge. Apparently, and no doubt correctly, the employer considered heating lunches unsafe, because employes who did so were more likely than operators to neglect to unhook the chain.

We conclude that the preponderance of the evidence supports the conclusion that no such communication to that shift occurred here; therefore, the employer's acquiescence in the use of the press for heating lunches on the graveyard shift continued. Accordingly, the claim is compensable.

Affirmed.

IN THE COURT OF APPEALS:
SAIF CORPORATION v. LUHRS

Robert Luhrs, Claimant — WCB 80-04643
Darrell E. Bewley, Petitioner's Attorney — CA A25587
James O'Rourke, Respondent's Attorney — May 11, 1983
Before Buttler, Presiding Judge, and Warren and Rossman, Judges

BUTTLER, P. J.

SAIF appeals from an order of the Workers' Compensation Board affirming the referee's opinion and order determining that claimant's carpal tunnel syndrome is a compensable occupational disease for which SAIF's insured, Northwest Scientific, Inc., is responsible. Although we believe the Board applied an erroneous rule of law in reaching its result, we affirm.

Claimant has been a welder since 1968; between 1968 and 1976, he welded on either a full or part-time basis. Between 1976 and 1980, claimant was employed continuously as a full-time welder. In the fall of 1976, he began working for Northwest Scientific, at which time he was asymptomatic. In February, 1977, he complained of numbness and tingling in his right hand and pain in his left forearm. On February 14, he consulted Dr. Gray, who attributed the pain and numbness to nerve compression in the neck and diagnosed claimant's condition as a "bursitis-type problem."

In March, 1977, claimant left Northwest Scientific and went to work for Stainless Steel Specialties for about a year. He continued to experience the symptoms about which he had complained in 1977. He returned to Northwest Scientific, where he worked until April or May, 1979, and then worked successively at B & G Quality Welding, Inc., Columbia Body and Empire Machining Co., where he was working at the time of the hearing.

On February 11, 1980, claimant saw Dr. Long, complaining of pain, numbness and tingling in his right hand; that doctor diagnosed carpal tunnel syndrome, which was confirmed by nerve conduction tests. On March 11, claimant, while continuing to work at Empire, filed a claim against Northwest Scientific, which was denied. Between February and August, 1980, the pain in claimant's right hand spread to his shoulder, and he underwent surgery in August. Shortly thereafter, Dr. Long diagnosed carpal tunnel syndrome in claimant's left wrist, and performed surgery for that condition in October.

SAIF relies on two propositions for reversal: (1) that claimant's condition is not an occupational disease as defined in ORS 656.802(1)(a), because he has not shown that on-the-

job conditions were the major contributing cause of his disability, *James v. SAIF*, 290 Or 343, 624 P2d 565 (1981); *SAIF v. Gygi*, 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982); (2) that even if it is an occupational disease, SAIF is not liable under the last injurious exposure rule. *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982). The first proposition fails, because claimant was asymptomatic when he began working for Northwest Scientific and did not develop symptoms requiring medical attention until February, 1977. By that time, he had been employed by that employer for several months. SAIF points out, however, that Dr. Gray did not diagnose a carpal tunnel syndrome and that there is no evidence that his diagnosis was wrong. Although there is no direct evidence of a misdiagnosis, Dr. Long stated in a letter dated April 23, 1981, that, based on claimant's history, his symptoms in late 1976 or early 1977 indicated that claimant's employment at that time was the major significant contribution to his carpal tunnel syndrome for which he underwent surgery. That evidence is sufficient.

SAIF also argues that claimant's off-the-job activity in remodeling his house was the major cause of his disability. However, claimant did not begin that work until his symptoms had already developed to the point where he sought medical help. The medical reports from Dr. Gray indicate that claimant's symptoms at that time were work-related. Dr. Long's opinion, summarized above, indicates that those symptoms continued and that, even though claimant's off-the-job activities could have contributed to the disease, his employment was the major cause. We conclude that claimant's disability is the result of an occupational disease and is compensable.

The more difficult question is whether the last injurious exposure rule permits Northwest Scientific to avoid responsibility. The referee, relying in part on our opinion in *Bracke v. Baza'r*, 51 Or App 627, 626 P2d 918 (1981), held that the employer could not assert the rule as a defense. The Board agreed with that result, but for different reasons, because by the time of the Board's order the Supreme Court had issued its opinion in *Bracke*. The combination of our opinion and the Supreme Court's opinion in *Bracke* and the new rule adopted by the Board here can only lead to confusion. We will attempt to clarify the problem, recognizing that the Supreme Court is the ultimate authority as to what it meant in *Bracke*.

In *Bracke*, the claimant had contracted an occupational disease while working for Baza'r; she worked for several other employers after leaving Baza'r, where the working conditions were similar and could have caused the disease from which she suffered. She asserted her claim against Baza'r, not the last employer. The medical evidence was that she contracted the disease while working at Baza'r and that, having once contracted it, it would get no better and no worse as a result of work exposures. The subsequent exposures would cause the symptoms but would not worsen the disease. We held that the last injurious exposure rule did not preclude the claim-

ant from successfully asserting her claim against Baza'r, because the subsequent work exposures were not injurious within the meaning of the rule. We had previously held in *Holden v. Willamette Industries,* 28 Or App 613, 560 P2d 298 (1977), that the rule works both ways; that is, if the claimant files a claim against his last employer and the record does not disclose whether claimant's disease worsened as a result of work exposure at that employer, the last employer could assert successfully the last injurious exposure rule to avoid liability. We disapproved that holding in *Bracke,* stating that if the claimant files a claim against the last employer where the working conditions could have caused the disease, that employer could not invoke the last injurious exposure rule to avoid responsibility.

The Supreme Court affirmed our decision in *Bracke,* but after discussing the rationale of the last injurious exposure rule and its assertion as a defense by Baza'r, the court stated:

> "The operation of the rule, as we said in *Inkley,* provides certainty in a way which is 'somewhat arbitrary.' It operates generally for the benefit of the interests of claimants. It is fair to employers only if it is applied consistently so that liability is spread proportionately among employers by operation of the law of averages. We hold that employers have and may assert an interest in the consistent application of the last injurious exposure rules, either as to proof or liability, so as to assure that they are not assigned disproportionate shares of liability relative to other employers who provide working conditions which generate similar risk.[5]

That language seems to say that any employer against whom a claim is filed may assert the last injurious exposure

rule as a defense, as in *Holden,*[1] and that our disapproval of *Holden* in *Bracke* was not correct. However, the court added a footnote:

> "There is no reason to apply the rule with any greater arbitrariness than is required to achieve its purposes, but there is no basis in this case to recognize an exception or qualification of the rule. It is arguable that an employer has no interest in the unnecessary dominance of an artificial rule when a claimant foregoes the benefit of the rule and relies upon proof of actual causation. It is questionable whether an employer can invoke the rule of proof as a defense to defeat the rights of a claimant who successfully proves actual causation. To allow that would be to allow an employer to inject the rule into a case to defeat the very interests of a claimant which the rule is intended to serve. Similar considerations may apply in cases presenting limitations problems, *see* n 1. In cases of incremental injury, such as *Inkley,* it may be that an employer may invoke the rule of liability assignment to shift liability to a later employer. Procedures exist whereby any causal employer can join a later causal employer in order to protect its proportional interest. *See, e. g.,* Oregon Administrative Rule 436-54-332. Also, an employer's interests may be protected where, as here, a claimant files against all possibly liable employers. Because we

[1] The author of the opinion in the Supreme Court was the author of the *Holden* opinion in this court.

> hold that disability occurred during Baza'r employment, we need not consider the application of the rules in those situations. *See also, Fossum v. SAIF, supra* at n 1." 293 Or at 249-50 n 5.

We share the Board's uncertainty as to where all of that language leaves us, but we do not agree with the Board that the Supreme Court's opinion in *Bracke* precludes an employer from asserting the last injurious exposure rule to defend its interest when the claim is filed against a single employer. We believe that the right to assert the rule defensively depends on whether that single employer is the last employer where working conditions were such that they could have caused the disease. If so, the rule may not be asserted as a defense. Where, however, the employer against whom the claim is filed is not the last employer where working conditions were potentially injurious, that employer may assert the rule as a defense; however, whether it will be successful depends on the medical

evidence, as in *Bracke.* In this case, the Board adopted the following rule:

> "The rule of law to be applied in claims such as this, where a claimant has filed an occupational disease claim against a single employer, is the rule of *James v. SAIF,* 290 Or 343, [624 P2d 565 (1981), and *SAIF v. Gygi,* 55 Or App 570 [639 P2d 655,] *rev den* 292 Or 825 (1982): whether the claimant's work conditions, when compared to claimant's nonemployment exposure, are the major contributing cause of the claimant's condition. If the employer is able to produce evidence of a subsequent work exposure which may be a contributing cause of the worker's condition, it is appropriate to consider such evidence, together with evidence of possible nonindustrial exposure, in making the determination of whether the exposure at *this* employer's place of business was a major cause of claimant's condition." (Emphasis in original.)

Clearly, that rule is a new one and, although it makes for an easy disposition of this case, it would undermine the last injurious exposure rule. A principal purpose of the rule is to permit a claimant suffering from an occupational disease to file a claim against the last employer where working conditions could have caused the disease, without being required to establish actual causation. *Fossum v. SAIF,* 293 Or 252, 646 P2d 1337 (1982). Under the Board's rule, the claimant would be required to prove that the last employer's place of business was a *major* cause of claimant's condition. We believe that under the Supreme Court's opinion in *Bracke* an employer in the position of Northwest Scientific may rely on the last injurious exposure rule as a defense. However, if, as in *Bracke,* the claimant's evidence is that the working conditions at Northwest Scientific were the actual cause of his carpal tunnel syndrome, the defense will not succeed.

Here the medical evidence indicates that claimant's carpal tunnel syndrome was caused by on-the-job conditions while he was working at Northwest Scientific and that the symptoms gradually worsened until surgical intervention became necessary. The substance of Dr. Long's testimony is

that, once a person develops a carpal tunnel syndrome, the syndrome remains, but the symptoms will vary depending on the person's activity. The claimant's work activity was a "definite aggravation of the symptoms," which will get progessively more painful with activity until surgery may be required to

relieve them. According to Dr. Long, the disease is not cured by surgery, but "you can frequently relieve all of the symptoms." There may, however, be a recurrence of symptoms, not because the disease worsens but because the symptoms do.

On this record, we conclude that claimant's carpal tunnel syndrome was caused by his work activity at Northwest Scientific and that the working conditions at subsequent employers caused an increase in claimant's symptoms until the pain became intolerable and surgery became necessary in 1980.

Accordingly, as in *Bracke,* claimant has established the cause of his occupational disease without relying on the last injurious exposure rule. Although the employer is not precluded from relying on that rule, the record does not support that defense here.

Affirmed.

IN THE COURT OF APPEALS:
BOISE CASCADE CORPORATION v. JONES

Billy Joe Jones, Claimant — WCB 81-06159
J.P. Graff, Petitioner's Attorney — CA A25053
Marianne Bottini, Respondent's Attorney — May 11, 1983
Before Joseph, Chief Judge, and Warden and Young, Judges

YOUNG, J.

The dispositive issue in this workers' compensation case is whether a medically stationary claimant who has completed a vocational rehabilitation program is entitled to temporary disability compensation for the period of time following completion of the program and before the Evaluation Division of the Workers' Compensation Department redetermines his status. The Workers' Compensation Board affirmed the referee's determination that claimant was entitled to the compensation. We affirm.

Claimant sustained a compensable injury in 1977, and a referee awarded permanent partial disability in 1980. While medically stationary, claimant entered a vocational rehabilitation program, which he completed June 13, 1981. Petitioner, a self-insured employer, paid claimant temporary total disability while he was enrolled in the rehabilitation program. ORS 656.268. Petitioner received notice from the Field Services Division that claimant's rehabilitation program was to be completed on June 13, 1981, and on that date petitioner unilaterally terminated the temporary disability payments. Petitioner did not resume the payment of permanent partial disability, because the award made in 1980 had been fully paid.

On July 22, 1981, the Evaluation Division redeter-

mined claimant's status and found that he was medically stationary and entitled to temporary disability compensation during the period when he was enrolled in the rehabilitation program (March 16, 1981 through June 13, 1981), but no permanent partial disability. A hearing was held, pursuant to claimant's request, to determine why temporary disability compensation was terminated June 13, 1981. The referee ordered petitioner to pay claimant temporary disability compensation for the period of June 13 to July 22, 1981, and awarded him attorney fees. On review, the Board affirmed and awarded claimant an additional attorney fee.

Resolution of the issue requires the construction of two administrative rules in the light of the law in effect at the date of claimant's injury. Former ORS 656.268(4) provided:[1]

"If, after the determination made pursuant to subsection (3) of this section, the director authorizes a program of vocational rehabilitation for an injured worker, any permanent disability payments due under the determination shall be suspended, and the worker shall receive temporary disability compensation while he is enrolled in the authorized vocational rehabilitation program. When the worker ceases to be enrolled and actively engaged in an authorized vocational rehabilitation program, the Evaluation Division shall redetermine the claim pursuant to subsection (3) of this section unless the worker's condition is not medically stationary."

Former OAR 436-61-410 provided:[2]

"CLAIM DETERMINATION PROCEDURE. (1) Upon receipt of notice from the Division that the worker has completed or is otherwise not enrolled and actively engaged in an authorized training program, the Compliance Division shall refer the Department claim file to the Evaluation Division for determination pursuant to ORS 656.268, if the worker's condition is medically stationary.

"(2) Workers injured after December 31, 1973, are entitled to temporary disability compensation while enrolled and actively engaged in an authorized training program.

"(3) If the department authorizes a training program after issuance of a determination order, Opinion and Order of a Referee, Order on Review, or Mandate of the Court of Appeals, the insurer shall suspend any award payments due under the Order or Mandate and pay time loss under 61-420(1) and (2).

"(4) During periods of interruption in the program, when temporary disability compensation is not due, the insurer shall resume any suspended award payments.

"(5) Upon completion or termination of the authorized training program, any award payments shall be resumed, pending a subsequent determination order by the Evaluation Division, unless the worker's condition is not medically stationary."

Under this rule, when an injured worker enters a

[1] Subsections of ORS 656.268 have been renumbered; however, the operative language remains the same: *e.g.*, ORS 656.268(3) is now ORS 656.268(4), and ORS 656.268(4) is now ORS 656.268(5). *See* Or Laws 1979, ch 839, §4.

[2] The amendments to OAR 436-61-410 are not material to our analysis.

vocational rehabilitation program, payment of permanent disability benefits ceases and payment of temporary compensation begins. When the worker completes the program, payment of unpaid and previously awarded permanent disability benefits resumes pending redetermination by the Division.

OAR 436-61-420(1) provides:

> "Subject to 61-410(2), the insurer shall pay temporary disability compensation to a worker who is enrolled and actively engaged in an authorized training program, *and payments will continue until termination of compensation is authorized by the insurer or the Department, as provided in ORS 656.268.* (Emphasis supplied.)

Petitioner contends that the emphasized language in this rule conflicts with former ORS 656.268(4) and OAR 436-61-410. Petitioner argues that ORS 656.268 does not require payment of temporary disability compensation beyond the date of completion of an authorized rehabilitation program. We disagree. Former ORS 656.268(4) clearly requires that a claim be redetermined following completion of a rehabilitation program. That redetermination must be completed within 10 working days after receipt of notice of termination of the program, unless additional information is required.[3] As observed by the Board, the requirement that the claim be redetermined serves as a stimulus to employers and carriers promptly to submit the claim for redetermination.

Petitioner is correct that OAR 436-61-150(2)[4] does not allow an insurer reimbursement from the Rehabilitation Reserve for any time loss paid beyond the completion date of the rehabilitation program. Former ORS 656.268(3) does, however, provide a method for recovery of temporary disability compensation paid beyond the termination date of a vocational rehabilitation program:

> "* * *Any determination under this subsection may include necessary adjustments in compensation paid or payable prior to the determination, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid. * * *"

When there is no permanent disability award against which to offset, an employer is obliged to absorb the temporary disability paid after claimant's completion of the rehabilitation program. Neither ORS 656.268(4) nor the rules allow petitioner unilaterally to terminate temporary total disability payments.

Affirmed.[5]

[3] The version of the statute in effect at the time of claimant's injury allowed the Evaluation Division 30 days to redetermine the claim. Or Laws 1979, ch 839, §4.

[4] OAR 436-61-150(2) provides:

> "Temporary disability benefits are reimburseable only for the actual time the worker is enrolled and actively engaged in training."

[5] Our disposition of employer's first assignment of error makes unnecessary consideration of the remaining assignment. Furthermore, although claimant may have sustained an aggravation during the vocational rehabilitation period, the matter was not before the Referee and the Board, and it is not before us.

IN THE COURT OF APPEALS:
MUNGER v. SAIF CORPORATION

Norman G. Munger, Claimant — WCB 81-05855
Alan M Scott, Petitioner's Attorney — CA A26056
Donna M. Parton, Respondent's Attorney — May 11, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges

NEWMAN, J.

Claimant appeals from an order of the Workers' Compensation Board reversing the referee's award of permanent total disability and awarding him 75 percent permanent partial disability. We reverse and reinstate the referee's order.

Claimant is in his mid-50s, has an eighth- to tenth-grade educational level and is experienced as a truck driver and laborer. He injured his back at work, suffering a herniated intervertebral disc. He has had two lumbo-sacral surgeries, the last of which left him with a weakness in the right leg and also an inability to urinate that a urologist diagnosed as a neurogenic dysfunction of the bladder of the flaccid type secondary to disc disease and back injury. He stated that the impairment of the bladder function was permanent and irreversible, requiring self-catheterization to urinate. The treating physician imposed work limitations of no lifting greater than 35 pounds; bending, stooping and crawling were not recommended. Claimant also has chronic paranoia, with a profound thought disorder.

Claimant had been employed many years in a company where he was supervised by his brother-in-law and had acquired seniority with the firm. He perceived the job to be safe, secure and non-threatening. The work involved loading and unloading framing lumber for construction and constant bending, lifting and repetitive handling of heavy loads. Due to his disabilities he was unable to continue to work for that employer.

The referee stated that no suitable or gainful work had been suggested for claimant and that realistically there was no present place for him to work with his skills and training that would have facilities that would enable him to catheterize himself during the day. The catheterization process, in order to be performed safely in an employment situation and reduce the risk of infection, requires a sterile shelf or table in an employer's restroom. It has to be performed approximately three times during each normal eight-hour work day and takes 15 minutes each time.

The board concluded that claimant was not permanently and totally disabled. It did not believe the catheterization problem was insurmountable and stated that claimant

could
adjust to other working situations and that his motivation was suspect.

Claimant's bladder problem developed in connection with the second surgery. Before the operation, Dr. Vincent Glauden, a clinical psychologist, reported

> "[A]pparently this man has been able to work despite a chronic paranoid schizophrenic condition because his employer has provided a vocational role which protected the client. Now in the face of physical disability and the possibility of some type of re-adjusted vocational role, the patient's psychiatric disorder is a severely limiting condition. It would appear that unless he can return to a highly protected job, the combination of physical and psychiatric disability makes him a candidate for permanent and total disability. * * *In any event, I do not believe that he has any capacity to adapt to a new vocational situation."

Claimant was rereferred to Ingram and Associates following the second surgery. Their report reads

> "[U]nfortunately, his physical limitations are even greater [now] than in 1980, when we gave the opinion that Mr. Munger was not feasible for vocational rehabilitation. Physical limitations coupled with severe and chronic psychiatric conditions (paranoid schizophrenia) were the basis of this opinion. * * *
>
> "* * * * *
>
> "We continue to believe that based upon Mr. Munger's work history of 20+ years with the same employer (a relative who apparently accommodated client's idiosyncracies), his age, 54, physical impairments and limits (20 lbs. occasionally, ambulation problems, incontinence - he must catherize [sic] himself each time), eight grade education, severe paranoid schizophrenia, he is not feasible for vocational rehabilitation. We regret we are not able to assist this sincere and interesting claimant."

Wilson Walker, a vocational consultant, stated that suitable restroom facilities for the catheterization process that claimant requires are difficult to find. While there might be restroom facilities with relatively private stalls and necessary clean tables or shelves available for catheterization on a single occasion, none would be suitable for catheterization three or four times a day, five days a week. It was also his opinion that claimant did not have transferrable skills. At the hearing

before the referee Walker responded to questions as follows:

> "Q. Now, taking those jobs and adding to – I guess it really isn't a hypothetical – adding to what the testimony and the review of the exhibits – if you add to that the Claimant's testimony and documented by the medical reports that he needs to have a sterile environment in which to catheterize himself, the catheterization taking approximately fifteen minutes and he has to do it in an eight-hour workday, it would probably have to be done in an eight-hour workday, at least twice, in your opinion could he engage in any of those jobs that you have just discussed?
>
> "A. No, he could not.
>
> "Q. Why not?
>
> "A. I have looked into the different agencies before this hearing because I was concerned about this issue and they do not have a central place available that would allow him to sterilize this and take that time off from an eight-hour job.

"Q. Were you able to come up with any jobs based on your past experience and training and association with various employers, any job that this man could do at the present time with the various physical problems he has, including the need for the catheterization?

"A. No, I could not."

Given claimant's physical and mental conditions, it is unrealistic to say that claimant has a reasonable expectation of being able to sell his services to an employer. *Looper v. SAIF,* 56 Or App 437, 642 P2d 325 (1982); *Wilson v. Weyerhaeuser,* 30 Or App 403, 567 P2d 567 (1977). Under the circumstances it would have been futile for claimant, even with the best of motivation, to attempt to find employment. *Fitzpatrick v. Freightliner Corp.,* 62 Or App 762, ___ P2d ___ (1983); *Looper v. SAIF, supra; Morris v. Denney's,* 50 Or App 533, 623 P2d 1118, *remanded* 53 Or App 863, 633 P2d 827 (1981); *Butcher v. SAIF,* 45 Or App 313, 608 P2d 575 (1980); *see also Deaton v. SAIF,* 13 Or App 298, 509 P2d 1215 (1973). Claimant has sustained his burden of proof that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a).

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS:
SHAW v. SAIF CORPORATION

Donald K. Shaw, Claimant — WCB 81-05922
J. Michael Alexander, Petitioner's Attorney — CA A26071
Darrell E. Bewley, Respondent's Attorney — May 11, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges

NEWMAN, J.

Claimant appeals the Workers' Compensation Board's order reversing the referee's award of increased permanent partial disability. The Board found that the referee lacked jurisdiction. We conclude that the referee had jurisdiction and reverse and remand to the Board to review the referee's award on the merits.

Claimant was employed by the Oregon Department of Commerce, Building Codes Division, as an electrical inspector. As part of his employment he was required to drive from 2,500 to 3,000 miles each month to perform inspections. On June 2, 1978, he suffered injuries when the state vehicle he was driving collided with another vehicle on the highway. He suffered facial lacerations, a facial bone fracture, laceration of the left wrist and damage to his left shoulder, back and right knee. In addition to experiencing particular problems with his right knee, he developed a psychological problem diagnosed as a driving phobia. He received surgery on his knee and psychotherapy for his neurosis.

On July 14, 1980, a determination order was issued awarding temporary total disability from June 2, 1978, through June 2, 1980, and 30 degrees permanent partial disability for loss of the right leg. On August 15, 1980, a second determina-

tion order was issued, rescinding the first order and reopening the claim. On October 28, 1980, a third determination order closed the claim a second time, awarded temporary total disability for the period June 2, 1978, through August 1, 1980, and for September 10, 1980, and awarded the same permanent partial disability as the first determination order, that is, 30 degrees for loss of the right leg.

Claimant returned to work on August 1, 1980, and worked until November, 1980, but continued to experience problems, primarily psychological, when driving. He took a leave of absence beginning in November, 1980, and has not returned to work.

On November 28, 1980, claimant wrote the Workers' Compensation Department, Evaluation Division, requesting reconsideration of the October 28, 1980, third determination order. He stated that he was "dissatisfied with the determination that has been made with regard to my knee. However, I will

pursue this at a later time." Claimant was advised that the medical opinions in the file at the time the third determination order was issued showed his condition was medically stationary and that a request for reconsideration must provide additional medical information that was not available at the time the determination order was issued. The Workers' Compensation Department letter also advised that, because claimant's letter "indicates on-going problems with the inability to continue working, we suggest you contact your doctor or your insurer about possible reopening of your claim."

On June 24, 1981, claimant retained his present attorneys to handle his workers' compensation claim. On June 25, 1981, his attorney wrote to the Board's Hearing Division:

> "This claim was closed by Determination Order of July 14, 1980, which was followed by a Determination Order dated August 15, 1980. Claimant disagrees with both Determination Orders and is accordingly requesting a hearing. The issue to be resolved at the hearing is the extent of permanent partial disability, and in addition claimant contends that he should have been awarded permanent partial disability for a psychiatric condition which he has developed as a direct result of the industrial accident of June 2, 1978."

Although the third determination order had been received by claimant in November, 1980, his attorney was unaware of it until he received a copy just prior to the hearing in January, 1982.

SAIF argues that the referee lacked jurisdiction to hear objections to the third determination order because claimant's attorney, in his request for a hearing, referred only to the first and second determination orders, and not to the third order. SAIF maintains that the controlling statute is ORS 656.319(2), which provides:

> "With respect to objections to a determination under ORS 656.268 (3), a hearing on such objections shall not be granted unless a request for hearing is filed within one year after the copies of the determination were mailed to the parties."

Claimant argues that the request for hearing of June 25, 1981, was filed within the one-year period required by ORS 656.319(2). The issue, he argues, is only the sufficiency of the request.

One of the objectives of the Workers' Compensation Law, as provided in ORS 656.012(2)(b), is

> "[t]o provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable * * *."[1]

We interpret ORS 656.319, therefore, in a manner consistent with the legislative declaration to eliminate "the adversary nature of the compensation proceedings, to the greatest extent practicable."

Here claimant's request for a hearing followed all three determination orders within one year of their issuance. The third determination order provided the same permanent partial disability as the first one. There is no claim of surprise, which would have provided a basis for continuance. OAR 436-83-200. The issues are clearly raised by claimant's June, 1981, request for a hearing, quoted above. Claimant's objections to the third determination order are the same as those to the first and second. In the light of the declared purposes of the Workers' Compensation Law, we find that claimant's request for a hearing was timely filed and sufficient to raise objections to the third determination order.[2]

The Board based its decision denying jurisdiction principally on a statement of claimant's counsel at the hearing:

> "So I think it goes without saying, I can clearly state for you we did not appeal within a year any October 28, 1980, determination order."

The Board concluded that the statement of counsel amounted to an admission that there was no jurisdiction in the referee to hold a hearing on objections to the third determination order.

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[1] The administrative rules of the Board also provide that its policy is "to expedite claim adjudication and amicably dispose of controversies. These rules shall be liberally construed in favor of the injured worker to carry out the remedial and beneficent purposes of the Workers' Compensation Law." OAR 436-83-020.

[2] We also note that ORS 656.283(2) provides:

> "A request for a hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, requesting the hearing, stating that a hearing is desired, and mailed to the board."

OAR 436-83-200 provides that:

> "In addition to the statutory requirements of ORS 656.283, the request for hearing shall state the issue(s) to be resolved. Failure to state an issue may be grounds for continuance if the adverse party is surprised thereby."

Claimant's request for a hearing complied with both ORS 656.283(2) and the rule just quoted. If claimant's request for a hearing had made no reference at all to the first and second determination orders, it would clearly have been sufficient.

We disagree. Counsel's statement, when read in context of his entire statement, clearly is not an admission that the referee lacked jurisdiction. To the contrary, counsel's full statement asserts that the referee had jurisdiction to proceed on claimant's objections to the third determination order.

We hold that the Board erred in finding that the referee lacked jurisdiction to consider the third determination order and reverse and remand to the Board to review the referee's award on the merits.[3]

Reversed and remanded for review on the merits.

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[3] Although not necessary to the result here, we also note that ORS 656.319(2) on which SAIF relies is of uncertain applicability. All the determination orders were made pursuant to ORS 656.268(4), not ORS 656.268(3). When the legislature amended ORS 656.268 in 1979, Or Laws 1979, ch 839, §4, it added to ORS 656.268 the present subsection (3) and renumbered the prior subsection (3) to be what is now substantially the present subsection (4). It did not amend ORS 656.319(2) to change the reference therein to ORS 656.268(3). By its terms ORS 656.319(2), therefore, does not apply to the third determination order. ORS 656.268(6), which is clearly applicable, provides:

> "The Evaluation Division shall mail a copy of the determination to all interested parties. Any such party may request a hearing under ORS 656.283 on the determination made under subsection (4) of this section within one year after copies of the determination are mailed."

This section does not contain the recitation in ORS 656.319(2) that "a hearing on such objection shall not be granted unless" a request is timely filed. The language of ORS 656.268(6) is permissive and is not inconsistent with our decision.

IN THE COURT OF APPEALS:
DAVIS v. SAIF CORPORATION

Harold W. Davis, Claimant — WCB 82-01397
David A. Dorsey, Petitioner's Attorney — CA A26319
Darrell E. Bewley, Respondent's Attorney — May 11, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges

NEWMAN, J.

Claimant appeals the Workers' Compensation Board's order reinstating and affirming SAIF's denial of the claim. The Board reversed the referee's order that SAIF accept the claim as nondisabling. We reverse and reinstate the referee's order.

Claimant was employed by the city of Coos Bay. He claimed that he injured his right knee on February 9, 1981, while repacking a pump. The task required him to kneel on a concrete floor for an extended period of time.

He reported the injury to his supervisor on February 10. The supervisor signed and filed an accident report. His coworker, Green, signed the accident report as a witness. Green testified that he had worked with claimant in February, 1981, and that claimant had mentioned to him that he had injured his knee. On February 13, 1981, claimant went to his physician, Dr. Henke, who had last seen him on January 28, 1981, and had been treating him for several problems. The doctor's medical record for the February 13 visit reads:

"His other problems at the present time include knee pain. He states that last summer he knelt on a grate. A couple of weeks after that he began to notice pain in the right knee. There is no locking or giving out but it occasionally does snap and swells a little. recently this has been worse. He apparently had some sort of injury in the lateral portion of the knee or upper lateral calf in 1979 which prompted him to lose a couple of weeks of work."

Claimant saw Dr. Henke again on March 13, 1981. The doctor reported with respect to the knee "His only other problem is some intermittent pain in the right knee - see the prior clinic note. For the present he is to continue taking the occasional Motrin for that."

On May 14, 1981, and July 20, 1981, claimant again saw Dr. Henke, but about other problems. The doctor's record does not refer to any knee complaint. On September 28, 1981, he again visited Dr. Henke, who reported:

"Mr. Davis presents today because of right knee pain. This first started in Feb. of this year after he did some kneeling on a concrete floor. Since then the pain has occurred off an on, seems to be gradually increasing. It is aggravated by walking

and at times when walking he hears a click in the knee. It is also aggravated by driving his car and at times it keeps him awake at night. Knee has not been swelling. At times it does feel a little unstable. It does not lock. Prior injury is denied, although he has had a prior muscle injury in the right calf.

"O - Weight 195 - unchanged. BP 120/80. Right knee is not swollen, and it is not warm. Ligaments are intact. No patellar crepitation is felt.

"LAB: X-ray of the right knee is relatively unremarkable.

"A - Knee pain, probably secondary to prepatellar bursitis or chondromalacia.

"P - Trial of naproxen 250 mg. q.a.m. He is to call back with a progress report with respect to his response to that."

SAIF denied the claim on the ground that the injury was unrelated to claimant's job. Although the referee found the injury compensable, the Board concluded that claimant had failed to carry his burden of proof:

"Claimant had right knee complaints some two weeks prior to the alleged event. Upon examination four days after the alleged injury claimant gave a history to Dr. Henke of injuring the right knee the summer before while kneeling on a grate. Claimant left this employer in August 1981 and really sought no medical treatment for his knee until September 1981 when he was employed by another employer in a job requiring walking and driving.

"Further, there is no medical opinion evidence that claimant's right knee condition arose out of the alleged incident at work on February 9, 1981. * * *"

We do not agree with the Board's statement of facts or its conclusions. Dr. Henke's report of claimant's visit of January 28, 1981, makes no reference to "right knee complaints." The Board also stated that there was no mention of any leg problems on claimant's visit to Dr. Henke on March 13 and

that claimant had sought no medical treatment for his knee until September, 1981. Dr. Henke's report is to the contrary. Claimant did seek medical treatment for his knee on both February 13 and March 13, 1981.

Although Dr. Henke's report of February 13 states that claimant told him that he had knelt on a grate the previous summer and a couple of weeks thereafter had noticed pain in the right knee, the referee could still find the claimant to be

credible.[1] His co-worker and supervisor both stated that claimant reported the injury to them promptly and before the visit to Dr. Henke occurred. Claimant's co-worker Green testified that he had also suffered pain in his knees when he knelt at work.

The referee concluded that the injury was a result of a specific incident that occurred on February 9, 1981. In matters of credibility we defer to the judgment of the referee who heard the testimony of claimant, his co-worker and his supervisor. *See Hannan v. Good Samaritan Hosp.*, 4 Or App 178, 471 P2d 831, 487 P2d 931 (1970), *rev den* (1971). We find that the record supports the referee's finding that claimant's nondisabling injury arose out of the incident at wor on February 9, 1981. Medical opinion evidence of causation is not necessary for this uncomplicated claim. *Uris v. Compensation Department*, 247 Or 420, 427 P2d 753, 430 P2d 861 (1967).

Reversed; the referee's order is reinstated.

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[1] At the hearing claimant was asked about the injuries to his knee in the summer of 1980 and February, 1981:

"Q. The doctor mentions, I think he says, you described your hurt in your knee as being a strain in your knee from bending over a grate last summer. What was that about?

"A. We wanted a particular sample for some reason, I can't remember the reason for getting the sample, but it would require going on a metal catwalk there. The sample I wanted to get was underneath it, so we had a short pull with a container on it and I knelt down on the steel grating and picked the sample and stood back up, again, and that's what happened. It stayed sore for just a little while, and then I forgot about it.

"Q. How long did that take? Did it take a half hour or just a couple of seconds?

"A. Oh, just a few seconds.

"Q. Do you recall mentioning that business with the grate to the doctor?

"A. I can't recall it, now.

"Q. Do you recall mentioning to the doctor the injury to your knee from kneeling on the concrete just a few days before you went to the doctor?

"A. I can't swear to it, no.

"Q. You were primarily being treated by Dr. Henke at that time for what?

"A. High blood pressure."

IN THE COURT OF APPEALS:
UNITED PACIFIC INS. CO. v. HARRIS et al

Margaret L. Harris, Claimant
Brian Pocock, Petitioner's Attorney
Stephen Frank, Attorney
Garry L. Kahn, Attorney
WCB 80-02418 & 80-06627
CA A24835
May 25, 1983

Before Richardson, Presiding Judge, Joseph, Chief Judge, and Van Hoomisen, Judge

JOSEPH, C. J.

The issue in this Workers' Compensation case is which of two successive insurance carriers is responsible for disability benefits for claimant's occupational disease.[1] The referee and the Board held the second insurer responsible. We reverse and remand.

The facts are uncontested. Claimant, a 47-year old woman, first suffered severe low back pain in 1970 while working at a laundry. She was hospitalized, and a lumbar laminectomy was performed. She received a permanent partial disability award. She continued working in hotels and restaurants despite her back problem. In 1973, she suffered an episode of back pain while making a bed. Her problem was diagnosed as chronic low back strain with lumbosacral disc degeneration. After physiotherapy, she substantially recovered and suffered no significant back problems after February, 1974.

Claimant began working for employer, a restaurant operation, in April, 1978. She was responsible for making salads and setting up the food line, which involved lifting large quantities of food. In September, 1979, the restaurant began a $1.99 lunch special, and that increased the weight of materials involved in claimant's work. Over the next three months, she developed left leg numbness and tingling and low back pain and numbness, but she continued on the job. The restaurant manager was aware of her back problems and sometimes helped her lift heavy items.

On December 18, 1979, claimant visited Dr. Rockey, who referred her to Dr. Englander. When she visited Dr. Rockey, Aetna Insurance Company was on the risk. However,

on January 1, 1980, the restaurant changed insurance carriers to United Pacific Insurance Company. Claimant saw Dr. Eng-

[1] Citing ORCP 9A, Aetna moved to dismiss United Pacific's petition for judicial review on the ground that Aetna's attorneys were not served with a copy of the petition. That motion was denied. In its brief, Aetna renews the motion. Although ORS 656.298(3), the statute controlling judicial review in Workers' Compensation cases, requires that a notice of appeal be sent to all *parties*, it does not *require* that it be sent to all *attorneys* representing the parties.

Aetna also argues that the petition should be dismissed because it does not set out verbatim the pertinent portions of the record as required by ORAP 7.19, which states in part:

> "An assignment of error must be specific and must set out verbatim the pertinent portions of the record, *if it relates to a specific ruling of the court.*" (Emphasis supplied.)

That rule does not apply in this case.

lander on January 8, 1980. He instructed her to continue with an exercise program that she had begun three weeks earlier and treated her conservatively on an out-patient basis. She continued her regular work. Later in January claimant again saw Dr. Englander, who diagnosed a recurrent lumbar strain or a herniated disc. He told her to leave work, because conservative treatment had not succeeded in improving her symptoms.

She was hospitalized for further conservative treatment for her condition, by then diagnosed as lumbosacral strain. She gradually improved and was discharged in February. She was eventually released for full-time work with no lifting over 20 pounds, but with a recommendation that she change jobs.

The referee characterized claimant's condition as an occupational disease. The Board agreed, and neither party challenges that characterization. (*But see Donald Drake Co. v. Lundmark,* 63 Or App 261, ___P2d ___(1983).) Compensability is not in issue.

Dr. Englander provided the only medical opinion regarding the contribution of claimant's employment to her back condition. He said that her condition had stabilized in December, 1979, and had remained essentially the same when he told her to stop work in January, 1980. He did not think that her employment after January 1, 1980, contributed to or affected her condition, but he admitted that it was "conceivable" that it had. Because of that possibility, the referee and the Board concluded that the "last injurious exposure" rule applied and that United Pacific, which was on the risk at a time when claimant's employment *could have contributed* to her disabling disease, was responsible.

Two conditions must be met for the assignment of responsiblity to a carrier under the "last injurious exposure" rule.[2] Not only must the carrier be on the risk at the time working conditions were such that they *could have contributed*

to claimant's disability, but claimant must also *have become disabled* during that time. *Bracke v. Baza'r, Inc.,* 293 Or 239, 247-249, 646 P2d 1330 (1982).

The decisive question then is when claimant became disabled. She sought medical treatment in December, 1979, for a condition which thereafter remained unchanged until she left work in January, 1980. Thus, in December, 1979, she was afflicted with a condition that had required medical treatment for symptoms that had interfered with her ability to work. She was disabled at that time, and the insurer then on the risk is responsible. *See Bracke v. Baza'r, Inc., supra,* 293 Or at 243-244; *see also SAIF v. Baer,* 60 Or App 144, 652 P2d 873 (1982).

Reversed and remanded for entry of an order that Aetna Insurance Company is responsible for claimant's occupational disease.

[2] The "last injurious exposure" rule applies to successive insurers of the same employer, as well as to successive employers. *Bracke v. Baza'r, Inc., supra,* 293 Or at 244 n 2.

IN THE COURT OF APPEALS:
DONALD M. DRAKE CO. v. LUNDMARK et al

Steven Lundmark, Claimant WCB 80-04474 & 80-03297
Margaret H. Leek Leiberan, Petitioner's Attorney CA A22003
Randee Fenner, Attorney May 25, 1983
Michael N. Gutzler, Attorney
Before Richardson, Presiding Judge, Joseph, Chief Judge, and Van Hoomisen, Judge.

JOSEPH, C. J.

The issue in this case is which of two successive employers is responsible for compensation for claimant's back condition. Both denied compensability. The first employer, Fred J. Early Company (Early), contended that the back problem was not the result of an injury incurred during employment with the company. The second, Donald Drake Company (Drake), claimed that the condition resulted from a pre-existing back problem. The referee characterized the condition as an injury incurred during the fist employment and held Early responsible. The Board found that the condition was an occupational disease and, applying the "last injurious exposure" rule, held Drake responsible.

Neither party contends here that claimant's back condition is anything other than an occupational disease. Both parties argue about the proper application of the "last injurious exposure" rule.[1] Nevertheless, whether it was proper to apply the rule to hold Drake responsible depends on whether claimant's condition was an injury or a disease. *Boise Cascade Corp. v. Starbuck*, 61 Or App 631, 659 P2d 424 (1983). Unlike the situation in *United Pacific Ins. v. Harris*, 63 Or App 256, ___ P2d ___ (1983), where the referee and the Board both treated the claim as involving an occupational disease, and no party challenged that characterization in this court, the Board here rejected the referee's injury characterization. The nature of the claim is decisive.

Claimant, 31 years old, had worked for eight years as an "operating engineer' before beginning work for Early on January 21, 1980. He had had no previous back problems. At

Early, half of his work day consisted of operating a front-end loader to scoop up materials and "ram" them into a pile. The

[1] Drake argues that, under *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982), it is entitled to shift responsibility imposed under the "last injurious exposure" rule to Early by showing that claimant's previous employment *actually* caused his "disease." *Bracke* does not say that proof of actual causation is a defense to liability that may be asserted by the last employer. *SAIF v. Luhrs*, 63 Or App 78, ___ P2d ___ (1983). As stated in *Fossum v. SAIF*, 293 Or 252, 256, 646 P2d 1337 (1982), decided the same day as *Bracke*,

> "In applying the last injrious exposure rule to claims for occupational diseases, however, the issue is not which employment *actually caused* the disease, but which employment involved conditions which could have caused it." (Emphasis supplied.)

Bracke holds only that, when a claimant proves actual causation during a previous employment, that employer cannot use the "last injurious exposure" rule to assign responsibility to a later employer merely because the latter employment could have caused the disease.

remainder involved operating a crane and doing light manual lifting. He testified that operation of the loader required "constant turning and moving and back and forth balancing."[2] He said that after two or three weeks he started having trouble with the transmission on the loader and, when he attempted to change directions with the machine, it would "instantaneous[ly] grab" as if he were "driving into a brick wall," causing a "terrific shock" that was "really affecting [him]." At the same time the loader's transmission troubles began, claimant also began to have neck and back pains. He said that he had complained about the pain to other employes. He continued operating the loader throughout his employment with Early, and his back pains grew progressively worse. He was fired on March 3, 1980, for tipping over a crane that he was operating without safety cantilevers.

Claimant was unemployed for about a week. During that time, his pain "seemed to kind of relieve itself a bit" but did not go away. Nevertheless, he called his union and said he was ready to go to another job. On March 12, 1980, he began a three-day job with Drake that involved running front-end loaders similar to the one at Early, but larger and more smooth running. They had no transmission problems. They bounced when he drove over potholes, but he said that the road conditions were the same at both jobs. He testified that, after two nine-hour work days at Drake, he could not stand the pain any longer and did not return to work.

Claimant was diagnosed as having "thoraco-cervical strain with attendant mild myofascitis." He was seen twice by Dr. Ebert, who reported:

> "The [patient's] medical condition is clearly related to his employment in February of 1980. The 2 days which he worked subsequently for Donald M. Drake only resulted in temporary symptomatic worsening."

He was also seen by Dr. Pasquesi, who concluded:

> "In my opinion, this patient has an occupational disease, which admittedly was becoming worse for a month or so prior to leaving his employment before working for the Donald M. Drake Company and made worse by the work at the Donald M. Drake Company.
>
> "From a medical standpoint, both conditions are applicable as far as respnsibility of his symptoms and having to lay off work, but the patient was having increasing symptoms before working the last two days at the Donald M. Drake Company. He admittedly became worse at the Donald M. Drake employment."

On March 14, 1980, claimant filed a claim with Drake, describing his "injury" as "[d]riving the loader jolted me too much, creating pain in neck and back."

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[2] Claimant said that, if he were working with the loader for *eight* hours, it would go forward or backward "probably 300 or 400 times."

He indicated the date or hour of injury was "All day" on March 13, 1980. On April 9, 1980, he also filed a claim with Early, stating, "I was operating heavy equipment, front end loader, and it caused back and neck to hurt," which occurred in February, 1980.

The referee found:

> "* * * [C]laimant's employment at Fred J. Early Co. in operating the old loader to have placed sufficient strain on his body to cause his injuries to his neck and back. This conclusion is supported by Drs. Ebert and Pasquesi * * *. Claimant's subsequent difficulty while at Donald M. Drake Co. was not a new injury but a worsening of claimant's injury which he received while at Fred J. Early Co."

The Board disagreed. It found that

> "* * * under the standards of *James v. SAIF,* 290 Or 343, 348 (1980), claimant has an occupational disease. In such a situation, the most recent employer is responsible under the last injurious exposure rule if that employment environment 'could have' contributed to the disease. *Inkley v. Forest Fiber Products Co.,* 288 Or 337, 344 (1980). From Dr. Pasquesi's opinion that claimant's work for the second employer, Drake, *did* worsen his condition, it rather easily follows that claimant's work at Drake *could have* contributed to the disease and Drake is responsible." (Emphasis is the Board's.)

In *James v. SAIF,* 290 Or 343, 624 P2d 644 (1980), the Supreme Court approved the distinction made between

"injury" and "disease" in *O'Neal v. Sisters of Providence,* 22 Or App 9, 537 P2d 580 (1975), where we quoted 1B Larson's Workmen's Compensation Law §41:31:

> "* * * What set[s] occupational diseases apart from accidental injuries [is] both the fact that they can[not] honestly be said to be unexpected, since they [are] recognized as an inherent hazard of continued exposure to conditions of the particular employment, and the fact that they [are] gradual rather than sudden in onset. * * *"

In *Valtinson v. SAIF,* 56 Or App 184, 188, 641 P2d 598 (1982), we construed the phrase "sudden in onset" to mean occurring during a short, discrete period, rather than over a long period of time. Claimant's condition meets this aspect of the injury test in that his back trouble *coincided precisely* with the traumatic jolting of the faulty loader. Claimant thus points to an identifiable event that caused his disability. The fact that his pain grew progressively worse over his six-week employment with Early does not make it "gradual in onset."

Moreover, claimant's condition meets the second aspect of the injury test in that it was unexpected. He had operated similar equipment for eight years prior to his employment with Early without any back trouble. It is more likely that his back condition was the result of the jolting of the loader at Early than "an inherent hazard from continued exposure" to the operation of front-end loaders, which the referee found usually involves bumping and bouncing.[3]

We conclude that claimant's back strain was the

result of an injury which occurred at Early, rather than an occupational disease. *See Boise Cascade v. Starbuck, supra,* 61 Or App at 641. The "last injurious exposure" rule is inapplicable. Early is responsible.

Reversed and remanded with instructions to reinstate the referee's order.

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[3] The concurrence would have us say that it is not unexpected that the operation of front-end loader with faulty transmission could cause disability and that, therefore, we recognize that claimant's back trouble is an "inherent hazard of continued exposure to conditions of [his] particular employment." To read this aspect of the "rule" as narrowly as the concurrence would have us do runs counter to our commonsensical notion of what institutes a traumatic injury. In that view, any disability caused by the faulty malfunctioning of equipment requiring repetitive operation would be treated as a disease. There is no authority for that.

RICHARDSON, P. J., specially concurring.

In determining which of two successive employers is responsible for compensation for claimant's present back condition, the lead opinion concludes the dispositive analysis is whether the cause of the disability is an injury or an occupational disease. The opinion states that there was an injury and that Early is responsible. I disagree with the conclusion that claimant's disability is the result of an injury rather than an occuptional disease. I, however, agree that Early is responsible for the claim.

The distinction between industrial injury and occupational disease has become blurred under the Workers' Compensation Act but it still is important, at least for the purpose of time limitations for claim filing and for application of the last injurious exposure rule. *See, e.g., Boise Cascade Corp. v. Starbuck,* 61 Or App 631, 659 P2d 424, *rev allowed* 294 Or 792 (1983). The distinction also assumes some importance in determining the cause of the disability, *i.e.,* whether the disability is related to the work environment. The definition of occupational disease devised by the courts is based, in part, on the necessities of applying the dictates of the Act and is not necessarily consonant with the medical definition of disease. In some measure the definition is an attempt to contrast occupational disease with accidental injury.

The key case for the appropriate definition of occupational disease under the Act is *O'Neal v. Sisters of Providence,* 22 Or App 9, 537 P2d 580 (1975). In that case we adopted the substance of the definition from 1B Larson's Workmen's Compensation Law §41:31:

> "* * * What set[s] occupational disease apart from accidental injuries [is] both the fact that they [can] not honestly be said to be unexpected, since they [are] recognized as inherent hazard of continued exposure to conditions of the particular employment, and the fact that they [are] gradual rather than sudden in onset. * * *"

The facts of *O'Neal* put the definition in context. The claimant worked as a hospital maid which required her to push a heavy

cleaning cart over the carpeted hallways. As a result, she developed strain and muscle spasms in her legs causing her disability. We held that she was suffering from an occupational

disease because the results were gradual in onset, as they occurred over a period of time and could not honestly be said to be unexpected, *i.e.*, it could be expected that pushing a heavy cart would cause strain and muscle spasms in the worker's legs. One of the principal bases for the distinction between the two types of disability we noted in *O'Neal* is that an accidental injury results from a distinct identifiable event such as a trauma that a worker can point to as the precipitating cause of the disability.

As we indicated in *Valtinson v SAIF*, 56 Or App 184, 641 P2d 598 (1982), the identifiable event distinguishing an injury from an occupational disease need not be an instantaneous happening. In *Valtinson* the claimant, who had been free from back pain for some period of time, drove a van from Grants Pass to Portland and experienced back pain during the trip. We held that he suffered an accidental injury because the trauma producing the disability occurred over a short discrete period of time.

The lead opinion takes a lead from *Valtinson* and utilizes the analysis there by stretching the time period of *Valtinson*—a one day trip—to include a six-week exposure to the jolting and jarring associated with the front end loader driven by claimant. Because claimant here had no back problems prior to starting his duties for Early, the lead opinion concludes the results of driving the front end loader were unexpected and were related to a discrete period of time, *i.e.*, six weeks.

Claimant identified the jerking and jolting of a particular front end loader as the cause of his back problem. The machine he drove for approximately six weeks was generally rough riding and had a faulty transmission that caused a substantial jolt each time a gear change was made. He changed gears from forward to reverse approximately 200 to 300 times each shift. Such work conditions over a substantial period of time could reasonably be expected to cause a back strain. Although the jolting may have been more intense than the exertion needed to push the cleaning cart described in *O'Neal*, it is conceptionally the same for determining if the resulting disability is an occupational disease. The work condition experienced by claimant and the resulting disability more nearly fit

the description of an occupational disease set out in *O'Neal* than the accidental injury described in *Valtinson*. I would conclude that claimant's disability is an occupational disease.

In situations where there are successive employers or successive periods of employment covered by different compensation carriers it is necessary to assign responsibility for the compensation due. The allocation of responsibility is deter-

mined by application of the last injurious exposure rule. *See Bracke v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982); *Boise Cascade Corp. v. Starbuck, supra.* In *Starbuck,* we concluded that the last injurious exposure rule applied particularly to occupational disease rather than accidental injury. In essence, the rule of substantive responsibility places sole responsibility on the last employer or insurer if the conditions of employment during that period could have caused the disability. Because I conclude that claimant suffers from an occupational disease, the critical inquiry is whether the working conditions at Drake could have caused claimant's present back problems. As indicated, claimant identified that the particular idiosyncrasies of the front end loader he used at Early as the cause of the back condition. The machine he drove for two days at Drake did not have a faulty transmission and was much smoother operating than the loader at Early. When viewed as a cause of the disability, the conditions at Early are not the same as the work conditions at Drake. It oversimplifies the analysis to compare only the type of machinery operated as Early does in its brief. I conclude that the working conditions could not be said to be the same at Drake and, therefore that an important part of the last injurious exposure analysis has not been established. Early is responsible for the claim.

IN THE COURT OF APPEALS:
SAIF CORPORATION v. GUPTON

David Gupton, Claimant — WCB 80-02460
Darrell E. Bewley, Petitioner's Attorney — CA A24501
James Francesconi, Respondent's Attorney — May 25, 1983
Before Richardson, Presiding Judge, Joseph, Chief Judge, and Van Hoomisen, Judge

JOSEPH, C. J.

SAIF, insurer of Dave's Bunker Hill Shell (Dave's), appeals a Workers' Compensation Board order finding that claimant had proved that his employment at Dave's had worsened his underlying epicondylitis (tennis elbow) and holding SAIF responsible. SAIF contends that, under *Bracke v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982), a subsequent employer is responsible.

Claimant, a 35-year old mechanic, first began having elbow pains while working for Automotive Engineer Repair in 1979. He received injections of xylocaine and hydrocortisone in July, August and September of that year. No claim was made against that employer.

On October 19, 1979, he began working as a mechanic at Dave's. His elbows began to bother him again, and he routinely received injections of hydrocortisone from Dr. Whitney every four to six weeks. In September, the pain grew more acute and interfered with his sleeping. He left work at Dave's sometime in November, 1980, and filed a claim for his "tendinitis" against Dave's on December 1, 1980.

On December 3, 1980, claimant began working for Goodyear. The sleeplessness continued, and the elbow pain became more acute. On January 19, 1981, Dr. Gritzka, his physician in Portland, told him to leave work. He underwent surgery in March, 1981, to correct his elbow problems. He filed no claim against Goodyear.

Dr. Whitney's reports state that claimant's working *as a mechanic* aggravated and caused a recurrence of his tennis elbow. He stated that the natural progression of the disease is that it will improve unless it is aggravated. However, Dr. Gritzka, in a letter to claimant's attorney, related claimant's condition to his employment at Dave's:

> "In my opinion, there is no question that [claimant's] underlying condition of bilateral humeral epicondylitis was made worse due to the work activities at Dave's Bunker Hill Shell Station. The forearm motions, required working as a mechanic, are especially stressful to the epicondylar area, and typically exacerbate underlying epicondylitis or tennis elbow. *I believe, with a reasonable degree of medical probability, that*

> *the patient's work activity as a mechanic at Dave's Bunker Hill Shell Station materially contributed to the worsening of the underlying condition of bilateral epicondylitis, to the point that surgery was required."* (Emphasis supplied.)

The referee found that, because claimant suffered no time loss while at Dave's, he was not then disabled and Dave's was not responsible. The Board reversed. Although it found that "the quality of exposure at Goodyear was at least as injurious as that at Dave's Shell,"[1] it said that, so long as claimant has elected to prove and has proved an injury in fact while employed at Dave's, the reasoning in *Bracke* prohibits Dave's from showing that a subsequent employment also exposed claimant to injury.

SAIF first argues that it is not responsible because claimant did not become disabled until he worked for Goodyear. In *Bracke v. Baza'r,* 293 Or at 250, the court held that, in occupational disease cases involving successive employers, liability for the disability is fixed when the disability arises, so long as the conditions of employment are potentially (or actually) causally related to the disease. Here, there is no doubt that claimant's tennis elbow was made worse by his work at Dave's. However, SAIF argues that, because claimant did not undergo surgery or suffer time loss while at Dave's, he was not disabled during that time.

The court in *Bracke* did not make clear how the date of disability is determined. In that case, the day that the claimant sought emergency room treatment for "shortness of breath, rapid breathing and related depression" was determined to be the date of disability, even though her condition of "meat

[1] We assume that by this the Board meant that the conditions in both employments *could have* contributed to the disease. There is no medical evidence that the employment at Goodyear *worsened* claimant's condition.

wrapper's asthma" was not then diagnosed and even though it is not clear that she suffered any time loss. The court suggested that, under ORS 656.005(8), the date when symptoms necessitate medical treatment *could* be deemed a triggering date, but it stated that it need not decide that question, because the claimant in that case was suffering "disabling symptoms" when she first sought medical treatment.

ORS 656.005(8)(c) defines a *non-disabling* compensable injury as one which "requires medical services." Under ORS 656.005(8)(b) a *disabling* compensable injury is one "which entitles the worker to compensation for disability or death." The two statutes imply that a disability involves more than medical treatment alone – perhaps, for example, time loss or loss of earning capacity. However, the statutes address *compensability* rather than fix a method for determining *liability* for a disability. They leave open the question of determining the *onset* of disability.

In this case, it is clear that, because claimant left his work at Goodyear and subsequently had surgery on his elbows, he suffered a potentially compensable disability within the meaning of ORS 656.005(8)(b). However, the evidence also shows that surgery was recommended or considered while he was working at Dave's.[2] There is nothing in the record to show that claimant's *underlying condition* was made worse by his employment at Goodyear or that that job precipitated the need for surgery. We hold that, because claimant's job at Dave's worsened his bilateral epicondylitis, which culminated in time loss and the need for surgery, the onset of disability began while he was employed at Dave's. *See also United Pacific Ins. v. Harris,* 63 Or App 256, ___P2d ___(1983), where we held that, where claimant's condition was stabilized from the date that she originally sought medical treatment until the time she left work because of failure of her condition to improve, her disability began at the time she originally sought medical treatment.

SAIF also argues that the Board erred in its interpretation of *Bracke* in saying that the case

> "* * * does not permit the *last employer* against whom a claimant has filed to show that the disease was caused during an earlier employment. * * * Similarly, we do not interpret the reasoning behind *Bracke* to permit an *earlier employer* against whom a claim is filed to show that a subsequent employment

> also exposed to injury. Therefore even though claimant suffered injurious exposure at Goodyear which was subsequent to the injurious exposure at Dave's Shell, Dave's Shell is not permitted to contend that Goodyear is responsible." (Emphasis in original.)

[2] In Dr. Whitney's August 5, 1980, medical record, he states that, if claimant "does not show some longer response pretty soon, we may have to surgically correct this." Dr. Gritzka's January 16, 1981, medical record states that "I think this patient will probably require bilateral Bosworth procedures. These have been recommended in the past but his claim has been contested by SAIF and therefore he didn't have it done."

Although we agree that the Board misapplied the rule in *Bracke, SAIF v. Luhrs,* 63 Or App 78, ___P2d ___(1983), that makes no difference to the result in this case. *Bracke* states that an employer may shift liability to a later employer *if* the later employment "contribute[s] to the cause of, aggravate[s], or exacerbate[s] the underlying disease." 293 Or at 250. There is no evidence that claimant's underlying condition was worsened by his employment at Goodyear. The necessary condition for the shifting of liability under *Bracke* has not been met.

Affirmed.

IN THE COURT OF APPEALS:
WARNER v. SAIF CORPORATION

Darryl G. Warner, Claimant — WCB 80-03034
Robert K. Udziela, Petitioner's Attorney — CA A24974
Darrell E. Bewley, Respondent's Attorney — May 25, 1983
Before Joseph, Chief Judge, and Warden and Young, Judges

JOSEPH, C. J.

Claimant appeals an order of the Workers' Compensation Board affirming the referee's award of 80 percent scheduled disability for an injury to his right knee. The referee did not admit in evidence a medical report which claimant had not furnished to opposing counsel before the hearing. The Board refused to remand the case to the referee for consideration of that exhibit. Claimant argues that that was an abuse of discretion, and that is the only issue presented.

Claimant suffered a compensable injury to his right knee on September 7, 1975. Since then, he has undergone numerous right knee surgeries and has been hospitalized several times for treatment of infections and complications. The issue at the hearing was the extent of disability. There were 99 exhibits admitted in evidence. Most were medical reports dealing with claimant's knee injury and its complications. Several of them reported difficulties he was having with his left knee. At least one described degenerative arthritis in that knee.

Exhibit 99 is a medical report that concludes that claimant suffers from pre-existing osteoarthritis in his left leg and lower back that was aggravated by his right knee injury. A copy of that report was received by claimant's attorney on April 7, 1981, and was sent to the Hearings Division in August, 1981. No copy was sent to SAIF, and the referee refused to admit it. Claimant argues that Exhibit 99 is the only piece of medical evidence showing a causal connection between his right knee injury and his low back and left knee problems. He claims that it is crucial evidence of the extent of his disability.

OAR 436-83-400 provides:

"* * * * *

"(3) As soon as practicable and not less than 10 days prior to the hearing each party shall file with the assigned referee

and provide all other parties with legible copies of all medical reports and all other documentary evidence upon which the party will rely except that evidence offered solely for impeachment need not be so filed and provided.

"(4) At the hearing the referee may in his discretion allow admission of additional medical reports and other documentary evidence not filed as required by (3) above."

Although a referee or the Board is not bound by "common law or statutory rules of evidence or by technical or formal rules of procedure," ORS 656.283(6), the record discloses no basis for us to say that discretion was abused in refusing the exhibit. Some compelling basis must exist for remanding, *Buster v. Chase Bag Co.*, 14 Or App 323, 513 P2d 504 (1973); *Tanner v. PSC Tool Co.*, 9 Or App 463, 497 P2d 1230 (1972), and we find none.

Affirmed.

IN THE COURT OF APPEALS:
GILBERT v. SAIF CORPORATION

William S. Gilbert, Claimant — WCB 81-05084 & 79-05397
Martin J. McKeown, Petitioner's Attorney — CA A25327 (Control) & A25360
Darrell E. Bewley, Respondent's Attorney — May 25, 1983
Before Gillette, Presiding Judge, and Warden and Young, Judges

GILLETTE, P. J.

Claimant seeks review of two Workers' Compensation Board (Board) orders affirming referees' conclusions that claimant was not entitled to compensation for aggravation of a compensable injury. On *de novo* review, we find that claimant has shown by a preponderance of the evidence that his condition worsened after the most recent arrangement of compensation and that his worsened condition resulted from his industrial injury. We therefore reverse and remand to the Board for reconsideration of one of the aggravation claims.

On September 21, 1977, claimant was injured in the course of his employment as a mechanic with the City of Roseburg. The following day, he visited Dr. Michalek's office, where he described the accident and complained of pain in his shoulder, his neck and the lower part of his chest. He was hospitalized for six days and then returned to work on October 5, 1977. After three or four days of work he quit his job, claiming that severe pain made him unable to work. Over the next three and a half years claimant visited numerous doctors, seeking treatment of his continuing symptoms and medical substantiation for his workers' compensation claims.

In November, 1978, the Workers' Compensation Department issued a determination order awarding claimant time loss for parts of 1977 and 1978, but no permanent partial disability. Also in November, SAIF denied responsibility for certain psychological problems that claimant attributed to the

1977 accident. Claimant filed an appeal from both actions and, on May 15, 1979, a referee entered a stipulated order stating that:

> "[1] * * * Claimant is presently awarded * * * 10% or 32 degrees of permanent partial disability of the neck and upper back [, and]
>
> "[2] * * * It is hereby determined that a bona fide dispute exists between the State Accident Insurance Fund and the claimant as to the compensability of the anxiety reaction claimed by the claimant. Claimant shall be paid the sum of $1,500.00 on a disputed claim basis settlement of this matter.
>
> "* * * * *"

A second determination order, issued in 1980, awared additional time loss but no additional permanent partial diability.

In December, 1980, claimant filed an aggravation claim that SAIF denied (the 1980 claim). A referee affirmed SAIF's denial and, on review, the Board affirmed the order of the referee. In March, 1981, claimant filed another aggravation claim (the 1981claim). SAIFagain denied the claim, a referee affirmed the denia, and the Board affirmed the referee's order.

In each instance, the referee upheld SAIF's denial because, in the referee's view, claimant had failed to prov (1) that his condition had worsened since the last arrangement of compensation and (2) that his condition in 1980 and 1981 was the result of his 1977 injury.

On review, the Board held, with respect to the 1980 claim, that claimant had failed to establish causation and that it was unnecessary to decide whether he had proved a change in his condition. With respect to the 1981 claim, the Board agreed with the referee that claimant had failed to establish both causation and aggravation. Claimant seeks review of both orders. All of the issues presented by the 1980 claim are also present in the 1981 claim; the two review proceedings have therefore been consolidated.[1] We address the questions of aggravation and causation separately.

In order to establish an aggravation claim, a claimant must demonstrate by a preponderance of the evidence that a compensable condition has worsened since the last award or arrangement of compensation. ORS 656.273(1). In this case, the last arrangement of compensation was the stipulated order entered on May 15, 1979, that awarded claimant 10 percent of the maximum amount for permanent partial disability. At the time the order was entered, claimant had been examined by at least eight doctors. Their diagnoses and impressions fell into two categories: physical problems and psychological problems.[2] Of the doctors who found organic sources for claimant's

[1] Both the 1980 and 1981 claims raised isues in addition to the aggravation issues. In each case, claimant waived the additional issues in oral argument before this court.

[2] The diagnoses were:

(1) "strain, * * * subperitoneal hemorrhage." (Dr. Michalek, September, 1977);

pain, some recommended conservative treatment and others recommended no medical treatment at all. It is evident, that as of May, 1979, claimant's physical difficulties appeared to be relatively minor—not severe enough to warrant additional testing and certainly not serious enough to require surgery.

By contrast, when Dr. Smith began to treat claimant in 1981, his initial examination and his review of prior doctors' reports and x-rays led him to conclude that

> "* * * [t]he patient's condition is not satisfactory nor stationary insofar as he has had no relief of symptoms over the past several years and in fact is *probably physically and psychlogically worsening.*" (Emphasis supplied.)

Dr. Smith then had claimant admitted to the hospital for a series of tests that revealed significant physical bases for

claimant's complaints.[3] Based on the test results, Smith diagnosed "cervical spondiosis with a ruptured and fragmented intervertebral disc and * * * nerve root compression at C5-6." He recomended surgery and, on July 1, 1981, performed an anterior discectomy and posterior bilateral decompression of C5-6. He described his findings as follows:

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(2) "acute, post-traumatic severe cervical sprain with myositis, muscle spasm, and radiculitis radiating the trajectory of the right brachial plexus." (Dr. Shelton, December, 1978);

(3) "pancreatitis, acute * * * prostatitus ubacute." (Dr. Michalek, September, 1977);

(4) conversion hysteria. (Dr. Streitz, February, 1978);

(5) anxiety reaction secondary to injury; passive aggressive personality disorder. (Dr. Brown, April, 1978);

(6) "The * * * pain in his neck * * * seems out of proportion to the duration of the mechanism of injury. * * * I presume a soft disc protrusion could be giving this type of clinical picture * * *." (Dr. Byck, June, 1978);

(7) "[1] hysterical or conversion reaction; [2] cervical scapular strain syndrome. * * * I do not feel at present that orthopedic treatment is indicated * * * The patient has been on disability for a prolonged period and out of keeping with his symptoms and findings." (Dr. Streitz, August, 1978);

(8) "cervical strain * * *, cephalgia, * * *, functional overlay * * *. We do not feel that here is orthopaedic disability and feel that most likely treatment should be from a psychological and psychiatric standpoint." (Orthopaedic Consultants, October, 1978);

(9) "* * * There is no neurological condition to render a disposition of disability." (Dr. Schostal, Novembr, 1978);

(10) "It is my impression that [claimant] is probably uffering from a chronic low back strain as ell as vascular muscle contraction headaches. * * * One must also consider the possibility that [claimant] is somewhat more adept at manipulating physicians than other patients [are]." (Dr. Norris-Pearce, November, 1978).

[3] X-rays revealed nerve root encroachment at the C5-6 level and "spondylotic changes with narrowing anterior spur formation at C5-6." A discogram showed disc fragmentation, and a myelogram revealed bilateral root encroachment at the C5-6 level.

> "* * * [T]he disc [was] removed piecemeal with * * * forceps. The disc space was extremely narrowed, sclerotic and the disc remnants were markedly degenerated fragments. There was considerable anterior spurring as well as * * * definite posterior spurring. * * *"

In a post-surgery repot, the doctor reported that:

> "* * *cervical spondylosis with nerve root compression and encroachment [w]as the cause of [claimant's] intractable pain problems."

In short, in 1981, Dr. Smith found claimant's condition serious enough to warrant surgery, and he found that his physical difficulties were serious enough to cause "intractable" pain. These medical findings, which were confirmed by surgery, are in marked contrastto the findings of the doctors who examined claimant prior to the 1979 award. We therefore conclude that he has demonstrated, by a preponderance of the evidence, that his condition had worsened since the award entered on May 15, 1979.

The Board held that claimant "failed to prove a causal relationship between his neck and shoulder condition, as it existed in 1981, and the 1977 industrial injury." We disagree. Here, claimant, who had no previous neck, back or shoulder problems, experienced an industrial accident that caused immediate pain in his neck and shoulder. He went to a doctor the next day complaining of neck, shoulder and chest pain, and he experienced neck and shoulder pain continuously until his surgery in July, 1981. Because these circumstances all indicate that claimant's 1981 condition resulted from the 1977 compensable injury and because the record contains nothing to suggest an alterntive cause for his complaints, we find that claimant has demonstrated by a preponderance of evidence a causal

relationship between his compensable injury and his condition in 1981. *Cf. Uris v. Compensation Department,* 247 Or 420, 427 P2d 753 (1967).

Our view rests in significant measure on the opinion of Dr. Smith, who believed that claimant's 1977 accident either caused claimant's spondylosis or aggravated a mild pre-existing spondylosis. While it is true that the force of his opinion is somewhat diminished because it rests heavily on claimant's unreliable description of the 1977 injuy, *Miller v. Granite Construction Co.,* 28 Or App 473, 476, 559 P2d 944 (1977), SAIF has not offered an alternative explanation for the cause of claimant's 1981 condition.

The Board' order on the 1981 claim is reversed and remanded for further proceedings consistent with this opinion. The petitioner did not have the benefit of Dr. Smith's testimony in the 1980 proceeding. The Board's order on the 1980 claim is affirmed.

IN THE COURT OF APPEALS:
SAIF CORPORATION v. HOLSTON

Kenneth L. Holston, Claimant — WCB 81-0401
Donna M. Parton, Petitioner's Attorney — CA A25447
Christopher D. Moore, Respondent's Attorney — May 25, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges.

VAN HOOMISSEN, J.

SAIF appeals from a Workers' Compensation Board order that awarded claimant reimbursement for travel expenses from his home in Springfield to Medford for treatment of a compensable injury. It contends that the Board erred in setting aside SAIF's denial of the travel claim. We affirm.

Claimant sustained a compensable injury in 1979. During the course of his claim, he was seen by Dr. Bryson, a chiropractor, Drs. Stainsby and Zivin, neurologists, Drs. Robinson, Marxer, Degge and Nagel, orthopedic surgeons, Dr. Myers, a neurosurgeon, and Drs. Hoffmeister and Litchman, whose specialties are not indicated. During diagnosis and treatment, he underwent extensive neurological testing, including E.M.G. testings and a lumbar myelogram. He also had an extensive laboratory work-up. Based on the recommendation of Dr. Nagel, claimant's then treating physician, and on the opinion of Dr. Degge, with which Dr. Nagel agreed, the claim was closed in June, 1981, by a determination order that found claimant's condition was medically stationary on April 13, 1981.

Thereafter, on the advice of his attorney, claimant sought another opinion from Dr. Campagna, a neurosurgeon practicing in Medford, 160 miles from Springfield. SAIF denied reimbursement for expenses for claimant's travel to see Dr. Campagna on the ground that those expenses were not reasonable or necessary.

At the hearing, the parties stipulated that Dr. Campagna was claimant's "treating physician." The referee found that:

> "Although claimant has chosen Dr. Campagna as his most recent attending physician, the recommendation, or referral, was made by his attorney, Mr. Steven C. Yates (Ex. 70). The parties have stipulated that Dr. Campagna is an attending physician, although the physician's first report dated July 30, 1981 does not so indicate, using the language: 'The patient has been continuing with therapy with Dr. Nagel and also has had a bone scan. Attorney Steven Yates referred the patient here *for another opinion.*' (emphasis added) (Ex. 70).
>
> "As is indicated by the dates in question, Dr. Campagna first saw the claimant on July 30, 1981, just one month and

> three days prior to the hearing. A subsequent report from Dr. Campagna indicates the claimant was to be hospitalized in Medford on August 10, 1981 for additional diagnostic testing (Ex. 71)."

In affirming SAIF's denial of travel expenses, the referee explained:

> "* * * Claimant has seen numerous doctors in his home area of Eugene-Springfield, as indicated earlier in this opinion. He was treated by or examined by no less than four neurosurgeons, four orthopedic surgeons, two physicians whose specialties are not indicated, and one chiropractic physician. His case was closed by Determination Order, inasmuch as his then treating physician had declared him medically stationary. On the recommendation of his attorney, the claimant then chose still another neurosurgeon, practicing in Medford, a distance of 160 miles from Eugene.
>
> "I make this finding because I feel there is a distinction between claimant's right to choose any doctor within the state, and whether such action is reasonable and necessary, so as to subject the carrier to payment of the expenses. Claimant's right to choose does not necessarily indicate an automatic duty of travel expense payment. Eugene is a metropolitan area with a population well in excess of 100,000. The Referee takes official notice that there are at least six neurosurgeons listed in the telephone book. It is unreasonable to assume that claimant was required to go to Medford to find a treating doctor. The statute gives him this right, but having the right does not make it a reasonable action."[1]

On review, the Board noted that, subsequent to the referee's decision, we decided *Pyle v. SAIF*, 55 Or App 965, 640 P2d 680 (1982), and *Smith v. Chase Bag Company*, 54 Or App 261, 634 P2d 809, *rev den* 292 Or 334 (1981). The Board then interpreted *Pyle*

> "* * * to adopt the rule that there is no reasonableness limitation on a claim for travel expenses despite the reasonableness limitation now stated on [sic] OAR 436-54-245(4). We, however, feel bound to follow our understanding of *Pyl*

> rather than the Department's administrative rule. * * * It matters not whether we agree with the analysis or conclusion of the Court of Appeals in *Pyle;* we are bound by that decision."

Accordingly, the Board reversed the referee and remanded the claim to SAIF for payment.

In this court, SAIF has apparently abandoned its first contention that its denial was proper because claimant could have obtained comparable treatment in the Eugene/Springfield area and that, therefore, it was unreasonable or unneces-

[1] In a supplemental opinion and order, the referee concluded that *Smith v. Chase Bag Company*, 54 Or App 261, 634 P2d 809, *rev den* 292 Or 334 (1981), did not mandate a different result. Accordingly, he "republished" his earlier opinion and order.

sary for him to travel to Medford.[2] SAIF now only contends that its denial was proper, because the *treatment* claimant received in Medford was unnecessary. It argues that, assuming claimant had the right under ORS 656.245(2) to choose Dr. Campagna as a treating physician, claimant did not establish that the *treatment* he received was necessarily required by the nature of his injury or for the process of recovery and that, because the record shows that that treatment was not necessary, travel expenses incurred in obtaining it are not reimbursable.

Claimant has moved to strike SAIF's brief and to dismiss this appeal on the ground that SAIF's brief diverges

sharply from the issue litigated and SAIF's argument below. He contends that (1) the only issue briefed and argued below by SAIF was whether claimant could travel to Medford for treatment by Dr. Campagna when comparable medical services were available in the Eugene/Springfield area, and (2) that that was the only basis on which the referee and the Board made their decisions. SAIF has not responded to those contentions.

We conclude that claimant's point is well taken. At the hearing, SAIF did not argue the reasonableness or necessity of the *treatment* in Medford. Rather, it argued only that reimbursement was not available because comparable treatment was available in the Eugene/Springfield area. The referee's opinion and order were made on that basis only; *i.e.*, he denied travel expenses because comparable treatment was available in the Eugene/Springfield area.[3] Claimant requested review. Not surprisingly, SAIF did not cross-petition. However, SAIF did mention in its brief before the Board, as a secondary argument, that claimant had not demonstrated that his *treatment* in Medford was necessary or reasonable and that

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[2] *Pyle v. SAIF* 55 Or App 965, 640 P2d 680 (1982), and *Smith v. Chase Bag Company, supra,* did not specifically addrss the question whether, under the circumstances, it was reasonable or necessary for claimant to travel for treatment. In those cases the claimants had begun treatment in the community where they then lived, then moved some distance away but continued treatment with the same doctor. We held that those claimants were entitled to reimbursement for travel expenses incurred to continue treatment with the same doctor. We did *not* decide whether OAR 436-54-245(4) is valid. That rule provides:

> "The worker may choose an attending physician within the state of Oregon. Reimbursement to the worker of transportation costs to visit the attending physician, however, may be limited to within a city, or metropolitan area, or the distance to the nearest city or metropolitan area, from where the worker resides and where a physician providing like services is available. A worker who relocates within the state of Oregon may continue treating with the attending physician and be reimbursed transportation coss accordingly. If an insurer or self-insured employer chooses to limit reimbursement to the nearest available city, or metropolitan area, a written explanation shall be provided the worker along with a list of physicians who provide the like services within an acceptable distance of the worker. The worker shall be made aware of the fact treatment may continue with any attending physician within the state of Oregon of the worker's choice, but the reimbursement of transportation costs will be limited as described."

In other than the relocated worker situation, the rule makes reimbursement for travel expense subject to a test of reasonableness.

[3] Several other issues had been raised by claimant in his request for a hearing; however, they were resolved pior to the hearing by stipulation of the parties.

the *treatment* was pursued merely to obtain an opinion for litigation. Claimant correctly observes that SAIF raised this issue for the first time at the Board level and that the Board did not address it in its opinion and order. The Board stated:

> "In addition, at the hearing the parties stipulated that Dr. Campagna was laimant's treating physician. It is unclear whether the parties were using this term in the same sense as it is defined in the Department's rules, which provide that a claimant may have only one treating physician at a time, OAR 436-69-401(2), because there is some indication in the record that claimant continued treatment with Dr. Nagel in Eugene even after he began 'treatment' with Dr. Campagna in Medford. But we decline to look behind the parties' stipulation."

SAIF's contention that the *treatment* was unnecessary, while arguably true, is not supported by evidenc in the record.

Affirmed.

IN THE COURT OF APPEALS:
MATHENY v. SAIF CORPORATION

Clifford Matheny, Claimant — WCB 81-01410
Mike Stebbins, Petitioner's Attorney — CA A25995
Donna M. Parton, Respondent's Attorney — May 25, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges.

NEWMAN, J.

The issue is the extent of disability. Claimant, age 61 at the time of the hearing, suffered a compensable injury to his lower back in July, 1976, by falling from his truck while on the job. He had suffered various injuries to his back and neck before that time. Subsequent back surgery revealed that claimant suffers from degenerative disc disease. A determination order in July, 1978, found claimant medically stationary as of November 3, 1977, and awarded him 25 percent unscheduled disability resulting from injury to his upper and lower back. The claim was reopened in November, 1979, on a stipulation that any temporary compensation awarded until the claim was again closed would be offset against his permanent award if he was not placed in an authorized vocational rehabilitation program, unless it was determined that he was not medically stationary during the interim period. He did not enter an approved vocational rehabilitation program.

The referee found that claimant had remained medically stationary throughout the reopened claim, that the treatment of Dr. Davis, a psychiatrist, was not compensable and affirmed the determination order of 25 percent permanent partial disability. The Board affirmed. Claimant appeals the amount of the award, claiming that he is permanently and totally disabled, that he did not become medically stationary until June 17, 1981, and that the treatment he received from Dr. Davis was compensable. We affirm in part and reverse in part.

The referee found claimant unreliable as a witness because of multiple inconsistencies and inaccuracies in his presentations to the doctors who treated him about the circumstances of the injury and his prior physical condition. On review of the record, we agree with the referee's findings, affirmed by the Board, that (1) the claimant is not permanently and totally disabled, (2) there is no reliable evidence in the record that the 1976 injury produced permanent partial disability in excess of that awarded in the determination order and (3) the claimant was medically stationary following the stipulated reopening on November 20, 1979.

We agree with claimant, however, that the referee erred in finding that the psychiatric treatment received from

Dr. Davis was not compensable. Dr. Davis had been submitting bills for the treatment since February 26, 1980. The purpose of the treatment was to help claimant to accept his physical problems, which included not only his left leg, neck and left arm, but also his lower back. There is no question but that his lower back condition is the result, at least in part, of the 1976 industrial injury. SAIF does not contest the award of 25 percent unscheduled disability resulting from "injury to his upper and lower back." The fact that the treatment was palliative and not curative does not effect its compensability. *Smith v. Chase Bag Company*, 54 Or App 261, 634 P2d 809, *rev den* 292 Or 334 (1981). Claimant sustained his burden of proving a causal connection between the 1976 injury and the psychiatric treatment.

SAIF did not deny payment of Dr. Davis's bills until the time of the hearing. Because we conclude that SAIF unreasonably denied claimant's claim for medical services, it is also liable for penalties and attorney fees pursuant to ORS 656.262(9).

Affirmed in part; reversed in part; and remanded for an order that SAIF pay for medical services rendered by Dr. Davis and for assessment of penalty and reasonable attorney fees.

IN THE COURT OF APPEALS:
DALLMAN v. SAIF CORPORATION

Goldie M. Dallman, Claimant — WCB 81-01057
Leeroy O. Ehlers, Petitioner's Attorney — CA A26171
Darrell E. Bewley, Respondent's Attorney — June 1, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges.

PER CURIAM

Claimant appeals from an order of the Workers' Compensation Board. She contends that the Board erred in (1) reversing that portion of the referee's order that had found SAIF was responsible for hospitalization and treatment for her mental condition; (2) reinstating SAIF's denial of compensability of her mental condition; (3) reversing the referee's

award of attorney fees; and (4) affirming the referee's order upholding SAIF's denial of her claim for aggravation of a previous compensable back injury. On *de novo* review, we affirm.

Claimant also assigns as error the Board's failure to consider the issue of the extent of her ermanent disability resulting from her compensable back injury. That issue was presented to the referee; however, he found that it was pemature, or rendered "mot," and he declined to decide it. Both parties appealed the referee's order. Neither specifically addressed this issue, and the Board did not decide it, even though the Board's reversal of the referee's order removed any impediment to consideration of the issue. Accordingly, we remand to the Board for consideration of that issue only.

Affirmed; remanded for determination of extent of claimant's permanent disability.

IN THE COURT OF APPEALS:
OAKLEY v. SAIF CORPORATION

Ray H. Oakley, Claimant WCB 81-04845
J. Michael Alexander, Petitioner's Attorney CA A26269
Darrell E. Bewley, Respondent's Attorney June 8, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges

VAN HOOMISSEN, J.

Claimant appeals from a Workers' Compensation Board order reversing the referee's finding that he had proved an aggravation of his previous compensable back strain. The issue is whether claimant has proven a compensable aggravation since the last arrangement of compensation. On *de novo* review, we affirm.

Claimant sustained an injury to his back in 1978. His claim was accepted and ultimately closed in 1979 by a determination order that awarded him 25 percent permanent partial disability. On appeal, a referee increased that award to 80 percent. The Workers' Compensation Board reduced that award to 50 percent. No appeal was taken from the Board's order.

Claimant later filed this claim fr aggravation, contending that he had been unable to work since December 17, 1980. SAIF denied that claimant had suffered a compensable aggravation and denied reopening. The referee found that claimant had suffered a compensable aggravation and ordered that his claim be reopened. SAIF appealed. The Board reversed the referee and upheld SAIF's denial. The Board found that claimant had established entitlement to compensation for medical services under ORS 656.245 but that he had failed to prove a worsening of his condition under ORS 656.273.

Three doctors examined claimant and issued reports after his original claim was closed. Dr. Anderson, who had also examined claimant prior to closure, concluded on re-examination that no objective substantiation existed for his complaints of increased disability and pain. He attributed the complaits to

functional overlay. Dr. DiIaconi, who had not treated claimant for his back injury, felt that claimant was "definitely disabled for gainful substantial activities in the field for which he is trained." Dr. Melgard, claimant's principal treating physician, stated on re-examination that he considered him "totally disabled." His conclusion apparently was based on both physical and non-physical factors, including claimant's age, lack of motivation and employers' reluctance to hire a worker with a history of back problems. Neither Drs. DiIaconi nor Melgard specifically found that claimant's condition had worsened, although both noted his assertion of a deteriorating condition.

An aggravation claim based solely on a claimant's statement that his condition has deteriorated is statutorily insufficient. Likewise, a medical report which only sets forth *claimant's* statement that his condition has deteriorated is insufficient. At the very least, an expression of opinion by the doctor that he believes the claimant or that he finds objective evidence from a medical standpoint to substantiate claimant's history, is necessary. *Larson v. Compensation Department,* 251 Or 478, 482, 445 P2d 486 (1968); *Collins v. States Veneer, Inc.,* 14 Or App 114, 119, 512 P2d 1006 (1973).

A comparison of the medical reports issued here prior to closure with the more recent reports of Drs. DiIaconi and Melgard does not support a finding of worsening. In July, 1979, prior to closure, Dr. Lawton wrote:

> "With his present degree of symptoms, it is not felt that he is considered employable although with time should he improve perhaps return to some degree of light work which does not require repeated bending or heavy lifting may be feasible."

Drs. Melgard and Bright concurred with Dr. Lawton's assessment. Further, Dr. Melgard specifically recommended that claimant's claim *not* be reopened for special treatment.

Aggravation of achronic lumbosacral strain presents a complicated question requiring expert medial evidence. *Jacobson v. SAIF,* 36 Or App 789, 792, 585 P2d 1146, *rev den* 284 Or 521 (978); *see Uris v. Compensation Department,* 247 Or 420, 427 P2d 753, 430 P2d 861 (1967). Where none of the medical reports expresses an opinion that claimant has sustained an aggravation or provides sufficient facts to support that inference, the claim lacks medical verification. *See Long v. Industrial Indemnity Co.,* 20 Or App 24, 530 P2d 524, *revden* (1975).

We conclude that claimant has failed to sustain his burden of proof that his condition has been aggravated since the last arrangement of compensation.

Affirmed.

IN THE COURT OF APPEALS:
BOISE CASCADE CORPORATION v. WATTENBARGER

Charles G. Wattenbarger, Claimant WCB 80-03922
Allan M. Muir, Petitioner's Attorney CA A25271
J. Michael Alexander, Respondent's Attorney June 15, 1983
Before Joseph, Chief Judge, and Warden and Young, Judges.

JOSEPH, C. J.

Employer appeals an order of the Workers' Compensation Board affirming the referee's award of permanent total disability. We affirm.

Claimant suffered a compensable crushing injury to his chest in March, 1976. His claim was closed by a determination order in September, 1977, awarding 15 percent unscheduled permanent partial disability. He continued to suffer breathing problems and requested a hearing. By a stipulated settlement on February 17, 1978, he agreed to accept an additional award of 17.5 percent unscheduled disability in lieu of pursuing his hearing rights. His breathing problems continued, and he was hospitalized in December, 1979, for treatment of a lung abscess and pneumonia. A medical report showed a causal relationship between those conditions and the 1976 injury, and his claim was reopened. A new determination order issued in April, 1980, awarding time loss only. Claimant appealed. The referee found him permanently and totally disabled. Employer appealed, and the Board affirmed.

Employer argues that claimant has recharacterized his claim on appeal as an aggravation claim when the issue litigated at the hearing was the extent of disability attributable to the 1976 injury. It maintains that, if we treat the claim as one for aggravation, claimant has not met the requirements for compensability of an aggravated condition stated in *Weller v. Union Carbide*, 288 Or 17, 35-36, 602 P2d 259 (1979). However, the *Weller* tests apply only to claims involving *occupational diseases. Florence v. SAIF*, 55 Or App 467, 638 P2d 1161 (1982). There is persuasive evidence that claimant's pneumonia and lung abscess were within the statutory definition of aggravation as "worsened conditions from the original injury." ORS 656.273(1). The claim was properly reopened for aggravation.

Employer does not argue that claimant is not permanently and totally disabled. It does, however, claim that the extent of his disability is attributable to bronchitis, emphysema and chronic pulmonary disease, which preexisted the 1976 injury but were not discovered until after the injury. It maintains, in essence, that the 1976 injury did not cause his permanent total disability — that the damage caused by the injury is permanent but only partially disabling.

The referee and the Board were free to consider conditions as they existed at the time of their decisions in determining whether claimant is permanently totally disabled, and claimant's preexisting disabilities were properly considered. Nothing in the statutes or the caselaw prohibits a redetermination of the extent of disability when a claim is reopened. *Lohr v. SAIF*, 48 Or App 979, 618 P2d 468 (1980).

Affirmed.

IN THE COURT OF APPEALS:
SAIF CORPORATION v. MITCHELL

Thomas Mitchell, Claimant — WCB 78-02298
Donna M. Parton, Petitioner's Attorney — CA A25857
Jerome F. Bischoff, Respondent's Attorney — June 15, 1983
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges.

VAN HOOMISSEN, J.

SAIF appeals an order of the Workers' Compensation Board that affirmed the referee's order that claimant was entitled to benefits for disability caused by mental illness arising out of his employment.[1]

The referee found the following facts:

"Claimant, 48 years of age, spent approximately 13 years in State and Federal prisons. He was released in 1964 and worked in food service for approximately six years before coming to Oregon in August 1971. In Oregon he worked as a car salesman and performed voluntary work motivating and securing jobs for released convicts. In April 1976 he began work fulltime as a human resource's assistant. This job entailed conducting weekly classes at correctional institutions relating his experiences and motivating persons to emulate his good example. In this position he had no specific problems. He had several confrontations with his supervisors about being too candid and was advised to bury his past, however, he found no discrimination which hindered him.

"During past years he had suffered near blackouts at times of stress. He had been treated for anxiety symptoms in 1953 while he was confined at a Federal prison at which time he went into complete withdrawal and was hospitalized. Subsequently, at the Oregon State Prison he suffered anxiety symptoms and was put on medication for several weeks, however, for many years he was not treated medically for anxiety symptoms.

"In July 1977 he left the human resources assistant's job in Salem, Oregon to take a probation officer's job in Portland, Oregon. His duties on this job were to monitor released prisoners on probation. He was advised by his supervisors to

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[1] ORS 656.802(1)(a) provides:

"* * * '[O]ccupational disease' means:

"Any disease or infection which arises out of and in the scope of the employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

SAIF denied the claim in 1978. A referee found that the claim was compensable and remanded it to SAIF for acceptance and payment of benefits. The Board reversed. We then reversed the Board in a *per curiam* opinion, citing *James v. SAIF*, 44 Or App 405, 605 P2d 1368 (1980). *Mitchell v. SAIF*, 44 Or App 656, 606 P2d 697, *rev allowed* 289 Or 209 (1980). On review, the Supreme Court remanded to us for further proceedings consistent with *James v. SAIF*, 290 Or 343, 624 P2d 565 (1981). 290 Or 361, 624 P2d 571 (1981). We then remanded to the Board for further proceedings pursuant to *James*. 51 Or App 206, 625 P2d 667 (1981). The Board remanded to the Hearings Division to allow the presentation of additional evidence and for entry of a new order. With the parties' consent, the referee reviewed the claim on the record made at the initial hearing, and he again found that it was compensable. Accordingly, he affirmed his earlier opinion and order remanding it to SAIF. The Board affirmed.

maintain a low profile regarding his background. He never discussed his prison background with people under his charge, however, the people with whom he worked knew his background and oftentimes made reference to convicts as 'flakes' or 'turkeys' which bothered him and his co-workers and supervisor had made reference to his background.

"On December 12, 1977 claimant had a violent argument with his co-worker and supervisor which caused him to become very upset. He left work an hour early in the afternoon, blacked out on the freeway driving from Portland to Salem, Oregon and was treated at the emergency room of a hospital. At the time he was taking valium regularly, two or three times daily since 1968, for back pain. He had been treated for several years and was seen in November 1977 for blackout symptoms believed to be on an emotional basis. In psychiatric examination, he indicated a number of conflicts in relationship to his family, marriage and employment situations.

"On January 31, 1978 claimant had another nervous attack when he was driving from Portland to Salem, Oregon. He had not been in the Portland office that day but had been in the field working.

"On February 1, 1978 claimant discussed the incident in the vicinity of Woodburn while working with a co-worker and supervisor and indicated that it was necessary for him to have someone drive him back to his work station in Portland, indicating that each time he came within the vicinity of Woodburn he had some sort of seizure; that his malady was in no way connected with any pressure or difficulties on-the-job or from conflicts in his position but being away from his wife and family and not being permanently established in Portland caused pressures.

"Tests in 1978 showed claimant to be an early mild diabetic; that he has problems sometimes found in early mild diabetics in association with emotional stress, tension and anxiety and explain the rather peculiar and unexplainable series of incapacitating episodes that he experienced. On March 7, 1978 claimant was hospitalized for further evaluation. The impression was that there may be some element of reactive hypoglycemia that was being magnified by an internal tension state that needed further clarification. Neurologic

evaluations were normal and psychiatric evaluations were considered essentially normal except for some underlying anxiety detected. The diagnosis was episodic lightheadedness, rule out hypoglycemia, low-back pain by history, history of excessive alcohol and history of valium excess.

"Dr. Winfred Needham who had treated claimant since 1973 for a variety of problems concluded that claimant was disabled because of blackouts believed to be on an emotional basis; that excessive use of valium for the past years was a factor in the continuing physical and psychosomatic complaints, that claimant could not return to the stressful situation at work.

"Dr. Erik S. Orwoll at the University of Oregon Health Science Center concluded that the origin of claimant's condition most likely lay in the tremendous anxiety produced by job-related problems; that the complaints of frequent lightheadedness spells were more likely the consequence of psychiatric disease rather than an endocrine disorder, a psychological

situation brought on by factors in relation to his job and stress under which he worked. The stress had nothing to do with the job itself, but with other personnel and other factors, rather than pure job stress from the type of work he was doing and these symptoms progressed until claimant soon became totally unable to carry out his work or any form of work or duties because of the stress and anxiety."

SAIF contends that claimant's disability is causally related to a number of off-the-job sources of stress, including the inability of his wife to find suitable employment in Portland, his commuting by car from Salem to Portland, telephone calls by ex-convicts to his home that distressed his wife, financial problems and perceptions of discrimination in his attempt to find other employment. SAIF notes that he had a history of adverse reaction to stress long before beginning his present employment. It argues that he has failed to show that his mental condition is caused by employment conditions that are not substantially similar to those encountered off the job or that the conditions of his employment were the major contributing cause of his present condition.

James v. SAIF, 290 Or 343, 348, 624 P2d 565 (1981), held that a claimant seeking compenstion for an occuptional disease must show, not only that the condition arose within the scope of employment, but that the condition "was caused by

circumstances 'to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment.' ORS 656.802(1)(a)." "[T]he cause of the disease, aggravation or exacerbation of the disease must be one which is ordinarily encountered only on the job." *James v. SAIF, supra,* 290 Or at 350; *see also Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979); *Beaudry v. Winchester Plywood Co.,* 255 Or 503, 469 P2d 25 (1970); *SAIF v. Gygi,* 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982). Employment conditions need not be the sole cause of the disability. If employment conditions, when compared to non-employment exposures, are the major contributing cause of the disability, or aggravation or exacerbation of the disability, then compensation is warranted. *Beaudry v. Winchester Plywood Co., supra; SAIF v. Gygi, supra.*

In determining whether claimant has met his burden of proof, it is proper to consider whether there are alternative, non-work explanations. *See Balfour v. SAIF,* 59 Or App 503, 651 P2d 179 (1982), *rev den* 294 Or 460 (1983). Claimant testified that he suffered "stress" at work. He contends that conflicts with fellow employes precipitated his disability. There is abundant evidence, however, of non-work stress that is causally related to his disability. He himself testified to the non-work stresses set out above.

Tests showed that claimant was an early mild diabetic. Dr. Needham stated that the symptoms he exhibited in reaction to stress were not uncommon in early mild diabetics. Dr. Hogue noted stress involving his family, his marriage and his employment situation that would create sufficient anxiety to be expressed somatically. Additionally, claimant had a his-

tory of adverse reactions to stress long before his present employment. In 1953, he was hospitalized for anxiety symptoms when his mother died. In 1956, he was treated for a mental condition.

The strongest medical evidence linking claimant's work to his disability is the opinion of Dr. Orwoll, who felt that claimant's lightheaded spells were probably not caused by hypoglycemia:

> "As we discussed with Mr. Mitchell, and which he understands and in fact agrees with, are that the origin of his spells

> most likely lies in the tremendous anxiety produced by job related problems."

That conclusion, however, was based on an incomplete and inaccurate history. Dr. Orwoll believed that the "spells" began early in 1978; however, claimant had been treating with Dr. Needham for seven years before this claim. He reported in April, 1978, that claimant's chief complaint for two to three years earlier was near-blackouts occurring at times of stress. Dr. Carney also stated that he had a two-year history of symptoms.

Claimant began his present employment in July, 1977. In December, 1977, he blacked out after leaving work early following an argument with fellow employees. He experienced identical symptoms, however, in January, 1978, after a normal day in the field. On that occasion, there was no immediate work stress that would have precipitated that particular episode, and, in a discussion with a fellow employe and a supervisor, he stated that his condition was caused by stress at home. Claimant last worked on January 31, 1978, yet he continued to experience the same symptoms after leaving work. On March 20, 1978, he called his supervisor and stated that he had suffered a fainting spell at home and was unconscious for a period of time.

Although claimant may have had adverse symptoms in response to work stress, he experienced numerous non-work stresses to which he had identical reactions. His reactin to stress began many years before beginning his present employment, and his symptoms continued after he left that employment.

On *de novo* review, we conclude that claimant has failed to prove by a preponderance of the evidence that his disability is compensable. ORS 656.802(1)(a); *James v. SAIF, supra.* The record does not persuade us that claimant's work was the major contributing cause of his disability. *SAIF v. Gygi, supra.*

Reversed.

NEWMAN, J., dissenting.

Both the referee and the Board correctly found hat the medical evidence was sufficient to establish that claimant's condition was compensable as an occupational disease caused by conditions on the job that were not substantially similar to conditions off the job and that claimant's on-the-job stress was the major contributing cause of his mental condition. Accordingly, I dissent.

Dr. Needham, claimant's treating physician, reported on June 5, 1978:

> "In December I became virtually convinced that we were dealing with a psychological situation brought on by the factors mentioned above in relation to his job and stress under which he worked. This stress had nothing to do wih his job itself, but with his superiors and other factors belonging in that category rather than pure job stress from the type of work he was doing. The symptoms progressed until he soon became totally unable to carry out his work or any form of work or any of his duties because of this stress and anxiety.
>
> "I am sure you have a copy of Dr. James Hogue's psychiatric evaluation of December 1977, which pretty much verifies what has just been said, only, as said before, it has been alluded to in a rather indirect fashion, and no one, to my knowledge, has really come out and indicated that the real reason for his problems is literally the fact that he is an 'ex-convict' and the attitude of his superiors in this connection."

Dr. Orwoll, of the University of Oregon Health Sciences Center, concurred that claimant's condition most likely resulted from anxiety produced by job-related problems. He concluded that the complaints of frequent spells of light-headedness were more likely the consequence of psychiatric disease than of an endocrine disorder brought on by factors in relation to his job and stress under which he worked. Dr. Orwoll stated:

> "As we discussed with Mr. Mitchell, and which he understands and in fact agrees with, are that the origin of his spells most likely lies in the tremendous anxiety produced by job-related problems."

Dr. Carney at the University of Oregon Health Sciences Center also supported the opinion of Dr. Needham.

In a complicated medical situation such as here, reliance must be placed on medical experts to establish the

causal relationship between the injury and the alleged disability. *Uris v. Compensation Dept.*, 247 Or 420, 427 P2d 753 (1967).

The majority dismisses too readily Dr. Orwoll's opinion as "based on an incomplete and inaccurate history," because Dr. Orwoll believed claimant's blackout spells began early in 1978. Claimant was emphatic in his testimony that the blackouts did not begin before November, 1977. Dr. Needham's April, 1978, report states that claimant had experienced black-

outs for two to three years. However, it would appear that this may be a transcription error, because Dr. Needham's handwritten report dated a month earlier states that the blackouts began in "the past few months," and his report of June 5, 1978, states that claimant's visits before November, 1977, were "all pretty much routine" and that his "real symptoms" of anxiety "came into the picture in October and November of 1977."

Dr. Carney reported that claimant's "problems" began two years before, but does not refer to any blackout occurring until approximately the beginning of 1978.

The referee correctly gave no weight to the assertion that claimant used Valium or alcohol to excess. Dr. Needham wrote on June 5, 1978:

> "To the best of my knowledge, Tom has had no alcoholic intake for well over 10 or more years. I feel very sure in my own mind that this is correct. Therefore, I would question a bit concerning the discharge diagnoses made by Dr. D. M. Carney on his discharge summary of March 1978, because the 'history' of excess alcohol should be extended to indicate that such intake has been 10 to 12 years ago, and therefore is not a factor in the present problem. Also, the history of Valium excess also gives an implication of an inaccurate situation. As I have indicated above, we have been trying to reduce Tom's Valium intake somewhat, but it is certainly not excessive, and it appears to be the only thing that really controls these episodes that Tom experiences. Thirty mg. of Valium per day is probably not an excessive amount for him. As has been indicated at various times, it has been felt that, if possible, some reduction in the Valium intake was desirable, but experience has shown that anything under 30 mg. per day does not control his symptoms. Some months back his daily dosage was 40 mg. per day. Dr. Carney, upon hospital discharge, tried to discontinue the Valium and substitute Vistaril, which Tom found to be of no value whatsoever.
>
> "The question of whether or not this is an industrial or occupational disease is obviously the main concern, and I feel that this is, in fact, an occupational disease related to the things that I have pointed above and which Tom will, at some future date I am sure, elaborate on more thoroughly. As to the date of onset, this is most difficult to determine precisely. Obviously, it was a gradual onset, but the real symptoms came into the picture in October and November of 1977, so a specific date is absolutely impossible to give."

The evidence supports the conclusion that before working for the probation office in Portland commencing in mid-1977, claimant had not manifested any symptoms of anxiety since 1956, over 21 years. Dr. Needham noted that claimant's mental condition had a gradual onset with a rapid deterioration in October and November, 1977. I believe that claimant carried his burden of proving by a preponderance of the evidence that on-the-job stress was the major contributing cause of his mental condition.

IN THE COURT OF APPEALS:
SAIF CORPORATION v. MOYER

Phillip D. Moyer, Claimant — WCB 81-01858
Donna M. Parton, Petitioner's Attorney — June 15, 1983
Alan M. Scott, Respondent's Attorney — CA A25784
Before Richardson, Presiding Judge, and Van Hoomisen and Newman, Judges.

VAN HOOMISSEN, J.

SAIF appeals an order of the Workers' Compensation Board affirming the referee's imposition of penalties against SAIF because of its failure to request that the Workers' Compensation Department designate a paying agent pursuant to ORS 656.307. That statute directs the department to enter suc order when there is an issue between two or more employers or their insurers regarding responsibility for payment of compensation. We affirm.

Claimant suffered a compensable back injury in 1976. SAIF was responsible, and it processed the claim to closure. In 1978 and 1979, claimant sustained two compensable aggravations of his condition, and SAIF again paid those claims. On December 8, 1979, while EBI insured his employer, claimant experienced further problems with his back following a fall at work. Four days later, he requested postponement of a hearing on the extent of the disability related to his previous aggravations, because he had "sustained either a new injury and/or an aggravation of his SAIF claim * * *" and he was not at that time medically stationary.

On December 19, 1980, EBI denied claimant's new injury claim on two grounds:

> 1. "There is no evidence to substantiate the compensability of your injury."
>
> 2. "If your present condition is compensable, it is as a result of an aggravation of your previous injury of which State Accident Insurance Fund is the carrier and should be contacted."

On January 12, 1981, claimant wrote to both EBI and SAIF. He requested that EBI rescind its denial and withdraw the contention of noncompensability, and he filed an aggravation claim with SAIF. On February 4, EBI amended its denial to deny on the basis of nonresponsibility only. On February 5, in response to a letter from SAIF requesting additional information, claimant's attorney sent the requested information and asked "that if SAIF denies Claimant's aggravation claim, that it does so exclusively on the basis of responsibility and not on the basis of compensability of the most recent claim." He

included the report of Dr. Cockburn, the only medical opinion on compensability in the case, which stated:

> "* * * While delivering beer on December 8, 1980, he [claimant] slipped on ice and fell onto his left hip. In the

examiner's opinion, he experienced an entirely new injury, not an aggravation of his old injury. He was injured in the same area of his body but by an entirely different injury.

"* * * * *

"The diagnosis for this injury: Strain, cervical and lumbar spine, acute, due to fall."

On February 23, 1981, claimant notified SAIF that EBI had withdrawn its contention of noncompensability and requested that SAIF request an order designating a paying agent so that claimant could receive temporary disability benefits pending the determination of responsibility for his claims. ORS 656.307.

The next day, SAIF denied the claim:

"In addition, the documentation available to SAIF does not establish the compensability of a new injury or a claim for aggravation."

Although claimant requested that SAIF amend its denial and reminded SAIF that its denial precluded the issuance of an ORS 656.307 order, SAIF continued to deny compensability. At the hearing, SAIF continued to deny compensability. The only medical evidence on compensability or responsibility was the report of Dr. Cockburn. The referee found the claim compensable and assigned responsibility to EBI.

Claimant requests imposition of penalties against SAIF on three grounds: (1) its failure to pay interim compensation pending its denial, (2) the alleged lateness of its denial, and (3) the unreasonableness of its denial.[1] The referee declined to

award penalties on the first two grounds because of irregularities in the presentation of the aggravation claim to SAIF. The referee concluded, howeve, that SAIF's denial of compensability was "totally without merit," and he imposed the maximum penalty of 25 percent of the temporary total disability benefits due claimant because of both SAIF's unreasonable refusal to concede compensability and its refusal to allow an ORS 656.307 order to issue. The Board affirmed.

SAIF appeals the penalty issue. The *only* medical evidence states unequivocally that claimant sustained an entirely new injury and not an aggravation. No legitimate basis existed for contending that the claim was not compensable as to at least one of the insurers. SAIF contends, however, that it had a legitimate doubt as to its "liability" on the claim and that, therefore, its denial of compensability was reasonable. SAIF confuses responsibility with compensability. OAR 436-54-332,

[1] Claimant also asked for a penalty against EBI for unreasonable denial of compensability and for unreasonable failure to request a paying agent order. EBI stipulated to the unreasonableness of its first denial of compensability, but the referee declined to award a penalty, because EBI denied within 14 days of the injury and, thus, no interim compensation was due on which a penalty could be based. The referee also denied a penalty for EBI's failure to request a paying agent, because an order could not be issued unless all involved insurers stipulated to compensability, and SAIF refused to stipulate.

"Designation And Responsibility of a Paying Agent," defines "Compensable Injury" as "an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death." "Responsibility" is also defined in OAR 436-54-332 as "liability under the law for the acceptance and processing of a compensable injury claim." If an employer or its insurer were llowed to deny compensability whenever its "liability" was in question, an ORS 656.307 order would never issue, becaue the question of each insurer's liability is always presented in an aggravation/new injury claim. Clearly, that would defeat the purpose of the statute, which is to provide copensation when only the liability of each insurer and not compensability is at issue. We conclude that SAIF's argument lacks merit.

SAIF also argues that, while claimant's actions were procedurally permissible, they constituted an improper manipulation of the compensation system to obtain benefits. It hypothesizes that, because there was no evidence of an aggravation, claimant brought a "frivolous" aggravation claim to secure temporary total disability payments through the issuance of an ORS 656.307 order. Although the only medical report in the record does not support an aggravation claim, the evidence shows that claimant sustained an injury to the same

part of his body that already had sustained two earlier compensable injuries, the last occurring the previous year. We conclude that, under these circumstances, it was not unreasonable for claimant to make an aggravation claim in the event that his new injury claim was denied. Claimant had advanced the possibility of an aggravation before EBI denied and before Dr. Cockburn gave his opinion. A claimant is not required to exhaust "new injury" contentions before proceeding on an aggravation claim. Further, the procedure utilized by claimant is granted by statute. Unless and until the legislature amends the statute, an insurer has the duty to comply with the statute requiring it to request a paying agent when the issue is responsibility but not compensability. Because SAIF failed unreasonably to follow the statutory scheme, a penalty was authorized.

SAIF contends that, even if its actions were unreasonable, no authority exists for imposition of this penalty. ORS 656.262(9) allows penalties for unreasonable delay or refusal to pay compensation or for unreasonable delay in acceptance or denial of a claim. SAIF contends that there is no penalty for unreasonable denial of the compensability of a claim. SAIF's denial in this instance, however, resulted in the delay of temporary total disability payments that would have otherwise issued had a paying agent order been requested. We conclude that imposition of a penalty is authorized under these circumstances. *See Elliott v. Loveness Lbr. Co.*, 61 Or App 269, 656 P2d 378 (1983).

SAIF finally contends that, even if a penalty could be assessed under ORS 656.262(9), there exists no "amounts then

due" to claimant from SAIF on which to assess penalties, because it was not found to be the responsible insurer. SAIF would have us read the statute to add the words "from the insurer against whom the penalty is assessed" after the words "amounts then due." No authority exists for that construction, and it would defeat the purpose of penalties to encourage insurers to withhold benefits.

Affirmed.

RICHARDSON, P. J., dissenting.

The majority says: "Because SAIF failed unreasonably to follow the statutory scheme, a penalty was authorized." (Slip opinion at 6.) In reality, SAIF refused to play the game that claimant initiated to circumvent the statutory scheme. By affirming imposition of a maximum penalty, we give authority to a procedure that ought not be encouraged.

When claimant sustained the injury which is the basis of this claim, he was examined by Dr. Cockburn, who had been his treating physician for the other injuries. The doctor was thus well aware of any potential relationship between the most recent injury and the prior injuries while SAIF was on the risk. He reported:

> "* * * While delivering beer on December 8, 1980, [claimant] slipped on ice and fell onto his left hip. In the examiner's opinion, he experienced an entirely new injury, not an aggravation of his old injury. He was injured in the same area of his body but by an entirely different injury."

There was no other medical evidence relating to this injury.

A claim was filed with EBI, employer's then carrier. EBI denied the claim within 14 days, and thus no temporary total disability benefits were due. ORS 656.262(4). At that point claimant would have had to request a hearing on EBI's denial. Claimant notified employer that he was asserting an aggravation claim. The only medical evidence submitted was the report of Dr. Cockburn. That report unequivocally stated that there was no aggravation of claimant's prior compensable injury. Claimant's counsel conceded during oral argument on appeal that there was no basis in the medical evidence for an aggravation claim. The claim was clearly frivolous and was filed solely to obtain temporary total disability benefits through an ORS 656.307 procedure. A "307" procedure would not have been arguably available if the claim had been honestly assessed. The majority suggests that the aggravation claim was not frivolous, because the new injury was to the same part of the claimant's body. Dr. Cockburn's report addresses that possibility and clearly denies it.

Thus, we have a frivolous aggravation claim filed solely for the purpose of obtaining temporary total disability

benefits to which claimant would not have been entitled under the statutory scheme. If the statute, when correctly followed, produces an inequitable result by denying interim compensa-

tion, the matter should be addressed to the legislature.

The referee expressed indignation that SAIF could consider denying compensability of the aggravation claim and thereby thwart a "307" procedure. That expression and our affirmance of the penalty imposed turns the process on its head. Any indignation should be directed at claimant who clogged the process with a clearly frivolous aggravation claim to obtain interim benefits that he was not otherwise entitled to receive. There was absolutely no basis for an aggravation claim, and SAIF should not have been involved in the proceedings. Because it was, by the simple filing of a claim, it was required to play the game at the risk of a substantial penalty and attorney fees.

I would not applaud the game plan as the majority does, but would reverse.

IN THE COURT OF APPEALS:
EDWARDS v. EMPLOYMENT DIVISION

Peter W. McSwain, Petitioner's Attorney 82-AB-514
Michael D. Reynolds, Ass't Attorney General CA A24724 June 15, 1983
Before Gillette, Presiding Judge, and Warden and Young, Judges.

YOUNG, J.

Claimant appeals from a split decision of the Employment Appeals Board which reversed the decision of the referee and denied unemployment compensation. The issue is the effect of the receipt of workers' compensation benefits on eligibility for unemployment compensation under ORS 657.155. We reverse and remand.

EAB approved and adopted the referee's findings of fact:

> "FINDINGS OF FACT: In Referee Decision 82-E-134, the referee entered the following facts which we find to be proper and complete and hereby accept as our own: '(1) Claimant worked for employer over two years and was off work after about June 15, 1981 because of an on the job injury. (2) Her job was feeding the dryer and performing clean up work at the time of the injury. (3) Claimant was released with restrictions to return to work September 21, 1981. (See Exhibit 1). (4) Because of the restrictions, claimant could not have performed her former job if such a position had been available for her at the time of her release, September 21, 1981. (See Exhibits 1, 2, and 3). (5) Doctors who examined claimant in September and October found her recovery from the injury was not yet in a stable condition. They also stated it was possible claimant would never be able to return to her former strenuous work. (6) Employer's plant where claimant worked reduced it's (sic) work force and at the time of the hearing considered claimant on layoff because of economic conditions. (7) Claimant received Worker's Compensation Benefits because of her injury. She has received such benefits for all the weeks since she was released to return to work September 21, 1981; and the amount of benefits has not changed during all the weeks she has been receiving Worker's Compensation. (8) Claimant reopened her unemployment claim and she has claimed unem-

ployment benefits for all the weeks thereafter starting with week 46, the week that began November 15, 1981. (9) That claim expired with week 47. She filed a new claim commencing with week 48 and continued to file and claim unemployments benefits. (10) During the weeks since reopening her claim in November, 1981, claimant has been seeking work as a cashier and sales clerk, for which she has experience, and other work for which she has experience, and other work for which she is qualified. (11) The work claimant is seeking is within her medical restrictions. Also, it is available in the area where she

is seeking work. (12) She is willing to accept the wages usually paid and to work the hours and days such work is usually available where she is seeking."

EAB then said:

"CONCLUSIONS AND REASONS: We do not agree with the referee. We find that the claimant is not eligible for benefits under ORS 657.155. Claimant clearly admits that, during the weeks in issue, she was not able to work at her regular job and was therefore receiving Worker's Compensation benefits. This raises the presumption that the claimant was not able to work as necessary under ORS 657.155 and OAR 471-30-036. The claimant has not overcome that presumption. Although she has some prior work experience as a cashier and sales clerk, her experience in that regard is minimal. The testimony clearly establishes that because of claimant's medical restrictions, she is not able to return to work with her primary employer, the Weyerhaeuser Co. As she cannot perform that work, she does not meet the requirements of the law for the weeks in issue."

The scope of our review is as for a contested case. ORS 657.282; ORS 183.482(7), (8). In order to obtain unemployment compensation, claimant must prove, among other things, that she is "able to work, available for work, and is actively seeking and unable to obtain suitable work." ORS 657.155(1)(c). We understand EAB's reasoning to be that, because claimant was receiving workers' compensation benefits during the weeks in issue, she is presumed to be unable to work. This interpretation of EAB's conclusions and reasons is consistent with the EAB dissent, which states in part:

"The majority's decision denying the claimant benefits is based solely upon the fact that she is drawing Worker's Compensation benefits."[1]

First, we reject the conclusion that claimant is presumed to be unable to work because of the simultaneous receipt of workers' compensation benefits. Neither ORS 657.155 nor the applicable rule[2] create such a presumption. Evidence that a

claimant is receiving workers' compensation benefits may in some cases give rise to an inference that she is unable to work,

[1] The referee also observed that the employer's principal objection was that claimant was receiving workers' compensation benefits.

[2] OAR 471-30-036 provides in part:

"(1) In considering suitable work factors under ORS 657.190 and for purposes of determining eligibility under ORS 657.155(1)(c), the Administrator may require an individual to actively seek the type of work the individual is most capable of

but not a presumption. *See e.g., Evjen v. Employment Division,* 22 Or App 372, 376-77, 539 P2d 662 (1975). However, before claimant can inferentially be found to be unable to work, there must exist a factual predicate that will give rise to the inference. *See, e.g., Dach v. Employment Division,* 32 Or App 433, 436, 574 P2d 684 (1978).

In this case, claimant's doctor released her for work on September 21, 1981, with restrictions to avoid heavy lifting. Claimant testified that she did not know the basis for the workers' compensation award. She also testified that she was receiving workers' compensation benefits and was still not "totally released by [her] doctor," presumably because she was not yet "medically stationary." In the context of the workers' compensation law, a worker receiving temporary total disability may be estopped from simultaneously claiming unemployment benefits, because it is implicit in a total disability award that a worker is unable to work. ORS 656.210. On the other hand, a worker receiving temporary partial disability under ORS 656.212, or permanent partial disability under ORS 656.214 may be "able to work." The fact that claimant may not be "medically stationary," as that term is defined, does not

necessarily mean that she is unable to work. ORS 656.005(17) provides:

> " 'Medically stationary' means that no further medical improvement would reasonably be expected from medical treatment, or the passage of time."

We do not know whether EAB concluded that claimant failed to carry her burden of proof that she was able to work, or whether on the basis of the impermissible presumption, it decided that she was unable to work. In either event, we remand for clarification of its order or in the alternative to take additional evidence by the referee, if in the interest of fairness that is considered necessary.

Reversed and remanded for reconsideration.

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performing due to prior job experience and training except that:

"(a) If an individual is unable to secure the individual's customary type of work after contacting the potential employers in the labor market where benefits are being claimed, the Administrator may require the individual to seek less desirable but similar work or work of another type which the individual is capable of performing by virtue of experience and training;

"(b) If the type of work an individual is most capable of performing does not exist in the labor market where the individual is claiming benefits, the Administrator may require the individual to seek any work that exists in the labor market for which the individual is suited by virtue of experience and training.

"(c) After the individual has contacted the potential employers in the labor market where benefits are being claimed and is still unable to obtain work as described in subsections (a) and (b) of this section, the Administrator may require the individual to further expand work-seeking activities.

"(2) For the purposes of ORS 657.155(1)(c), an individual shall be considered able to work only if physically and mentally capable of performing work during all of the customary workweek for the type of work being sought pursuant to section (1) of this rule. However, an occasional and temporary disability for less than half the customary workweek shall not result in a finding that the individual is unable to work for the week.

"* * * * *"

IN THE SUPREME COURT:
BARRETT v. COAST RANGE PLYWOOD

Phillip J. Barrett, Claimant — WCB 81-03112
Rolf Olson, Petitioner's Attorney — CA A24457
Marshall Cheney, Respondent's Attorney — SC 29076
April 6, 1983

Before Lent, Chief Justice, and Peterson, Campbell, Roberts, Carson and Jones, Justices.

ROBERTS, J.

We accepted review in this workers' compensation case to consider language in the Workers' Compensation Board's opinion which states:

> "The Referee found that there was no evidence to show that the functional component is not injury related. That may be true but irrelevant as the burden is on claimant to prove causal relationship. Claimant never did have a psychological evaluation even though numerous physicians diagnosed functional overlay. Therefore this record is devoid of any proof that claimant's psychological component is injury-related or permanent in nature. We will not consider that condition in rating claimant's compensable disability."

This statement by the Board implies that no matter how much evidence there may be of psychological functional overlay, claimant has not met his burden of proving a causal relationship between the functional overlay and the injury unless the evidence includes a psychological evaluation. Based on this conclusion the Board modified the referee's order awarding permanent total disability to an award of forty percent unscheduled low back disability. The Court of Appeals affirmed without opinion.

Claimant, a 37 year old male, was injured when his low back was jarred. His condition was diagnosed as a severe strain of the lumbosacral spine. After being treated by three physicians for a period of approximately seven months, claimant attempted to return to work but was unable to endure more than a few hours' activity because of back pain. He has not worked since. Various examinations have disclosed functional overlay in varying degrees.

At argument counsel for the insurer described "functional overlay" as an "over-reaction or over-response to pain" and as a "psychological or psychiatric condition which develops subsequent to compensable injury in some occasions and in some cases exists prior to a compensable injury. It manifests itself by perhaps phantom pain, perhaps an over-response to pain." Stedman's Medical Dictionary (4th ed 1976) explains "functional" as "* * * nonorganic; *i.e.*, a functional ailment is one that is not caused by a structural defect." "Overlay" is defined as "an addition to

an already existing condition." "Functional overlay" then is an ailment in addition to an already existing condition which is not caused by a structural defect.[1] Applying these definitions to this case functional overlay may be explained as the psychological component of the injury claimant sustained to his back and it manifests itself in the pain and

discomfort he continues to experience after the structural causes of his injury are no longer apparent.[2] Claimant alleges that it is the functional overlay which causes his disability. Such a disability has been compensated in Oregon. *See Elliott v. Precision Castparts Corp.*, 30 Or App 399, 401, 567 P2d 566, *rev den* 280 Or 171 (1977), and *Guerra v. Transport Indemnity*, 30 Or App 415, 417, 567 P2d 573, *rev den* 279 Or 301 (1977).

Evidence of functional overlay which appears in the record is as follows: Orthopedic Consultants first suggested functional overlay in January, 1980, when they diagnosed "1) lumbar strain with leg symptoms, by history; 2) functional overlay, conversion type," and also stated, "[i]t is difficult to estimate the impairment in a patient with so much functional overlay that interferes with the examination. Our best estimate is that the impairment in the lower back due to this injury is minimal." In February, 1980, Dr. Berkeley, a neurosurgeon, remarked, "I would not call his disability caused by these symptoms even in the presence of functional overlay as minimal." In January, 1981, Dr. Roof, a neurosurgeon, was of the opinion that there was a marked functional overlay; in March, 1981, Dr. Winkler, claimant's treating physician said, "I feel that this individual is credible in his complaints and symptoms because he was a fulltime worker working hard and successful until this injury occurred. It has been stated by another physician that he has a lot of functional overlay

but I believe if he does have functional overlay, this is due to pain and suffering that he occurs [illegible] more than exhibiting it for financial gain." In April, 1981, Dr. Berkeley did not specifically use the words "functional overlay" but did say, "In his present condition, this patient's disability seems to be quite severe in spite of the negative neurological findings."

The issue in this case is whether the presence of functional overlay is a subject of such a scientific or technical nature that only testimony of psychological experts may suffice to establish the causal relationship between claimant's injury and his disability. We conclude it was an error of law for the Board to disregard all evidence of functional overlay because a particular kind of evidence, expert psychological testimony, was not presented.

Oregon cases have considered the requirement for expert medical testimony in establishing workers' disability. Both this court and the Court of Appeals have recognized the compensability of an injury even without expert medical evidence establishing the causal relationship between the incident and the injury. *See Uris v.*

[1] We take judicial notice of the dictionary definition. OEC 201(b)(2), *Bend Millwork v. Dept. of Revenue*, 285 Or 577, 592 P2d 986 (1979).

[2] We have found cases in which physicians have testified about functional overlay. In *Balestri v. Highway & City Transpor. Inc.*, 57 Ill App 3d 669, 672, 373 NE2d 689 (1978), *aff'd* 76 Ill2d 451, 394 NE2d 391, *cert denied* 444 US 1018, 100 S Ct 671, 62 LEd 2d 648 (1980), an orthopedic surgeon testified that his diagnosis of functional overlay meant that he could find no objective medical justification for plaintiff's pain. In *McKenney v. School Bd. of Palm Beach County*, 408 So2d 655, 658 (Fla App 82) a physician testified that functional overlay means claimant's symptoms were of psychological origin.

Compensation Department, 247 Or 420, 427 P2d 753, 427 P2d 753, 430 P2d 861 (1967); *Volk v. Birdseye Division,* 16 Or App 349, 518 P2d 672 (1974). More frequently, however, expert medical testimony is indispensable. Professor Larson points out that "[t]he rule relaxing the necessity for medical testimony * * * is not justified when the medical question is no longer an uncomplicated one and carries the fact-finders into realms which are properly within the province of medical experts." 3 Larson, Workmen's Compensation Law § 79.54.

We have required expert medical testimony for proof of both the causal connection between accident and injury and proof of the degree of disability. *Marston v. Compensation Department,* 252 Or 640, 452 P2d 311 (1969); *Larson v. State Industrial Accident Commission,* 209 Or 389, 307 P2d 314 (1957); *Orr v. Industrial Accident Commission,* 217 Or 249, 342 P2d 136 (1959). These cases indicate that expert medical testimony is generally required to prove the causal connection between accident and

injury and between injury and disability. The issue presented by this case is a question of what kind of expert medical testimony is necessary to prove the causal relationship between an injury and the psychological components of the injury.

The term "expert witness" means:

> "a witness who is qualified, by reason of special knowledge or skill gained from experience, training, or education in a particular field, to express an opinion on a matter within that field that will be of assistance to the trier of fact in discharging the trier's function. *Galego v. Knudson,* 281 Or 43, 47, 573 P2d 313 (1978)." *W.R. Chamberlin & Co. v. Northwestern Agencies, Inc.,* 289 Or 201, 203, 611 P2d 652 (1980).[3]

State Highway Com. v. Arnold, 218 Or 43, 341 P2d 1089, 343 P2d 1113 (1959) observes that an expert is one who has acquired certain habits of judgment based on experience or special observation which enable an expert to draw from the facts inferences uniquely beneficial to the jury.

Physicians may be expert witnesses but to what may they testify? "No expert is competent to express an opinion on every subject." *Myers v. Cessna Aircraft,* 275 Or 501, 521, 553 P2d 355 (1976). Wigmore states:

> "The capacity is in every case a relative one, *i.e.,* relative to the topic about which the person is asked to make his statement. The object is to be sure that the question to the witness will be answered by a person who is fitted to

[3] OEC 702 provides:

"If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise."

answer it. His fitness, then, is a fitness to answer on that point. He may be fitted to answer about countless other matters, but that does not justify accepting his views in the matter in hand * * * A person may be sufficiently skilled upon one question, and totally unskilled upon the next." 2 Wigmore on Evidence 634, § 555 (3d ed 1940).

Accord, Meyer v. Harvey Aluminum, 263 Or 487, 501 P2d 795 (1972).

In spite of that admonition it has been said that a witness who is qualified to give expert testimony in a general field need not demonstrate expertise in a specialized aspect of that field. *See* McCormick, Handbook of the Law of Evidence 30 (2d ed 1972); *Wulff v. Sprouse-Reitz Co., Inc.,* 262 Or 293, 305, 498 P2d 766 (1972); *Unified Sewerage Agency v. Duyck,* 33 Or App 375, 380, 576 P2d 816 (1978). We held in *Mayor v. Dowsett,* 240 Or 196, 219, 400 P2d 234 (1965), that a physician who was not a neurological expert was competent to testify as to whether paralysis and its symptoms following spinal anesthesia may ensue after an anesthetic has worn off. This is consistent with the great weight of authority holding that a physician or surgeon is not incompetent to testify as an expert merely because he or she is not a specialist in the particular branch of the profession involved in the case. Most cases have held that a physician's specialty usually affects only the weight but not the competence of the expert testimony. *See generally* Annot., 54 ALR 860 (1928). For example, in *Seawell v. Brame,* 258 NC 666, 129 SE2d 283 (1963) a doctor engaged in the general practice of medicine testified that he had received psychiatric training while in medical school but did not hold himself out to be a psychiatrist. The court would have upheld admission of his testimony concerning the development of neurosis, leading to an ulcer and an asthmatic condition as a result of an injury, if his opinion had been based upon either personal knowledge or facts in evidence. Similarly, *Parker v. Gunther,* 122 Vt 68, 164 A2d 152 (1960) held that there was no error in allowing a general practioner to testify as to brain damage suffered by plaintiff as the result of an accident, even though the physician was admittedly not a specialist in injuries or diseases of the brain.[4]

An Arizona court addressed a similar challenge to the competence of a medical expert in a workers' compensation setting. In *Haynes v. Industrial Commission,* 19 Ariz App 559, 509 P2d 631 (1973), the claimant, a nurse's aide,

experienced sharp pain in her neck and right shoulder while shaking down a thermometer. Some months later she

[4] We note there are some exceptions. *See, e.g., Moore v. Belt,* 34 Cal2d 525, 212 P2d 509 (1950) (testimony of physician in field of urology excluded where physician had never practiced urology); *Hunt v. Bradshaw,* 251 F2d 103 (4th Cir 1958) (exclusion of testimony of physician with experience as radiologist but none in chest surgery as to proper method for performing chest operation).

was released to work but was unable to work steadily and eventually terminated her employment. Claimant sought to prove a causal connection between the pain of her on-the-job injury and an aggravation of a pre-existing condition, angina pectoris (chest pain). She argued that the aggravation, which would not otherwise have occurred but for the pain, resulted in her disability. Dr. Robinson, a cardiologist, while not drawing a conclusion regarding the relationship between the neck pain and the aggravated chest pains, testified more favorably for compensation than did Dr. DePaoli, an orthopedic surgeon, who specifically rejected any demonstrated relationship. Claimant urged that Dr. DePaoli was not qualified to testify to the relationship between the industrial injury and the cardiac disability because he was an orthopedist; and that Dr. Robinson's testimony was, therefore, the only competent evidence as to that relationship. The court said, "We disagree. Clearly the field of specialization of a competent medical witness affects the weight to be accorded his evidence, not its admissibility, and the Commission is the judge of the weight of the evidence." 509 P2d at 633.

Guillory v. Travelers Insurance Company, 326 So2d 914 (La Ct App), *writ den, no error of law,* 331 So2d 494 (La 1976), addresses precisely the issue raised in this case. In *Guillory* claimant sought to prove total and permanent disability for a job related injury to his right hand. Medical experts testified that they found no physical cause of claimant's pain but two out of the three testified that claimant suffered from overlaying conversion hysteria, described by one doctor as a condition which arises "when the mind thinks you're hurt and you're really not hurt and it's a mental thing." 326 So2d at 917. The insurer argued that a claim for conversion hysteria may not be proven by the testimony of physicians because the matter was outside their field of expertise. The court rejected the argument. It indicated that the diagnosis of conversion hysteria is within the competency of medical doctors even though treatment of the ailment may not be.

We are persuaded by the authorities cited herein and believe that *Guillory* states the correct rule to be

applied in this case. Accordingly, we hold that because the diagnosis of functional overlay is within the competency of medical doctors, they may express expert opinions about the disability. The fact that they are not psychotherapists may go to the weight to be accorded their testimony but that fact cannot serve as the reason to disregard the testimony entirely.

In this case the Board refused to consider the evidence of functional overlay presented by the medical doctors who were not psychologists or psychiatrists. This was error.

The decision of the Court of Appeals is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings consistent herewith.

INDEX CONTENTS

OVERVIEW OF SUBJECT INDEX

PERMANENT TOTAL DISABILITY

PSYCHOLOGICAL CONDITIONS & FACTORS

RECONSIDERATION See APPEAL & REVIEW

REMAND See APPEAL & REVIEW

REOPENING CLAIM WITHIN ONE YEAR OF DETERMINATION ORDER

REQUEST FOR HEARING See APPEAL & REVIEW

REQUEST FOR REVIEW--BOARD See APPEAL & REVIEW

RES JUDICATA

SETTLEMENTS & STIPULATIONS

SUBJECT WORKERS See NON-SUBJECT/SUBJECT WORKERS

SUCCESSIVE INJURIES See AGGRAVATION/NEW INJURY

TEMPORARY TOTAL DISABILITY

THIRD PARTY CLAIM

TORT ACTION

VOCATIONAL REHABILITATION

CASE CITATIONS

Name, Citation-----Page(s)

Name, Citation-----Page(s)

Name, Citation-----Page(s)

Name, Citation-----Page(s)

CASE CITATIONS

Name, Citation-----Page(s)

VAN NATTA CITATIONS

Name	Citation	Page(s)
Joyce Adair	34 Van Natta 203 (1982)	358,532
Robert L. Akins	35 Van Natta 231 (1983)	556
Angel Albarez	33 Van Natta 598 (1981)	716
James Albers	34 Van Natta 1622 (1982)	678,789
Claude Allen	34 Van Natta 769 (1982)	299
Marcella Anderson	27 Van Natta 119 (1979)	716
Edward M. Anheluk	34 Van Natta 205 (1982)	93,377
Ernest A. Annette	35 Van Natta 35 (1983)	190
Warren C. Bacon	35 Van Natta 41 (1983)	47
Zelda M. Bahler a	33 Van Natta 478 (1981)	1,13,16,25,72,198, 329,635,665,739,802
Zelda M. Bahler	31 Van Natta 139 (1981)	117
Roger Ballinger	34 Van Natta 732 (1982)	75,772
Clarice Banks	34 Van Natta 689 (1982)	598,655
Robert A. Barnett	31 Van Natta 172 (1981)	72,94,112,115,203, 235,235,299,320,325, 557,559,634,797,896
Phillip J. Barrett	34 Van Natta 450 (1982)	789
Brent Bennett	34 Van Natta 1563 (1982)	684
Phillip A. Bertrand	35 Van Natta 874 (1983)	869
Phillip A. Bertrand	35 Van Natta 869 (1983)	874
Curtis H. Best	35 Van Natta 298 (1983)	582
Daniel K. Bevier	35 Van Natta 258 (1983)	789
David D. Blair	30 Van Natta 407 (1981)	716
Edwin Bolliger	33 Van Natta 559 (1981)	52,181,532,586,665
Anthony A. Bono	35 Van Natta 1 (1983)	161,198,350,744,802, 869
W. Leonard Bradbury	32 Van Natta 246 (1981)	363
George Brasky	34 Van Natta 453 (1982)	761
Kelly P. Britt	34 Van Natta 1182 (1982)	813
Ronald Bronski	34 Van Natta 612 (1982)	143,885
Ronald D. Brown	34 Van Natta 1004 (1982)	1,233
Clyde V. Brummel	34 Van Natta 1183 (1982)	63
Wilma Kim Buhman	34 Van Natta 252 (1982)	299
William Bunce	33 Van Natta 546 (1981)	19,572
Harvey Burt	22 Van Natta 42 (1977)	716
John Cameron	34 Van Natta 211 (1982)	231,556
Jess Campbell	15 Van Natta 146 (1975)	47
Larry Campuzano	34 Van Natta 734 (1982)	515,859
Clea B. Carpenter	34 Van Natta 456 (1982)	789
Ruth M. Case	33 Van Natta 490 (1981)	885
Richard A. Castner	33 Van Natta 662 (1981)	281
David Cheney	35 Van Natta 21 (1983)	368,695,744
Douglas Chiapuzio	34 Van Natta 1255 (1982)	104,386,660
Bonnie Chytka	35 Van Natta 86 (1983)	699
Gary L. Clark	35 Van Natta 117 (1983)	131,257,772,802,818
Mary Lou Claypool	34 Van Natta 943 (1982)	25,716,851
Angela V. Clow	34 Van Natta 1632 (1982)	120
Warren Collins	17 Van Natta 236 (1976)	93
Ora M. Conley	34 Van Natta 1698 (1982)	72,112,115,203, 235,235,299,320, 325,557,559,634,896

Name	Citation	Page(s)
Leon E. Cowart	34 Van Natta 1597 (1982)	695
Larry Crane	29 Van Natta 113 (1980)	587
Harlan Crawford	34 Van Natta 1010 (1982)	789
Sylvia Crites	7 Van Natta 100 (1971)	332
Kathie L. Cross	34 Van Natta 1064 (1982)	125,310,840
Max D. Cutler	34 Van Natta 1480 (1982)	286,716
Shawn Cutsforth	35 Van Natta 515 (1983)	823
Pauline Cutter	34 Van Natta 1709 (1982)	355
Robert W. Dalton	35 Van Natta 352 (1983)	557
John R. Daniel	34 Van Natta 1020 (1982)	12,198
Patricia Davis	35 Van Natta 635 (1983)	716,814
Roberta Davis	6 Van Natta 251 (1971)	56
Patricia M. Dees	35 Van Natta 120 (1983)	131,348,377,528
Robert DeGraff	29 Van Natta 893 (1980)	75
Ada C. Del Rio	32 Van Natta 138 (1981)	358
Juanita DesJardins	34 Van Natta 595 (1982)	31,136,789
Ray D. Dezellum	34 Van Natta 213 (1982)	63
Dale Donaldson	34 Van Natta 1154 (1982)	707
Douglas Dooley	35 Van Natta 125 (1983)	120,131,624,740
Gayle Duckett	32 Van Natta 284 (1981)	355
Anthony J. Duman	35 Van Natta 260 (1983)	789
Madonna Duman	34 Van Natta 1642 (1982)	260,789
Hettie M. Eagle	33 Van Natta 671 (1981)	384,528
Earl E. Ekstrand	34 Van Natta 742 (1982)	262
Patrick Elliott	32 Van Natta 155 (1981)	156
Vernon D. Ellis	35 Van Natta 45 (1983)	47
Marion L. Ells	34 Van Natta 1010 (1982)	298
Frederick Estabrook	17 Van Natta 66 (1976)	716
Billy J. Eubanks	35 Van Natta 131 (1983)	117,120,125,140, 216,257,289,368,377, 699,818
Willard B. Evans	34 Van Natta 490 (1982)	62,125,528,859
Herb Ferris	34 Van Natta 470 (1982)	678
Yvonne C. Fish	34 Van Natta 1038 (1982)	86
Dixie Fitzpatrick	34 Van Natta 974 (1982)	96,136
Dennis Fraser	35 Van Natta 271 (1983)	851
Gary A. Freier	34 Van Natta 543 (1982)	332,614,678
John Galanopoulos	34 Van Natta 615 (1982)	282,548,859
Norman Garbutt	28 Van Natta 351 (1979)	262
Billie Gardner	34 Van Natta 218 (1982)	528
Norman J. Gibson	34 Van Natta 1583 (1982)	16,72,117,665
Paul Gill	34 Van Natta 1471 (1982)	75,772
Anita Gilliam	35 Van Natta 377 (1983)	384
John P. Ginter	34 Van Natta 547 (1982)	598
Christine N. Givens	34 Van Natta 258 (1982)	21
Donald A. Godell	34 Van Natta 50 (1982)	587
Frank Gonzales	34 Van Natta 551 (1982)	125,358
Elmer C. Gregory	35 Van Natta 93 (1983)	377
Glenn O. Hall	35 Van Natta 275 (1983)	282,365
Glenn O. Hall	34 Van Natta 1725 (1982)	789,863
Mary Ann Hall	31 Van Natta 56 (1981)	117,125,528,859
Isla M. Halligan	34 Van Natta 594 (1982)	716
Ruby J. Hampton	30 Van Natta 708 (1981)	642
Fred Hanna	34 Van Natta 1271 (1982)	9,47,143,271, 299,368,885

Name	Citation	Page(s)
Jesse E. Hardy	35 Van Natta 171 (1983)	523
Clyde M. Hargens	34 Van Natta 751 (1982)	109,111,358,744
Quinten Hargraves	35 Van Natta 156 (1983)	155
Margaret L. Harris	34 Van Natta 558 (1982)	156
Michiel Harth	34 Van Natta 703 (1982)	88,388,406
Lavona Hatmaker	34 Van Natta 950 (1982)	252,678,789,824
Robert Heilman	34 Van Natta 1487 (1982)	241,684,847
Rose Hestkind	35 Van Natta 250 (1983)	251,695
Julia I. Hicks	33 Van Natta 497 (1981)	151
Donald W. Hill	34 Van Natta 1291 (1982)	587,700
Robert Hill	24 Van Natta 39 (1978)	332
Benjamin Hockema	26 Van Natta 437 (1979)	299
Herman J. Howland	28 Van Natta 368 (1979)	716
William W. Hughes	35 Van Natta 358 (1983)	532
David S. Hunter	33 Van Natta 273 (1981)	47
Lorena Iles	30 Van Natta 666 (1981)	350,830
Norman Jager	34 Van Natta 1558 (1982)	716
William Jameson	34 Van Natta 1532 (1982)	268
James B. Johnson	35 Van Natta 47 (1983)	41,45,56,296,299
Vivian Johnson	11 Van Natta 98 (1974)	253
Billy Joe Jones	34 Van Natta (1982)	713
Harry C. Jordan	35 Van Natta 282 (1983)	275
Derral D. Kelley	34 Van Natta 73 (1982)	329
Donna P. Kelley	30 Van Natta 715 (1982)	363
Karen K. Kephart	34 Van Natta 707 (1982)	281
Michael J. King	33 Van Natta 636 (1981)	176,295,628,699
Richard Kirkwood	35 Van Natta 140 (1983)	131,818
Leonard F. Kisor	35 Van Natta 282 (1983)	548
Henry A. Kleeman	7 Van Natta 70 (1971)	56
Marlene L. Knight	34 Van Natta 278 (1982)	89
Francis Knoblauch	35 Van Natta 218 (1983)	744
Jim Lafferty	33 Van Natta 530 (1981)	806
Jimmy Layton	35 Van Natta 253 (1983)	578,830
James Leppe	31 Van Natta 130 (1981)	716
Patricia Lewis	34 Van Natta 202 (1982)	350
Jay Long	34 Van Natta 1519 (1982)	587
Dianne Lopatin	29 Van Natta 466 (1980)	789
Brad L. Loren	35 Van Natta 303 (1983)	314
Robert A. Lucas	34 Van Natta 1553 (1982)	716
Robert Luhrs	34 Van Natta 1089 (1982)	325
Laura Maitland	34 Van Natta 1294 (1982)	772
Frank Mason	34 Van Natta 568 (1982)	52,755,844,863
David S. Mathews	35 Van Natta 75 (1983)	83,179,203
Richard L. McBee	34 Van Natta 1119 (1982)	787
Joyce McCammon	22 Van Natta 28 (1977)	332
Roy A. McFerran	34 Van Natta 621 (1982)	19,58,179,267,572,797
Henry McGarrah	33 Van Natta 584A (1981)	205
Dorothy McIver	32 Van Natta 192 (1981)	716
Violet B. McKinnon	26 Van Natta 40 (1978)	716
Darrell Messinger	35 Van Natta 161 (1983)	156
Harold Metler	34 Van Natta 710 (1982)	797
Vernon Michael	34 Van Natta 1212 (1982)	540,569,617,764
Richard R. Miller	34 Van Natta 514 (1982)	303
Richard D. Minshall	34 Van Natta 1173 (1982)	303
Lorrie A. Minton	34 Van Natta 162 (1982)	665,789

VAN NATTA CITATIONS

Name	Citation	Page(s)
David Mobley	34 Van Natta 35 (1982)	789
Steven E. Moffet	35 Van Natta 56 (1983)	47
Ronald W. Mogliotti	35 Van Natta 384 (1983)	377
Jack G. Monroe	34 Van Natta 1106 (1982)	757
Edward Morgan	34 Van Natta 1590 (1982)	271,768
Charles A. Murray	34 Van Natta 249 (1982)	678
Edwin L. Mustoe	34 Van Natta 659 (1982)	86,830
Victoria Napier	34 Van Natta 1042 (1982)	86
Donald P. Neal	34 Van Natta 237 (1982)	190,578
Patricia R. Nelson	34 Van Natta 1078 (1982)	21,591
William A. Newell	35 Van Natta 629 (1983)	716
John J. O'Halloran	34 Van Natta 1504 (1982)	695,859
John J. O'Halloran	34 Van Natta 1101 (1982)	695
Mark O'Hara	35 Van Natta 587 (1983)	700
Gordon L. Ogden	34 Van Natta 1567 (1982)	736
Raymond Orsborn	34 Van Natta 576 (1982)	10,81,365
Alvy Osborne	34 Van Natta 127 (1982)	716
Mary E. Osborne	35 Van Natta 186 (1983)	181,660
Dorotha L. Oyler	34 Van Natta 1128 (1982)	89,821
Robert A. Parker	32 Van Natta 259 (1981)	695,859,866
Susan Parries	32 Van Natta 19 (1981)	355
Rose E. Pederson	34 Van Natta 1658 (1982)	143,298
Flora Pelcha	34 Van Natta 1141 (1982)	368,824
Clara M. Peoples	31 Van Natta 134 (1981)	515,807
Dock A. Perkins	31 Van Natta 180 (1981)	388,806
Harold O. Peterson	30 Van Natta 273 (1980)	275
Michael Petkovich	34 Van Natta 98 (1982)	89
Keith Phillips	35 Van Natta 388 (1983)	885
Walter C. Phillips	33 Van Natta 505 (1981)	93
Richard Pick	34 Van Natta 957 (1982)	346,388,785
Dean Planque	34 Van Natta 1116 (1982)	563,658
Fred H. Poehler	34 Van Natta 76 (1982)	789
Adelma Potterf	30 Van Natta 275 (1981)	716
Raymond Presnell	21 Van Natta 44 (1977)	716
Jeri Putnam	34 Van Natta 744 (1982)	125,840
Mike A. Ratliff	30 Van Natta 814 (1981)	83,203
Bringfried Rattay	17 Van Natta 171 (1976)	716
Hazel Ray	34 Van Natta 1183 (1982)	63
Darreld W. Rayle	34 Van Natta 1204 (1982)	156
James H. Roberts	34 Van Natta 1603 (1982)	282,695
George Roth	14 Van Natta 202 (1975)	716
Wilma H. Ruff	34 Van Natta 1048 (1982)	761
Barbara Rupp	30 Van Natta 556 (1981)	176,295,628
Peter J. Russ	33 Van Natta 409 (1981)	189
Danny H. Sackett	34 Van Natta 1107 (1982)	757
Lucine Schaffer	33 Van Natta 511 (1981)	253,621,859,866
Anna Scheidemantel	35 Van Natta 740 (1983)	897
LeRoy R. Schlecht	32 Van Natta 261 (1981)	548,695
William Schneider	34 Van Natta 520 (1982)	104
Richard Schoennoehl	31 Van Natta 25 (1981)	233
James C. Schra	34 Van Natta 1577 (1982)	716
Howard Shirley	9 Van Natta 254 (1973)	253
Richard S. Short	27 Van Natta 274 (1979)	253
Mark L. Side	34 Van Natta 661 (1982)	12,869
Lenford Simmons	30 Van Natta 400 (1981)	716
Juanita Skophammer	18 Van Natta 18 (1976)	35

VAN NATTA CITATIONS

Name	Citation	Page(s)
Allen M. Sparks	34 Van Natta 526 (1982)	353
Carlton A. Spooner	34 Van Natta 1594 (1982)	690
Susan K. Spratt	34 Van Natta 1028 (1982)	570
Terry L. Starbuck	34 Van Natta 81 (1982)	241
Johnnie L. Stepp	34 Van Natta 1685 (1982)	624
Edith Stevens	34 Van Natta 642 (1982)	253
Victor Stewart	30 Van Natta 472 (1981)	125
Eonia Z. Stoa	34 Van Natta 1206 (1982)	186
Sidney A. Stone	31 Van Natta 84 (1981)	555,558
Marlene Strauser	34 Van Natta 168 (1982)	377
Dorothy Swift	34 Van Natta 1059 (1982)	86,729
Eugene Thomas	35 Van Natta 16 (1983)	75
Minnie Thomas	34 Van Natta 40 (1982)	143,271,321,660, 787,885
James Thurston	32 Van Natta 146 (1981)	789
Bonnie R. Tolladay	35 Van Natta 198 (1983)	740
Juanita Trevino	34 Van Natta 632 (1982)	363
Lewis Twist	34 Van Natta 290 (1982)	75,83,120,203,310, 332,525,528,635
Keith G. Underwood	34 Van Natta 1305 (1982)	303
William E. Urton	34 Van Natta 1263 (1982)	789
Inez Van Horn	35 Van Natta 342 (1983)	328,611
Clair Vandehey	26 Van Natta 27 (1978)	716
Michael Vernon	34 Van Natta 1212	318,319
Delbert Walker	29 Van Natta 149 (1980)	716
Nick L. Ward	34 Van Natta 1739 (1982)	642
Darryl G. Warner	34 Van Natta 634 (1982)	143,885
Barbara Wasson	34 Van Natta 1094 (1982)	249,619
George F. Weiland	34 Van Natta 961 (1982)	205
Wayne E. Welch	34 Van Natta 766 (1982)	755,789
David C. Welsh	34 Van Natta 1246 (1982)	642
Curtis L. West	31 Van Natta 106 (1981)	570
Cecil Whiteshield	4 Van Natta 203 (1970)	267
Glen A. Williams	34 Van Natta 1222 (1982)	716
Donald Wischnofske	32 Van Natta 136 (1981)	198,349,740
Ardean Woodfin	30 Van Natta 281 (1980)	587
Donald Woodman	34 Van Natta 178 (1982)	256
Robert B. Woodruff	35 Van Natta 249 (1983)	619
Donald J. Young	35 Van Natta 143 (1983)	151,271,368,660,885
Lesley Young	28 Van Natta 958 (1980)	716
Gilbert Zapata	8 Van Natta 99 (1972)	56

ORS CITATIONS

LARSON CITATIONS

The following Memorandum Opinions are not published in this volume. These decisions may be ordered from the Workers' Compensation Board using the numbers provided.

MEMORANDUM OPINIONS

Name, WCB Number (Month/Year)

Alexander, Dennis G., 81-00731 (2/83)
Anderson, Bill R., 82-02459 (6/83)
Anderson, Edwina J., 82-01866 (3/83)
Anderson, Gerald L., 79-08942 (3/83)
Anderson, James W., 81-03907 & 81-04409 (5/83)
Anderson, Mayrie, 82-05127 (6/83)
Anderson, Walter L., 81-11056 (3/83)
Archer, Catherine, 82-01131 & 82-01132 (3/83)
Armstrong, Veston C., 81-06683 (3/83)
Arnhold, Terry L., 82-01722 (6/83)
Bailey, Phyllis L., 81-07298 (5/83)
Baker, Ernest Jr., 81-04390 (3/83)
Banks, James A. (Deceased), 82-08738, 82-08739 etc. (6/83)
Barcicevic, John J., 81-11310 (3/83)
Barnett, Everett E., 82-04329 (5/83)
Barnett, Tom, 81-10824 (3/83)
Bartlett, Robert G., 82-02880 (6/83)
Batman, James, 80-10907 (2/83)
Beedy, Rocky, 81-01067 (5/83)
Behnke, Leo R., 82-575 (2/83)
Bellmore, Charles F., 82-01208 (5/83)
Bennett,Ray, 82-01352 (6/83)
Berov, Valentin S., 81-07326 (3/83)
Bichler, Elmer J., 82-01447 (5/83)
Bisbey, Geoffrey, 82-04779 (6/83)
Bloomer, Gary, 81-05847 (6/83)
Bonner, Melvin, 81-09837 (2/83)
Boyd, Thora, 81-10508 (2/83)
Braxmeyer, James A., 82-02856 (6/83)
Breasaw, Dionne D., 82-06826 (4/83)
Britt, William E., 81-09702 (4/83)
Brown, Douglas, 81-09136 (3/83)
Brown, Linda J., 81-10742 (5/83)
Brown, Ralph, 81-10213 (3/83)
Bryant Evick, Niada M., 82-02938 (5/83)
Burch, Phyllis, 82-07534 (6/83)
Bureau, Donna M., 81-07527 (3/83)
Burgess, Edward E., 81-11521 (5/83)
Burke, Kathy D. (Leeth), 82-06053 (5/83)
Caddell, Avis C. 82-00301 (1/83)
Campbell, Daniel, 82-01745 (6/83)
Card, H. Roger, 81-05569 & 81-05569 (1/83)
Cardoza, Linda, 83-0009M (1/83)
Carlston, Larry W., 82-04823 (6/83)
Carpenter, Charles E., 80-01687 (1/83)
Carter, Ronald P., 82-04684 (6/83)
Cartwright, Leatha, 81-01112 & 81-01113 (2/83)
Case, Patrick A., 81-09780 (2/83)
Champ, Sherman L., 81-06786 (2/83)

Name, WCB Number (Month/Year)
Chandler, William, 81-08446 (2/83)
Chappell, Leslie H., 81-00881 (3/83)
Charitar, Ram, 81-10223 (1/83)
Chubbuck, Curtis G., 82-00057 (5/83)
Colcord, Ronald, 82-07958 (3/83)
Conken, Chester S., 81-10093 (6/83)
Conner, Gary B., 82-08472 (5/83)
Cook, John A., 82-02897 (6/83)
Cornell, John H., 82-06759
Corry, David B., 81-02675 (6/83)
Counts, James R., 82-03729 (3/83)
Coutinho, Augusto, 81-1790 (3/83) (4/83)
Cox, Charley N., 82-02066 (5/83)
Cox, Sandra J. (Mills), 82-01892 (5/83)
Culley, Robert J., 80-09954 (6/83)
Culp, Charles L., 81-03091 (2/83)
Cureton, Lonnie, 81-04237 (3/83)
Currin, Robert A., 81-07800 (5/83)
Cutsforth, Shawn, WCB n/a (5/83)
Daugherty, Charles W., 80-09223 & 81-01183 (1/83)
Davis, Janet D., 81-01117 (3/83)
Davis, William A., 81-08455 (1/83)
Day, Lorri K., 81-09685 (3/83)
DeLong, Barbara J., 82-01571 & 82-01154 (5/83 & 6/83)
Deos, Jack, 81-02829 (2/83)
Desau, David R., 81-05375 (2/83)
Dials, Crayton J., 81-08908 (4/83)
Dodge, Theodore J., 82-02559 (5/83)
Dooley, Douglas, 81-06280 (5/83)
Dunsmore, Sandra, 82-02555 (1/83)
Duran, Nancy A., 81-04607 (1/83)
Durham, David R., 81-05933 (3/83)
Duvall, Kay, 80-08624 (1/83)
Elliott, Norma J., 82-04519 & 82-04520 (6/83)
Esquivel, Juventino, 82-03874 (3/83)
Everson, Ernest E., 80-09191 & 80-09192 (3/83)
Fisher, Laurel T., 82-00769 (3/83)
Flick, Mike R., 81-11402 (5/83)
Forsyth, James, 81-02716 (1/83)
Franzel, Joan P., 81-02107 (1/83)
Freeman, Leslie (Sanders), 81-06083 (1/83)/83)
Gardiner, William T., 81-01564 (6/83)
Gates, Mary, 82-04403 (1/83)
Gates, Patricia J., 82-06135 (6/83)
Gates, Thomas D., 80-10515 (6/83)
Gaylord, William R., 80-04832 (2/83)
Gill, Thomas P., 81-02329 (6/83)
Giofu, Robert, 81-09105 (3/83)
Glover, Bernice, 81-05776 (5/83)
Goddard, Donna F., 81-09102 (6/83)
Greer, Dimidy A., 80-08353 (3/83)
Gross, Leon F., 81-06755 (1/83)
Gutierrez, Clemente E., 82-03054 (3/83)
Hackett, Julia, 82-02055 (1/83)
Haines, Robert J., 82-0316M (1/83)
Hall, Jay, 81-011495 (1/83)
Hankins, Roy L., 82-04944 (5/83)

Name, WCB Number (Month/Year)
Hannick, Robert A., 82-02736 & 82-01846 (6/83)
Harris, Carl F., 82-01036 (3/83)
Hassler, Maxine, 81-03872 (2/83)
Hauser, Benton L., 82-00700 (3/83)
Hawes, Charlene D., 82-00049 (5/83)
Helzer, Joanne M., 81-07340 (3/83)
Hendren, Madeline C., 81-01990 (4/83)
Hess, Candy J., 82-02550 (6/83)
Hilderbrand, James, 82-00123 (3/83)
Hill, Del Ray, 81-00862 (1/83)
Hoban, Jerry, 81-11726 (1/83)
Hoover, Esther, 81-02324 (2/83)
Hoppe, Lois, 81-10080 & 80-06520 (2/83)
Horner, Lloyd J., 80-02020 (3/83)
Hort, Albert E., 80-11056 (2/83)
Hunnel, Sandra J., 81-10600 (2/83)
Hurt, John M., 82-00329 (3/83)
Hutchinson, Marc, 81-01715 (1/83)
Iiams, Michael G., 82-06091 & 82-06092 (6/83)
Isaacs, David R., 81-01071 (5/83)
Jeffries, Frances M., 81-11401 (3/83)
Johnson, Raymond P., 81-11074 & 82-04730 (6/83)
Johnston, Cheryl A., 82-05651 (5/83)
Jones, Murl E., 81-06864 (1/83)
Jones, Stoddard (Deceased), 82-02121 (6/83)
Jones, Walter A., 81-09474 (5/83 & 6/83)
Jordan, Melvin, 81-08472 (1/83)
Joyner, Debra A., 82-01942 (6/83)
Kaforski, Lawrence J., 81-08076 (1/83)
Kallimanis, William S., 81-04832 (6/83)
Kappitz, William H., 81-08674 (3/83)
Kassahn, Jerry E., 82-08351 (6/83)
Kelly, James R., 82-06154 (5/83)
Ketchum, Frank, 81-04706 (1/83)
Keyes, Kevin W., 82-04338 (5/83)
Kight, Lee M., 81-11508 (6/83)
King, Randy, 82-03625 (3/83)
Kirkpatrick, Jerry H., 79-05300 (5/83)
Kiser, Delroy, 82-06010 (6/83)
Kivisto, Harold A., 81-01752 (6/83)
Knight, Margaret, 82-05544 (3/83)
Kniskern, Judith Ann, 81-09014 (1/83)
Koehler, Jack S., 82-02324 (6/83)
Kramer, Dennis R., 81-11127 (2/83)
Kutch, Gerald, 82-00202 (2/83)
Kyllo, Hilda E., 81-05118 (5/83)
Lane, George W., 82-02357 (6/83)
Langley, Billey L., 81-06997 (1/83)
LaQue, Bernard, 82-04830 (5/83)
Lawson, Wesley A., 81-09032 (3/83)
Lawver, Charles E., 81-07097 (6/83)
Leap, Dale L., 81-07262 (2/83)
Lemay, James P., 82-07306 (5/83)
Lewis, D.H & E.M., 81-05850 (3/83)
Lewis, Paul E., 78-04577 (3/83)
Lipe, William, 81-06071 (5/83)
Littlefield, Raymond S., 81-10191 & 81-06530 (3/83)

MEMORANDUM OPINIONS

Name, WCB Number (Month/Year)
Londo, Beulah I., 81-03379 (2/83)
Lundy, Eyvonne, 81-04501 (1/83)
Lyon, Claude, 81-11497 (3/83)
MacIvor, Frank H. (Deceased), 82-02901 (6/83)
Macon, Wyman L., 81-11568 (2/83)
Madden, Essie F., 80-00127 (2/83)
Manning, Ronald, 81-10733 (3/83)
Margison, Harold A., 81-07478 (3/83)
Marshall, Danny C., 81-07627 (2/83)
Mary, Jerry D., 81-05956 (5/83)
Mason, Sammy J., 82-01982, 82-01784 & 81-10922 (6/83)
Masoumpanah, Ahmad, 81-02934 (1/83)
Maxwell, Carl, 79-00195 (1/83)
McCann, Albert, 81-11537 & 82-02702 (3/83)
McCarty, Jean, 82-02576 (5/83)
McCormick, Timothy I., 81-06127 (3/83)
McCoshum, Gary, 81-09301 (2/83)
McDevitt, Timothy J., 81-07972 (6/83)
McGinnis, Monty D., 82-01697 (5/83)
McGril, Thomas H., 81-10781 (5/83)
McKinney, Kenneth N., 79-02868 (1/83)
McLaughlin, Thomas P., 81-11623 (3/83)
McPhail, Richard, 81-05023 (5/83)
Mead, James W., 81-09602 (5/83)
Mead, Kenneth R., 82-03356 (3/83)
Mead, Russell J., 82-00953 (2/83)
Mespelt, Beverly, 81-07030 & 82-01317 (5/83)
Miles, Ray M., 81-07012 (6/83)
Miller, Sharon, 82-01711 (3/83)
Mills, Rhonda G., 81-10908 (3/83)
Millus, Debra, 82-02443 & 81-00941 (2/83)
Minnick, William, 81-04753 (3/83)
Montgomery, Eautie P., 82-04946 (5/83)
Morris, James R., 82-01899 (5/83)
Moser, Mary F., 81-04008 (2/83)
Nacoste, James A., 81-00180 (5/83)
Nall, Shelby J., 81-08980 (6/83)
Nixon, Tom A., 82-04343 (6/83)
Nordberg, Marion, 81-07851
O'Neal, Billy L., 81-02144 (5/83)
Olinghouse, Ronald S., 82-04653 (6/83)
Oliver, Cheryl K., 80-10666 & 81-06952 (5/83)
Orth, Michael J., 82-08717 (6/83)
Osorio, Martha O., 82-01241 (3/83)
Owen, David C., 81-08660 (1/83)
Owens, Donald L., 81-10633 (5/83)
Parker, Thomas D., 80-10438 (3/83)
Parks, William N., 81-06839 (1/83)
Paul, Vesta G., 81-01113 (2/83)
Payne, Rosalie Bauman, 81-00152 (6/83)
Pearson, Kathie, 82-01284 (6/83)
Pence, Russell, 80-10831 (3/83)
Pennington, Mollie A., 82-02875 (3/83)
Perez, Jose, 80-03457 (5/83)
Perkins, Opal, 82-04458 (6/83)
Peterson, Kenneth M., 80-06187 (1/83)
Pettijohn, Lewis D., 82-01599 (3/83)

Name, WCB Number (Month/Year)
Peyton, Gary B., 81-11299 (3/83)
Peyton, Gwen A., 82-02345 (2/83)
Phillips, Richard, 80-9518 (5/83)
Pine, Vickie, 80-05172 (6/83)
Poe, Theodis E., 82-0324M (1/83)
Pollard, Keaver H., 82-02898 (4/83)
Popoff, Floreen A., 82-01327, 82-00116 etc. (3/83)
Potts, Marvin L., 82-04885 (5/83)
Powers, Colleen G., 80-02368 (3/83)
Purifoy, Bordy, 81-09206 (2/83)
Ramm, Leroy L., 81-08806 (2/83)
Rasmussen, Warren F., 81-11138 (6/83)
Reavely, Dolores, 81-09587
Redwing, Edward J., 82-03439 (5/83 & 6/83)
Reed, Rick R., 81-00172 (3/83)
Rice, Diana R., 82-01886 & 82-01885 (5/83)
Richter, Katharine, 81-09260 (5/83)
Riddle, Charles W., 82-04901 (5/83)
Rietkerk, Dick, 82-02490 (5/83)
Rigot, Cindy, 80-10186 (1/83)
Rinck, Robert, 82-08696 (6/83)
Robbins, Teresa, 82-00224 (2/83)
Robertson, Jesse, 80-00717 (2/83)
Rodriguez, Lupe, 81-06244 (1/83)
Russworm, Hubert D., 82-03960 & 82-06406 (6/83)
Ruzicka, Mary E., 82-02222 (3/83)
Salinas, Panfilo, 80-06680 (6/83)
Sampson, Charles, 81-06270 (2/83)
Sanders, Juanita M., 81-08252 (5/83)
Sarich, Judy A., 82-02672 (1/83)
Saville, Nellie M., 82-04607 & 82-05922 (6/83)
Schaffer, Karl, 81-09005 (2/83)
Schultz, Marie, 81-07798 (3/83)
Schuster, Carrie L., 82-03084 (3/83)
Schwanke, Marvin, 81-04820 & 80-08259 (5/83)
Scofield, Dale, 82-02777 (5/83)
Scott, Larry H., 82-03645 (6/83)
Scruggs, Maggie, 81-09732 (1/83)
Sharp, Jesse, 81-04002 & 82-01934 (1/83)
Shaw, Gerald W., 82-05364 (5/83)
Sherrill, Tim, 80-11067 (2/83)
Shipman, William, 81-10119 (6/83)
Shirley, Larry H., 82-02369 (6/83)
Shotsky, Linda, 81-11135 (3/83)
Singleton, Roy, 82-03047 (5/83)
Sisemore, Jeffrey, 81-05374 (3/83)
Skinner, Holly A., 81-09171 (3/83)
Smith, Richard, 81-07640 (2/83)
Smith, Roy L., 82-01544 (2/83)
Smith, Walter M., 81-05462 & 81-05463 (6/83)
Sold, Frederick J., 81-03459 (3/83)
Solomon, Reginald B., 81-10476 (2/83)
Spiering, Betty J., 81-09303 (6/83)
Spilde, David, 82-01266 (2/83)
Stedman, Robert W., 81-01763 (5/83)
Steele, George, 81-06823 (2/83)
Steele, Helen J., 81-11420 (6/83)

MEMORANDUM OPINIONS

Name, WCB Number (Month/Year)
Stenkamp, Robert, 82-02579 (6/83)
Stevens, Doris M., 81-08495 (1/83)
Strawn, Darrell G., 80-06395 (1/83)
Strickland, Donald, 78-06887 (3/83)
Strohecker, Ken L., 81-10398 (5/83)
Sunseri, Gerald J., 82-00729 & 82-03147 (2/83)
Taylor, Gene R., 81-10917 & 82-04748 (3/83)
Tennant, Kevin E., 82-07689 (5/83)
Thacker, Donald J., 80-11388 (1/83)
Thacker, Michael E., 82-06083 (5/83)
Thedford, Doris B. (Employer), 82-04779 (6/83)
Theriault, Arthur, 81-09550 (2/83)
Thomas, Leora A., 81-03307 (2/83)
Thompson, Glen, 82-04025 (6/83)
Thompson, Sam, 81-08775 & 81-08774 (4/83)
Tippie, Clarence C., 81-00460 (5/83)
Tolman, Gordon B., 81-01036 (2/83)
Travis, Paula, 81-11054 (3/83)
Treanor, Mary J., 82-02891 (5/83)
Tristan, Estela M., 81-07733 (6/83)
Trow, Barbara J., 82-02336 (6/83)
Tucker, Lindberg M., 80-09391 (3/83)
Tupper, Lovie, 81-00482 (3/83)
Turner, Frank J., 82-02803 (6/83)
Turner, James E., 81-07597 (1/83)
Turner, Susan, 81-06582 (6/83)
Vaden, Tracy, 81-10222 (5/83)
Vierra, Carol A., 81-04322 & 81-04547 (1/83)
Volkers, Edgar B., 82-03455 (3/83)
Volkers, Edgar, 81-04175 (2/83)
Wager, Russell W., 81-11590 (1/83)
Waldron, Duane E., 81-04702 (3/83)
Walker, Sandra, 81-10314 (2/83)
Wallace, Harvey M., 80-05364 (2/83)
Walter, Clark M., 81-11714 (5/83)
Watson, Linda K., 81-11655 & 81-11656 (6/83)
Weir, John R., 81-06324 (2/83)
Welborn, Shirley, 81-09686 (3/83)
West, Carl F. 80-00288 (3/83)
Westfall, Marvin D., 81-02120 (1/83)
Whitley, James E., 80-06085 (2/83)
Widenmann, Leo, 81-05767 (2/83)
Wight, Betty W., 78-08991 (1/83)
Wilhelm, Adam N., 82-02705 (6/83)
Winkler, Karen M., 81-04022 (2/83)
Wood, Winston, 81-11385 (6/83)
Wright, Steven L., 79-10371 (5/83)
Zandofsky, John S., 81-00185 (2/83)
Zehe, Frederick H., 81-04884 (3/83)

The following decisions under Own Motion Jurisdiction are not published in this volume. They may be ordered from the Workers' Compensation Board using the numbers provided.

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)
Allmon, Thomas, 83-0121M (5/83)
Anderson, Dianna, 81-0182M (3/83)
Armstrong, Bill, 82-0258M (1/83)
Audas, Troy, 82-0193M & 82-0328M (3/83)
Baker, Richard, 83-0035M (2/83)
Baldwin, Gerald A., 83-0058M (3/83)
Barnes, Diane, 82-0042M (3/83)
Barnes, Harvey, 83-0023M (2/83)
Barnes, Rita M., 83-0154M (6/83)
Bass, Corrie, 83-0005M (1/83)
Beatty, Lyn, 81-0056M (5/83)
Been, Norman, 83-0021M (1/83)
Betker, Larry, 83-0026M (4/83)
Blevins, Jack, 83-0076M (4/83)
Bones, Leonard W., 83-0006M (1/83)
Brewis, Evelyn P., 83-0142M (6/83)
Brooks, Donald, 83-0102M (5/83)
Brown, Frank, 83-0129M (5/83)
Brown, Raymond, 83-0063M (3/83)
Bruce, Walter J., 83-0137M (6/83)
Buckshnis, Rick, 83-0135M (5/83)
Buffum, Marvon C., 83-0045M (5/83)
Bush, Dorothy, 81-0333M (3/83 & 4/83)
Bustamante, Enrique, 83-0167M (6/83)
Cabal, Robert C., 82-0259M (1/83)
Cardoza, Linda, 83-0009M (1/83)
Champlin, Mauri, 83-0002M (1/83 & 3/83)
Christensen, Marian, 83-0091M (4/83)
Clemons, Richard E., 82-0185M (3/83)
Coble, Steven, 83-0028M (2/83)
Combs, Harold W., 83-0015M (3/83)
Cooper, Edward E., 82-0148M (1/83)
Crocker, Peter E., 83-0059M (3/83)
Cunningham, Josette, 83-0139M (5/83)
Curry, Harold, 81-0215M (1/83)
Davis, Denise, 82-0175M (1/83)
Davis, Wallace J., 83-0029M (2/83 & 3/83)
Delgado, Joseph, 83-0036M (3/83)
Deos, Jack, 83-0112M (5/83)5/83)
Dick, Ralph, 83-0085M (4/83)
Donathan, Wilson, 83-0110M (4/83)
Doroski, Anthony, 83-0037M (2/83)
Doster, Milton L., 83-0123M (5/83)
Dowdy, Roscoe, 82-0292M (3/83 & 5/83)
Duffy, Patrick, 83-0050M (3/83)
Ellerbroek, Harvey, 83-0128M (5/83)
Elwell, John, 81-0320M (2/83)
Fast, Donald D., 82-0318M (1/83)

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)
Fifer, Eva, 83-0138M (5/83)
Fones, Edward, 83-0099M (4/83)
Forrester, Billy, 83-0071M (3/83)
Foust, George, 83-0087M (3/83)
Franks, William Allen, 83-0038M (3/83)
Frear, James, 82-0291M (3/83)
Freauf, Lillian, 83-0117M (5/83)
Gardner, Dennis L., 82-0284M (1/83 & 6/83)
Gardner, John, 83-0051M (3/83)
Gardner, Walton, 83-0049M (4/83)
Gascon, Fred, 82-0269M (1/83)
Giffin, Jerry D., 83-0079M (3/83 & 4/83 & 6/83)
Gold, Crystal, 82-0270M (6/83)
Gorman, Oma, 83-0089M (4/83)
Grant, Frederick, 83-0042M (3/83)
Hacker, Roy L., 83-0066M (3/83)
Haines, Robert J., 82-0316M (1/83)
Hamilton, Walter J., 83-0106M (5/83)
Hampton, Frank, 83-0100M (5/83)
Hansen, Kathleen, 81-0262M (1/83 & 3/83)
Hansen, Richard, 83-0114M (5/83)
Heidenreich, Karl F., 83-0056M (3/83)
Hetrick, Gregory, 83-0032M (3/83)
Hills, Frank, 82-0232M (1/83)
Hinzman, Bernie, 83-0097M (4/83)
Holliday, Richard, 83-0024M (3/83)
Holmes, Joe, 81-0034M (4/83 & 5/83)
Holmstrom, Paul, 81-0277M (3/83)
Howard, Terry O., 83-0084M (3/83)
Howell, Michael, 83-0107M (5/83)
Hubbs, Warren, 82-0171M (3/83)
Hudson, Nancy, 83-0086M (5/83)
Hulbert, David, 83-0075M (3/83 & 6/83)
Hurley, Howard, 83-0018M (1/83)
Idlewine, James R., 81-0197M (6/83))
Jackson, David, 83-0105M (4/83)
Jackson, Eugene, 83-0153M (6/83)
Jackson, Robert D., 83-0025M (1/83 & 5/83)
Jelineo, James M., 83-0148M (6/83)
Jerome, David, 82-0137M (2/83 & 3/83)
Jones, Leo, 82-0164M (1/83 & 3/83)
Kallay, Dezo, 83-0118M (5/83)
Karstens, Harvey K., 83-0067M (3/83)
Kaufman, Ivan L., 82-0297M (3/83)
Keen, Gwen, 83-0116M (5/83)
Kildow, Karen, 82-0208M (3/83) (4/83)
Kimbrel, Sadie M., 81-0317M (2/83)
Kloehn, Donald, 83-0096M (4/83)
Koenig, Tom, 83-0061M (3/83)
Kreamier, Fred W., 83-0041M (3/83)
Landers, Arthur, II, 81-0265M (3/83)
Larson, Donald, 83-0108M (4/83)
Larson, Shirleen, 83-0077M (3/83)
Leas, Teresa, 83-0003M (1/83)
Lesh, Lynn, 83-0092M (4/83)
Lewis, Russell, 81-0295M (3/83)

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)
Lewis, Wilbur A., 82-0160M (3/83)
Linder, Janice, 83-0068M (3/83)
Lindsley, Stanley, 81-0064M (3/83 & 6/83)
Long, Larry, 83-0115M (5/83)
Louden, Mariva, 83-0130M (5/83)
Lovell, Hazel Stanton, 81-0037M (2/83)
Lovins, Lloyd, 83-0043M (3/83)
Ludlow, Helen, 83-0125M (5/83)
Mack, John, 83-0034M (3/83)
Mansker, Melba, 83-0083M (3/83)
Marcott, Kevin L., 83-0040M (3/83)
McCasland, Margie, 81-0226M (3/83)
McClay, Taylor L., 82-0309M (2/83)
McConly, Richard, 83-0017M (1/83)
McDaniel, Shelley A., 83-0150M (6/83)
McFadden, William H., 83-0122M (5/83 & 6/83)
McKelvey, Ronald, 83-0014M (3/83)
McKinney, Mary, 83-0057M (3/83)
Merrigan, Michael, 83-0119M (5/83)
Milano, Catherine, 82-0230M (5/83)
Miller, Lynn, 83-0074M (3/83)
Miller, Raymond, 83-0047M (3/83)
Moreno, Erica, 83-0152M (6/83)
Morton, William, 83-0111M (5/83)
Muehlhauser, Eugene, 83-0027M (2/83)
Myers, Lavene M. Reigard, 83-0062M (3/83)
Nicks, Edward, 83-0158M (6/83)
Noah, Edward, 83-0060M (3/83)
Noyes, Darrel, 83-0022M (3/83)
Nunez, Ray, Jr., 83-0065M (4/83)
Orman, Louis, 83-0113M (5/83)
Palmer, Mary R., 83-0081M (3/83) (4/83))
Parazoo, Marshall G., 83-0101M (4/83)
Park, Thomas D., 83-0133M (5/83)
Paulsen, John A., 83-0048M (3/83)
Paynter, Warren, 82-0325M (1/83)
Peabody, Eileen Mae, 83-0053M (3/83)
Peabody, Horace E., 83-0030M (2/83 3/83)
Perry, Wayne, 83-0103M (4/83)
Peyton, Gary, 82-0253M (1/83 & 5/83)
Phillips, Clifford, 80-0156M (5/83)
Pinney, John, 82-0264M (5/83 & 6/83)
Poe, Theodis E., 82-0324M (1/83)
Pope, Robert R., 83-0136M (6/83)
Pullen, Edward, 83-0033M (2/83)
Randall, Nathan, 83-0127M (5/83)
Reed, Allen L., 82-0155M (4/83)
Rentz, Dennis, 83-0001M (4/83)
Rinck, Robert, 82-0295M (5/83)
Robertson, David, 81-0130M (2/83) (4/83)
Robinette, Gary D., 83-0093M (4/83)
Romero, Oscar, 82-0313M (1/83)
Ross, Robert, 83-0094M (4/83)
Rowley, Steven, 83-0156M (6/83)

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)

Salvetti, Roy, 81-0223M (2/83)
Savage, Fred, 83-0131M (6/83)
Schenck, Robert A., 81-0198M (1/83)
Schra, James, 82-0281M (1/83)
Schuster, Carrie, 82-0299M (4/83 & 5/83)
Serbick, Laura, 83-0055M (4/83)
Shine, Patrick, 82-0228M (5/83)
Short, Lloyd, 83-0120M (5/83)
Siewell, Noel R., 83-0013M (1/83 & 6/83)
Smith, Bob B., 83-0109M (4/83)
Smith, Phillip R., 83-0073M (3/83 & 5/83)
Smith, Walter G., 82-0181M (2/83 & 6/83)
Socia, Michael, 83-0143M (6/83)
Spooner, Carlton, 81-0060M (5/83)
Stockton, Jack, 81-0296M (4/83)
Suverly, Raymond T., 82-0238M (4/83)
Sykes, Robert Foster, 83-0020M (1/83 & 6/83)
Tall, Donald, 82-0095M (1/83)
Thompson, Lawrence, 83-0044M (3/83)
Todd, Earlene, 83-0054M (3/83)
Tonkin, Thomas, 82-0312M (3/83)
Travis, Pauline, 83-0147M (6/83)
Troiano, Matthew, 83-0052M (3/83)
Turnbull, James, 82-0320M (3/83)
Turner, Cecil Jenetta, 81-0325M (1/83)
Turpen, Charles, 83-0016M (5/83)
Vanderschuere, Victor, 82-0025M (5/83)
Vinsonhaler, Melvin, 83-0039M (3/83)
Warkentin, Jerry L., 83-0046M (3/83)
Weber, Donald, 81-0089M (3/83)
Weckerle, Joe, 81-0221M (1/83)
Wells, Herbert J., 81-0276M (1/83 & 6/83)
Whisenhunt, Andrew, 83-0083M (3/83)
White, James Carlos, 82-0213M (3/83)
Widener, Lucille M., 83-0012M (2/83)
Wilken, Keith, 83-0008M (1/83)
Wilkinson, Melvin F., 83-0070M (3/83)
Williams, Norman, 82-0326M (1/83)
Wilmoth, Vyron, 82-0145M (1/83 & 5/83)
Wilson, Erma Jean, 83-0095M (4/83)
Wilson, Norman L., 81-0297M (4/83)
Woody, Ulyess L., 83-0064M (3/83)
Wray, Raleigh, 82-0319M (1/83)
Wyers, Frank, 83-0011M (1/83)
Yarberry, Roger D., 83-0010M (1/83)
Zeleznik, John M., 81-0139M (4/83)

CLAIMANTS INDEX

Claimant (WCB Number and/or Court Citation)-----Page(s)

CLAIMANTS INDEX

Claimant (WCB Number and/or Court Citation)-----Page(s)

CLAIMANTS INDEX

CLAIMANTS INDEX

Claimant (WCB Number and/or Court Citation)-----Page(s)

CLAIMANTS INDEX

Claimant (WCB Number and/or Court Citation)-----Page(s)

CLAIMANTS INDEX

Claimant (WCB Number and/or Court Citation)-----Page(s)

CLAIMANTS INDEX