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Edited and published by:
Robert Coe and Merrily McCabe
1017 Parkway Drive NW
Salem, Oregon 97304
(503) 362-7336

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35 Van Natta ___ (1983)

R. W. BROWN, Claimant
Marvin S. Nepom, Claimant's Attorney
Stoel, Rives, et al., Defense Attorneys

WCB 81-11334
October 4, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee Mulder's order which awarded claimant compensation for permanent total disability. We find that claimant has declined offered employment that he may be capable of performing and thus, under ORS 656.206(3), cannot be found to have established total disability at this time.

Claimant, 41 years old at the time of hearing, injured his back at work in May 1980. Surgery was performed at the L4-5 level in June 1980. A second operation was performed in February 1981, primarily at the L5-S1 level. After claimant recovered from the second surgery, his doctors noted permanent impairment in the form of limited back motion, disabling back pain and left foot dysesthesia. Claimant's claim was closed by Determination Orders dated October 28, 1981 and December 16, 1981 that awarded 144° for 45% unscheduled low back disability and 47.25° for 35% loss of use of the left foot. Claimant then requested this hearing.

At the hearing, the employer introduced evidence of an available inspector job that had been offered to claimant. A job description and a film of the inspector's work were introduced. Employer witnesses also testified about additional ways in which the job could be modified to accommodate claimant. The worker performing this job would sit or stand at a lighted work bench and then, according to the job description, "manipulate aluminum orplastic face plate panels weighing from one (1) ounce to two (2) pounds as necessary to inspect for surface or printing defects and measure according to blueprint or chart." The inspector job involves no back bending, twisting or turning. The job would involve some walking, but the employer witnesses suggested ways in which walking could be virtually eliminated by having the items to be inspected delivered to the work station. The employer offered this job to claimant at his pre-injury salary.

In short, the offered job appears to be quite sedentary and very much within the physical limitations that have been imposed by claimant's doctors.

In this kind of situation, the seek-work requirement of ORS 656.206(3) comes into play. We recently interpreted that statute in the context of a specific offered job in Keith Phillips, 35 Van Natta 388, 390-91 (1983):

> "From this evidence we cannot affirmatively conclude either that claimant has the physical capacity to perform the offered night watchman job or that claimant lacks the physical capacity to perform that job. The Court of Appeals addressed a very similar situation in Shaw v. Portland Laundry/Dry Cleaning, 47 Or App 1041, 1044 (1980):

'At the hearing before the referee, the employer for whom claimant was working when she became disabled stated that a seamstress position was available in his plant and in effect offered the job to claimant. Claimant had prior experience as a seamstress. She never clearly answered, we find, questions about whether she thought she was able to do that work. There is some indication in the medical evidence that working as a seamstress may involve more sitting than claimant is capable of doing and may involve more manipulation of sewing machine controls with her feet and knees than claimant is capable of doing. Like so many other parts of this record, however, the evidence about claimant's ability to work as a seamstress is inconclusive.

'In sum, the medical evidence does not show total disability, and claimant was offered a job that she may or may not be capable of doing. Under these circumstances, we conclude that claimant's failure at least to attempt working as a seamstress is the most telling fact that forecloses a finding of total disability.' (Emphasis added.)

"Likewise, in this case, we find that claimant was offered a job that he may or may not be capable of doing and conclude that claimant's failure at least to try working as a night watchman forecloses a finding of total disability under ORS 656.206(3).

"The ultimate rule stated in ORS 656.206(3) is a rule of reasonableness, and rules of reasonableness in statutes administered by agencies are generally for agency, rather than judicial, definition. McPherson v. Employment Division, 285 Or 541 (1979). Quite aside from the authority of the Shaw case, when questions arise under ORS 656.206(3) in the context of a specific job offered to a claimant, we think the better policy approach is: (1) If the evidence affirmatively establishes that the claimant is capable of performing the job, then ORS

656.206(3) forecloses an award for total disability; (2) if the evidence affirmatively establishes that the claimant is not capable of performing the job, then ORS 656.206(3) is irrelevant to an award for total disability; and (3) if, as in Shaw and this case, the evidence is inconclusive and the claimant may or may not be capable of performing the job, then we think ORS 656.206(3) requires that the claimant do what is reasonable and try to perform the offered employment. Cf. Dock A. Perkins, 31 Van Natta 180, 181 (1981), in which we referred to 'the acid test of applying for work'; that metaphor is even more applicable to attempting offered work which a claimant may be capable of doing."

Claimant in effect here argues that we should make the second finding mentioned in Phillips, that the evidence affirmatively shows that he is not physically capable of performing the inspector job. Claimant relies on the fact that in January 1981, between his first and second back operations, claimant did return to an inspector job for parts of two days but was unable to continue working due to back pain. After the film of the proposed inspector job was shown at hearing, claimant testified that it was the same job he had attempted to perform in January 1981 but was unable to perform because of pain:

"Q. As you worked on that job [in 1981], were you able to perform the job?

"A. The best I could, until the pain got so bad that I couldn't sit any more.

"Q. Describe where the pain was. You said you couldn't sit any more, it got so bad. Where was the pain?

"A. The hip, and the leg, and, then, I have to get up and lean against the wall."

Claimant's description of his difficulties in 1981 actually document that the employment now being offered is quite different. The presently offered employment includes working at an adjustable-height bench so that the inspecting work could be done either sitting or standing, or varied from one to the other, whatever was the most comfortable way to do the work. Moreover, the employer even offered that "a cot or bench can be placed in a low traffic area within twenty (20) paces" of the workstation for claimant to lie down on if necessary.

Another difference between claimant's experience in 1981 and the job he has since been offered is claimant's second, intervening surgery. Claimant testified that he perceived his condition as being worse, not better, after his second operation. However, there is substantial medical evidence which either records a

history of improvement after the second surgery or documents objective improvement. We are not sure that it is necessary for present purposes to resolve this conflict between claimant's hearing testimony and the medical evidence to the contrary; we only note that claimant's physical condition after his second surgery is now different than it was when he briefly tried to do the inspector job in 1981.

Finally, claimant and his wife testified about claimant's current social and recreational activities. Suffice it to say it appears to us that claimant's current nonvocational activities are about as physically demanding as the offered inspector job probably would be.

For all of these reasons -- additional jobsite modifications, changed physical status after the second surgery and comparable current activities -- we conclude that claimant has failed to affirmatively establish that he is not physically capable of performing the offered job within the meaning of Phillips. Rather, we conclude that the evidence on this point is inconclusive, i.e., that claimant may or may not be capable of performing the inspector job. Under these circumstances, ORS 656.206(3) requires at least a good faith attempt before claimant can be found to be totally disabled. Shaw v. Portland Laundry/Dry Cleaning, supra.

We have not overlooked the opinions of Dr. Gritzka expressed in his report dated January 4, 1981 (not 1982, as stated in claimant's brief -- the correct date indicating that Dr. Gritzka was not commenting on the more modified job that the employer was tendering at the time of the August 1982 hearing). In that report, Dr. Gritzka opined that claimant would be unable to do the inspector job that he attempted to perform for parts of two days in January 1981 because he "is not comfortable except when sitting absolutely still or lying down." We are simply not convinced that this assessment, rendered before the second surgery, was correct after the second surgery in light of claimant's nonvocational activities after the second surgery.

The remaining question is the extent of claimant's partial disability. We find virtually no evidence in the record regarding the extent of claimant's scheduled left foot disability; we will thus not disturb the award for 35% loss of the left foot awarded by Determination Order.

As to the extent of claimant's unscheduled back disability, the employer argues that the proper award would be 40%, less than the 45% awarded by Determination Order; claimant presents no alternative argument on the extent of his partial back disability. We first note, in this regard, that several doctors comment on claimant's obesity contributing to his disability. While the matter is not well developed in the record, it would appear that disability due to obesity should not be considered in this case. See Nelson v. EBI Companies, 64 Or App 16 (1983). We conclude that just the injury-related impairment is about 35%. Claimant's age (41) and education (high school graduate) have little impact. Under the adaptability rule, OAR 436-65-605, claimant was previously performing medium work and is now limited to sedentary work, which has an impact of +15. Under the labor market rule, OAR 436-65-608, claimant has so little of the labor market remaining available that we think assigning another +15 is appropriate. Contrary to the employer's argument, albeit a close question, we conclude that no

subtraction is indicated for emotional/psychological findings, such as lack of motivation, for purposes of rating partial disability. Combining our impairment, adaptability and labor market findings leads to the conclusion that claimant would be appropriately compensated by an award of 192° for 60% unscheduled disability.

ORDER

The Referee's order dated December 20, 1982 is reversed. In addition to the 144° for 45% unscheduled permanent partial disability awarded by the Determination Orders dated October 28, 1981 and December 16, 1981, claimant is awarded 48° or 15%, for a total award of 192° for a 60% unscheduled permanent partial disability for injury to the low back. Claimant's attorney is allowed a fee of 25% of the increased compensation granted by this order, in lieu of the attorney's fee allowed by the Referee.

RICHARD A. FILONCZUK, Claimant
Lynch & Siel, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-10911
October 4, 1983
Order on Reconsideration

The SAIF Corporation moves for reconsideration of our Order on Review dated July 29, 1983 as amended by our Amended Order on Review dated August 5, 1983. On August 25, 1983 we abated our orders to allow time to consider SAIF's motion for reconsideration. On reconsideration, we adhere to our Order on Review but rescind our Amended Order for the reasons set forth below.

In our Order on Review we held that claimant's psychological condition should have been considered in determining the extent of claimant's disability. In our Amended Order we noted that the effect of our Order on Review was to overturn SAIF's denial of claimant's psychological condition. We, therefore, awarded an insurer paid attorney's fee for overturning the denial.

SAIF argues in its motion for reconsideration that the Board should not have considered the propriety of SAIF's denial of claimant's claim for psychological problems because claimant had not raised that issue on Board review. SAIF argues that the Board has violated its own standards as set forth in Michael R. Petkovich, 34 Van Natta 98 (1982), by considering the propriety of the denial. In Petkovich we said:

> "Referees (and this Board too) should concentrate on making the best possible decisions on the issues raised by the parties without the distraction of volunteering decisions on issues not raised."

We continue to agree with that policy statement. However, claimant argues and we agree that in this case the compensability question was raised. Therefore, Petkovich is inapplicable.

At hearing the issues before the Referee were the propriety of a denial of an aggravation claim, the propriety of a partial denial of claimant's psychological problems, and extent of disability including permanent total disability. The Referee upheld the two denials and found that claimant's disability was no greater than

the 96° for 30% unscheduled disability previously awarded. Claimant requested review of the Referee's order asserting that he is indeed permanently and totally disabled.

In his brief before the Board claimant argued that he is permanently and totally disabled. He urged us to consider the entire record. He said:

> "It is claimant's position that all evidence presented on his behalf was clear, cogent and creditable and that the sum of that evidence could lead to but one (1) conclusion, that claimant in the November 4, 1981 Determination Order should have been found to be permanently and totally disabled. A review of even some of the independent examinations reveals that the claimant suffers from a significant amount of disability which resulted from his industrial injury. Claimant would urge the Board to review the transcript and exhibits and reverse the referee's order and find claimant to be totally and permanently disabled."

In its respondent's brief SAIF summarized its argument as follows:

> "Claimant has not established permanent total disability because (1) he has not made reasonable efforts to obtain regular gainful employment, and (2) claimant's disability is almost entirely the result of a non-work related psychological condition for which Respondent/SAIF Corporation is not responsible."

In its argument SAIF stated that claimant's difficulties are almost entirely caused by his psychological problems. It then argued:

> "The medical evidence shows that his psychological problems are not work related."

On Board review we agreed with SAIF that claimant had not made reasonable efforts to seek work and consequently could not be found to be permanently and totally disabled. However, we disagreed with SAIF that it was not responsible for claimant's psychological problems. SAIF argues on reconsideration that we should not have decided the question of the compensability of the psychological condition.

In this case, the psychological problem of which claimant complains is in the nature of a chronic pain syndrome. His psychological condition is inextricably interwoven with his claim for permanent total disability status. The objective medical evidence does not support a finding of disability much greater than the 30% unscheduled disability previously awarded. Claimant's only argument for permanent total disability status is that the combined effect of his objective physical problems together with his chronic

pain syndrome render him permanently and totally disabled. Compare Juanita M. DesJardins, 34 Van Natta 585 (1982), (claimant found entitled to permanent total disability status despite little objective evidence of impairment because of chronic pain syndrome). Given the particular facts of this case, in which the partially denied psychological condition is inextricably intertwined with the claim for permanent total disability status, we believe that claimant sufficiently raised the compensability issue by requesting review of the Referee's order and by arguing that he is indeed permanently and totally disabled.

It is clear that SAIF believed the compensability of the psychological condition was in issue before the Board. It asserted only two reasons that claimant is not entitled to permanent total disability status. One reason stated was the non-compensability of the psychological condition. Further, SAIF specifically argued that the medical evidence shows that the psychological problems are not work related. SAIF supported this argument with references to reports from three different physicians. SAIF believed compensability was in issue and presented argument on that issue. It was, therefore, not prejudiced by our decision on that issue.

We find that claimant sufficiently raised on Board review the issue of the compensability of his psychological condition. Accordingly, we adhere to our Order on Review finding the psychological condition compensable.

However, on reconsideration, we find that claimant's attorney should not have been awarded an insurer paid fee for overturning SAIF's denial of the psychological condition. At hearing the only reason the issue of the denial was preserved was that the Referee recognized that it was properly in issue and articulated it as an issue at the outset of the hearing. Claimant's attorney merely assented to the Referee's characterization of the issues. Claimant's attorney did not present any evidence specifically concerning the denial. Even on Board review, despite the fact that the Referee specifically ruled on the denial, claimant's attorney did not directly address the denial either in his request for review or in his brief. It is only because the propriety of the denial is so inextricably intertwined with the extent issue which claimant did raise that we reached that issue at all. Accordingly, we do not believe that claimant's attorney is entitled to an attorney's fee for overturning the denial.

ORDER

On Reconsideration of the Order on Review dated July 19, 1983, as amended by our order of August 5, 1983, we adhere to our original Order on Review, which hereby is reaffirmed and republished, and rescind our Amended Order on Review.

ROGER L. LUKER, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-05281
October 4, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review of Referee Gemmell's order which set aside its denial of claimant's aggravation claim and awarded claimant's attorney a fee of $1,500 for services in overcoming the denial. Claimant cross-requests review of that portion of the Referee's order which failed to award penalties and an associated attorney's fee for the alleged failure of the insurer to pay interim compensation in relation to the claim for aggravation. The employer contends that claimant has not established his 1977 industrial injury to be a material contributing cause of his herniated L5-S1 disc, which was diagnosed following claimant's off-the-job athletic activities of January 21, 1981. See Grable v. Weyerhaeuser, 291 Or 387 (1981).

Claimant has a long history of back difficulties and injuries which began when he was eight years of age. When he was fourteen, claimant suffered a low back injury when he fell from a bicycle; he experienced intermittent low back pain thereafter which persisted until the time of his 1977 compensable injury. Claimant also suffers from a somewhat severe preexisting scoliotic back condition.

On June 3, 1977 claimant was lifting in a bend-over position at work when he experienced pain in his dorsal spine just below his left shoulder blade. This injury was initially diagnosed by Drs. Torres and Rieke as a dorsal back sprain. Claimant was examined by Dr. Gripekoven on June 3, 1977. At that time claimant was complaining of pain across the lumbosacral junction. Dr. Gripekoven diagnosed a dorsolumbar soft tissue sprain superimposed on a long-standing preexisting back condition and noted a strong functional component to claimant's symptoms. Claimant was also examined by Dr. Davis, an orthopedic surgeon. Dr. Davis reported on July 11, 1977 that claimant suffered from dorso-lumbar scoliosis and a hypo-mesenchymal type of body build, neither of which were caused by claimant's work injury. He felt that these diagnoses were adequate to explain claimant's complaints. Dr. Davis felt that claimant was "ill-prepared" to engage in any strenuous back activity and expected that claimant would continue to suffer back difficulty in the future whenever he engaged in any such activity. Claimant was eventually found to be medically stationary on July 11, 1977.

In May of 1977 claimant's wife of four years left him. The next month claimant's resulting mental and emotional state had deteriorated to the point that psychiatric hospitalization was necessary. Dr. Newman diagnosed claimant as suffering from an acute schizophrenic reaction and delusional pain. Dr. Newman felt claimant's complaints concerning injury and/or disability were impossible to evaluate in his then present state.

On October 7, 1977 claimant was examined by Dr. Mason at the Callahan Center. Other than his preexisting scoliosis, Dr. Mason felt claimant's orthopedic condition was essentially normal. Based on the minimal exam findings, Dr. Mason concluded that claimant had

"virtually recovered" from the back strain. Psychiatric difficulties similar to those reported by Dr. Newman were noted. Dr. Mason stated that claimant's slender build and scoliosis were not compatible with any work involving heavy lifting, and that these two problems indicated a job change was in order.

Claimant thereafter became involved in an electronic assembly vocational training program from February through May 1978. There is no indication in the record that claimant suffered any difficulties during that period of time other than some cervical pain of unknown origin which occurred on May 1, 1978. A Determination Order issued on June 19, 1978 awarding claimant no benefits for permanent disability.

In June 1978 claimant secured employment with Tektronix. Beginning in August 1978 claimant experienced a series of minor back strains. On August 2, 1978 claimant experienced back pain after stretching. X-rays taken on September 13, 1978 revealed that claimant's scoliosis was increasing. On October 9, 1978 claimant filed an 801 form indicating that he suffered another back strain when he bent over at work to pick up a piece of paper. Claimant was eventually awarded one day of time loss for that claim. Dr. MacMillan reported that claimant's physical characteristics predisposed him to recurrent muscular strains. In December 1979 claimant experienced back pain while lifting a bag of groceries, and he sought further treatment for back pain in April 1980 and in September 1980.

The aggravation claim which is the subject of the current dispute had its genesis in claimant's off-the-job activities of January 31, 1981. The Referee describes the events as follows:

> "On Saturday, January 31, 1981, claimant and his wife attended a church activity night, where they spent approximately three hours. During the course of the evening, claimant jumped on a trampoline for one to one-and-one-half hours, played volley ball, shot some baskets and played some ping pong. * * * The following morning, claimant felt stiff. While sitting through church, he began to experience back and leg pain which was severe enough that after church, he went to the Emergency Room at Tuality Community Hospital."

On April 10, 1981 Dr. Nash reported that claimant might have a herniated disc. On April 16, 1981 the insurer denied the aggravation claim. A myelogram performed on April 22, 1981 verified that claimant had a herniated L5-S1 disc. Surgery was performed about a month later.

On May 12, 1981 Dr. Balmer reported: "It is impossible to be sure that his present condition is not associated with his initial injury, and . . . I feel that we should give him the benefit of the doubt."

On the other hand, Dr. Gripekoven opined that: "By history, it would appear that his disc herniation was a result of his athletic endeavors on January 31, 1981 and they are not specifically related to his previous industrial injury on June 3, 1977."

The Referee concluded that claimant had established the 1977 industrial injury was a material cause of his 1981 herniated disc. The Referee apparently based this conclusion on medical records in July 1977 indicating that claimant was complaining of leg symptoms, Dr. Davis indication that claimant was experiencing left thigh symptoms in July 1977 and the opinion of Dr. Balmer who testified at the hearing.

We agree with the insurer that the evidence does not establish that claimant's relatively minor 1977 industrial injury was a material contributing cause of the herniated disc he suffered in 1981. The most that the evidence establishes is that the industrial injury played a very minor role (if any role at all) in claimant's subsequent lumbar disc herniation.

We begin our analysis by examining the question concerning the anatomical location of claimant's 1977 industrial injury. In Grable v. Weyerhaeuser, supra, the court stated:

> "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 back injury and a subsequent off-the-job back injury to the same part of the body if the worker establishes that the on-the-job injury is a material contributing cause of the worsened condition." 291 Or at 401 (Emphasis added.)

Claimant's 1981 surgery was for a herniated disc in the lumbosacral area of his back, specifically at L5-S1. With two exceptions, the medical reports contemporaneous with claimant's 1977 industrial injury all indicate that claimant suffered a dorsal strain with pain below the left shoulder blade. The two exceptions are references to low back pain in Dr. Gripekoven's June 24, 1977 report and Dr. Davis's July 7, 1977 report.

Despite these two references in 1977 to lumbosacral pain, we are not convinced that claimant sustained an injury to that portion of his back in 1977. All initial 1977 reports refer only to a dorsal strain. In addition, claimant has a long history of chronic low back pain and discomfort as a result of non-work injuries sustained specifically to the lumbo-sacral area of his back. His complaints of such pain following his 1977 dorsal injury are consistent with that history. Also, when Dr. Davis noted claimant's lumbar complaints in July 1977, he stated that those complaints were adequately explained by claimant's preexisting scoliosis and his hypo-mesenchymal body build. We also think it is also relevant that claimant was experiencing marital, psychiatric and emotional difficulties during this same period of time, and virtually every physician who examined claimant noted that these problems were interfering with an accurate diagnosis. The most graphic example is Dr. Newman's July 15, 1977 report in which he noted that claimant was complaining of lower left scapular and mid-dorsal pain, bilateral chest pain, pain in the cervical spine, pain in both lower extremities and both upper extremities, sinus headaches, stomach pains, alternating diahrrhea and constipation, loss of

sense of taste, intermittent blurry vision and continuous ringing in the ears. Dr. Newman stated that it was impossible to evaluate or make sense out of claimant's complaints and that claimant was "vacillating between being delicately in touch with reality and totally and frankly out of touch."

Under all of these circumstances, we conclude that it is more likely that claimant did not sustain an injury to his lumbosacral spine in 1977. The most contemporaneous medical reports so indicate. And the two fleeting 1977 references to low back pain appear most likely to either be just a continuation of claimant's pre-1977 low back problems or a manifestation of his noncompensable 1977 emotional distress. Moreover, even if claimant sustained an injury to his lumbar spine in 1977, the medical reports indicate that claimant fully recovered from that injury; there is nothing indicating that any permanent damage resulted.

There are additional reasons for our disagreement with the Referee. In concluding that this aggravation claim was compensable, the Referee relied in part on a finding that claimant experienced leg symptoms soon after the 1977 industrial injury. We find that the 1977 references to leg pain in the medical reports are not sufficient to support an inference that claimant injured his low back in 1977. As we noted above, at the time claimant was examined by Dr. Newman on July 15, 1977, he was complaining of aches, pains and symptoms in at least twelve different body locations, and Dr. Newman felt that claimant was at that time suffering from delusional pain. Dr. Davis did note that claimant made some complaints of pain in the posterior aspect of his left thigh upon examination on July 7, 1977, but he found that claimant had a completely normal neurological examination with normal straight leg raising, normal ranges of motion and no loss of sensation in the legs.

The Referee relied rather heavily on Dr. Balmer's opinions in finding this aggravation claim to be compensable, but we think that his explanation of his opinion leaves much to be desired. We begin by noting that, unlike Dr. Gripekoven, Dr. Balmer never examined claimant in connection with his 1977 injury; Dr. Balmer's first examination of claimant took place in February 1981, nearly four years after the industrial injury. Additionally, Dr. Balmer exhibited a definite lack of knowledge concerning claimant's pre-1977 back difficulties and an equal lack of knowledge concerning the specifics of the 1977 injury. Dr. Balmer explained his indifference to these details by saying that any injury for which no compensation was received was not a "significant" injury. He also stated that claimant's post-1977 low back difficulties were consistent with his opinion that the 1977 industrial injury damaged that area of claimant's back, but he fails to take into account the fact that claimant had chronic low back difficulties and injuries which occurred prior to the 1977 industrial injury. Although claimant was found medically stationary approximately one month after the 1977 injury, Dr. Balmer testified that he understood that claimant was totally disabled for a period of one year following the injury. When questioned concerning the differences between the anatomical location of the claimant's 1977 dorsal injury and his 1981 herniated L5-S1 disc, Dr. Balmer acknowledged that the original diagnosis involved the dorsal back area, but stated that the

findings of the physicians who examined claimant after the 1977 injury were "incomplete," although he does not explain how or why he so concluded. Dr. Balmer was also questioned concerning claimant's preexisting scoliosis condition, and the post-1977 x-rays which indicated that the condition was progressing. Dr. Balmer acknowledged that this progressive scoliosis could have led to a herniated disc.

Considering all of the above, we prefer to rely on Dr. Gripekoven's opinion.

In summary, we find that claimant had a long history of low back difficulties prior to his 1977 industrial injury which were superimposed on a preexisting and progressive scoliotic back condition. Claimant sustained a relatively minor injury to his dorsal spine in 1977; was found medically stationary approximately one month after the injury; and he received no permanent partial disability. Claimant continued to experience low back difficulties thereafter, just as he did prior to the 1977 injury, and virtually every physician who examined claimant following the 1977 injury predicted that he would have such difficulties due to his scoliosis and body build. Claimant's severe radiating leg symptoms, indicating disc herniation, occurred immediately after his off-the-job athletic activities on January 31, 1981. Dr. Balmer agreed that the disc likely herniated following claimant's January 31, 1981 off-the-job activities. Dr. Balmer's opinion that claimant sustained damage to the lumbar spine as a result of the 1977 injury is not supported in the record, and his opinion is undermined by the difficulties noted above. Dr. Gripekoven, who has treated claimant since the 1977 injury, opines that there is no causal link between that injury and claimant's 1981 herniated disc. For all of these reasons, we conclude that claimant has not established that his relatively minor 1977 dorsal sprain was a material contributing cause of his 1981 herniated disc, which occurred following his off-the-job athletic activities on January 31, 1981.

With regard to claimant's cross-appeal on the issues of penalties and attorney fees, we affirm and adopt the relevant portions of the Referee's order.

ORDER

The Referee's order dated March 26, 1982 is affirmed in part and reversed in part. Those portions of the order which set aside the April 16, 1981 aggravation claim denial and awarded claimant's attorney a fee of $1,500 are reversed. The April 16, 1981 denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

DENNIS R. WALTON, Claimant
Bischoff & Strooband, Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 82-06553
October 4, 1983
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

The employer requests review of Referee Brown's order overturning its denial and awarding temporary disability from March 25, 1982 through September 24, 1982. The employer challenges the propriety of both rulings.

In his order the Referee stated:

> "I made oral findings of fact and conclusions of law with regard to the time loss issue at the close of evidence. I incorporate those remarks herein by reference."

Unfortunately, the transcript transmitted to the Board does not contain a transcript of the Referee's oral findings of fact and conclusions of law on the time loss issue. ORS 656.295(5) allows the Board to remand a case to the Referee when it determines that the case has been "improperly, incompletely or otherwise insufficiently developed or heard by the referee..." We find that because of the omission of the Referee's oral findings of fact and conclusions of law on the time loss issue, the case has been incompletely and insufficiently developed.

We remand the case to the Referee to develop the record on the time loss issue. The Referee should either supply the Board with a copy of the transcript of his oral remarks, or he should make written findings of fact and conclusions of law on the time loss issue. No further evidentiary hearing should be required to develop the issue. However, the Referee may request written or oral argument.

ORDER

This case is remanded to the Referee for processing consistent with this order.

CAROL E. WEBB, Claimant
Emmons, et al., Claimant's Attorneys
Keith Skelton, Defense Attorney

WCB 82-01612
October 4, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of that portion of Referee McCullough's order which awarded claimant 176° for 55% unscheduled permanent partial disability, that being an increase of 144° or 45% over and above the February 17, 1982 Determination Order. The insurer contends the Referee's award was excessive. Claimant has cross-requested review of the Referee's order, contending that the Referee erred in not finding the Determination Order to have issued prematurely. Alternatively, claimant argues that she is entitled to an award of unscheduled disability greater than that allowed by the Referee, including permanent total disability.

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

With regard to claimant's contention that the February 17, 1982 Determination Order issued prematurely, we disagree and we affirm and adopt those portions of the Referee's order relevant to that issue.

The issue of the appropriate extent of claimant's disability is another matter. We do not believe claimant's contention that she is permanently and totally disabled is well-taken. It does not appear that permanent total disability was an issue before the

Referee. The extent of disability issue was set forth by the Referee at the hearing as follows:

> "Finally, as an alternative issue in the event the evidence does not establish reopening under any of the theories put forth by claimant, claimant contends she's entitled to a greater award of permanent disability, the issue being extent of permanent partial disability for the back. Correct, for the low back?
>
> "Mr. Kropp: For the low back and scheduled for the legs." (Emphasis added.)

Nor does it appear that any evidence was presented with regard to permanent total disability. Since permanent total disability does not appear to have been an issue at the hearing and, since there was no evidence presented relative to that issue, we do not believe that this is an issue properly before the Board. Neely v. SAIF, 43 Or App 319 (1979); Bonnie J. Chytka, 35 Van Natta 86 (1983); Edwin L. Mustoe, 34 Van Natta 659 (1982), affirmed without opinion, 61 Or App 296 (1983). Therefore, the only issue left for our determination in the current case is the appropriate extent of claimant's permanent partial unscheduled disability.

Claimant's physical disability is difficult to determine. Despite numerous diagnostic procedures, there is little in the way of objective findings which would explain claimant's continued disability. Her condition has generally been diagnosed as an unresolved lumbar strain.

As of November 8, 1982 Dr. Snodgrass reported that claimant's right and left lateral bending were 60% of normal. Her hyperextension was found to be 60% of normal and her forward flexion was 20° (about 20% of normal). He noted no muscle spasm or significant tenderness in the paravertebral lumbar muscles but noted that her straight leg raising was limited by a sensation of "slight pulling" rather than pain. No sensory loss was found in claimant's thighs, legs or feet. Her strength was noted to be "excellent" in the lower extremities and no muscle atrophy was found. All reflexes were normal. Dr. Snodgrass concluded:

> "I think [claimant's] permanent impairment would be in the range of mildly moderate to lower moderate. I should make clear that my assessment of her degree of impairment is based totally on her history of symptoms and limitations with no supporting physical findings. Her limitations in forward bending and limitations on straight leg raising were not because of severity of pain nor even 'refusal' to perform movements."

Although the objective physical findings are minimal, claimant has great difficulty bending, stooping or lifting anything other than very moderate or light weights. She generally avoids activities which would require such movements. Claimant experiences pain and tingling in her legs if she sits for periods in excess of 15 to

30 minutes, and she sleeps with a pillow under her legs to help relieve pain. There is no indication in the record that claimant's symptoms are not genuine.

Despite her physical limitations, the social/vocational considerations in claimant's case are relatively favorable. Claimant is only 38 years of age and is of at least average intelligence. She has completed two years of community college coursework, majoring in education. As noted by the Referee, claimant has a varied occupational background including work as a teacher's aide, teacher, sales clerk, food service salesperson, bookkeeper for a bank, some secretarial work, production line and inspection work, janitor and librarian. The reports of Drs. Ackerman and Kuttner indicate that claimant has no emotional or psychological problems whatsoever. Many of claimant's skills appear to be transferable to a variety of other occupations.

Despite her physical limitations, we believe that the Referee's award of 55% permanent partial disability is somewhat excessive for an individual who has undergone no surgeries, is only 38 years of age, has two years of community college coursework and who has a varied occupational background with many apparently transferable skills. We conclude that an award of 35% unscheduled disability more accurately reflects claimant's disability and that such an award is generally consistent with similar cases.

ORDER

The Referee's order dated February 4, 1983 is affirmed in part and modified in part. That portion of the Referee's order which awarded claimant 176° for 55% unscheduled permanent partial disability is modified. Claimant is awarded a total of 35% (112°) unscheduled permanent partial disability, that being an increase of 25% (80°) over and above the February 17, 1982 Determination Order. This is in lieu of and not in addition to that awarded by the Referee. Claimant's attorney's fee should be adjusted accordingly. The remainder of the Referee's order is affirmed.

ANNE G. UDALOY, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11218
October 6, 1983
Order of Dismissal

Claimant seeks Board review of the Opinion and Order in the above referenced matter which was issued August 19, 1983. The thirty days for filing a Request for Review expired September 18, 1983 and the request was dated September 19, 1983 and received by the Board on September 20, 1983. Therefore, the order of the Referee is final by operation of law, and claimant's Request for Review is hereby dismissed as being untimely filed.

IT IS SO ORDERED.

THOMAS B. WARD, Claimant
Garrett, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 80-10573
October 6, 1983
Order on Review

Reviewed by the Board en banc.

Argonaut Insurance Company requests review of Referee Peterson's order which apparently set aside its November 13, 1980 denial of a claim for a back injury alleged to have occurred while claimant was employed by Bannister Pipeline Company of America (Bannister). The issues for review are compensability and the propriety under OAR 436-83-400(3) of the Referee's admission of Dr. Miller's February 19, 1982 report.

Claimant, a 41 year old truck driver who resides in Pocahontas, Arkansas, was employed by Bannister in September of 1980 in LaGrande, Oregon where the company was involved in a construction project. Although claimant's work duties were normally restricted to driving truck, on the day in question he was asked to help another worker lift a 400 pound three-inch pump into the back of a truck. Although claimant could not remember the exact day this event took place, he thought it occurred in the latter part of September 1980.

Claimant testified that he felt no immediate pain when he lifted the pump and, in fact, felt nothing out of the ordinary. He finished his shift and returned to the motel where he was living until completion of the project. Claimant testified that the following morning he:

> ". . . started to get out of bed and when I started to rise up, my back was hurting. I attempted to get up and stand on it. I couldn't stand on my -- I couldn't put weight on my right leg."

Claimant stated that he experienced a "real sharp pain in the lower part of the back, and . . . felt like something burning down the right leg."

Claimant did not work the next day, although he did return to work the next two days after that. He testified that he was unable to work thereafter, stayed at the motel for a few more days and then drove his truck back to Arkansas. He further testified that when he initially drove from Arkansas to LaGrande, it took him two days and one night, but that due to the pain, it took him six days to drive from LaGrande to Arkansas following the injury.

Upon his arrival in Arkansas claimant was examined by Dr. Lombardo. Dr. Lombardo reported on October 21, 1980 that:

> "This 30 [year old white male] truck drive, has had some problems in the lower back intermittently since 1971. He had gotten worse this past year, in particular over the last month. He states that over the last month, he has had back pain constantly down the right side of the leg with burning and numbness, primarily in the right side

> of the foot and in the lateral side of the foot and in the toes. He has had a rather constant pain problem with it during this past month."

Claimant was referred to Dr. Miller in Memphis, Tennessee. Dr. Miller performed a partial hemilaminectomy at L4-5 and L5-S1 right, with an L-5 discectomy. Dr. Miller related the following history in his November 1, 1980 discharge summary:

> "Thirty-nine-year-old white male who has had problem with his back off and on over the past nine years but has not had leg pain of this type that he has had this time was admitted [sic]. He indicated he had helped lift a pump out of the back of a truck at work about September of 1980 and after that he had pain going down the right leg with numbness in the right foot."

On November 4, 1980 a Form 801 was completed, apparently by the employer. The 801 form indicates:

> "Mr. Ward states that he doesn't exactly [know] when he injured his back, or where. He states it could possibly have happened while lifting a 3" water pump."

On November 13, 1980 Argonaut denied the claim.

On November 21, 1980 claimant, through his counsel in Arkansas, requested a hearing in relation to the denial. Presiding Referee Daughtry subsequently informed claimant's attorney of the necessity of securing representation by an attorney who was a member of the Oregon State Bar Association. On June 23, 1981 the Board received a letter from claimant's current attorney indicating that he would be representing claimant. He indicated that claimant's current address was the Brazos Ben Motel, 1700 Highway 90, Richmond, Texas. On September 11, 1981 the Hearings Division received claimant's application to schedule a hearing. Thereafter, a notice of hearing was mailed to claimant and his attorney. The notice carried the standard reference to OAR 436-83-400(3), and indicated that a hearing was scheduled to take place on February 22, 1982 in Salem before Referee Seifert. This hearing, however, was postponed when claimant and the employer failed to appear. Referee Seifert's notes indicate that claimant was out of the state at the time. A hearing was rescheduled for July 2, 1982 before Referee Peterson.

When the hearing convened claimant was present and represented by counsel, as were the employer and insurer. The Referee began by addressing the preliminary matter of admission of exhibits and noted that there were only five exhibits which had been submitted by claimant's attorney. These were the same exhibits that had been submitted for the February 2, 1982 hearing. These exhibits were received with no objection and the insurer indicated that it had no exhibits to submit. At that time claimant's attorney called the Referee's attention to Dr. Miller's letter of February 19, 1982 (Exhibit 6), which stated:

> "It is my medical opinion that the ruptured disc found at surgery on 10/27/81 is consistent with the history of the work related injury in September 1980 while lifting a pump out of a truck with the onset of pain going down the right leg and numbness in the right foot."

Claimant's attorney stated that he had first received this letter the previous day. He indicated that neither he nor claimant had been aware of the letter as claimant had been temporarily living and working in Texas, that a friend had been picking up his mail, that claimant had only returned to Arkansas on June 29, 1982, and that he had brought the letter with him when he flew to Oregon for the hearing on July 1, 1982. Claimant's attorney stated that claimant had not received a notice of hearing when he was in Texas, and that he had not been aware that a hearing was scheduled until he returned to Arkansas. The insurer immediately objected to the admission of the documents based on OAR 436-83-400(3), Minnie Thomas, 34 Van Natta 40 (1982), and Darryl G. Warner, 34 Van Natta 634 (1983).

The Referee ordered that Exhibit 6 would be admitted under subsection (4) of OAR 436-83-400, subject to the record being kept open to allow the insurer an opportunity either to obtain an independent medical examination, or to depose Dr. Miller or submit interrogatories to him. The Referee refused to allow the insurer's motion to postpone the hearing.

By letter of September 18, 1982 the insurer requested that Dr. Miller answer several questions concerning claimant's alleged injury and his subsequent back difficulty. Specifically, the insurer asked Dr. Miller if his opinion had been premised on the assumption that claimant experienced pain immediately following the lifting incident, and if his opinion would change if he were aware that the pain first occurred when claimant was getting out of bed the morning after the pump lifting incident. Dr. Miller replied on November 22, 1982 that:

> "No, Mr. Ward indicated that the onset of pain and numbness was not immediately after the lifting of the pump incident but had occurred the same day that he had lifted the pump.
>
> "Under the hypothetical set of facts mentioned it would still be my medical opinion that it was due to the pump lifting incident. It would not be uncommon to see some delay before the onset of symptoms."

The insurer furnished the Referee with a copy of its letter and Dr. Miller's reply, but did not offer them as exhibits. Claimant's attorney subsequently offered them and they were admitted by the Referee as Exhibits 7 and 8.

The Referee concluded that although claimant had a poor memory for dates, he was nevertheless a credible witness and it was more

likely that the pump-lifting incident occurred on or about October 7, 1980. He additionally stated:

> "Although this record is sparse and Dr. Miller's opinions are succinct, I am persuaded by them. I believe that they are, since uncontradicted by any other medical opinion, more than sufficient to carry the claimant's burden of having to prove that the pump-lifting incident was a material contributing cause of his need for medical treatment."

The insurer argues that the Referee's admission of Exhibit 6 (and also Exhibits 7 and 8) constituted a gross violation of the ten-day rule, that claimant's attorney failed to exercise due diligence in obtaining and presenting written medical evidence more than 10 days prior to the hearing and that the cases cited at the hearing, in particular the recent Board decision of Donald J. Young, 35 Van Natta 143 (1983), require exclusion of the exhibits. Alternatively, the employer argues that even if the offending exhibits are considered, claimant has failed to sustain his burden of proving that his back condition was caused by the alleged pump-lifting incident.

We conclude that the Referee made the proper determination in relation to both issues raised by the insurer.

Turning first to the issue involving OAR 436-83-400(3), we find that the Referee was correct in allowing admission of Exhibit 6 pursuant to his discretionary authority under subsection (4) of OAR 436-83-400, notwithstanding the fact that the exhibit was not furnished to either the Referee or the insurer at least 10 days prior to the hearing. The rule 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 the 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 the (3) above." (Emphasis added.)

The insurer is correct in noting that we stated in Young 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." 35 Van Natta at 149.

However, subsequent to our decision in Young, we decided Walter L. Hoskins, 35 Van Natta 885 (1983), which qualified some of the language contained in Young. We noted that the phraseology of the rule announced in Young was overly restrictive in that it emphasized certain fact situations which would always constitute good cause, without considering the possibility of other situations which would also constitute good cause for failure to comply with the rule. Among other things, we noted that, "it is implicit in the Young interpretation of the 10-day rule that there be some underlying actual or potential prejudice to somebody." 35 Van Natta at 888.

We conclude that the current case represents one of the "other factual situations" noted in Hoskins that constitutes good cause for failure to comply with the 10-day rule. As related in claimant's brief:

> "In the instant case, respondent's attorney did not acquire the particular medical report until the day before the hearing. This record shows that the claimant was a truck driver for various construction projects around the country and that he was away from home for months at a time. Consequently, counsel for the claimant had difficulty staying in touch. During the time in which counsel attempted to acquire the subject medical report, claimant was away from his home in Arkansas and was employed in Texas. During that period, a neighbor collected his mail and held it until the claimant returned -- some four months later. Because of counsel's difficulties in staying in touch with his client, he had to rely on contacts in areas across the country to get information necessary for the preparation of claimant's case. Counsel's attempt to acquire the necessary medical reports included contact with the claimant's local attorney in Arkansas, but due to the same complications arising from the claimant's being out of state for long periods at a time, and the possible slow response by the treating physician to such inquiries anyway, even the local Arkansas counsel was of little assistance."

We believe that this explanation constitutes an adequate excuse for claimant's failure to comply with the 10-day rule and establishes that as much diligence as possible was exercised.

Claimant resided in another state and was working in yet a different state until just prior to the hearing. He was having his mail picked up by a neighbor and was not even aware of the hearing date until just a few days before it was scheduled to occur, and was also unaware of the existence of the report until that same time. We are satisfied that even if additional efforts had been made by claimant's attorney, such efforts likely would have been of little avail. We conclude that claimant has met his burden of showing good cause for failure to comply with the 10-day rule. We conclude that the Referee properly admitted Exhibit 6, as well as Exhibits 7 and 8, and that he did not abuse his discretion.

We also conclude that there was no underlying actual or potential prejudice to the insurer caused by admission of the exhibit. The Referee took appropriate steps to insure that no prejudice would result from his decision to admit the document. Specifically, the Referee ordered that the hearing record would remain open to allow the insurer an opportunity to obtain an independent medical examination of claimant, to depose Dr. Miller, to submit interrogatories to Dr. Miller or to present additional witnesses to enable it to further contest the claim. These were exactly the measures which the insurer argues would be necessary if the document were admitted. Even if there was prejudice, the Referee's remedial measures were a satisfactory cure. We note that out of all of the options made available by the Referee, the only one the insurer exercised was the option to submit interrogatories to Dr. Miller. It did not obtain an independent medical examination, it did not arrange for Dr. Miller's deposition and it did not present any additional witnesses. Any prejudice that might have resulted seems to have been the result of the insurer's own inaction. We, therefore, conclude that Exhibit 6, as well as Exhibits 7 and 8, were properly admitted.

Turning to the issue concerning compensability, we believe that the Referee reached the correct conclusion with regard to this issue also. Claimant's testimony was neither evasive nor contradictory, and the Referee found him to be a credible witness although somewhat deficient in regard to his memory for dates. There is no medical opinion in the record from any physician other than Dr. Miller. It is clear that Dr. Miller had an accurate history of the events surrounding the pump-lifting incident and that it was his considered medical opinion that this history was consistent with his surgical findings. Although it is true that we are not necessarily bound by an uncontroverted medical opinion, Edwin Bolliger, 33 Van Natta 559 (1981), we find no basis in the record to question his findings or conclusions. We are thus left with: (1) The credible testimony of claimant; and (2) a medical opinion based on that credible history which states within a reasonable medical probability that claimant's need for medical treatment was the result of his work activities. We, therefore, agree with the Referee that claimant has carried his burden of establishing the compensability of his claim.

ORDER

The Referee's order dated April 12, 1983 is affirmed. Claimant's attorney is awarded $550 as a reasonable attorney's fee for services before the Board, to be paid by the insurer.

Board Member Barnes Dissenting:

I believe that there was a consistent doctrinal thread in this Board's interpretations of OAR 436-83-400, at least between Minnie Thomas, 34 Van Natta 40 (1982), and Donald J. Young, 35 Van Natta 143 (1983). As the majority points out, the insurer in this case relies upon our prior consistent decisions in Thomas, Young, Darryl G. Warner, 34 Van Natta 634 (1982), aff'd 63 Or App 280 (1983), and Ronald Bronski, 34 Van Natta 612 (1982), in support of its argument that the Referee erred in admitting Exhibit 6. The majority does not say that the insurer misreads our prior decisions or that those decisions do not support the insurer's argument. Rather, the majority seems to say that Walter L. Hoskins, 35 Van Natta 885 (1983), adopts a new and different interpretation of OAR 436-83-400 -- an interpretation that apparently sub silentio overrules at least major parts of the Thomas to Young line of cases -- and that the insurer's reliance in this case on our pre-Hoskins decisions is thus misplaced.

A majority of this Board is obviously free to overrule or change prior Board doctrine. I suggest to my Board colleagues, however, that significant policy changes should be announced with considerably more clarity and the new doctrine should be defined with considerably more precision than characterizes the majority order in Hoskins.

I find the majority order in Hoskins to be disjointed and confusing, as indicated by the fact that I find as many passages in Hoskins that support the exact opposite result in this case. If Hoskins is to be the new road map to guide in the application of OAR 436-83-400, I submit it is a maze rather than a map, as indicated by the wrong turn the Board makes in its decision of this case.

I

Before discussing Hoskins further, I highlight the material facts, some of which are either glossed over or ignored by the Board majority.

November 24, 1980: Claimant's request for hearing on the insurer's November 13, 1980 denial of his claim was filed. The request was from an out-of-state attorney and there was some initial correspondence about the need to associate Oregon counsel.

June 23, 1981: Claimant's Oregon attorney advised the Board of his involvement, conveyed claimant's "current address" in Richmond, Texas and stated: "I intend to file an application to schedule a hearing in the near future after I receive some additional information concerning this claim."

September 14, 1981: Claimant's Application to Schedule Hearing was filed. In that application claimant's attorney certified that he was "ready for the hearing and prepared with all medical reports and other evidence."

January 19, 1982: Claimant's attorney submitted five proposed exhibits to the Hearings Division and opposing counsel.

July 2, 1982: The hearing was held. Claimant then offered and furnished to opposing counsel for the first time an additional exhibit. It is a one-sentence letter, addressed "to whom it may concern," from Dr. Thomas Miller of Memphis, Tennessee. It is dated February 19, 1982, i.e., more than four months pre-hearing.

Claimant testified that his Arkansas lawyer had asked him to obtain an additional report from Dr. Miller; that claimant then called Dr. Miller's office and asked for the additional report, presumably sometime before February 19, 1982; that Dr. Miller mailed the report to claimant's Pocahontas, Arkansas address; and that claimant actually had received the report in late June, apparently, although claimant did not specifically so testify, upon returning to Arkansas from where he had been working in another state; and that claimant had brought the report to Oregon when he came to attend the July 2 hearing. In addition, claimant's attorney represented that claimant had been working in Texas when Dr. Miller must have sent his February 19, 1982 report to claimant's Arkansas address; that claimant's attorney had first learned of the existence of the February 19 report in a telephone conversation with claimant about five days pre-hearing; and that claimant's attorney first had seen the February 19 report the day before the hearing.

In summary, despite having represented in September 1981 that claimant was "ready for hearing and prepared with all medical reports and other evidence," claimant's Arkansas and Oregon attorneys continued attempting to gather favorable evidence -- which was certainly their right (and probably duty) to do. However, their evidence-gathering techniques were hardly models of efficiency. The Oregon lawyer may have called the Arkansas lawyer. In any event, the Arkansas lawyer called claimant. Claimant then called Dr. Miller. We do not know exactly what claimant told Dr. Miller's office; it is apparent that, at a time when claimant must have known he was going to be working out of Arkansas for an extended period of time, instructions to mail a report to someplace other than claimant's Arkansas address were not effectively communicated to Dr. Miller's office.

II

Whether the Referee erred in admitting Dr. Miller's February 19 report as Exhibit 6 in the face of claimant's noncompliance with the ten-day rule stated in OAR 436-83-400 apparently now depends entirely on Walter L. Hoskins, supra, and the Board's pre-Hoskins interpretations of OAR 436-83-400 are, to borrow a term from a former presidential press secretary, "inoperative."

A

It would seem, however, that there is one element of consistency in Hoskins and the pre-Hoskins cases. Hoskins states: "A party offering an exhibit in violation of the 10-day rule has the burden of showing good cause for admitting the exhibit." 35 Van Natta at 888. Hoskins also seems to recognize that one effect of OAR 436-83-400 is to put an emphasis on diligent pre-hearing preparation for hearing. See 35 Van Natta at 886. Combining this expectation of pre-hearing preparation with the concept of good cause, would it not follow that good cause generally would mean an

inability to submit a proposed exhibit at least 10 days pre-hearing despite diligent preparation? Apparently not, as indicated by the facts of this case. We are here considering the admissibility of a report written in February 1982 at the time of a July 1982 hearing. Obviously, the report was in existence in time to submit it pre-hearing in the manner required by OAR 436-83-400.

The majority nevertheless finds "good cause" for noncompliance with our administrative rule based on communication difficulties between claimant and his two attorneys. I appreciate that any situation involving an out-of-state claimant, who is represented in part by an out-of-state attorney, is going to present certain logistic problems. However, I am simply not impressed by the alleged communication difficulties in this case. As the majority notes, claimant's Oregon attorney advised the Board of claimant's Texas address in June 1981. Claimant apparently continued to live at that address for the next year, i.e., until the hearing; at least there is no allegation to the contrary. I fail to see any impediment to attorney-client communications.

Moreover, and more importantly, I submit the real inquiry should be whether there was any impediment to communications between claimant's attorneys and Dr. Miller. Obviously, there was none. The majority quotes the reasons stated in claimant's brief for the failure to submit Dr. Miller's February report before the July hearing. I find it particularly interesting that nowhere in his brief or elsewhere does claimant's counsel itemize or detail what, if any, efforts he made to secure or solicit any information from Dr. Miller. In my opinion, it was claimant's attorney's responsibility to diligently prepare for the hearing, specifically meaning to directly request any needed medical information from claimant's doctors. There is no suggestion that this was done, but the majority finds good cause for noncompliance with OAR 436-83-400. Does it follow, despite the suggestion to the contrary in Hoskins, that diligent hearing preparation is no longer expected?

B

In Hoskins, the majority stated that the factors to be relied upon in determining the admissibility of evidence offered in violation of the 10-day rule 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." 35 Van Natta at 888.

The majority then went on to state that none of these factors were present in Hoskins:

> "[The insurer] was not surprised or prejudiced in the presentation of its case at the 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." 35 Van Natta at 888.

I understand these passages from Hoskins to indicate that one consideration is that OAR 436-83-400 should be interpreted and applied in a way that does not impair the ability of Referees to decide cases in a timely manner. That consideration should be, but is not, mentioned by the majority in this case. The hearing in this case took place on July 2, 1982. Since the Referee decided to admit Exhibit 6 when it was presented for the first time on the day of the hearing, the Referee then left the record open to allow the insurer an opportunity to present rebuttal evidence. It was not until December 13, 1982 that the insurer was able to secure answers to its interrogatories from Dr. Miller. It was not until February 8, 1983 that the Referee finally closed the record. It was not until April 12, 1983 that the Referee finally issued an order. In short, due to claimant's violation of OAR 436-83-400, it was a full seven months before the Referee was able to close this record and more than nine months before this case was decided. How can the Board majority express concern about timeliness of decisions in Hoskins and then countenance -- indeed, ignore -- an embarrassing delay of this magnitude?

C

My final concern about the meaning of Hoskins, and its application in this case, is the most fundamental: What does the Board majority mean by "prejudice" and to what extent do we now authorize the delay associated with leaving the record open as a "cure" for "prejudice"?

The latter point is critical to the integrity and efficiency of the entire hearing process. In each and every one of about 400 hearings held every month, the parties could offer exhibits for the first time at hearing; the records in all of those hearings could be held open, as was done in this case. If keeping records open is, as the majority puts it in this case, a "satisfactory cure" for noncompliance with OAR 436-83-400, the net effect is that the requirement of pre-hearing submission of exhibits stated in our rule has been interpreted out of existence.

Before Hoskins, the Board's position was categorically to the contrary. In Minnie Thomas, supra, we concluded:

> "The offer by the carrier's counsel at hearing to make Dr. Thomas available post-hearing for deposition and to pay temporary total disability benefits between the hearing and the taking of the deposition in no way cures the violation of the 10-day rule." 34 Van Natta at 41.

We elaborated in Darryl G. Warner, supra:

> "The Legislature has directed that the

> Board's rules 'may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings.' ORS 656.726(5). The ten-day rule in OAR 436-83-400(3) expresses the Board's judgment that full prehearing disclosure of evidence expedites adjudication, promotes settlement and simplifies the presentation of evidence at the hearings.
>
> "Claimant argues we should now promote 'substantial justice,' ORS 656.283(6), by remanding to the Referee for introduction of Exhibit 99. Substantial justice can be an elusive concept. This Board receives over 1,000 hearing requests a month. It strains the present resources of this Board to schedule that many hearings reasonably promptly without unreasonable delays and an embarrassing backlog. Every time the Board remands a case for further action at the hearing level it slows down the processing of cases awaiting hearing and increases the delay the thousands of claimants awaiting hearing must experience. Substantial justice for one claimant can thus create substantial injustice for other claimants awaiting hearing." 34 Van Natta at 635.

Everything we said in Warner about the practical problems caused by remands is also applicable to leaving records open. And even in Hoskins itself, the Board majority mentioned the fact that, if an exhibit offered in violation of OAR 436-83-400 had been admitted, "it does not appear it would have been necessary to leave the record open for post-hearing depositions or other litigation." 35 Van Natta at 888.

Now, contrary to everything the Board has said on this subject at least since Thomas, the majority here concludes that leaving the record open in this case for post-hearing proceedings "cured" claimant's violation of OAR 436-83-400.

The fundamental question is whether we are going to interpret and apply our procedural rules with a microcosmic view (looking only at the interests of specific parties in specific cases) or with a macrocosmic view (considering also the interests of all parties in all cases). I favor the latter. At any given time there are usually between 7,000 and 9,000 pending requests for hearing awaiting hearing. All of the parties in all of these cases are interested in and deserve a reasonably prompt resolution of their disputes. Those parties are not going to get what they want and deserve under today's ruling that post-hearing proceedings can "cure" a violation of OAR 436-83-400. The decisions of individual cases will be delayed, as indicated by the nine month delay in this case. And it is clear to me that the post-hearing processing of cases in which the record is kept open because of violation of OAR

436-83-400 will necessarily slow down the processing of other cases awaiting hearing. In other words, when "prejudice" is viewed in the macrocosmic sense of prejudice to the entire hearing process and all the clientele of the process, which was part of the basis of the discussion of "prejudice" in Hoskins, then prejudice is present in this case.

However, under today's decision, apparently the Board majority is now going to approach "prejudice" in the context of noncompliance with OAR 436-83-400 solely in the microcosmic sense of prejudice to specific parties in an individual case. It might help if the majority would tell us what "prejudice" means to them; given the conclusion that post-hearing proceedings can "cure" a violation of OAR 436-83-400, it is hard to imagine a "prejudicial" violation of OAR 436-83-400 that warrants exclusion of offered evidence.

If there was not prejudice in this case, even in a microcosmic sense, there is not going to be prejudice in any case. It is apparent from a reading of the transcript that the insurer came to the hearing prepared to litigate its denial based on the five exhibits that claimant had submitted pre-hearing. I would not be surprised if the insurer actually did little to prepare a defense because claimant had no case with only those five exhibits. The Board majority concludes that the at-hearing addition of Exhibit 6, the only medical report which supports compensability, did not prejudice the insurer's opportunity to defend. Although the majority has not defined prejudice, that is a strange conclusion under any definition.

It is clear to me that, had Exhibit 6 been submitted in a timely manner, the insurer would have had to either (1) revoke its denial and accept this claim or (2) take further steps to prepare its defense. The first possibility would have meant a prompter resolution, less insurer-paid fees awarded to claimant's attorney and the possibility that other pending hearing requests could move toward resolution more promptly. As for the second possibility of additional defense preparation, I think that the insurer's options were rather limited. The majority notes that the insurer did not obtain an independent medical examination to contest Exhibit 6. But when the insurer first learned of the existence of Exhibit 6, it had been about two years since claimant had undergone surgery for his alleged compensable injury and about one year since claimant had returned to regular work. Any medical report based on an examination then would have been virtually worthless. The majority is naive to suggest otherwise.

Additional defense preparation would have had to focus on Dr. Miller, claimant's treating physician in Tennessee. There are significant financial and practical problems associated with taking the deposition of an out-of-state doctor. Without belaboring the point, if I were defending this case or any case involving the possible deposition of an out-of-state doctor, I would rather deal with those problems and associated tactical considerations pre-hearing than post-hearing because I think that post-hearing pressure from a Referee to get a record closed tends to (and probably should) reduce options. In short, I think the at-hearing surprise offer of Exhibit 6 likely could have had a material impact on the insurer's preparation of and presentation of its defense. If that is not "prejudice," what is?

In summary, I believe the Board's interpretations of OAR 436-83-400 are now chaotic and will lead to subjective and inconsistent applications of that important administrative rule. I believe the Board has made a serious mistake in its emphasis on "prejudice" (undefined) as part of its interpretation of OAR 436-83-400; to the limited extent that "prejudice" should be relevant when considering violation of a discovery-type rule, I would rely on macroprejudice to the entire hearing process, a concern that the rest of the Board apparently no longer shares. I continue to categorically reject the idea that post-hearing proceedings can "cure" a violation of OAR 436-83-400.

Applying my view of the administrative rule in this case, in the absence of one word of explanation as to why claimant's attorney did not seek information directly from Dr. Miller in time to submit it in the manner required by the rule, I conclude that claimant did not establish good cause for noncompliance with the rule. I would, therefore, conclude that the Referee erroneously admitted Exhibits 6, 7 and 8. Considering then the record properly before us, I would conclude that there is no medical evidence to support the compensability of this claim and would reinstate and affirm the insurer's denial.

BERT G. HARR, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Lindsay, Hart, et al., Defense Attorneys

WCB 82-03306
October 10, 1983
Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review dated August 25, 1983.

The request is granted. On reconsideration, the Board adheres to its former order.

IT IS SO ORDERED.

LOYCE ROBINSON, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 81-0150M
October 12, 1983
Own Motion Determination

On July 16, 1981 the Board issued an Own Motion Determination which granted claimant additional compensation for temporary total disability but no increase in compensation for permanent disability. In December 1981 the Board received from claimant, by and through his attorney, a request that he be granted compensation for permanent total disability. Due to a clerical error, the matter has been "pending" up to the present. Claimant has requested that the matter be referred to a hearing. It is not Board policy to refer these types of cases to the Hearings Division. Both parties are free to submit any documentation in support of their position that they may desire, including written arguments. Assuming that the record is now complete, the Board has proceeded to review the matter.

Claimant has submitted the following arguments in support of his contention that he is permanently and totally disabled. At the time of claimant's petition for own motion relief, he was 51 years old with an eighth grade education, but with a third grade reading level. His work background was mostly sawmill work up until the date of his injury. Other factors work against claimant, such as his inability to adapt to non-physical labor, emotional and psychological factors, the condition of the labor market and claimant's unsuccessful attempts to return to work.

It is evident that claimant is quite disabled with respect to his low back. He continues to receive palliative treatment from Dr. Saboe, who feels claimant will never be able to return to work again. He also states, however, that the periodic chiropractic treatments have worked to reduce claimant's symptoms considerably.

Claimant has participated in an authorized program of vocational rehabilitation which was basically unsuccessful. The report of a vocational counselor in May 1981 indicated that claimant averaged a 35.05% production level over a six-month period of time. They did not feel this level was adequate for claimant to be able to participate in competitive employment. They found that claimant had arthritis in his hands and fingers which prevented him from doing any type of work which required finger dexterity. He was unable to stand or sit for long periods of time, although, over the six-month period he was able to build up his work time to seven hours a day. He apparently

> ". . . showed a definite lack of motivation and ambition in his work. He appeared to do the job just to get it done, showing very little pride in the finished product. Lack of interest compounded by his medical problems would make Loyce an unlikely candidate for competitive employment."

We find claimant is definitely disabled and will probably have a hard time finding gainful employment. However, we do not find he is entitled to compensation for permanent total disability. It is evident that claimant's arthritis is a significant factor in preventing him from working. There is no medical evidence to show whether this condition pre-existed his 1974 injury, whether it has worsened since the injury, and/or whether the injury contributed to its progression in any way. We assume, although we lack medical evidence, that claimant's arthritis condition pre-existed his injury and progressively worsened over the years as claimant got older. In Frank Mason, 34 Van Natta 568 (1982), the Board stated:

> "We decide that when 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."

There is no evidence to show that claimant's disabling arthritis was just as disabling at the time of the 1974 injury. We can only conclude that, absent this disabling problem, claimant would have much more ability to adapt to work requiring finger dexterity, work which oftentimes is light or sedentary in nature.

We also are not impressed with claimant's effort to find suitable employment. Although he participated in at least two authorized programs of vocational rehabilitation, it is apparent that he did not really make an effort to complete the program successfully.

We note that claimant stipulated to an award of 60% in September 1980. There is no evidence in the record to indicate that his condition is worse than it was then. We are persuaded by the record that claimant has been adequately and fairly compensated for his compensable injury of May 6, 1974. Claimant's request for own motion relief is hereby denied.

IT IS SO ORDERED.

SANDRA J. HUBBARD, Claimant
Cummins, et al., Claimant's Attorneys
Alice M. Bartelt, Attorney
Lindsay, Hart, et al., Defense Attorneys

WCB 82-04524 & 82-01681
October 13, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Wilson's order which: (1) Upheld Travelers Insurance Company's denial of claimant's aggravation claim and also upheld Argonaut Insurance Company's denial of claimant's alternative new injury claim, essentially on the basis of a credibility finding that no injurious incident occurred in December 1981 as contended by claimant; (2) found that claimant was not entitled to an award for permanent disability as a result of her October 1980 low back injury while employed by Imperial Fabrics, insured by Travelers; and (3) rejected claimant's various arguments for interim compensation on her December 1981 claims and various arguments for penalties and attorney fees. On review, claimant apparently challenges all of the Referee's conclusions.

The Board affirms and adopts the order of the Referee. In addition, to the extent that claimant may be contending that she is entitled to interim compensation during a period that she was actually working, we note that any such contention is inconsistent with our analysis and conclusions in Anthony A. Bono, 35 Van Natta 1 (1983).

ORDER

The Referee's order dated March 9, 1983 is affirmed.

ELNORA SPRAGUE, Claimant
Hansen & Wobbrock, Claimant's Attorneys

Own Motion 83-0205M
October 13, 1983
Own Motion Determination

On August 10 and August 19, 1983 the Board issued closure orders in the above claim resulting in an increased award for claimant for a total of 80% loss of the right leg. Claimant, by and through her attorney, has requested that the Board reconsider and grant her compensation for permanent total disability. She states that she is now mostly confined to a wheelchair and that she not only has lost significant function of her leg, she also has a related lumbar back strain. The insurer responded to claimant's request indicating that claimant is using a printing-press in her home and realizing an income and, therefore, was not entitled to a permanent total disability award.

The Board has again reviewed the medical evidence in the file. We note, first of all, that Dr. Rusch saw claimant in May 1983 at which time she told him she was unable to work with her printing-press as it was difficult for her to manuever around in her wheelchair in order to perform printing work. She did not feel modifications of her home would improve the situation any. She apparently sold some of her printing equipment and was mentally resigned to being unable to do that type of work. Absent proof, we are not persuaded that claimant is making an income from this venture.

Claimant contends she is suffering back problems as a result of her leg condition. There is no medical evidence to support this contention. We conclude that we must consider claimant's physical condition on the basis of her leg disability alone.

Claimant's compensable injury predated the 1975 amendment to ORS 656.206(1) [1975 Oregon Laws ch. 506§1]. Under the former ORS 656.206(1), a worker was entitled to an award for permanent total disability if she/he had a " . . . 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." Not until July 1, 1975 could an injured worker receive permanent total disability compensation for conditions resulting from an injury to one scheduled member alone. Due to the law in effect at the time of claimant's injury, we are unable to grant claimant an award for permanent total disability. We note in passing that even if claimant could qualify for such an award, we are not persuaded by the medical evidence that she is entitled to it. Claimant's request for an award of permanent total disability is hereby denied.

IT IS SO ORDERED.

PETER A. ZAKLAN, Claimant
Galton, Popick & Scott, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

Own Motion 83-0104M
October 13, 1983
Own Motion Order

The self-insured employer requests that the Board exercise its own motion authority and issue an order, "finally adjudicating the rights of the parties herein by affirming the Opinion and Order of July 22, 1982 of Referee H. Don Fink which, not only affirmed the employer's denial of March 17 and May 26, 1982, but also, in the alternative, held that claimant had not established entitlement to an increase of permanent partial disability and had not established entitlement to additional temporary total disability during a vocational rehabilitation program beyond June 22, 1981."

The genesis of the employer's request for own motion relief is this Board's Order on Review in Peter A. Zaklan, 35 Van Natta 716 (1983), in which we reversed the above-referenced Referee's order which had upheld the employer's back-up denials under the rule of Frasure v. Agripac, 290 Or 99 App (1980). While this case was before the Board on review, the Court of Appeals decided Bauman v. SAIF, 62 Or App 323 (1983), which placed certain limitations on the ability of employers/insurers to retroactively deny a previously accepted claim. In our Order on Review in Zaklan, we found that the employer's back-up denials were prohibited under Bauman; therefore, we reversed the Referee's order and set aside the denials. We also remanded the case for further proceedings on the issues of extent of temporary and permanent disability. Our records indicate, as does the employer's petition for own motion relief, that the employer petitioned the Court of Appeals for judicial review of our Order on Review, and that pursuant to claimant's motion, the court dismissed the employer's petition on the grounds that our Order on Review was not a final, appealable order in that we had remanded to the Referee for further proceedings. There presently is a hearing set in November for further proceedings on the issues of extent of temporary and permanent disability.

In our Order on Review, we discussed at length the possibility of allowing an employer or insurer to retroactively deny a claim by requesting that the Board afford this remedy in the exercise of its own motion authority, where the employer/insurer was prohibited from doing so unilaterally under the rule established by Bauman. 35 Van Natta at 719-725. We concluded that the Board might have jurisdiction under ORS 656.278 to allow the employer to retroactively deny this claim from its inception, and that the Board could exercise its own motion authority to decide the issue of compensability. We also stated that we regard the granting of such own motion relief, "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 arrangement 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.'" 35 Van Natta at 723.

See Alvy Osborne, 34 Van Natta 127 (1982).

Although we found that the record strongly supported the Referee's conclusion that no compensable event occurred, we declined to allow the employer's denials to stand as an exercise of our authority under ORS 656.278, in the absence of a specific request for such relief and an opportunity for the parties to brief the issue of the Board's jurisdiction to grant such relief in this case.

The employer's petition for own motion relief correctly points out that, in the last paragraph of his order, after observing that by allowing the employer's back-up denials to stand the substantive issues raised by claimant's request for hearing were moot, the Referee made an alternative finding concerning these issues and stated:

> "However, were I to go to the merits of issues No. 2 and 3, I would leave claimant where he is. I would not increase his permanent partial disability award, nor would I authorize additional TTD during his vocational rehabilitation program beyond June 22, 1981."

In view of this fact, it probably was unnecessary to remand this case for further proceedings on these issues, since we had before us the Referee's alternative findings and easily could have ruled on these issues. Assuming that it was improvident to remand as we did, the question remains whether we now should consider curing this oversight by exercising our own motion authority in accordance with the employer's request. We believe that we should not and, therefore, deny the employer's request for own motion relief.

As we stated in our Order on Review in Zaklan, the relief which we contemplated granting as an exercise of our authority pursuant to ORS 656.278, would constitute a major departure from prior practice with regard to the interpretation and application of the own motion statute, particularly in view of the fact that claimant's aggravation rights have not yet expired. We intimated that, upon making a proper showing, the employer would be granted own motion relief and be allowed to retroactively deny this claim, once we determined that we had jurisdiction to grant such a remedy. The employer has chosen to request own motion relief, but the remedy requested is not that discussed in our Order on Review. Rather, the employer has requested that we cure an apparent oversight and eliminate the need for it to proceed to hearing in November as presently scheduled.

Although the Board's own motion authority is broad, as discussed in our Order on Review in Zaklan, the Board's exercise of this broad grant of authority has been tempered by various policy considerations. For example, the Board's authority is sufficiently broad to grant relief where it appears that a gross error has been made in the past and now should be cured -- in other words, the authority to right manifest wrongs.

However, the Board also has denied requests for own motion relief where the request was intended to circumvent other procedures provided as a matter of right, or to obtain relief which could have or should have been pursued by other procedural avenues which, for some unexplained reason, were not pursued.

In this case, after the Board issued its Order on Review remanding this case to the Referee, the employer petitioned the Court of Appeals for judicial review. The employer did not request that the Board reconsider that portion of its order remanding the case in light of the Referee's alternative finding concerning extent of temporary and permanent disability. We are not inclined to grant relief under ORS 656.278 where the relief requested might have been available as a matter of right had the proper procedural avenues been followed. If we were to grant the employer's request for own motion relief under the facts and circumstances of this case, it would be difficult to justify declining relief in any case in which the petitioner, within a relatively short period after the last order adjudicating the party's rights had become final, requested that the Board cure an apparent error or oversight as an exercise of its authority pursuant to ORS 656.278. We may have opened a new door and left is slightly ajar in our Order on Review in Zaklan; however, the relief presently requested by the employer, if granted, truly would open a floodgate of potential "own motion requests." We feel constrained, to say the least, to avoid this result, in order to allow the Board sufficient opportunity to devote its limited resources to legitimate requests for own motion relief, in addition to the review of Referees' orders pursuant to ORS 656.295.

Claimant's attorney has stated claimant's opposition to the employer's request for own motion relief. We find it appropriate to award a reasonable attorney's fee pursuant to OAR 438-47-070(1).

ORDER

The self-insured employer's request for own motion relief is denied. Claimant's attorney is awarded $250 as a reasonable attorney's fee, to be paid by the employer.

LOYE CARMONEY, Claimant
Allen & Vick, Claimant's Attorneys
Tooze, Kerr, et al., Defense Attorneys

WCB 82-00771
October 14, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Johnson's order which set aside its denial of claimant's occupational disease claim for various physical and psychological conditions allegedly worsened by claimant's job stress. The issue is compensability.

Claimant worked as a secretary in a manufacturing company from March 1981 to April 1982. In that job she had contact with both the office personnel and the production workers. Most of claimant's fellow employes, apparently especially among the production workers, were relatively young, relatively uneducated and doing

basically entry-level jobs. The crux of this claim is apparently that the use of "foul language" by claimant's co-workers and supervisors was so offensive to her that it caused her "disease." This offensive obsenity included both spoken words and restroom graffitti. Claimant also testified generally about other objections to her one year of work for this employer: The "plant was in constant turmoil"; supervisors "abused" the employes; "everybody was fighting"; the employes smoked marijuana and sold drugs at work; and some vague reference to employes bringing guns to work.

Claimant's testimony about her working conditions is long on conclusions and short on details. When pressed for details, claimant admitted she had never seen marijuana used at the plant, but had only heard about it; that "constant fighting" really meant "one or two scuffles that I know about"; and that claimant could only recall one person on one occasion who brought in a hunting rifle to show prior to a hunting trip. Claimant's only examples of employe abuse involved a plant manager (for whom she worked for about six months and toward whom claimant obviously has strong negative feelings) suggesting to one employe that she get an abortion and calling another employe a thief. Claimant seemingly admitted that the obsenity and abuse were not directed at her personally.

A fair summary of the testimony of several employer witnesses would be that claimant's description of the working conditions was exaggerated. The testimony of Ms. Webber is typical; that profanity was used in the plant, but "no more than any other place that I worked," including a state agency.

We thus think the first question involves credibility. The Referee found the testimony of all witnesses except claimant to be "credible" and "entitled to full weight." The Referee found claimant to be "basically a credible witness," but that her testimony was "not entitled to full weight" because of "inconsistencies between claimant's testimony and the" testimony of the employer witnesses. We are not quite sure what to make of these credibility findings. Our own conclusion, considering claimant's testimony as a whole, is that: (1) Claimant was angry at her employer, as she admitted at one point ("I was really very angry . . . at the way the plant was run."); and (2) her anger resulted in her conscious or unconscious use of hyperbole to portray the allegedly adverse conditions of her employment in the worst possible light.

Our impression of claimant's myopic preoccupation with aspects of her employment is reinforced by some of the medical evidence. Dr. Wight, claimant's treating psychiatrist, testified:

> "[Claimant] talked about the work conditions and that's what she really dwelt on. You know, you want to look beyond that and you think that perhaps there are other reasons. And, you know, I tried to do that. I wasn't successful in finding any other reasons, to be frank about that."
>
> * * *
>
> "And I wasn't really willing just to sit there, you know, hour after hour and talk to

her about the work and what was going on with the work, you know, because that's really what we were doing. And I can understand that she had a need to do that. But I also wanted to find out something about her, what made her tick, and why this was affecting her so severely."

In sum, we have sufficient doubts about claimant's testimony that we are willing to accord it little weight.

The second question involves the medical opinion evidence. As a preliminary matter, we note that opinion evidence in this kind of case is especially dependent on information from the patient. Melodie A. Gage, 34 Van Natta 1245 (1982); Kay L. Murrells, 33 Van Natta 586 (1981). Therefore, to the extent that we have doubts about claimant as a reliable source of information, those doubts will have an impact upon the persuasiveness of the medical evidence.

Dr. Porter has been claimant's primary physician for a number of years. Dr. Wight provided psychiatric treatment in connection with this claim. Dr. Hogue examined claimant once on a consulting basis in May 1982. Drs. Porter, Wight and Hogue all opine that claimant's physical and psychological symptoms here in issue are causally related to stress in claimant's employment. None of these doctors uses the "magic" word of "major" causation, but all of them opine in essence that they cannot identify any other cause of claimant's difficulties.

Dr. Parvaresh opines that claimant's work was not the major cause of her depression. Rather, in his hearing testimony, Dr. Parvaresh suggested that the death of claimant's father about a month or two after claimant began working for this employer was more likely the major source of her depression and associated symptoms. This is plausable because all doctors who said anything at all about claimant's relationship with her father commented on potentially psychologically-significant aspects of that relationship. However, in assessing Dr. Parvaresh's opinion about the impact of that death, we confront another possible example of claimant's selective reporting to her doctors; nothing in the reports from or testimony of Drs. Porter, Wight or Hogue suggests even any awareness of the death of claimant's father.

The insurer does not have to prove that this death or any other nonwork factor was the major cause of claimant's illness; claimant has the burden of proving that work-related factors were the major cause of her illness. Considering claimant's borderline credibility, that the opinions of Drs. Porter, Wight and Hogue were necessarily based on claimant's description of her working environment and, most significantly, those doctors' apparent unawareness of the death of claimant's father, we are not persuaded by their opinions.

If we were convinced that obscene language at work was the major cause of claimant's illness, the third and final question would involve interpretation of ORS 656.801(1)(a). That statute provides that a disease claim is compensable only when the disease is caused by something "to which an employe is not ordinarily

subjected or exposed" except in employment. While our conclusion that claimant has not proven her claim factually makes it unnecessary to reach this legal issue, we note that exposure to much of the language that claimant found objectionable is probably ubiquitous in contemporary life; at least this claimant had sufficient prior exposure to the words in question to know what they meant. In this kind of situation, an analogy could perhaps be drawn to other claims in which the disease-producing mechanism is ubiquitous. See Barbara Watson, 34 Van Natta 1094 (1982), aff'd 62 Or App 399 (1983) (chicken pox claim not compensable); David A. Rhodes, 35 Van Natta 619 (1983) (hepatitis claim not compensable).

However, we are frankly uncertain about the status of ubiquitous-exposure versus work-exposure in mental stress cases. In Daniel Leary, 33 Van Natta 613 (1981), we concluded that the claimant's objection to having women as supervisors was not a "disease exposure" limited to employment:

> "[T]he phenomenon of women in positions of authority is not limited to the telephone company, but rather, in our changing contemporaneous society, is increasingly common. Claimant undoubtedly had difficulty coping with his own aging process and the changing world around him, but these stress factors he claims caused an occupational disease are really factors which any person claimant's age encounters everywhere." 33 Van Natta at 614.

In reversing the Board and finding that claim compensable, the Court of Appeals only briefly mentioned women supervisors as a "disease exposure" and did not directly discuss whether such a factor was uniquely work related. Leary v. Pacific Northwest Bell, 60 Or App 459 (1982). On the other hand, in SAIF v. Mitchell, 63 Or App 488 (1983), the Court of Appeals seems to suggest that the claimant's arguments and friction with co-workers about his being an ex-convict was not a "disease exposure" limited to employment; in any event, the court in Mitchell concluded that stress claim was not compensable. Assuming it is an open question, we think the better answer would be that the "disease exposure" of hearing spoken profanity or reading profane restroom graffitti is not limited to employment and thus not compensable under ORS 656.802(1)(a).

For all of these reasons, we conclude that claimant has not established a compensable occupational disease.

ORDER

The Referee's order dated September 30, 1982 is reversed. The insurer's denial dated January 20, 1982 is affirmed.

DONNA L. MAXON, Claimant
Rex Q. Smith, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-01836
October 14, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Williams' order which, in effect, affirmed the January 22, 1982 Determination Order which had awarded no permanent disability for claimant's September 1981 back injury. Claimant suggests that she is entitled to an award for 40% unscheduled disability.

We agree with the Referee's analysis with one exception. The Referee found it "established" that claimant's back pain was due to a noncompensable condition; we find this is only a possibility. Our own emphasis is on the objective medical evidence of lack of impairment due to the September 1981 injury, our policy that objective medical evidence usually takes precedence over contrary lay testimony in this kind of situation, see James G. Thomas, 35 Van Natta 714 (1983), and our impression that even the lay testimony in this case does not document truly disabling pain. For all of these reasons, we agree with the Referee's conclusion.

ORDER

The Referee's order dated January 31, 1983 is affirmed.

DONALD M. VanDINTER, Claimant
Peter Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwenn, et al., Attorneys
Roberts, et al., Attorneys
Lindsay, Hart, et al., Attorneys

WCB 81-05303, 82-06302, 82-07084 & 82-09038
October 18, 1983
Order on Review (Remanding)

Reviewed by the Board en banc.

This case has reached a level of confusion which, fortunately, is not commonly seen by this Board. It is a procedural morass.

The case probably seemed simple enough when a hearing first convened before Referee Fink on May 18, 1982. In addition to contesting a Determination Order closing his April 22, 1980 industrial injury claim while employed with Trailer Equipment Distributors, then insured by the SAIF Corporation, claimant was contending that an episode which had occurred on April 13, 1981, while he was still employed with Trailer Equipment Distributors, constituted a new injury which should be processed as such by the SAIF Corporation, as opposed to an aggravation of his 1980 injury, on which basis SAIF had accepted and paid compensation for the apparent consequences of that 1981 incident. At that hearing there was evidence that claimant had incurred some time loss during December of 1981 after leaving his employment with Trailer Equipment Distributors and going to work for Columbia Battery Manufacturing, which SAIF had processed as another aggravation of claimant's original April 1980 injury. By an order dated June 7, 1982, Referee Fink ordered,

among other things, that SAIF reclassify claimant's April 13, 1981 incident as a new injury, rather than an aggravation of the 1980 injury.

Upon receipt of Referee Fink's order, and apparently in the course of reprocessing the April 1981 episode as a new injury claim, SAIF discovered that on April 13, 1981 the employer, Trailer Equipment Distributors, was no longer insured by SAIF but was provided coverage by Fireman's Fund Insurance Company. Counsel for SAIF, therefore, requested that the Referee reconsider his order and reopen the record. The Referee declined to do so. SAIF requested Board review, requesting that the Board remand the case to the Referee for further proceedings in light of the recently discovered fact that, on the date of claimant's April 1981 incident, SAIF did not provide coverage.

By the time SAIF had requested review and remand, SAIF had issued a denial of claimant's original aggravation claim by denial letter dated August 13, 1982. Claimant had requested a hearing on this denial (WCB Case No. 82-06302). Fireman's Fund had issued a denial of claimant's new injury claim, and claimant had requested a hearing contesting that denial (WCB Case No. 82-07084). SAIF also happened to insure claimant's subsequent employer, Columbia Battery Manufacturing, and had issued a denial in behalf of that employer concerning the incident in December of 1981. Claimant had requested a hearing contesting that denial as well (WCB Case No. 82-09038). Claimant's three requests for hearing had been consolidated and were pending when SAIF requested that the Board remand the case decided by Referee Fink for consolidation with those proceedings. We stated in our Order of Abatement, suspending the proceedings on review of Referee Fink's June 7, 1982 order: "The Board does not deem remand to be the solution to the procedural quagmire presented by SAIF's mistake of fact." Donald M. VanDinter, 34 Van Natta 1485 (1982). We held the proceedings on review of Referee Fink's order in abeyance pending resolution of the proceedings in the Hearings Division.

A hearing was held on December 28, 1982 before Referee Pferdner, who issued three separate orders, each of which separately dealt with the issues arising under each of the employers/insurers' denials. All the potentially responsible employers/insurers were before Referee Pferdner, but the proceedings obviously were complicated by the fact that Referee Fink's June 7, 1982 order was outstanding and had ordered SAIF to accept and process the April 13, 1981 episode as a new injury claim. One of the issues in WCB Case No. 82-06302 addressed by Referee Pferdner was claimant's request that SAIF be ordered to process the claim in accordance with Referee Fink's June 1982 order, and that SAIF be assessed a penalty and attorney's fee for their failure to do so. Issues were raised and argued concerning the res judicata or collateral estoppel effect to be given the contentions made and issues decided in the original proceeding before Referee Fink.

In WCB Case No. 82-07084 (Trailer Equipment/Fireman's Fund), Referee Pferdner set aside the insurer's denial and ordered that the claim be accepted and processed, including payment of temporary disability as of April 13, 1981. Referee Pferdner also imposed a penalty for unreasonable refusal to pay compensation.

In WCB Case No. 82-06302 (Trailer Equipment/SAIF), Referee Pferdner ordered that SAIF pay a penalty and associated attorney's fee for SAIF's failure to comply with Referee Fink's June 1982 order. SAIF had moved to dismiss claimant's hearing request based on principles of collateral estoppel and res judicata. Referee Pferdner denied SAIF's motion.

In WCB Case No. 82-09038 (Columbia Battery/SAIF), after finding that "[t]he evidence clearly establishes SAIF Corporation was not the carrier on the risk on April 13, 1981," the Referee ordered that "neither party take anything by this Order." It is our understanding that WCB Case No. 82-09038 involves, or should involve, claimant's hearing request contesting the September 29, 1982 denial issued by the SAIF Corporation in behalf of its insured, Columbia Battery Manufacturing Company, denying responsibility for an alleged injury with an assigned date of December 2, 1981.

Board review was requested of Referee Pferdner's three orders. The SAIF Corporation, as insurer for Trailer Equipment Distributors, moved the Board to consolidate review of Referee Pferdner's three orders with the review of Referee Fink's 1982 order which previously had been abated by the Board. The other parties stated that they either joined in SAIF's request or had no objection thereto. Accordingly, on July 27, 1983 the Board reinstated the proceeding on review of Referee Fink's 1982 order and consolidated that proceeding with the proceeding on review of Referee Pferdner's three orders.

On September 27, 1983, the Board received a motion to expedite Board review filed jointly by the three employers/insurers involved in this proceeding. The motion recites the procedural history of this case to date and further indicates that there presently are further proceedings pending before the Hearings Division in which claimant has requested a hearing contesting an apparent denial issued by Fireman's Fund subsequent to Referee Pferdner's orders, and in addition is seeking enforcement of Referee Fink's 1982 order and/or Referee Pferdner's February 17, 1983 order(s). The employers/insurers' motion to expedite Board review includes a request that the Board abate the proceedings presently pending in the Hearings Division (WCB Case Nos. 83-02631, 83-06962, 83-06963, and 83-06964).

If ever an injured worker has been whipsawed between insurers, this truly is such a case. It is clear that there are four outstanding Referees' orders in this case, two of which direct a particular employer/insurer to accept and process a claim. It is equally apparent that, aside from the procedural and legal issues that arise by virtue of the original proceeding before Referee Fink, and the collateral estoppel effect of that proceeding, if any, the essence of this case is employer/insurer responsibility for an otherwise compensable claim.

Rather than abate the proceedings presently pending in the Hearings Division, a request previously directed to the Referee before whom the proceedings are pending and, we believe, properly denied, it appears most appropriate, considering what already has

transpired, to remand the proceedings presently before the Board to the Referee who has been assigned the pending hearing requests. Because of the peculiar facts and circumstances of this case, we deem it appropriate to vacate the orders previously issued by Referees Fink and Pferdner, in order to give the litigants, particularly claimant, and the Referee the opportunity to make a "fresh start" to determine the real question in this case, i.e., employer/insurer responsibility.

We note that the record reflects a previous effort to obtain from the Compliance Division an order designating a paying agent pursuant to ORS 656.307, which was thwarted because of the "compensability" issues in the case, which issues appear to be related to questions concerning coverage and the res judicata/collateral estoppel effect of the original proceeding before Referee Fink. By vacating Referee Fink's order as well as Referee Pferdner's orders and remanding this case for further proceedings, those "compensability" issues no longer are present in this case. We, therefore, anticipate that no further obstacle to issuance of a .307 order and designation of a paying agent will be present.

ORDER

Referee Fink's order dated June 7, 1982 and Referee Pferdner's orders dated February 17, 1983 are vacated, and these proceedings are remanded to the Hearings Division for further proceedings consistent with this order.

Board Member Barnes Concurring in Part and Dissenting in Part:

I agree with and join the Board in "wiping the slate clean" as the best solution to the present procedural mess.

I disagree with the majority's decision not to designate a paying agent at this time pending resolution of the issue of employer/insurer responsibility. The Board has authority to "make such disposition of the case as it determines to be appropriate." ORS 656.295(6). In my opinion, that includes authority to designate a paying agent. And not only do I think it would be appropriate to do so in this case; I think failure to do so is grossly inappropriate. Prose about the claimant being "whipsawed" sounds good; designating a paying agent would be doing something good.

I hope the majority's expectation that the Compliance Division will promptly designate a paying agent comes to pass. If it does not, I urge the Referee on remand to do so.

SANDRA AUSTIN, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-04705
October 19, 1983
Interim Order of Remand

The insurer has requested and claimant has cross-requested review of various portions of the Referee's order. A complete transcript of the testimony is not available due to an inadvertent erasure of a portion of claimant's electronically recorded testimony. Respective counsel for the insurer and claimant have indicated that it is, therefore, appropriate to remand this case. We agree.

Accordingly, this case is remanded to the Referee with instructions to reconvene the hearing as expeditiously as possible for the sole purpose of taking claimant's testimony. Within 30 days of the hearing on remand the Referee shall have a transcript of the proceedings prepared and shall issue an Order on Remand taking into consideration claimant's testimony. Because the purpose of this remand is to make a proper record of claimant's testimony, and because claimant's testimony presumably will be the same, all that may be necessary is for the Referee to acknowledge the fact that the testimony taken on remand is consistent with the findings and conclusions stated in the Referee's original order of June 20, 1983.

The Board retains jurisdiction over this proceeding. Upon receipt of the transcript of the claimant's testimony and the Referee's Order on Remand, the Board will provide the parties with copies and establish a new briefing schedule.

ORDER

This case is remanded to the Referee for further proceedings consistent with this order.

KIM M. GRIFFIN, Claimant
Fallgren & McKee Associates, Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys

WCB 82-00664
October 19, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of those portions of Referee Braverman's order which set aside the September 24, 1981 Determination Order as premature and awarded claimant's attorney an insurer paid attorney's fee of $650. The insurer also objects to the Referee's refusal to determine the issue of claimant's entitlement to temporary total disability benefits from November 11, 1981 through February 18, 1982.

Claimant was employed as a general laborer for Pacific Coast Nursery on February 26, 1981 when she sustained a compensable injury to her left knee. She was examined by Dr. Pliska who diagnosed a medial collateral ligament injury. The claim was accepted and a surgical repair of the medial collateral ligament with a partial medial meniscectomy was performed by Dr. Laycoe on March 21, 1981.

Claimant was examined by Dr. Laycoe on July 14, 1981. He reported that claimant was asymptomatic with no sensation of instability, swelling or pain in the left knee and that she was released to return to her regular work. The September 24, 1981 Determination Order awarded claimant benefits for temporary total disability from February 26, 1981 through July 24, 1981 and 7.5° for a 5% scheduled permanent partial disability.

Claimant returned to work on July 15, 1981. For the next several months claimant continued working on a full-time basis, ten to twelve hours per day. Claimant worked until November 11, 1981 when her job was terminated due to a regular seasonal layoff. Claimant filed for and collected unemployment benefits following her layoff.

On November 10, 1981, one day prior to her seasonal layoff, claimant was seen by Dr. Berselli with complaints of pain and "giving away" in her knee. An arthrogram was performed on November 11, 1981 which was interpreted to reveal "a tiny tear" in the posterior portion of the medial meniscus. It was undetermined what the significance of this tear was. Dr. Berselli reported that he was uncertain what was transpiring in claimant's knee and suggested that an arthroscopic examination of the knee would be useful in order to "chart a course of action."

The insurer requested a second opinion from Dr. Goodwin. Dr. Goodwin reported on December 21, 1981 that claimant experienced some left knee pain after returning to work, but that it was much better after her layoff. Dr. Goodwin was of the opinion that claimant's excess weight had a direct bearing on the amount of pain she was experiencing. He agreed with Dr. Berselli that an arthroscopy was indicated as he also believed that claimant had a tear on the posterior undersurface of the medial meniscus.

On February 18, 1982 Dr. Berselli performed the arthroscopy and the insurer reopened the claim on the basis of aggravation. Contrary to his prior belief that claimant had a tear on the posterior portion of the medical meniscus, Dr. Berselli found nothing but a regrown meniscus with no evidence of a tear. Claimant was released to return to her regular work by Dr. Berselli on June 15, 1982.

Claimant requested a hearing in relation to the September 1981 Determination Order, raising numerous issues. Those issues included: (1) Entitlement to temporary total disability benefits from November 11, 1981 to February 18, 1982; (2) premature closure versus aggravation; and (3) unreasonable resistance and/or delay in the payment of compensation.

The Referee concluded that the September 1981 Determination Order did issue prematurely. Since he found a premature closure, he concluded that the question of claimant's entitlement to temporary total disability benefits from November 11, 1981 through February 18, 1982 would be determined by the Evaluation Division. He also concluded that:

> ". . . the need to set aside the Determination Order of September 24, 1981 was so patent on its face from the medical evidence that the failure of the carrier to do so is evidence of general unreasonable conduct so as to justify a fee to claimant's attorney for work performed in these proceedings on claimant's behalf . . . ."

The insurer contends that all of these conclusions are wrong. We agree.

The Referee's conclusion that the September 1981 Determination Order issued prematurely was apparently based on the Board's decision in William Bunce, 33 Van Natta 546 (1981). The claimant in Bunce sustained a compensable back injury. Several months after his claim was closed claimant consulted a different physician who

informed him that he was suffering from a herniated disc and had been suffering from a herniated disc ever since his compensable injury. In deciding whether to treat the matter as a premature closure or an aggravation, we noted that at the time the claim was originally closed, the then available information did indicate that claimant was medically stationary. We also noted, however, that there was no viable aggravation claim because claimant's condition could not technically be said to have worsened. We concluded that the better approach should be based on the "objective reality" of the situation; that is, since the objective reality was that claimant had an undiagnosed herniated disc at the time of the first closure, the matter was better treated as a premature closure rather than an aggravation. We also noted that the claimant in Bunce was unable to work between the date of injury and the date of the belated discovery of the herniated disc.

We believe that the Referee misapplied our decision in Bunce. The objective reality of the current case is that although it was suspected in November 1981 that claimant may have had a tear on the posterior portion of her medial meniscus, the arthroscopic examination of February 1982 revealed that there was nothing wrong with claimant's knee. There was, in fact, no misdiagnosis at all. Moreover, claimant was able to work with little or no difficulty from the date of her release to return to work in July 1981 until the date of her seasonal layoff. Under these circumstances the insurer's action of reopening the claim on the basis of aggravation was eminently proper. See also Roy McFerran, Jr., 34 Van Natta 621, aff'd. 60 Or App 786 (1982).

Since we have concluded that the Referee erred in finding a premature closure, we must address the issue of claimant's entitlement to temporary total disability benefits from November 11, 1981 through February 18, 1982. ORS 656.273(6) requires a medical verification of inability to work before an insurer is required to pay temporary total disability in relation to claims for aggravation. With regard to the period between November 11, 1981 and February 18, 1982, no such verification exists. A claimant's testimony is not medical verification. It follows that claimant has not established entitlement to temporary total disability benefits for the period in question, and that the insurer acted properly in instituting time loss payments when claimant underwent surgery by Dr. Berselli.

Since we have concluded that the claim was not prematurely closed and that the insurer acted properly in reopening the claim on the basis of aggravation on February 18, 1982, it follows that the Referee's award of an insurer paid attorney's fee must be reversed. Even if the Referee had been correct in finding a premature closure, we nevertheless would question his award of an insurer paid attorney's fee in this case. There was nothing about the insurer's action which was unreasonable. We are uncertain what medical evidence the Referee is referring to as "patent." We find no such evidence in the record and we are unaware of any statute or rule which gives an insurer any authority to "set aside" a Determination Order.

ORDER

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

and reversed in part. Those portions of the order which set aside the September 24, 1981 Determination Order as premature and awarded claimant's attorney an insurer paid attorney's fee of $650 are reversed. Claimant's request for additional temporary total disability compensation for the period November 11, 1981 through February 18, 1982 is denied. The remainder of the Referee's order is affirmed.

DANIEL J. HUMELAND, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-02718
October 19, 1983
Order on Remand

On review of the Board's order dated July 14, 1982, the Court of Appeals reversed that portion of the order which failed to award claimant's attorney a reasonable attorney's fee for services on Board review and remanded for such an award.

Now, therefore, that portion of the aforementioned Board order failing to award claimant's attorney a fee is vacated, and 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 medical services claim. ORS 656.382(2).

IT IS SO ORDERED.

DAVID F. LOVELL, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-05242
October 19, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Leahy's order which upheld the SAIF Corporation's denial of claimant's leg and feet rash condition, which several doctors have been unable to diagnose. Claimant does not contest the Referee's decision regarding compensability, but argues that the Referee erred in not ordering that interim compensation be paid and in not assessing a penalty and attorney's fee for nonpayment of interim compensation.

We agree with SAIF that the issue of nonpayment of interim compensation was not raised either in claimant's request for hearing or in the statement of the issues at the start of the hearing. Claimant argues that we have authority to decide issues not raised, citing Russell v. A & D Terminals, 50 Or App 27 (1981). That may well be, but see Richard Pick, 34 Van Natta 957, 959 (1982) ("there is some obligation to specifically define the claimed basis for imposition of a penalty so that it will be known what evidence is relevant"); however, we do not think we have any duty to reach issues not raised at the hearing, and we generally decline to do so. E.g. William Swenson, 35 Van Natta 346 (1983); Timothy D. Blaser, 34 Van Natta 1463 (1982); Michael Petkovich, 34 Van Natta 98 (1982).

Claimant also argues that the issue of nonpayment of interim compensation was adequately raised in the course of claimant's redirect testimony when claimant, rather confusingly, first testified that he had received "a couple hundred dollars" in time loss

benefits after filing his claim but then testified that he had not received any time loss benefits after filing his claim. Aside from the Referee's adverse finding on claimant's credibility, we do not think this testimony was sufficient to put SAIF on notice that it had to be prepared to present evidence on the issue of payment or nonpayment of interim compensation and/or evidence on the issue of the reasonableness of nonpayment. Richard Pick, supra.

ORDER

The Referee's order dated January 17, 1983 is affirmed.

EARL W. ANDREWS, Claimant
Rolf Olson, Claimant's Attorney
Lindsay, Hart, et al., Defense Attorneys

WCB 82-08563
October 21, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of that portion of Referee McCullough's order which refused to award a penalty because of the insurer's payment of temporary total disability benefits at an incorrect rate.

Before claimant was injured in July 1982, the employer's mill was being periodically shut down because of economic conditions. Even before claimant's injury, questions had arisen about how to compute time loss benefits for workers injured under these circumstances and, in April 1982, the employer requested guidance from the Workers Compensation Department. The apparent thrust of the Department's response appears to be a description of how to compute time loss benefits for regular employes working shortened work weeks.

After claimant's injury, the insurer computed and paid time loss benefits on the basis that claimant was employed on an irregular or unscheduled basis as provided in OAR 436-54-212(3), rather than on the regular-employe-on-reduced-schedule basis that had been discussed in the prior correspondence. Claimant requested a hearing on the question of the proper computation of his time loss benefits.

The Referee found that claimant was a regular employe rather than an "on-call" employe and thus should have been paid temporary total disability at a higher rate based on ORS 656.210(3). The Referee correctly relied on our decision in Eldon Britt, 31 Van Natta 141 (1981), in which we concluded that a worker's employment was "regular" within the meaning of the statute so long as there was a history of full time work and there was an ongoing employment relationship in which the worker would be given full time work when full time work was available. Such was the case here. The rate at which the insurer paid temporary disability benefits was inconsistent with our decision in Britt, and the insurer does not contend otherwise on review.

In a very similar situation involving the proper computation of benefits, we have ruled that an insurer's conduct in violation of a prior Board decision is unreasonable and warrants a penalty.

Barbara Holder, 32 Van Natta 205 (1981). We conclude that analysis is applicable in this case. We also deem it appropriate to award claimant's attorney a fee pursuant to ORS 656.382(1).

On the facts of this case, we do not think the fact that the employer requested guidance from the Department is a mitigating circumstance because, as previously noted, the Department's response does not appear to have addressed the regular-employe-versus-sporadic-employe issue that was the basis of the insurer's incorrect computation of claimant's benefits.

ORDER

The Referee's order dated March 30, 1983 is affirmed in part and reversed in part. That portion which declined to impose a penalty is reversed. The insurer shall pay claimant a penalty of 25% of the additional benefits for temporary total disability due under the terms of the Referee's order between the date of claimant's injury and the date of the Referee's order. The insurer shall pay claimant's attorney a fee of $500 pursuant to ORS 656.382(1), in addition to the fee allowed by the Referee's order. The remainder of the Referee's order is affirmed.

EDWARD J. BUTLER, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 79-10462
October 21, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee St. Martin's order which dismissed his request for hearing on the ground that claimant had failed to timely request a hearing in relation to the insurer's May 5, 1980 denial.

Claimant filed a request for hearing on December 7, 1979 which stated one of the issues as the insurer's denial dated April 25, 1979. There is no such thing as a denial dated April 25, 1979; claimant's claim was in accepted status when he filed his December 1979 hearing request. The insurer later issued a backup denial of the claim on May 5, 1980. Claimant did not thereafter file any hearing request or supplemental hearing request in relation to that denial. When the hearing convened in September 1982, claimant indicated he was contesting the May 5, 1980 denial and the insurer objected that there had been no timely hearing requested on that denial.

The Referee correctly concluded that, under Syphers v. K-W Logging, Inc., 51 Or App 769 (1981), a December 1979 hearing request was insufficient to confer jurisdiction over a May 1980 denial. Since the date of the Referee's order the Court of Appeals has explained Syphers in a somewhat different light in Thomas v. SAIF, 67 Or App 193 (1983), but we find nothing in Thomas that suggests any reason for reversal of the Referee's order in this case.

While we agree with the Referee's ultimate conclusion, it appears that the Referee's order is in need of a clerical correction. Claimant's December 1979 request for hearing did set forth certain issues that were properly before the Referee, which the Referee recognized at that hearing:

"Seems to me you filed a request for hearing raising an issue of a denial which there wasn't any in existence [sic]. You raised the issue of entitlement to further medical care and treatment and temporary disability payments and penalties, and also about his not being vocationally stationary; those are all issues that you're entitled to try in front of me."

Although the Referee's order indicates that he ruled against claimant on all of these additional issues, he failed to expressly so indicate, and instead stated that claimant's request for hearing was dismissed in its entirety. The order should properly provide for dismissal of jurisdiction over the propriety of the insurer's May 1980 denial and indicate that all other relief requested by claimant is denied.

With that minor correction, we affirm and adopt the order of the Referee.

ORDER

As corrected above, the Referee's order dated October 27, 1982 is affirmed.

ROBERT N. FAUGHT, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 79-07797
October 21, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Baker's order which set aside its partial denial by which SAIF took the position that claimant's psychiatric condition was not a compensable consequence of his industrial back injury. Claimant cross-requests review of those portions of the Referee's order which failed to award penalties and attorney fees for SAIF's alleged failure to pay "interim" compensation and its alleged failure to accept or deny the claim within sixty days.

In December of 1976 claimant sustained a compensable injury while operating a backhoe. Claimant intially treated with Dr. Rocky. A myelogram administered on January 4, 1977 revealed a disc herniation at L5-S1 on the left, a probable herniation at L4-5 and chronic lumbar disc degeneration. Conservative therapy was instituted. Dr. Rocky and Dr. Stainsby, a neurologist, believed that claimant exhibited functional difficulties.

Claimant was next examined by Dr. Tsai, who recommended surgical intervention, but referred claimant to Dr. Ackerman for a psychological examination prior to the surgery. Dr. Ackerman reported that claimant was free from personality problems and psychosis but exhibited a "moderate increase in hypochondriasis and hysteria." In September 1977 Dr. Tsai performed a laminectomy. Subsequent medical reports indicate that the findings at surgery were more minimal than had been anticipated.

Claimant was thereafter referred to the Callahan Center. On February 7, 1978 Dr. Johnson, a psychologist, reported that claimant was highly motivated for rehabilitation, but that he was mildly emotionally disturbed and demonstrated a tendency to overfocus on physical problems.

A July 3, 1978 Determination Order awarded claimant 35% for 112° unscheduled permanent partial low back disability.

Due to continued complaints of low back pain, a second myelogram was performed on claimant by Dr. Hockey on August 10, 1978. The myelogram showed some slight asymmetry at L4-5, but was otherwise normal. Claimant was also examined by Orthopaedic Consultants, who concluded that claimant was not medically stationary and that he required a psychiatric examination. On October 4, 1978 claimant was examined by Dr. Parvaresh, a psychiatrist. Dr. Parvaresh found no evidence of any significant psychiatric impairment and did not believe psychiatric treatment was necessary.

In December 1978 claimant's employer offered him a light duty assistant shop clerk's job. The job allowed claimant to move about as his needs dictated, did not require bending, stooping or twisting and paid $1,600 per month. Dr. Hockey indicated that this job was within claimant's physical limitations. Although claimant took the job, he complained that it was causing him considerable discomfort.

Dr. Becker reported on February 23, 1979 that he believed it would be a mistake for claimant to quit working because he believed it was unlikely claimant would ever return to work if he quit. Dr. Becker also reported that claimant was overusing medication. On February 26, 1979 Dr. Hockey reported that claimant required two weeks off from work due to an acute lumbosacral strain. On June 1, 1979 Dr. Hockey reported that claimant was displeased with him because he had released claimant to return to work; Dr. Hockey stated that he had advised claimant to find another physician and reiterated that claimant was able to perform a light duty job such as shop assistant.

In June 1979 claimant's employer offered him a second light duty job as a maintenance records clerk. Claimant also accepted this job but immediately sought treatment from Dr. BreMiller, expressing complaints of pain and memory loss. Dr. BreMiller reported on June 22, 1979 that claimant's work schedule only involved about four and one-half hours of actual work, with time off for physical therapy and a weight loss clinic. Dr. BreMiller stated that it was very important for claimant to continue working, otherwise "he probably will actively seek withdrawal from the situation."

A second Determination Order issued on July 13, 1979, awarding claimant additional time loss benefits.

On May 29 and 30, 1980 claimant was examined by Dr. Lewinsohn, a professor of psychology at University of Oregon. Dr. Lewinsohn diagnosed an affective disorder characterized by hypochondriacal tendencies, psychic conflicts represented in somatic symptoms, depression, multiple neurotic manifestations, secondary gain from

symptoms, demands of sympathy from others, inner conflicts about self-assertion and other difficulties. Dr. Lewinsohn recommended psychiatric treatment. Claimant was referred to Dr. Cook for further psychiatric evaluation. Dr. Cook related claimant's memory loss to his overuse of pain medication or to a depressive disorder. Dr. Cook characterized claimant as being "financially secure" because he was receiving social security benefits for permanent total disability and living off funds from the sale of a construction business.

In September 1981 a psychiatric examination of claimant was conducted by Drs. Holland and Henderson. Dr. Holland reported that tests indicated claimant suffered from a conversion reaction and a psychophysiologic reaction suggestive of an individual preoccupied with somatic symptoms related to emotional conflicts which result in significant secondary gain. Dr. Holland stated that when afflicted with an illness such people tend to become invalids. He concluded claimant was not motivated to return to work and that he was comfortable in his disability role. He found it difficult to view claimant as entirely credible and felt claimant to be an example of a dependent personality disorder. Dr. Henderson was of the opinion claimant suffered from an underlying personality disorder, that he was experiencing a psychogenic pain disorder and claimant was holding on to his pain because of secondary gain considerations with the goals of achieving a "settlement from SAIF," reimbursement for past medical bills and a desire for a lump sum payment to use to purchase his own business. Dr. Henderson further stated that claimant's conscious prolongation of his pain behavior indicated there was an element of "malingering" present. The 1976 industrial injury was felt to be a moderate to severe psychological stressor and the death of claimant's father in 1977 was considered to be a severe stressor.

Although Dr. Holland diagnosed claimant's condition as a conversion reaction and Dr. Henderson diagnosed a psychogenic pain disorder, neither physician felt this to be a serious disagreement.

On March 16, 1982 SAIF partially denied the compensability of claimant's psychiatric condition.

In June 1982 Dr. Carter submitted a report concerning his psychiatric evaluation of claimant. Dr. Carter stated that he had informed claimant on November 18, 1981 that he believed Drs. Holland and Henderson were correct when they concluded that claimant was consciously elaborating his symptoms and exaggerating his impairment for the purpose of a settlement. Claimant then failed to attend his next evaluation session with Dr. Carter and, when asked why, stated that he thought the doctor had told him to wait until his hearing was completed.

Dr. Carter's diagnosis basically agreed with those of Drs. Holland and Henderson. He also reported that the industrial injury, medication overuse and the death of claimant's father were severe psychological stressors. He felt claimant's psychogenic pain disorder was related to his injury, but that there also was a "good deal" of conscious elaboration of pain and impairment which was manipulative and self-serving. He concluded that claimant, "does have a rather strong stake in obtaining a good settlement

through two separate litigations. He will be reluctant to give up any of his symptoms of conscious or unconscious origin until there is some reasonable settlement."

The Referee stated that a "substantial part" of claimant's perception and complaints of disabling pain is due to psychopathology which had been caused by the industrial injury. He noted that, although there was a certain conscious element in claimant's behavior, it did not account for all of claimant's complaints. The Referee concluded that claimant had established his injury as a material contributing cause of his psychopathology. We disagree.

In order to establish the compensability of his psychological condition, claimant must establish that his industrial injury was a material contributing cause of that condition or the worsening thereof. Patitucci v. Boise Cascade Corp., 8 Or App 503 (1972). The difficulty with this case is determining whether or not claimant has established the injury to be a material factor. Substantial amounts of medical evidence with regard to claimant's psychological difficulties have been produced. There is little outright conflict in the evidence, but considerable differences in medical nuance and emphasis. Despite the difficulty in evaluating this evidence, based on our understanding of the term "material cause," we conclude that the gist of all the evidence indicates that, although there is some causal link between claimant's industrial injury and some portion of his psychological condition, that causal link is something less than a material one.

There does seem to be a general consensus among the psychological and psychiatric experts that claimant's industrial injury was a psychological stressor and had some effect on claimant's psychological condition. How much of an effect is not entirely clear because other things, such as the death of claimant's father, are also noted by the examiners to be contributing factors. Virtually every physician who has examined claimant has opined that there is an element of conscious and deliberate manipulation on the part of claimant to enhance his appearance of disability and present himself in a light that would be most conducive to obtaining the largest amount of compensation possible. For example, Dr. Carter stated in his June 28, 1982 report that only claimant's "Axis 1" diagnosis (psychogenic pain disorder) could be said to be related to his injury. Having so stated, however, Dr. Carter proceeded to caution that there was a "good deal" of conscious elaboration on claimant's part which Dr. Carter described as "manipulative" and "self-serving" in nature.

Drs. Holland and Henderson reached the same conclusion. Dr. Holland concluded in his report of September 18, 1981 that he could not view claimant as being an "entirely credible" individual. He found that claimant was not motivated to return to work and he was "comfortable" in his disability role. As noted above, Dr. Henderson was of the opinion that claimant was, to a certain extent, consciously and voluntarily prolonging and emphasizing the intensity of his pain with the apparent goal of achieving a "settlement from SAIF," and that continued disability behavior enabled him to continue to also receive social security benefits and private disability payments. Dr. Henderson did find that a certain portion of claimant's behavior was unconscious.

We are thus left with an individual with a psychological condition which is composed of: (1) Conscious, deliberate and not compensable behavior designed to enhance his appearance of disability; and (2) some unconscious behavior of the same type which is inseparable from claimant's conscious behavior and which is referred to as a psychogenic pain disorder. With regard to causation, we are left with a situation where that inseparable portion of claimant's behavior which is unconscious was caused in part by: (1) Claimant's 1976 industrial injury; (2) the death of his father in 1977; (3) his overuse of medication (which has not been directly connected to the industrial injury); and (4) claimant's underlying personality structure. With all of those factors to consider, and with virtually no medical agreement on the relative causal force of any of these factors, we are not satisfied on this record that claimant has established his industrial injury to be a material contributing or aggravating factor in relation to his psychological difficulties.

Having concluded that SAIF's partial denial should be affirmed, we address next the question of penalties and attorney fees. Claimant contends that we should assess penalties and attorney fees against SAIF for its alleged failure to pay "interim compensation" between the date of its receipt of "any of the reports from Drs. Henderson, Holland or Carter" and its partial denial of March 16, 1982.

Liability for interim compensation on an original claim attaches on the fourteenth day after notice or knowledge of the claim. ORS 656.262(4). Liability for interim compensation on an aggravation claim attaches on the fourteenth day after notice or knowledge of medically verified inability to work. ORS 656.273(6). We do not understand why claimant believes that interim compensation is due in the current situation because this clearly is not an original claim and is at most a doubtful aggravation claim.

Claimant's original 1976 back injury claim was last closed by Determination Order dated July 31, 1979 before there was any clear issue about a psychological component to that claim. Claimant thereafter began receiving psychiatric and psychological evaluation (as opposed to treatment) from various physicians. The only possible basis for an argument that the results of these evaluations should be viewed as an aggravation claim would rest on the 827 form signed by Dr. Carter on October 28, 1981; even in that report, however, Dr. Carter indicates uncertainty as to whether claimant's condition was work related. Assuming this report or any other reports from Drs. Holland, Henderson or Carter could trigger a duty to pay interim compensation on an aggravation claim, claimant failed to prove when SAIF received any notice or knowledge of such a claim. We thus find no basis for assessment of penalties or attorney fees.

ORDER

The Referee's order dated December 10, 1982 is affirmed in part and reversed in part. Those portions of the Referee's order which set aside SAIF's partial denial of March 16, 1982 and awarded claimant's attorney a fee of $1,500 are reversed and SAIF's denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

DAVID A. SACKETT, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07347
October 21, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Quillinan's orders which found that claimant's condition worsened after the last arrangement of compensation and thus ordered claim reopening.

Claimant's present physical problems resulting from his June 1981 industrial injury primarily involve his low back and left knee. The last arrangement of compensation for these problems is a June 1982 stipulation. The simple question is whether claimant established a worsened condition after that date. The Referee's complex analysis seems to blend that question and the distinct question of whether claimant was medically stationary at the time the April 21, 1982 Determination Order was issued -- an issue that we do not think was ever raised or could be raised after the June 1982 stipulation resolved claimant's request for hearing on the April 1982 Determination Order. More specifically, the Referee concluded: "[B]etween April 1982 and August 1982, claimant's back and knee conditions worsened." (Emphasis added.)

SAIF's argument on review seems to focus primarily on the finding that claimant's back condition worsened. We agree with SAIF that there is absolutely no medical evidence that claimant's back condition worsened after the June 1982 stipulation; indeed, the post-June medical reports and chart notes are replete with references to claimant's back being "improved," "doing better," etc.

On the other hand, we are persuaded that claimant's left knee condition did worsen after June 1982. The exact nature of that knee condition is not clear. Claimant did sustain some trauma to his knee at the time of the 1981 industrial injury; but the most recent and most comprehensive analysis of claimant's knee condition in Dr. Wichser's December 15, 1982 report concludes that claimant's knee pain is "a referred pain syndrome" due to or "associated with muscle spasm in his low back." Whatever the nature of claimant's knee condition, the post-June medical reports and chart notes are unanimous in recording a deterioration in that condition in the form of a significant increase in knee pain.

In summary, although we disagree with parts of the Referee's analysis, we agree with the Referee's ultimate conclusion that claimant has proven an aggravation and is entitled to claim reopening.

ORDER

The Referee's orders dated January 24, 1983 and February 14, 1983 are affirmed. Claimant's attorney is awarded a fee of $350 for services rendered on Board review, to be paid by the SAIF Corporation.

MARK A. DOWNEY, Claimant
Thomas O. Carter, Claimant's Attorney
Moscato & Meyers, Defense Attorneys

WCB 83-01002
October 24, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer requests review of Referee Gemmell's order which set aside the January 21, 1983 denial of compensability of claimant's hernia condition. The employer contends that Exhibits 1, 2 and 3 should not have been admitted because they were not offered by claimant until the day of hearing which is in violation of OAR 436-83-400 and Donald J. Young, 35 Van Natta 143 (1983). Further, the employer contends the Referee erred in finding the claim compensable because claimant is not credible in his story as to the onset of his hernia, nor is the medical evidence adequate to prove medical causation.

First, we find that the Referee properly admitted Exhibits 1, 2 and 3. We have clarified our opinion in Donald J. Young, supra, by our later opinion in Walter L. Hoskins, 35 Van Natta 885 (1983). In Young, we stated that OAR 436-83-400(3), commonly referred to as the "ten day rule" should be applied by Referees with exceptions made for those cases in which it is shown that, in the exercise of due diligence, the documents could not reasonably have been made available at an earlier date due to forces beyond the control of the party offering the late documents. In Hoskins, we held that it is implicit in the Young interpretation of the Ten Day Rule that there be some underlying actual or potential prejudice to the adverse party or to the forum before the rule must be applied.

In this case, the employer conceded at hearing that he had the documents in his possession before the hearing and he claimed no surprise to the documents being introduced at that time. It was the employer who provided the documents to claimant in the first place. The employer specifically declined the Referee's offer to postpone the hearing and elected to proceed with the hearing at that time. Under these circumstances, we find the Referee did not abuse her discretion in admitting Exhibits 1, 2 and 3 as their admission did not actually or potentially prejudice the employer or the forum. Further, claimant had good cause for the late admission due to the fact that the expedited hearing was held less than ten days from the date the notice of hearing was sent out, which was only seventeen days from the date the hearing was requested, leaving little time for claimant to obtain the documents and mail them ten days prior to the hearing. See also Thomas B. Ward, WCB Case No. 80-10573, 35 Van Natta 1552 (October 6, 1983).

Regarding the remaining issue concerning the compensability of the claim, we defer to the Referee's findings of credibility of the witnesses, including claimant, and affirm the order on that issue as well.

ORDER

The Referee's order dated February 24, 1983 is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee on Board review, to be paid by the insurer.

NED HOLT, Claimant
Charles A. Thompson, Assistant A.G.

WCB CV 83001
October 24, 1983
Crime Victim Order

Reviewed by Board Members Ferris and Lewis.

A hearing was held in Medford, Oregon before Referee Mongrain pursuant to ORS 147.155 to determine whether the applicant should be entitled to relief through the Compensation of Crime Victims Act (ORS Chapter 147). After the hearing, upon consideration of all the evidence, Referee Mongrain recommended to the Board that the decision by the Department of Justice to deny relief to the applicant be affirmed. We adopt the following findings and opinion of the Referee and, thereupon, affirm the Department of Justice's May 20, 1982 Findings of Fact, Conclusions and Order and the July 6, 1982 Findings of Fact, Conclusions and Order on Reconsideration denying the claim of the applicant:

> "FINDINGS
>
> On January 11, 1982 Ned Holt (the applicant) was attempting to see under the curtained front door window of a house for the purpose of contacting and communicating with Marcia Benedict, a woman with whom he had had an emotional and stormy relationship. Ms. Benedict apparently did not realize the person outside the door was Mr. Holt and believed that she and her children were in danger. The applicant failed to respond verbally to the woman's demand to leave and continued to attempt to peer under the window, at which point Ms. Benedict fired two shots through the door from a pistol, one of which struck the applicant in the forehead. As a result of the wound Mr. Holt incurred medical bills and lost time from work, and according to his testimony his life was in general seriously disrupted.
>
> "Mr. Holt's assailant was charged with and eventually indicted for assault, which the claimant initially felt was too minor a charge. However, a few weeks before trial the applicant signed a statement indicating that he believed his 'peculiar behavior' had caused the shooting and Ms. Benedict had probably been trying to protect herself and her children. The applicant also indicated in the statement that he did not wish to pursue the matter, and the investigator who obtained the statement was of the belief that the claimant represented he would not appear at any trial. Mr. Holt testified that he signed the statement because it was his first impression the District Attorney's office was not interested in prosecuting the matter and wanted a statement of that kind.

"Upon being made aware of the above declarations allegedly made by the applicant, the Deputy District Attorney in charge of the case, Lew Dahlin, called the applicant to his office by a ruse and served him with a subpoena. At that point Mr. Holt made a number of assertions that Mr. Dahlin felt basically confirmed the statements previously attributed to Mr. Holt. Mr. Holt admitted in his testimony at the hearing that he said some things in anger to Mr. Dahlin that supported these statements. On the basis of this information, Mr. Dahlin concluded that it would be inappropriate to proceed with prosecution of Ms. Benedict and the charges were dismissed. Mr. Holt's claim against the Crime Victim's Fund was thereafter denied on the basis of a lack of cooperation in prosecution and also substantial provocation of the assailant.

"OPINION

"I am persuaded that the applicant made statements reflecting his belief that his own conduct contributed to his injury, and also that it was his desire his assailant not be prosecuted, even if that required he make himself unavailable for the trial. A possible motive for such statements can be found in Mr. Holt's intense emotional involvement with Ms. Benedict. I think that it is probable that even after the shooting Mr. Holt harbored hopes of a reconciliation, and concluded that the best way to further that goal would be to decline to press Ms. Benedict's prosecution. In any event, his clear reluctance resulted in dismissal of the charges, which in my opinion represented a failure to cooperate in prosecution sufficient to make the applicant ineligible for relief from the Crime Victims' Fund. ORS 147.015(3). On the basis of the available information I would also conclude that the applicant's injury was due to his substantial provocation of Ms. Benedict, in that Ms. Benedict had a reasonable basis for concluding that she and her children were in danger from some unknown person. Therefore, the applicant would also be ineligible for relief on this basis. ORS 147.015(5)."

ORDER

The Department of Justice's May 20, 1982 Findings of Fact, Conclusions and Order and the July 6, 1982 Findings of Fact, Conclusions and Order on Reconsideration are affirmed.

ROXANNE JONES, Claimant
Jeff Gerner, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Mitchell, et al., Defense Attorneys

WCB 82-07559 & 82-07560
October 24, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Thye's order which found it responsible for claimant's mental disorder as the insurer for Salem Area Mass Transit District. At hearing there was an issue concerning the compensability of claimant's condition; however, the only issue on review is employer/insurer responsibility. SAIF contends that claimant's preceding employment with the City of Salem, a self-insured employer, is responsible for claimant's condition.

We adopt the Referee's findings of fact and affirm his conclusion with the following additional comments. Claimant's condition is compensable as an occupational disease. ORS 656.802(1)(a). Gygi v. SAIF, 55 Or App 570 (1982), James v. SAIF, 290 Or 343 (1981). The proper rule of law for determining employer/insurer responsibility, therefore, is the last injurious exposure rule applicable to occupational disease claims, the rule of Inkley v. Forest Fiber Products Company, 288 Or 337 (1980), and Bracke v. Baza'r, 293 Or 239 (1982).

> "Two conditions must be met for the assignment of responsibility to a carrier under the 'last injurious exposure' rule. 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." United Pacific Ins. v. Harris, 63 Or App 256, 259-260 (1983). (Emphasis in original, citation omitted.)

The court found in Harris that claimant's condition was stabilized from the date that she originally sought medical treatment until the time that she left work because of the failure of her condition to improve. Therefore, it was determined that claimant's disability commenced at the time she originally sought medical treatment. See also SAIF v. Gupton, 63 Or App 270 (1983).

If a claim is one for medical services only, the date that medical services are first sought may be considered the date of onset of disability. See, e.g., SAIF v. Carey, 63 Or App 68 (1983). In this case, however, claimant first sought medical treatment for stress symptoms while employed by the City of Salem, and her mental disorder required that she stop working during her employment with Salem Area Mass Transit District. This compensable claim, therefore, is not one for medical services only, and does include a claim for disability benefits.

If the evidence indicated that there was no independent contribution to claimant's mental disorder from any work exposure during her more recent employment with the Transit District, it would be appropriate to find the earlier employment at the City of

Salem responsible for her condition. Bracke v. Baza'r, Inc., supra; United Pacific Insurance v. Harris, supra, SAIF v. Gupton, supra. The evidence in this case, however, indicates that, during the two and a half days that claimant worked under the auspices of the Transit District, not only were the conditions of employment such that they could have contributed to her mental disorder, but the incidents which occurred during that period actually did contribute to a worsening of claimant's mental disorder, resulting in claimant's disability. Accordingly, we affirm the Referee's order finding the SAIF Corporation, as the insurer for Salem Area Mass Transit District, responsible for claimant's condition.

ORDER

The Referee's order dated March 18, 1983 is affirmed.

JACK D. PATZKE, Claimant
Lyle Velure, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-01161
October 24, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of those portions of Referee Mongrain's order which affirmed the January 22, 1982 Determination Order, which had awarded claimant benefits for temporary disability from October 19, 1981 through January 4, 1982. Claimant contends that he is entitled to benefits for temporary total disability until July 7, 1982. Claimant also contends that he is entitled to an award for permanent partial disability.

At the time of the hearing claimant had been employed as a timber faller for approximately ten years. Over a period of time claimant gradually developed bilateral intermittent aching, numbness and weakness in his arms and hands. On November 17, 1981 Dr. Hartmann reported that claimant was suffering from bilateral thoracic outlet syndrome which was related to his employment as a timber faller. Dr. Hartmann indicated that he was instituting a non-surgical treatment regimen in the hopes that he could resolve claimant's symptoms sufficiently to allow him to return to work in his previous capacity. The claim was accepted by the employer.

On January 4, 1982 Dr. Hartmann reported:

> ". . . since [claimant] has not improved significantly, I imagine he could be considered medically stationary at this point. I still would not recommend that he be returned to his usual job as timber faller . . . "

On January 22, 1982 a Determination Order issued awarding claimant temporary disability benefits from October 19, 1981 through January 4, 1982, with no award for permanent disability.

Claimant continued treating with Dr. Hartmann. In a chart note dated May 3, 1982 Dr. Hartmann stated that claimant was "about the same clinically," and indicated that he still did not feel claimant was able to return to work as a timber faller. On July 7, 1982 Dr. Hartmann reported:

> "[Claimant's] condition has remained medically stationary since January 4, 1982. I am releasing him now to operate a power saw on a trial basis, with the understanding that he bid off on a job not requiring the use of a power saw at the first opportunity."

Claimant thereafter returned to work as a timber faller. On December 23, 1982 Dr. Hartmann reported that claimant was functioning adequately with minimal episodic symptoms. Claimant was still working as a timber faller at the time of the January 1983 hearing.

The Referee concluded that the Determination Order properly terminated claimant's temporary disability benefits as of January 4, 1982 because: "There is no persuasive evidence that the claimant experienced any material improvement in his condition subsequent to January 4, 1982."

We disagree and conclude that claimant was not medically stationary until July 7, 1982. Despite the fact that Dr. Hartmann used the term, "medically stationary," in his report of January 4, 1982, the actual events indicate that claimant was in fact not medically stationary at that time. We think it is clear that, as of January 1982, claimant was not able to return to work as a timber faller. Following continued treatment with Dr. Hartmann claimant was able to and, in fact, did return to work as a timber faller in July 1982. Although it is not clear in the record what the exact medical mechanism of this improvement was, the simple fact that claimant was not able to work as a timber faller in January but, after further treatment, he was able to do so in July, leads us to conclude that a material improvement of some sort had taken place and that Dr. Hartmann's treatment was not merely palliative in nature.

Our conclusion regarding temporary disability requires us to address an additional issue. The Referee found that the employer was entitled to setoff future benefits in an amount equal to its overpayment of temporary disability benefits for the period from January 5, 1982 through January 22, 1982. Since we have found claimant entitled to such benefits until July 7, 1982, it follows that the employer is entitled to no such offset.

With regard to the issue of extent of claimant's disability, we agree with the Referee and affirm and adopt those portions of his order relevant to that issue.

ORDER

The Referee's order dated February 28, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which found that claimant was medically stationary on January 4, 1982 and which allowed the employer a setoff of temporary disability benefits paid claimant from January 5 through January 22, 1982 are reversed. Claimant is entitled to additional temporary total disability benefits from January 5, 1982 through July 7, 1982, less time worked and less any amounts previously

paid. Those portions of the Referee's order finding claimant entitled to no benefits for permanent partial disability are affirmed.

Claimant's attorney is allowed a reasonable attorney's fee in the amount of 25% of the temporary disability benefits made payable by this order, not to exceed $750.

MICHAEL D. COPLEY, Claimant
Zafiratos & Roman, Claimant's Attorneys
Robert Lee Olson, Attorney
Carl Davis, Assistant A.G.

WCB 83-00158
October 25, 1983
Order Denying Request to Dismiss

The Board has received claimant's request to dismiss the appellant's request for Board review on the grounds appellant has not filed an appellant's brief.

There is no requirement in the workers' compensation law or the Board rules 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.

ANNE G. UDALOY, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11218
October 25, 1983
Order Withdrawing Order of Dismissal and Reinstating Review

On October 6, 1983 the Board entered an order dismissing claimant's request for review of the Referee's order dated August 19, 1983 on motion of the SAIF Corporation, after concluding that claimant's request was not timely filed. Claimant has requested reconsideration of that order, pointing out that the thirtieth day of the period for requesting review was Sunday, September 18, 1983 and that Monday, September 19, 1983, therefore, was the last day for timely requesting review. Claimant's request for Board review was mailed September 19, 1983. See OAR 436-83-700(2). Accordingly, claimant's request for review was timely, and it was error for the Board to dismiss her request for review.

ORDER

The Board's October 6, 1983 Order of Dismissal hereby is withdrawn, and this proceeding on review is reinstated. A copy of the transcript of the proceedings before the Referee will be provided to the parties and a briefing schedule established in due course.

ALMA A. BERRY, Claimant
Cash Perrine, Claimant's Attorney
Minturn, et al., Defense Attorneys

WCB 82-09397
October 26, 1983
Order on Reconsideration

Claimant requests reconsideration of our Order on Review dated September 29, 1983. Alternatively, claimant requests that this matter be remanded to the Referee for the taking of further evidence.

Although numerous issues were originally raised in claimant's request for hearing, and although some of the present problems are magnified by having to sort out the issues, the present dispute centers on whether to affirm or reverse the SAIF Corporation's November 5, 1982 denial of aggravation reopening. Claimant was injured in October 1980 and the last award of compensation is a notice of claim closure issued in May 1981. More specifically, the questions are whether (1) claimant's condition worsened after May 1981 (2) due to the October 1980 industrial injury.

First, we conclude that there is no viable reason for remand. Claimant does not identify what additional evidence would or should be developed on remand; nor does claimant explain why the undefined additional evidence could not have been obtained before and offered at the time of the hearing. See Ora M. Conley, 34 Van Natta 1698 (1982), aff'd 65 Or App 232 (1983).

Second, on the merits of the aggravation claim, claimant argues that we have misinterpreted the medical evidence. That may well be, since the medical evidence in this case is sufficiently confusing and conflicting as to be capable of many different interpretations. Certain facts, however, are reasonably clear. Following claimant's October 1980 back injury, she received only chiropractic care. On March 24, 1981 her treating chiropractor reported a "complete resolution of her symptoms" and claimant was able to, and did, return to work the next day. There is no record of further medical care or treatment until claimant was hospitalized in April 1982.

The present dispute seems to come down to whether the circumstances of that hospitalization establish an aggravation claim. On this point, the medical evidence ceases to be reasonably (or at all) clear. The hospital discharge report lists 13 conditions under the heading "final diagnosis," most of which could not possibly be related to claimant's October 1980 industrial injury. Dr. Brenson's July 21, 1982 report states claimant "was admitted to the St. Charles Medical Center by her family physician, Dr. Stuart Garrett, because of other medical problems." In context, we understand "other" to mean nonindustrial.

On the other hand, as pointed out in claimant's motion for reconsideration, Dr. Garrett's May 12, 1982 report states that claimant had "increasing back pain in the 24 hours prior to [hospital] admission," and a subsequent chart note refers to a "follow-up of hospitalization for back pain." On the other hand, increased back pain is not necessarily related to claimant's October 1980 industrial injury because the record contains diagnoses of spondylolisthesis and degenerative arthritis. In addition, claimant has complained of foot pain since her injury, and apparently was complaining of foot pain at about the time of

her hospitalization, but Dr. Altrocchi's June 23, 1982 report suggests that the foot pain is probably peripheral neuropathy related to claimant's diabetes, rather than related to the industrial injury.

We agree with claimant to the extent that a phrase can be picked from one report, a clause from another, etc., and pieced together to establish a compensable aggravation. However, most of these phrases and clauses are from the "history" portions of the medical reports and, as we have often stated, a doctor repeating a claimant's story does not add anything in the sense of being medical verification of that story. Darwin Ting, 35 Van Natta 1173 (1983); Therien M. Thornton, 34 Van Natta 1549 (1982); Jack W. Peterson, 33 Van Natta 469 (1981); Evelyn M. LaBella, 30 Van Natta 738 (1981), aff'd 54 Or App 779 (1981); see also Oakley v. SAIF, 63 Or App 433 (1983). Moreover, and in any event, we adhere to the conclusion stated in our Order on Review in this case -- that the preponderance of the evidence does not establish a worsening of claimant's condition in April 1982 due to the results of the October 1980 injury.

ORDER

Claimant's motion to remand is denied. On reconsideration, the Board adheres to its Order on Review dated September 29, 1983 as supplemented herein and readopts and republishes that order effective this date.

FRED A. CHATFIELD, Claimant
Hansen & Wobbrock, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-03927
October 26, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of that portion of Referee Knapp's order which set aside SAIF's partial denial of claimant's psychological problems as a compensable consequence of the injuries he sustained in an on-the-job truck accident in August 1981. The issue is compensability.

We have considered the analysis of the record and the authorities in the parties' briefs, claimant's brief being in the form of a four-sentence letter. We essentially agree with and basically adopt the analysis in SAIF's brief.

We highlight two considerations which we find particularly relevant. First, claimant had significant psychological disability before his August 1981 truck accident, and we find no persuasive basis for concluding that accident worsened claimant's psychological condition within the meaning of Partridge v. SAIF, 57 Or App 163 (1982).

Second, after the truck accident and about the time of the onset of claimant's psychological symptoms here in issue, claimant's girlfriend terminated their relationship by leaving and taking their daughter which led to both a restraining order against claimant and a criminal charge that he had sexually abused his daughter. All doctors involved who were aware of these events opine that they were significant sources of stress in claimant's

life, which is such a self-evident proposition that we could probably so conclude even in the absence of expert opinion. Against this background, we are not persuaded that the contribution, if any, from the compensable truck accident to claimant's psychological symptoms rises to the level of material causation.

ORDER

The Referee's order dated October 11, 1982 is affirmed in part and reversed in part. Those portions that set aside the SAIF Corporation's partial denial and awarded an attorney fee for prevailing on a denied claim are reversed. SAIF's partial denial dated March 31, 1982 is reinstated and affirmed. The remainder of the Referee's order is affirmed.

WAYNE A. DETTWYLER, Claimant
Parks, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-10992 & 81-10482
October 26, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

EBI Companies requests review, and the SAIF Corporation cross-requests review, of Referee Braverman's order which set aside EBI's denial of claimant's aggravation claim and upheld SAIF's denial of a new injury claim. EBI contends that claimant's condition in October 1981 and thereafter represents a new injury, which is the responsibility of SAIF, and that the Referee erroneously found that claimant's condition represented an aggravation of his June 16, 1979 injury claim. SAIF contends that the Referee committed error by ordering it to pay claimant interim compensation for a period during October and November 1981 because this provision of the Referee's order results in a double payment of compensation to claimant: One payment from SAIF and another payment from EBI, for the same period of time.

The Referee found that SAIF failed to issue a timely denial of claimant's new injury claim and failed to properly commence payment of interim compensation benefits. He ordered SAIF to pay interim compensation for the period October 19, 1981 through and including November 20, 1981, imposing a penalty of 15% of that amount of compensation for SAIF's failure to timely accept or deny the claim and to pay interim compensation, as well as a $50 attorney's fee pursuant to ORS 656.382(1). The Referee also ordered payment of temporary disability compensation by EBI for the period in October and November of 1981 during which claimant was disabled. Payment of temporary disability by EBI in conjunction with the aggravation claim for which the Referee found EBI responsible, and payment of interim compensation for the same period by SAIF, result in claimant's immediate receipt of double compensation. SAIF claims that this double payment unjustly enriches claimant and is contrary to the policy of ORS 656.307 and the general compensation scheme of the Workers' Compensation Act.

In Darrell Messinger, 35 Van Natta 161 (1983), we held that where a claimant files simultaneous multiple claims against multiple employers, each of the employers' insurers must provide the claimant with interim compensation. We reached this conclusion after considering the possible alternative result of a claimant receiving no interim compensation benefits from any employer under

these circumstances; and after considering the purposes of interim compensation, we concluded that the possible result of a claimant receiving double compensation was preferable to the possible result of a claimant receiving no interim compensation from any source. The Court of Appeals appears to agree. Petshow v. Ptld. Bottling Co., 62 Or App 614, 618-619 (1983).

The issue in this case is not exactly the same as the issue in Messinger, which involved claimant's receipt of interim compensation from multiple sources. In this case the issue is SAIF's obligation to pay interim compensation for the same period that EBI was ordered to pay temporary total disability in connection with the aggravation claim, which now is in accepted status pursuant to the Referee's order. At first blush it appears as though the court's decision in Petshow, supra, is dispositive. The court stated that each insurer has the statutory obligation to pay "time loss," i.e., interim compensation, when a claim is filed against each and neither has denied compensation; however, the court went on to hold that a claimant is not entitled to recover more than the fixed percentage of lost wages provided by ORS 656.210(1), simply because an issue is present concerning which insurer is responsible for payment of claimant's compensation. The court rejected the possible distinction between temporary disability payments made in connection with an accepted claim, and interim compensation payments made prior to acceptance or denial, that was urged by claimant in support of his contention that he was entitled to retain the interim compensation payments made by one insurer in addition to temporary disability benefits paid by another insurer ultimately found responsible for processing the claim. The Referee and the Board in Petshow had ordered that the "non-responsible" insurer was required to pay interim compensation for the same period that the responsible insurer was required to pay temporary total disability; and the responsible insurer was allowed an offset against any eventual award of permanent partial disability in order to prevent a "double recovery" by claimant.

The issue decided by the court in Petshow is essentially the same issue that is raised by SAIF's cross-request for review. That is, the payment of temporary disability benefits by EBI in processing the accepted aggravation claim does not relieve SAIF of the obligation to pay claimant interim compensation for an overlapping period during which SAIF was undecided whether to accept or deny the claim filed with it. Claimant, however, would not be entitled to retain "double time loss payments," and, therefore, the responsible insurer is entitled to an offset against future compensation payments to which claimant becomes entitled. See OAR 436-54-320.

There is a significant factual difference in this case, however. In Petshow and Messinger claims were filed with multiple employers. The discussion in both cases, therefore, and their respective holdings, may not be applicable to this case, which involves only a single employer which has changed insurers. For the following reasons, however, we believe that our holding in Messinger, as well as the court's holding in Petshow, require the conclusion that interim compensation is due from multiple insurers providing coverage for a single employer, and that SAIF, therefore, is obligated to pay interim compensation as ordered by the Referee.

ORS 656.265 anticipates that notice of an accident shall be given to the injured worker's employer. The employer is required to promptly notify its insurer of a claim for injury. ORS 656.262(3). The primary responsibility for processing claims and providing compensation rests with the insurer, even to the extent that the insurer may be liable for payment of a penalty imposed as a result of the employers failure to comply with obligations under the law. ORS 656.262(1), (2) and (3). See Roscoe Howard, 35 Van Natta 329 (1983). The aggravation statute provides that in order to obtain additional benefits for a worsened condition, "the injured worker must file a claim for aggravation with the insurer or self-insured employer." ORS 656.273(2).

The precedent upon which we relied in deciding Darrel Messinger, supra, Kenneth Taylor, 23 Van Natta 479 (1978), involved a factual setting identical to that which is presently before us; i.e., a single insurer whose workers' compensation coverage at different times was provided by different insurers. In Taylor we stated:

> "The Board finds that although the Fund is liable for claimant's present condition, nevertheless the decision of the Oregon Supreme Court in Jones v. Emanuel Hospital, 280 Or 147, requires that both carriers pay claimant 'interim compensation' and both carriers are subject to the assessment of penalties and award of payment of an attorney's fee." 23 Van Natta at 482.

In Messinger we stated our agreement with the conclusion reached in Taylor and reaffirmed its "continuing vitality." 35 Van Natta at 165.

Historically the determination of employer/insurer responsibility has been evaluated the same whether the question of responsibility for payment of compensation involves a dispute between different employers or different insurers providing coverage for the same employer. Considering the nature of the statutory and regulatory provisions governing the processing of claims in general and, in particular, the processing of claims where an issue regarding employer/insurer responsibility exists, we can find no logical basis for differentiating between the multiple employer and single employer-multiple insurer situations vis-a-vis the obligation to pay interim compensation in accordance with our decisions in Messinger and Taylor. See ORS 656.307(1), OAR 436-54-332. Cf SAIF v. Moyer, 63 Or App 498 (1983) (single employer, multiple insurers); Elliott v. Loveness Lbr. Co., 61 Or App 269 (1983) (single employer, multiple insurers). See also Patrick Elliott, 32 Van Natta 155, 32 Van Natta 295 (1982).

Accordingly, we affirm those portions of the Referee's order requiring SAIF to pay interim compensation for the period October 19 through November 20, 1981. We also affirm the Referee's imposition of a penalty and associated attorney's fee. We note that SAIF's denial was issued in a timely manner under ORS 656.262(6); however, SAIF failed to initiate interim compensation payments within 14 days as required by ORS 656.262(4). It is on this basis that we affirm the Referee's imposition of a penalty and attorney's fee.

On the issue of EBI's responsibility for claimant's condition as an aggravation of claimant's June 16, 1979 injury, we affirm and adopt the Referee's order.

Claimant's attorney on Board review has successfully defended that portion of the Referee's order finding that claimant sustained an aggravation rather than a new injury, and we, therefore, award a reasonable attorney's fee on Board review to be paid by EBI. Robert Heilman, 34 Van Natta 1487 (1982). In addition, claimant's attorney has successfully defended that portion of the Referee's order directing SAIF to pay interim compensation; however, we have determined that EBI is entitled to an offset against claimant's future benefits, the effect of which may be to "disallow or reduce" the compensation ordered by the Referee. See ORS 656.382(2). This recovery by EBI is contingent, and claimant presently retains all compensation payable under the terms of the Referee's order. Accordingly, we deem it appropriate to award claimant's attorney a fee for prevailing on the issue raised by SAIF's cross-request for review. The Board requested supplemental briefs addressing this issue in light of the factual differences between this case, Darrell Messinger, supra, and Petshow v. Ptld. Bottling Co., supra. We have taken claimant's supplemental brief, and the efforts expended thereon, into consideration solely with regard to the attorney's fee to be paid by the SAIF Corporation.

ORDER

The Referee's order dated September 9, 1982 is modified to provide that EBI is entitled to an offset against future compensation payments to which claimant becomes entitled, in an amount equal to the interim compensation SAIF is required to pay for the period October 19 through November 20, 1981. Except as so modified, the Referee's order is affirmed. Claimant's attorney is awarded $600 to be paid by EBI, and $400 to be paid by the SAIF Corporation, as a reasonable attorney's fee on Board review.

LEROY HIGHSMITH, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-11268
October 26, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of those portions of Referee Howell's order which set aside its partial denial of claimant's bilateral shoulder condition. SAIF argues that claimant did not establish that his shoulder condition is a compensable consequence of his January 1979 industrial back injury. Claimant cross-requests review of those portions of the Referee's order which upheld SAIF's denial of claimant's aggravation claim for worsening of his compensable back condition. Claimant argues that the evidence establishes that his worsened back condition is related to the 1979 injury.

We first consider the question of the aggravation of claimant's back condition. Claimant's compensable January 1979 back

injury appears to have been primarily a sprain/strain type of injury. Before the 1979 injury, claimant had back surgery in 1966 and also had one or more degenerative spinal conditions that developed as a result of the 1966 surgery or independently thereof. The last award or arrangement of compensation for that injury was by a Referee's order in September 1980. There is little question that claimant's back condition has worsened since that last award. The disputed question is whether that worsening is due to the 1979 compensable injury or, instead, due to the natural progression of claimant's degenerative disease(s), the course of which was not altered by the 1979 sprain/strain injury.

Drs. Anderson and Coletti opine that claimant's worsened back condition is due to the progression of his degenerative disease and is unrelated to his 1979 injury. Dr. Semon basically takes the opposite position. Dr. Steele is basically noncommittal, as we read his report.

We find that we are unable to improve on the Referee's analysis of this record:

> "Dr. Anderson . . . is in, by far, the best position to evaluate the cause of claimant's worsening since 1980. He examined and treated claimant both before and after the 1966 surgery, before and after the 1979 industrial injury and before and after the last award of compensation. None of the other physicians examined claimant before 1980."

We thus agree with the Referee that claimant has not established a worsening of his back condition due to his 1979 industrial injury.

We turn next to the question of the compensability of claimant's shoulder condition. We understand claimant's position on this issue to be that the pain resulting from his 1979 back injury made it impossible for him to turn over in bed at night without using his arms and that this arm use (and his use of a cane for a short period of time) caused his shoulder condition that has been diagnosed as bilateral rotator cuff tears with adhesive capsulitis.

The first indication that claimant was suffering from shoulder difficulties is contained in Dr. Steele's report of October 29, 1981:

> "This 58-year-old man comes in complaining of bilateral shoulder pain which he relates to his chronic back problem that occurred in 1979. * * * The patient states that . . . he was just beginning to get some ache in his shoulders since he was having difficulty rolling over in bed at night and had to do all of the turning with his shoulders. * * * [H]is back has progressively been hurting him more and he has had to rely entirely upon his arms in rolling and turning in bed."

With regard to the relationship between the shoulder condition and the 1979 back injury, Dr. Steele related:

> "Rotator cuff tears in older people are related to many years of use or wear and then usually brought on by specific use or injury. The history given to me by the patient indicated that he has not been doing any activity at home and that the injury occurred while he was rolling over in bed and that this was necessitated because of his back pain. With no other history or injury I feel it is reasonable to conclude he could injure his shoulders rolling over in bed."

On November 2, 1981 Dr. Anderson reported that:

> "The complaints referrable to the shoulders would seem to be quite logically related to the increased strain upon his arms and shoulders as a result of having to do much lifting and manipulating of the rest of his body because of his low back disturbance."

On November 16, 1981 Dr. Anderson further reported:

> "The increased [back] problem is throwing additional strain upon his shoulders, which has caused the shoulders to become symptomatic and will require treatment which is being instituted currently by Dr. Steele."

The above quotations consitute virtually all of Dr. Anderson's comments on claimant's shoulder condition.

On March 22, 1982 Dr. Coletti, an orthopedic surgeon, reported that he had reviewed claimant's medical records, and opined:

> "Certainly degenerative disease in the rotator cuff is common in [claimant's] age group and is often unrelated to any form of injury. It is rather likely that these diagnoses are correct, but it is mere speculation to suggest that there is a relationship between [claimant's] low back condition and his shoulders. * * * The bulk of individuals who present with degenerative problems in their shoulder certainly do not have a medical corollary of limited spine motion or spine pain. The bulk of patients present with lumbo-sacral disc disease of an advanced nature who have severe spine pain and limitation of motion do not present with shoulder complaints. There appears to be an implied relationship then that this man's back pain has occasioned him to use his shoulders more. The use of the shoulder basically is related primarily to the degree

> of positioning of the hand that one does as a consequence of activities of daily lifting and not particularly related to the back. The shoulder function in turning from side to side in bed is in no way heightened by the patient's back condition; as has been suggested and as a matter of fact even those individuals with severe paraplegia and no motion below the level of the upper chest do not have heightened exposure to this type of problem. I believe that the relationship implied between the shoulder and the back problem is nowhere within the province of medical probability and is difficult to construe on even a remote basis as a medical possibility."

Unlike the Referee, we find Dr. Coletti's analysis and conclusion convincing. Dr. Coletti is the only physician who attempts to give a reasoned medical analysis of the relationship or nonrelationship between claimant's back injury and his shoulder condition. The other physicians appear to merely repeat claimant's opinion of cause and effect, with little or no additional analysis of their own. We find Dr. Coletti's reasoned opinion that any relationship between claimant's shoulder difficulties and his back injury is "nowhere within the province of medical probability," to be persuasive.

Even assuming that claimant's shoulder difficulties were caused by using his arms to turn over in bed, we would nevertheless affirm SAIF's denial. Since the evidence indicates that claimant's current back pain is the result of noncompensable preexisting and degenerative conditions, and since claimant is contending that his back pain necessitated such use of his arms, it would be inconsistent to find the shoulder condition compensable after finding the back condition not compensable.

ORDER

The Referee's order dated December 1, 1982 is affirmed in part and reversed in part. Those portions of the Referee's order which set aside those portions of the December 8, 1981 denial regarding the compensability of claimant's bilateral shoulder condition are reversed. The remainder of the Referee's order is affirmed.

ISSA KARAM, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 81-06048
October 26, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee McCullough's order which 1) refused to award a penalty for unreasonable denial; 2) refused to increase claimant's award for unscheduled disability beyond the 10% previously awarded; and 3) allowed the insurer to take a 25% offset against claimant's past due temporary total disability benefits which the insurer was

required to pay by the Referee's order. The insurer cross-requests review on the offset issue, arguing that it should not have been limited to 25% of the past due benefits.

The Board affirms and adopts those portions of the Referee's order concerning a penalty and extent of disability. We find, however, that the Referee erred in limiting the amount of offset to 25% of the past due benefits.

In his order, the Referee overturned a denial of an aggravation claim. The effect of that ruling was to require the insurer to pay temporary total disability benefits for the period following the denial while claimant was off work. This amounts to three days of temporary total disability. The insurer requested that it be allowed to offset an overpayment against this award. The Referee noted that claimant did not contest the amount of overpayment. Claimant merely argued that overpayments prior to a Determination Order could only be recouped against benefits payable in connection with that Determination Order. The Referee dismissed that argument, noting that OAR 436-54-320 provides the mechanism for recovering overpayments. It does not limit recovery of overpayments to awards pursuant to the same Determination Order. Rather, overpayments are generally recoverable from benefits due on the same claim. The Referee allowed the insurer to recoup its overpayment. The Referee concluded, however, that OAR 436-54-320(1)(a) limits the amount recouped from the past due temporary total disability benefits to 25%.

Claimant argues that he is not liable for any overpayment because he was never informed when he became medically stationary until a Determination Order issued some four months after he was declared medically stationary. He argues that it is unfair to now charge him for an overpayment during the period between when he became medically stationary and the Determination Order issued. Claimant did not challenge the Determination Order in question. He may not now raise what is in effect a challenge to that Determination Order.

The insurer argues that the offset for the overpayment should not be limited to 25%. We agree. OAR 436-54-320 provides generally that insurers may recover overpayments. The regulation describes permissible methods for recovering overpayments in various situations. We do not believe that the regulation is intended to describe all situations in which an overpayment may be recovered. It does not deal with the situation here in which the insurer seeks to withhold an overpayment from past due temporary total disability benefits. We do not believe the regulation was intended to prevent the insurer from recovering an overpayment from past due temporary total disability benefits.

The Referee applied OAR 436-54-320(1)(a) to this situation even though that regulation deals with continuing temporary total disability benefits. However, as the insurer points out, the rationale behind limiting offsets to 25% of continuing temporary total disability benefits is that a total offset of continuing temporary total disability benefits would substantially impair an injured worker's subsistence during the time he is unable to work. That rationale does not apply to past due temporary total disability benefits. Such benefits are not for continuing maintenance so

claimant is not deprived of subsistence while he is unable to work. We think a better approach is to allow the insurer a dollar for dollar offset as is allowed against permanent partial, permanent total and fatal disability benefits. OAR 436-54-320(1)(c).

ORDER

The Referee's order dated November 22, 1982 is modified in part. That portion of the Referee's order in which he limits the insurer's recoupment of an overpayment to 25% of the past due temporary total disability benefits is modified to allow the insurer to recoup its overpayment from the entire amount of past due temporary total disability benefits. The remainder of the Referee's order is affirmed.

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

WCB 82-10398
October 26, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Baker's order which directed that it pay claimant accrued temporary disability compensation and continue to process this claim in accordance with a prior Referee's order, and imposed a penalty and attorney's fee for unreasonable claims processing. We reverse that portion of the order which imposed a penalty and attorney's fee and modify the remainder of the Referee's order in accordance with a recent Order on Review entered in this claim.

Claimant injured his right arm in January 1979 while working for this employer. His claim was closed with no award for permanent disability, and by a stipulation approved in October of 1980, he was granted an award of 28.8° of scheduled permanent partial disability for 15% loss of the right arm. In April of 1981 claimant began work with another employer under the auspices of the Field Services Division as part of a training and wage subsidy program. In December 1981 claimant returned to his treating chiropractor complaining of pain in his right hand, wrist and shoulder. The chiropractor, Dr. Samuel, referred claimant to Dr. Campagna for a neurosurgical examination. Dr. Campagna concluded that claimant had a right carpal tunnel syndrome, which he related to claimant's 1979 occupation with this employer. Dr. Campagna scheduled claimant for a surgical decompression of the right median nerve. The date of Dr. Campagna's examination was December 17, 1981, and he scheduled surgery for January 14, 1982. Claimant ceased working after Dr. Campagna's examination.

By letter of December 23, 1981, Dr. Campagna advised the employer that he was recommending decompression surgery, requesting the employer's authorization for this surgical procedure. By letter of January 6, 1982, Dr. Samuel corresponded with the insurer, advising that claimant, "should begin authorized time loss 1-4-82 until released following the surgery date projected on 1-15-82." Office records from Dr. Samuel's office indicate that this correspondence issued after Dr. Samuel's examination of claimant on January 4, 1982, at which time claimant was experiencing right

shoulder soreness, neck stiffness and right wrist and hand pain. An office note dated January 8, 1982 indicates that claimant was experiencing some improvement by not using his right arm as much as he had been using it while working.

By denial letter dated January 14, 1982, the insurer denied that claimant's right carpal tunnel syndrome was causally related to his 1979 injury, stating that it was due instead to "other causes and subsequent employment." Upon issuance of this denial, the previously scheduled surgical procedure was cancelled and surgery was not performed.

By an order dated September 21, 1982, a Referee set aside the insurer's denial and ordered: "The claim shall be reopened for the prescribed treatment and time loss, and shall be redetermined under ORS 656.268." As of the date of the hearing before the Referee and the date of the Referee's order, claimant had neither undergone surgery nor returned to gainful employment.

On November 8, 1982, in response to an inquiry from the insurer, Dr. Campagna reported that, had claimant undergone decompression surgery, he would have authorized temporary disability compensation for three weeks. Claimant did not return to see Dr. Campagna, however, until December 2, 1982, at which time Dr. Campagna again diagnosed right carpal tunnel syndrome secondary to claimant's 1979 occupation and recommended a right carpal tunnel release. Surgery was performed on December 10, 1982. Claimant was discharged from the hospital on December 13, 1982. On February 4, 1983, Dr. Campagna reported to counsel for the insurer as follows:

> ". . . it is my considered opinion that [claimant] was employable up to the time that he had his carpal tunnel surgery in December of 1982 and that it would take approximately three weeks after this time before he would be suitable for employment at that time. I have not seen [claimant] since his carpal tunnel surgery and assume that he is doing fine, however, he did have an appointment and failed to keep it. In view of this fact, I would consider his condition stationary and I have no reason to suspect that there would be any permanent impairment of the hand as a result of his carpal tunnel syndrome."

After issuance of the Referee's order on September 21, 1982, setting aside the insurer's denial, the insurer issued claimant a check for two months' time loss, i.e., January 4, 1982 through March 4, 1982, which was received by claimant on or about October 20, 1982. No further temporary disability benefits were received by claimant, and claimant requested a hearing seeking enforcement of the Referee's September 21, 1982 order, contending that the insurer was required to pay temporary disability benefits continuously from January 4, 1982, through the date of surgery in December of 1982, and until the claim was properly closed pursuant to ORS 656.268. The Referee agreed. He found that claimant was unable to perform his regular work activity pending surgery, and that the surgical procedure had not been performed because of the insurer's

denial. He considered Dr. Samuel's report of January 6, 1982, sufficient verification of claimant's inability to work in the absence of surgery, and ordered the insurer to pay claimant all temporary disability benefits accrued and unpaid as of the date of the enforcement hearing and to continue paying periodically until claim closure. He also imposed a penalty equivalent to 25% of the unpaid temporary disability compensation for the period March 4, 1982, through the date of the hearing, February 9, 1983, for the insurer's unreasonable delay in payment of this compensation.

We begin with the observation that the Referee's September 21, 1982 order overturning the insurer's denial is less than a model of clarity. It orders reopening of the claim for prescribed treatment and time loss without specifying a date as of which the claim should be reopened. As might be expected, this ambiguity generated another hearing request. See also, e.g., Albert Nelson, 34 Van Natta 1077 (1982), Kathie L. Cross, 34 Van Natta 1064 (1982), Frank R. Gonzales, 34 Van Natta 551 (1982), Lewis Twist, 34 Van Natta 52, 34 Van Natta 290 (1982). In Frank R. Gonzales, supra, we stated: "Ideally, when setting aside the denial of an aggravation claim . . . a Referee or the Board should specifically state the dates of claimant's entitlement to temporary total disability compensation. Many records, however, simply do not permit such specificity." 34 Van Natta at 552.

We held in Gonzales that after a claim is ordered reopened, the insurer's failure to make reasonable efforts "to determine the claimant's entitlement to temporary total disability or other compensation, which results in delayed payment of compensation, is a form of delay in the payment of compensation. If unexplained or unexcused, i.e., unreasonable, penalties should be assessed." We also stated that although it is primarily the employer/insurer's duty to process the claim and ascertain this information, the claimant, particularly one represented by counsel, bears some responsibility to clearly identify what periods of time loss are claimed. 34 Van Natta at 554.

There really is no issue in this case concerning what period of time temporary disability was claimed. Claimant stopped working after he was examined by Dr. Campagna in December of 1981 and surgery was scheduled for the following month. Claimant did not return to work. Therefore, it is clear that, as of the date of the Referee's September 21, 1982 order, claimant was seeking compensation for temporary disability as of the date he stopped working. There is a substantial issue, however, concerning claimant's entitlement to the temporary disability claimed for this period of time.

As of the date of the initial hearing on the merits of the insurer's denial, August 4, 1982, it would appear from the record presently before us that the only indication of an inability to work due to claimant's allegedly worsened condition was contained in Dr. Samuel's January 6, 1982 letter to the insurer, in which he authorized time loss as of January 4, 1982, and Dr. Samuel's chart note of that date. After issuance of the Referee's order on September 21, 1982, the insurer issued a check for two months of time loss which, as previously stated, was received by claimant in late October of 1982. Immediately after issuing this check to

claimant, inquiry was made of Dr. Campagna concerning claimant's medically verified inability to work, in response to which Dr. Campagna indicated that had claimant undergone decompression surgery, he would have authorized time loss for three weeks. When no further temporary disability benefits were forthcoming, claimant requested a hearing, received on November 15, 1982, alleging the insurer's failure to pay temporary disability benefits within fourteen days of the Referee's September 21, 1982 order. Before this hearing convened on February 9, 1983, counsel for the insurer obtained the above-quoted statement from Dr. Campagna, clearly indicating that in his opinion claimant had been employable up until the time of surgery in September of 1982 and that three weeks was the approximate convalescent period post-surgery.

Dr. Samuel's January 6, 1982 letter authorizing time loss would constitute medical verification of an inability to work, which, for purposes of paying interim compensation, would trigger the duty to pay. ORS 656.273(6). However, a physician's statement which constitutes medical verification of inability to work for purposes of paying interim compensation may not necessarily establish entitlement to temporary total disability benefits when the claim is in accepted status pursuant to a litigation order remanding the claim for acceptance and processing. Dr. Samuel is a chiropractic physician, and he referred claimant to Dr. Campagna for a neurological examination. It was Dr. Campagna, not Dr. Samuel, who had diagnosed claimant's carpal tunnel syndrome, which is a medical condition generally not subject to treatment by a chiropractic physician. It may be questionable, therefore, whether Dr. Samuel's statement, which obviously is premised on the assumption that surgery was to be performed within the following two weeks, can or should be considered sufficient to establish claimant's entitlement to temporary disability benefits.

Dr. Campagna examined claimant once when he initially diagnosed claimant's carpal tunnel syndrome, and a second time in December, after which surgery was performed. Dr. Samuel, on the other hand, had treated claimant for problems associated with his right upper extremity since the time of his original injury in 1979, and the insurer obviously appreciated the significance of his statement in January 1982 authorizing time loss, as is apparent from its payment of temporary disability for two months commencing January 4, 1982. Because there was doubt concerning the import of Dr. Samuel's statement, we believe it would have been most reasonable for the insurer, upon receipt of the Referee's order setting aside its denial, to request clarification from Dr. Samuel in light of the fact that claimant had not submitted to surgery.

Based upon the information that was available to the insurer at the time it was required to process the claim as an accepted claim pursuant to the Referee's September 21, 1982 order, we find that it was required to pay claimant temporary disability benefits as of the date claimant had last worked.

There were alternatives to not paying time loss beyond the two months that were paid, such as requesting reconsideration of the Referee's order in order to ascertain the date that the Referee had intended the insurer to commence payment; or, if the insurer reasonably believed that claimant did not intend to submit to surgery despite the Referee's order, as they apparently did according to

the arguments of counsel for the insurer, a closing report could have been solicited from Dr. Samuel or Dr. Campagna, and assuming claimant's condition was medically stationary, the claim promptly could have been submitted for closure. Alternatively, if the insurer had commenced payment of time loss and then obtained Dr. Campagna's statement that none was due other than for three weeks post-surgery, the insurer could have requested a hearing and requested that it be permitted to terminate the time loss it was required to pay under the terms of the Referee's order. ORS 656.283. Although there were various alternatives that the insurer more reasonably could have and should have pursued, we nevertheless find that its failure to pay the time loss in issue was not unreasonable, in light of the vagueness of the Referee's order, the questionable nature of Dr. Samuel's authorization, and Dr. Campagna's November 8, 1982 statement that time loss would have been authorized for three weeks in the event of surgery.

The time loss payment that was made did not issue in accordance with the administrative rule regulating the employer/insurer's claims processing obligations. An insurer is required to pay temporary disability within fourteen days of a litigation order directing that such payments be made. OAR 436-54-310(3)(e). Although we generally are not tolerant of such delay, under the peculiar facts and circumstances of this case, we find that the insurer's delay was not unreasonable. Based upon what was known to the insurer at the time it received the Referee's order directing payment of reopening "for the prescribed treatment and time loss," it would have been reasonable to assume that the Referee had intended that the claim be reopened as of the date that claimant submitted to surgery, in light of Dr. Samuel's letter which, as already noted, gave the appearance of authorizing time loss based upon the projected surgery date. The manner in which this claim was processed was wrong; however, considering all of the circumstances, we cannot conclude that it was unreasonable.

On April 14, 1983 we reversed the Referee's September 21, 1982 order and reinstated the insurer's denial. David A. Kimberley, 35 Van Natta 532 (1983). This order is not part of the record made before the Referee in this enforcement proceeding, indeed, our order issued almost two months after the Referee's order presently before us; however, we believe that this Order on Review is a proper matter for official notice for the reasons stated in Dennis Fraser, 35 Van Natta 271 (1983). Accordingly, we modify that portion of the Referee's order presently before us which requires that this claim be processed to closure pursuant to ORS 656.268, to require that temporary disability be paid only until the date of the Board's April 14, 1983 Order on Review. Although this results in a reduction in the amount of the temporary disability which the insurer is required to pay, we nevertheless believe that claimant's attorney is entitled to a reasonable attorney's fee for services before the Board in connection with the issue of the insurer's obligation to pay temporary disability pursuant to the Referee's September 21, 1982 order.

ORDER

The Referee's order dated February 24, 1983 is reversed in part and modified in part. That portion of the order which imposes a penalty and attorney's fee for unreasonable claims processing is

reversed. That portion which orders the insurer to pay claimant temporary disability following surgery and until closure pursuant to ORS 656.268, is modified to require the insurer to pay time loss in compliance with the Referee's order but only through and including April 14, 1983. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $450 for services rendered on Board review.

JOHN P. KLEGER, Claimant
Williams, et al., Claimant's Attorneys
Richard C. Pearce, Defense Attorney

WCB 80-10752
October 26, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of those portions of Referee Mulder's order overturning its denial of claimant's aggravation claim. The insurer argues that claimant has failed to prove by a preponderance of the evidence that his current cervical condition is causally related to his compensable injury of November 22, 1978. In addition, the insurer moves for remand to have the Referee consider evidence developed after the hearing in this case.

In November 1978 claimant was compensably injured in an automobile accident. He was diagnosed as having osteoarthritis and a suspected narrowing at C6-7. In June 1979 Dr. Carl Mead performed an anterior fusion and excision at the left C6-7. Dr. Mead's operative reports make no mention of any problems being visible at C5-6. An attending physician states:

> "The anterior bony fusion has been performed at the C6-7 level and the alignment appears to be excellent. The upper cervical area is unremarkable."

In March 1980 Dr. Mead pronounced claimant medically stationary. A Determination Order issued April 1, 1980 awarding claimant 5% unscheduled disability compensation. Claimant was involved in a non-compensable automobile accident in October 1980. Chart notes from a Dr. Schostal who had previously seen claimant for a consultation indicate that claimant was complaining about excruciating neck pain at the emergency room immediately after the non-compensable accident.

In March 1981 claimant's cervical spine was x-rayed. The x-rays revealed that the C6-7 spinal fusion was stable. Some spurring was noted at C5-6 and C4-5. Claimant first began complaining of right arm pain in April 1982. Shortly, thereafter his then treating physician, Dr. Emmons stated:

> "The above patient had his myelogram today and this showed a large defect at C5-6 mostly on the right which corresponds with his symptoms. I think this gentleman is going to have to come to further surgery. I don't see any sign of fusion at C5-6. I think it might be worthwhile to decompress it and fuse it seeing he has had so much problems in the past."

The insurer denied claimant's aggravation claim on May 27, 1982. In June 1982 in response to the insurer's denial, Dr. Emmons forcefully stated that he thought the defect at C5-6 was related to the compensable 1978 incident.

> "The above patient returns today. I have a letter from the Universal Underwriters Insurance Co. from Portland and they have refused his claim for the most radiculous [sic] reason that I have ever seen in my entire experience with dealing with industrial insurers. They states [sic] that his original problem was a disc at C6-7 and that the disc at C5-6 is not related to the industrial accident.
>
> "My contention is that he should have had both discs repaired at the time of his original injury. I seldom if ever do a single disc. It has always been my experience you have to do two and particularly C5-6 C6-7 and that I don't think there is any doubt in my mind that C5-6 is directly related to his industrial injury."

In August 1982 in response to an inquiry from the insurer, Dr. Mead stated:

> "I have reviewed the notes of Dr. Emmons which indicate that a second myelogram has been done, showing a herniated disc at C-5, C-6. I do not know that this necessarily can be related to the industrial injury of 1978; it may very well be related to an injury in 1980. Certainly there was no evidence of it in 1979 at the time of his first myelogram. I would not agree with Dr. Emmons that fusions are usually done at two levels primarily. This is certainly at variance to my experience and certainly there was no indication in 1979 for any surgical intervention at the C-5, C-6 interspace.

At hearing, claimant and his father testified that the non-compensable automobile accident in 1980 was a minor accident. The Referee accepted this characterization, although he stated his finding that "claimant's credibility on several collateral matters was somewhat eroded."

We find that claimant was not credible. His tendency to exaggerate and to fabricate stories is apparent throughout the record. The father's statement that claimant did not complain of increased neck pain following the 1980 incident is contradicted by the emergency room reports and the reports found in Dr. Schostal's notes. Because of the father's bias toward the claimant and the fact that claimant is, himself, not credible, we accept the version found in

the contemporary medical reports. We believe claimant began complaining of much more severe pain following his non-compensable injury of 1980.

The Referee found Dr. Emmons' opinion relating claimant's condition to the compensable incident more persuasive than Dr. Mead's opinion to the contrary. We disagree. Dr. Emmons' opinion is based on an incomplete history. Claimant testified that he had never informed Dr. Emmons of the 1980 accident. Dr. Mead, on the other hand, was aware of the 1980 incident. In addition Dr. Mead was the surgeon who operated on claimant in 1979 and he states categorically that in 1979 there was no indication that claimant needed a fusion at C5-6. This contradicts Dr. Emmons' assertion that claimant obviously needed the C5-6 fusion in 1979. We find Dr. Mead's opinion more persuasive because it is based on a complete history and on personal observation whereas Dr. Emmons' is based on an incomplete history and supposition. Accordingly, we find that claimant has failed to prove by a preponderance of the evidence that his condition at the time of hearing was causally related to his compensable injury.

The insurer's motion to remand is mooted by our determination of the case on the merits. We, therefore, deny the motion to remand.

ORDER

The Referee's order dated Octbober 29, 1982 is reversed. The insurer's denial of May 27, 1982 is reinstated and affirmed.

ELEANOR WHITTLINGER, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07806
October 26, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Seymour's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome.

Claimant contends that her carpal tunnel syndrome was caused or aggravated by her short period of work as a turkey bagger. Claimant worked as a turkey bagger from May 12 to July 1, 1982, working a total of 84 hours between those dates. That job consisted of pushing raw turkeys into plastic bags at the average rate of about four to five turkeys per minute. Claimant testified that, after about a week of this work, she began to experience numbness, tingling, pain and swelling in both hands.

Drs. Ellison and Nathan have expressed opinions on the causal link or lack thereof between claimant's work and carpal tunnel condition. (There are also reports in the record from Dr. Winkler who seems to rely primarily on a diagnosis of tendinitis and arthritis, conditions that we do not understand claimant to now be contending are compensable; we thus find little from Dr. Winkler that contributes to deciding the question of the causation of claimant's carpal tunnel syndrome.)

Dr. Ellison's opinion is expressed in his report dated October 5, 1982:

> "I think [claimant] has bilateral carpal tunnel syndrome. Symptoms are sufficient to justify surgical intervention. Whether or not it is work-related is an administrative matter. I find that Dr. Nathan's reports generally support the concept that carpal tunnel is not an industrial disease. I feel quite strongly that in many cases it is. I do not, however, have any desire to become embroiled in another administrative hassle over [claimant].
>
> "I have suggested in my report that work causation is likely in [claimant]. Of course, I cannot substantiate this beyond my own reasonable experience with the problem."

Dr. Ellison followed this up on November 18, 1982 with the following one-sentence statement: "I think that [claimant's] symptoms, and carpal tunnel syndrome, is directly related to her employment activities."

Dr. Nathan is of the opinion that claimant's carpal tunnel syndrome is not work related. Dr. Nathan wrote a comprehensive report dated August 10, 1982 which includes claimant's statement regarding the onset of her symptoms and a work history, discusses the type of hand and wrist motions required for claimant to perform her job as a turkey bagger and concludes:

> "I believe [claimant] presents with bilateral carpal tunnel disease, which is unrelated to her employment activities. Females in their mid-years may develop carpal tunnel syndrome in both hands whether they are or are not gainfully employed and, further, I find no specific movement pattern in [claimant's] employment which would be considered an aggravating cause for the development of carpal tunnel syndrome symptoms. I believe more probably than not [claimant] would have developed a carpal tunnel syndrome whether she was or was not employed at Oregon Turkey Growers."

Dr. Nathan also visited the worksite to view the work activity of turkey baggers, and relied on those observations in basically reiterating the above opinions in his deposition.

The Referee found that the claim was compensable because, "I am more persuaded by the opinion of Dr. Ellison, than of Dr. Nathan . . ." The Referee gave no specific reason why he found Dr. Ellison's opinion more persuasive. We agree with the Referee to the extent that, in order for claimant to carry her burden of proof, we would have to affirmatively be able to say that Dr. Ellison's opinion is more persuasive. We disagree, however, with the Referee's conclusion that it is.

Our reasons are as follows. First, Dr. Ellison's reports are cryptic and conclusory; they do not contain any detail about claimant's work as a turkey bagger or express any apparent awareness of the brief duration of that work. Second, possibly as a consequence of their cryptic nature, Dr. Ellison's reports do not speak in terms of the major-cause test applicable to occupational disease claims; Dr. Ellison's ultimate opinion that claimant's carpal tunnel syndrome is "directly related" to her employment does not necessarily mean the same thing to us as employment being the major cause of a disease. Third, unlike Dr. Nathan, Dr. Ellison did not visit the worksite and observe the turkey bagging activity. Fourth, as a matter of common sense, it seems unlikely that 84 hours of work over less than two months could cause a condition like carpal tunnel syndrome; we thus think that Dr. Ellison, as the proponent of this proposition, had some obligation to explain his reasoning in reasonable detail -- but has failed to do so.

ORDER

The Referee's order dated April 13, 1983 is reversed. The SAIF Corporation's denial dated August 17, 1982 is reinstated and affirmed.

MARY WINTER, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-04528
October 26, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests and the SAIF Corporation cross-requests review of Referee Menashe's order which awarded her a total of 75% (240°) unscheduled permanent disability, that being an increase of 45% (144°) over previous disability awards, and which assessed a penalty and attorney's fee for nonpayment of a medical bill. Claimant contends she is entitled to a greater award. SAIF argues that no penalty issue was raised before or at hearing as required by Mavis v. SAIF, 45 Or App 1059 (1980), and Richard Pick, 34 Van Natta 957 (1982).

The Board affirms and adopts the order of the Referee with the following additional comment. We find the penalty issue was adequately raised pre-hearing by claimant's attorney's September 10, 1981 letter to the Referee which states: "Claimant hereby amends her request for hearing to include the issue of unreasonable resistance and delay in paying for .245 treatment, namely Dr. C. W. Davis' billings."

ORDER

The Referee's order dated December 13, 1982 is affirmed.

DONNA L. ANDERSON, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-02143
October 27, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Seymour's order which modified the October 28, 1981 Determination Order by increasing the unscheduled permanent partial disability award from 64° for 20% to 96° for 30% due to claimant's low back injury.

In calculating the extent of claimant's disability, the Referee did not include disability due to functional overlay in reliance on the Board's opinion in Phillip J. Barrett, 34 Van Natta 450 (1982). Barrett held, in essence, that the Board would not consider evidence of disability due to functional overlay in the absence of a diagnosis by a psychiatrist or psychologist. Subsequent to the Referee's order, the Board's order in Barrett was reversed by the Oregon Supreme Court in Barrett v. Coast Range Plywood, 294 Or 641 (1983), in which the court held that opinions of non-psychiatrist medical doctors should be taken into account: "Because the diagnosis of functional overlay is within the competency of medical doctors, they may express expert opinions about the disability." 294 Or at 649.

On review, claimant contends that the evidence of disability due to functional overlay should be taken into account because there is evidence in the record by medical doctors that there is a related psychological component to claimant's low back injury. Claimant further contends she is permanently and totally disabled or, in the alternative, she deserves a greater award of permanent partial disability.

With regard to the Barrett issue, we find, as did the Referee, that there is evidence in the reports from medical doctors, who are not psychiatrists or psychologists, that claimant had disability related to functional overlay. On October 18, 1979 Dr. Casey, an orthopedist, reported, ". . . I feel her sensory loss is hysterical in nature." On June 30, 1981, Dr. Seip, an orthopedist, reported:

> "I think Ms. Anderson has suffered a permanent impairment resulting from her injury in that she will never be able to return to physical activity. I would not recommend any further diagnostic or further medical evaluation until psychological testing was obtained. It is my opinion that there is a psychological component to her illness."

On October 5, 1982, Dr. Aslam, an orthopedist, reported:

> "After discussing all the forms of treatment she has undergone and the long length of time that has elapsed since her complaints began, I advised the patient that she probably might get some help by some psychiatric help. I also explained to the

patient that it is not possible for me to remain involved with her problem as I do not have anything to offer her. She probably has reached a stage where any more exercises or any conservative treatment for her lower back pain is not going to be significantly helpful to her. The only hope I see, because of the emotional overlay, which, in my judgment, she has would be for her to seek psychiatric help."

Based on the above evidence and the court's decision in Barrett, we now consider the disability claimant suffers from the related functional overlay. However, even considering claimant's psychological component of her injury, we do not find that claimant is permanently and totally disabled for the reasons stated by the Referee in his order, and we affirm his findings on that issue.

With regards to claimant's permanent partial disability, we find the following. Claimant was 47 years old at the date of hearing which yields a +4 impact factor. She possesses a GED and has taken four secretarial courses. This yields no impact factor. At the time of injury she was working as a waitress. This work experience impact factor is +3. Her work was classified as medium-weight work, and claimant is now limited to lifting not over 10 pounds, which is classified as sedentary work. This yields an adaptability impact factor of +15. The evidence shows she has a psychological component (functional overlay) in the form of anxiety and pain which indicates an inability to adjust to her low back injury. We assign an impact factor of +5. Considering claimant's residual functional capacity for sedentary work, her highest specific vocational preparation value of 3 and an education level equal to a high school education, we find that the labor market impact factor is +15. Due to chronic disabling pain, frequent spasms and left-sided hypoesthesia which sometimes extends to the left leg and around to the chest, we find that the impairment impact factor is +10 based on moderately disabling pain. Combining these factors yields a total of 40% permanent partial disability. In comparing this case to other similar cases and considering claimant's psychological component, we find this award more adequately compensates claimant for her back injury then does that awarded by the Referee.

ORDER

The Referee's order dated January 24, 1983 is modified. Claimant is awarded an additional 32° for 10% unscheduled disability for a total award of 128° for 40% unscheduled permanent partial disability for injury to her low back. In lieu of the fee allowed by the Referee claimant's attorney is allowed 25% of the additional compensation awarded by the Referee's order and this order (i.e. 64°), not to exceed $3,000, payable out of claimant's compensation and not in addition thereto.

ARNOLD ANDROES, Claimant
Michael B. Dye, Claimant's Attorney
David Horne, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 82-04339 & 82-08873
October 27, 1983
Order Denying Approval of
Dsiputed Claim Settlement

A Disputed Claim Settlement has been submitted to the Board for approval, the terms of which are set forth fully herein:

> "IT IS HEREBY STIPULATED By and Between Arnold Androes, through his attorney . . . and Willamette Industries, self-insured employer, by and through . . . their attorneys, and Willamette Industries, insured by Employers Insurance of Wausau, by and through their attorney . . . that claimant originally suffered an injury to his right shoulder in November 1977 for which benefits were paid through Employers Insurance of Wausau. Claimant was subsequently injured in his left shoulder in 1979, which claim was accepted and benefits paid through Willamette Industries, self-insured. Claimant has received 20% unscheduled disability for right shoulder disability and 15% unscheduled disability, as well as 20% loss of use of the arm with respect to the 1979 injury. This claim was again closed by Determination Order dated August 13, 1982, awarding an additional 35% unscheduled disability for injury to the left shoulder. Claimant alleges that his right shoulder condition has worsened and become aggravated, and that as a result thereof he is entitled to additional temporary total disability and permanent total disability. Employers Insurance of Wausau has denied claimant's claim of aggravation for the reason that claimant's industrial injury has not become aggravated, but that claimant has suffered intervening and superceding events which are responsible for his condition, and that his industrial injury is no longer a material contributing cause of his present disability or need for treatment. Claimant further contends that his left shoulder injury has worsened and that he is entitled to greater temporary total disability or permanent total disability on account of his left shoulder. The employer, Willamette Industries, has denied and does hereby deny that claimant's condition has become aggravated or worsened, or that he is entitled to either temporary total disability or permanent total disability on account of this industrial injury, and further contends and denies that claimant's industrial injury is a material contributing cause of his present

disability or need for medical care and treatment, but that his disability and need for medical treatment is due to intervening and superceding events. Claimant is dissatisfied with this denial and does hereby amend his Request for Hearing to include a Request for Hearing from this denial. In addition, claimant contends that the Determination Order awarding permanent disability is inadequate and does not fairly compensate him. There being a bona fide dispute and the parties wishing to resolve this matter on a disputed claim basis;

"IT IS HEREBY STIPULATED AND AGREED that claimant will be paid the total sum of $10,000.00 in full and final settlement of all his claims of aggravation or claims of entitlement to temporary total disability or permanent total disability from both injuries. In consideration for this payment, claimant agrees that his claims of aggravation regarding both the right and the left shoulder shall remain in their denied status, and that he shall take no further workers' compensation benefits on account thereof. Claimant further agrees that his industrial injuries to his right and left shoulder are no longer a material contributing cause of his disability or need for medical treatment and that as a result of intervening and superceding events, he is now and will forever in the future, be personally responsible for any medical care and treatment to his shoulders or any other areas of his body needing medical attention. Claimant understands that by this settlement, he will be forever barred from receiving additional workers' compensation benefits, either on account of aggravation or under Board's Own Motion relief.

"IT IS FURTHER AGREED that this resolves all issues of temporary total disability, medical care and treatment, permanent partial and permanent total disability claimed on a disputed claim basis.

"IT IS FURTHER AGREED that claimant will be personally responsible for all present and future medical expenses incurred for any reasons, and that his industrial injuries to either the left or right shoulder are not material contributing causes to his ongoing, continuing problems and that as a result thereof, he will hold Willamette Industries harmless from any and all medical expenses incurred for any medical treatment to either his left or right shoulder or any other area of his

body, now or at any in the future[sic].

"IT IS FURTHER AGREED that this is settlement on the basis of a doubtful and disputed claim, and that this considers anticipated future medical expenditures, but is not a settlement based on account of disability.

"IT IS FURTHER AGREED that claimant's attorney . . . shall receive an attorney's fee of $2,200.00, payable out of this settlement and not in addition thereto."

This stipulation is signed by claimant, his attorney, counsel for Willamette Industries as a self-insured employer and counsel for Willamette Industries as an insured of Employers Insurance of Wausau. It originally was submitted to the Hearings Division for approval by a Referee, but due to the questionable nature of its terms, it was referred to the Board.

"No release by a worker or his beneficiary of any rights under ORS 656.001 to 656.794 is valid." ORS 656.236(1). The exception to this general prohibition against releases is stated in ORS 656.289(4):

> "Notwithstanding ORS 656.236, in any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a Referee, the Board or the court, by agreement make such disposition of the claim as is considered reasonable."

We conclude that the present situation presents no "bona fide dispute over compensability," and thus does not come within the exception to the statutory "no release" rule. We, therefore, decline to approve the disputed claim settlement.

By the terms of this agreement, claimant is foreclosed from ever again making a claim for any workers' compensation benefits for conditions that may be related to his original industrial injury, including any claim for future medical services. Claimant presently has the right to claim compensation for reasonable and necessary medical services causally related to his injury. This is a lifetime right. ORS 656.245(1). We have held that, generally speaking, there cannot be a denial of future medical services on a previously accepted claim. David A. Smith, 35 Van Natta 1400 (1983); Gary E. Freshner, 35 Van Natta 528 (1983); Anita Gilliam, 35 Van Natta 377 (1983); Patricia M. Dees, 35 Van Natta 120 (1983). Because there cannot be a denial of future medical services, it would seem to follow that presently there can be no bona fide dispute concerning claimant's entitlement to medical services in the future.

Furthermore, this is not a situation in which the subject of dispute is whether claimant sustained compensable injuries at all. Claimant's original injury claims were accepted and, so far as we are now aware, there is no question that they should have been accepted. Yet the effect of this settlement agreement is to extinguish any and all rights that claimant has or may have under the Workers' Compensation Act in relation to his original, accepted

industrial injuries. Aside from the question of whether there presently can be a bona fide dispute concerning claimant's entitlement to future benefits under the Act, we find that this settlement agreement, which by its express terms states that claimant "will be forever barred from receiving additional workers' compensation benefits," is in clear violation of the statutory prohibition against releases.

ORDER

The Disputed Claim Settlement submitted to the Board for approval, being in violation of the statutory prohibition against releases, is not approved.

DONALD T. CAMPBELL, Claimant
Evohl F. Malagon, Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 83-04369
October 27, 1983
Order Denying Approval of Disputed Claim Settlement

Claimant and the employer/insurer, by and through their respective counsel, have submitted a document entitled "Stipulation" to the Board for approval. This document appears to be a disputed claim settlement pursuant to ORS 656.289(4). There presently is pending a request for hearing filed by claimant concerning a claim for medical benefits pursuant to ORS 656.245 allegedly causally related to claimant's 1973 industrial injury. Claimant also has petitioned the Board pursuant to ORS 656.278, requesting that his claim be reopened for payment of additional temporary and/or permanent disability benefits. The parties' stipulation recites that since 1975 claimant has engaged in a series of different jobs, all of which allegedly have caused claimant's industrial knee condition to worsen, and that these subsequent work exposures constitute more recent injurious exposures. Based on these subsequent exposures, Argonaut, the insurer on the risk for the 1973 injury, has denied further responsibility for claimant's condition.

The parties' stipulation recites:

> "Claimant fully understands that if the Referee and the Board approve this stipulation that Argonaut's denial of responsibility will remain in full force and effect forever. He has been advised by his attorney that Argonaut will not be responsible for any time loss, medical or other expense, or permanent disability which claimant has alleged, alleges, or may in the future allege as related to the injury of March 7, 1973. In particular, claimant fully understands that all unpaid medical bills and expenses are and will remain his responsibility."

The portion of the claim arising under ORS 656.245 ostensibly has been settled by virtue of a Referee's approval dated September 9, 1983. The matter has come before the Board for approval of that portion of the settlement which relates to claimant's request for own motion relief.

For the reasons stated in Arnold Androes, WCB Case Nos. 82-08873, 82-04339, 35 Van Natta 1619 (decided this date), and Duane Maddy, WCB Case No. 82-08939, 35 Van Natta 1629 (decided this date), we find that the settlement agreement entered into by the parties in this case violates the statutory prohibition against a worker's release of rights under the Workers' Compensation Act. We, therefore, decline to grant our approval. Because the settlement agreement requires approval of the Board in order to effectively resolve the issues addressed therein, the Referee's purported approval is of no binding effect. Cf. Jack R. Hadaway, 34 Van Natta 669 (1982), aff'd without opinion, 62 Or App 399 (1983); Phyllis J. Moore, 33 Van Natta 703 (1981); Minnie K. Carter, 33 Van Natta 574 (1981), appeal dismissed on other grounds, 55 Or App 73 (1982).

ORDER

The disputed claim settlement submitted to the Board for approval, being in violation of the statutory prohibition against releases, is not approved.

DANIEL J. CANNON, Claimant
Peter O. Hansen, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-02247
October 27, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

This is an enforcement proceeding in which both claimant and the insurer requested review of various portions of Referee Pferdner's order. On August 11, 1982 we issued an Interim Order on Review which, among other things, requested the parties to provide us with supplemental statements of their positions in view of the conclusions we expressed in that order. 35 Van Natta 1181 (1983). Both parties have now done so.

We first note that the supplemental statements of both parties include documentary evidence that is not in the record. We have not considered any of this material in our review of this case.

We next express our appreciation to claimant's counsel for a responsive, professional and helpful supplemental statement.

By contrast, the insurer's supplemental position is: In this situation in which the insurer unilaterally ceased payment of benefits for temporary disability, claimant has not proven that he was not stationary beyond the date when benefits were terminated. We appreciate that this is one of those claims that could reasonably cause some frustration, but the insurer has to know that its position is simply untenable.

The principal remaining question is: What relief should now be granted in relation to the benefits for temporary disability that claimant should have been paid beyond May 20, 1980, the date when the insurer ceased payments. For the reasons stated in our prior interim order, we believe that claimant is entitled to (1) compensation for temporary total disability beyond that date for those periods of time when he was not receiving either wages or

unemployment compensation benefits and (2) compensation for temporary partial disability beyond that date for those periods of time when he was receiving either wages or unemployment compensation benefits, all until the date when his claim is or was properly closed pursuant to ORS 656.268. Claimant's supplemental statement includes some, but not all of the dates and amounts of income necessary to compute the amount of workers' compensation benefits due; claimant's counsel advises that he is in the process of obtaining the other needed dates and amounts. Under these circumstances, we now conclude that it is appropriate to remand this matter to the insurer to compute the amount of workers' compensation benefits due as follows: (1) Claimant's counsel shall furnish the insurer with a statement of dates claimant worked and the wages claimant earned between May 20, 1980 and claim closure; (2) likewise, claimant's counsel shall furnish the insurer with a statement of the dates claimant received unemployment compensation benefits and the amounts received between May 20, 1980 and claim closure; (3) the insurer shall then compute the amount of workers' compensation benefits for temporary total disability and temporary partial disability to which claimant is entitled under the analysis in our interim order and in this order; and (4) the insurer shall pay to claimant the compensation thus computed within seven days of receipt of the required information for claimant's counsel.

Because the insurer unilaterally terminated benefits, it may not set off the additional benefits ordered herein against other compensation paid or payable. Mark L. Side, 34 Van Natta 661 (1982).

Our Interim Order on Review dated August 11, 1982 is incorporated herein by reference. The following final order is based on that prior order as supplemented herein.

ORDER

The Referee's order dated November 8, 1982 is reversed.

The insurer shall pay claimant a penalty of 15% of the compensation for temporary total disability due and paid for the period between January 22, 1980 and March 5, 1980 on the grounds and for the reason that the March 5, 1980 payment was unreasonably delayed.

The insurer is not obligated to pay any additional percentage penalty, either as a percentage of medical services paid or as a percentage of compensation due pursuant to post-hearing Determination Order.

Claimant is entitled to compensation for either temporary total disability or temporary partial disability for the period between May 20, 1980 and the closure of his claim pursuant to ORS 656.268; this matter is remanded to the insurer for computation and payment of such compensation.

Claimant's attorney is awarded $1,500 as a reasonable attorney fee, pursuant to ORS 656.382(1), for services at the hearing and on Board review, to be paid by the insurer.

BENNY E. DAVIS, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-08002
October 27, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Leahy's order which upheld the SAIF Corporation's denial of claimant's aggravation claim and dismissed the issue of extent of disability in relation to the September 11, 1981 Determination Order. The issues are the compensability of claimant's aggravation claim and, alternatively, the propriety of the Referee's action dismissing the issue of extent of disability.

We disagree with several of the Referee's findings of fact. We make the following findings of fact.

Claimant became employed by Northwest Natural Gas Co. in 1968 and continued working there for appoximately nine and one-half years. The first indication that claimant suffered difficulties with his back is contained in a Kaiser Permanente chart note dated November 5, 1969, which indicates that claimant suffered an acute lumbosacral sprain while pulling on a piece of pipe. There is no indication whether or not this occurred at work. There is no additional medical evidence in the record concerning this 1969 incident.

On July 20, 1977, while still working for the gas company, claimant completed an 801 form alleging he sustained a low back injury at work on June 22, 1977. Claimant sought no medical treatment for this injury. The claim was accepted as a nondisabling injury. Claimant thereafter terminated his employment at the gas company for personal reasons and went to work at Western Farms.

On August 8, 1978 claimant fell and hurt his right elbow and shoulder while unloading chickens at Western Farms. Claimant treated with Drs. Silver and Borman for this injury. The medical reports surrounding this incident contain no history concerning back difficulties. Claimant was eventually awarded 5% permanent partial disability for this injury.

Claimant subsequently went to work for MK Development Company. On September 20, 1979 claimant was seen by Dr. Daack with complaints of back pain which developed after three days of shoveling gravel at work. With the exception of the 1969 chart note and another obscure reference in a 1973 chart note, this is the first medical verification regarding claimant's back difficulties. By history, Dr. Daack related the 1979 back difficulty to claimant's 1977 injury. After an examination by Orthopaedic Consultants, claimant was found not medically stationary and was diagnosed as suffering from an acute lumbosacral sprain.

Responding to these 1979 reports as an aggravation claim, on February 12, 1980 SAIF, as insurer for Northwest Natural Gas, denied aggravation reopening. That denial was the subject of prior litigation in WCB Case No. 80-01692. That prior litigation resulted in orders by a Referee and the Board setting aside SAIF's denial and remanding claimant's aggravation claim for acceptance and processing.

Claimant was eventually found to be medically stationary following an examination by the Orthopaedic Consultants on February 13, 1981. The Consultants were of the opinion that claimant would be unable to return to any of his previous occupations and would require training in a field which would not require heavy lifting or bending. Claimant then entered an authorized vocational training program in motel management. This program was terminated in August 1981 when claimant voluntarily left in order to take a job as motel manager in Carson City, Nevada. A Determination Order issued on September 11, 1981 awarding claimant 10% unscheduled permanent partial disability for injury to his low back.

On January 14, 1982 claimant returned to Dr. Daack complaining of increased back pain since December 2, 1981. Dr. Daack reported that claimant's condition was "materially and significantly worsened," although at that time he could not be sure that claimant's worsening was related to the 1977 industrial injury or to some underlying progressive pathology. Dr. Daack requested that claimant be examined by Orthopaedic Consultants again.

On March 1, 1982 Orthopaedic Consultants reported that claimant was not medically stationary. Claimant was diagnosed as suffering from chronic lumbosacral strain with possible rheumatologic disease and a possible herniated disc at L5-S1. The Consultants recommended an examination by a rheumatologist. That examination was performed by Dr. Rosenbaum, who reported that there was no evidence to suggest claimant was suffering from any inflammatory rheumatic disease.

Claimant requested a hearing in relation to the September 11, 1981 Determination Order. On April 19, 1982, claimant and the SAIF Corporation entered a stipulation by which it was agreed that claimant's request for hearing was compromised and settled. SAIF agreed to reopen the claim as of January 18, 1982 and to provide claimant with medical care and treatment. In rather curious terms, the stipulation provided that claimant preserved his right to raise the issue of additional temporary total disability and that SAIF would have the right to deny its reopening of the claim if it received future medical documentation not then available. Claimant retained the right to contest any such denial.

On May 26, 1982 Dr. Rosenbaum performed a myelogram. The myelogram demonstrated a lumbosacral lesion on the left consistent with a disc extrusion. Dr. Rosenbaum expressed some uncertainty about how to interpret the myelogram results because claimant's pain pattern predominantly involved the right leg.

Claimant was referred to the Callahan Center where a number of psychological and vocational tests were administered. Claimant was found to exhibit a tendency to convert social and emotional problems into physical symptoms. The diagnosis was adjustment disorder with depressed and anxious mood. Dr. Schwan reported that claimant's physical condition was worsening and that he was not medically stationary. Due to the inconsistency between the myelographic findings and claimant's symptoms, Dr. Schwan suggested a CAT scan and an EMG.

On August 2, 1982 Dr. Schwan responded to several questions submitted by SAIF. Dr. Schwan stated that, in his opinion, claimant's work at the Nevada motel "aggravated the condition which was a result of his 6/22/77 injury" and that "his motel duties exacerbated the condition which was a result of the June 22, 1977 injury." Dr. Daack reported on August 16, 1982 that he agreed with Dr. Schwan that claimant's current difficulty was a result of the 1977 injury and "that no new injury ensued, but was aggravated by his motel work activities."

On August 26, 1982 SAIF issued a denial of the current aggravation claim.

On September 21, 1982 Dr. Daack reported:

> "It is my opinion that the current treatment would include possible surgery for lumbar disc problems relative to his injury of 6-22-77.
>
> "I fully concur with [claimant] and his opinion that his current condition and need for treatment is not related to any of his work activities as a hotel/motel manager in Carson City, Nevada."

In affirming SAIF's denial of aggravation, the Referee seemed to question claimant's credibility on the ground that "claimant did not start claiming that his left leg was becoming worse . . . until this hearing." The Referee also seemed to question Dr. Daack's opinions because: "The first low back pain mentioned by Dr. Daack, claimant's treating doctor . . . was in a letter dated November 29, 1979, almost 12-1/2 years after the 1967 [sic] low back injury previously mentioned."

Claimant contends that the medical evidence relating his current aggravation to the 1977 injury is unrefuted and that it clearly establishes the compensability of his current claim. We agree. After questions concerning any underlying disease processes were ruled out, Dr. Daack, claimant's treating physician throughout the course of his claim, unequivocally concluded that claimant suffered a worsening of his condition, and relates that worsening directly to the 1977 injury. Moreover, Dr. Daack was aware of the type of activities which claimant engaged in while working as a motel manager for a short time in Nevada and opined that claimant's condition represented an aggravation of his previous injury rather than a new injury. We find no basis to question Dr. Daack's opinion. Clearly Dr. Daack is in the best position to render an opinion on the causal relation between claimant's current condition and his 1977 injury. And contrary to the Referee's apparent interpretation of the evidence, we understand Dr. Daack to relate claimant's current back condition to the 1977 injury, not to a 1967 injury, the 1969 injury or any other pre-1977 injury. Similarly, Dr. Schwan, who examined the claimant following both his 1979 aggravation and again following his current aggravation opined that claimant's current condition represented an aggravation of the 1977 injury.

With regard to the question of claimant's left leg pain, claimant is correct in pointing out that left leg difficulties are documented in the record, and that claimant's first complaints of

such pain were made prior to the hearing. Although the references to such difficulties are not substantial, they do exist. Whether the relatively minor and infrequent mention of left leg symptoms makes any difference in assessing the evidence in this case is a question which no doctor has been asked and about which we are not prepared to speculate.

A reading of the Referee's order could leave one with the impression that he may have believed it was error to find, in the prior litigation, that claimant's 1979 back condition was a compensable result of his 1977 injury. Viewing this matter in retrospect, we can understand that possible belief. Nevertheless, the 1979 aggravation was found compensable, and the doctrine of res judicata protects the integrity and finality of both correct and incorrect decisions. Thus, if claimant is able to establish that his current difficulties are related to the condition found compensable by prior order, there can be only one possible conclusion. We find that claimant has so established. It follows that SAIF's denial must be set aside.

Since we have concluded that claimant has established a compensable aggravation, it is unnecessary for us to make a determination concerning the propriety of the Referee's action dismissing the issue of extent of disability in relation to the September 11, 1981 Determination Order. A new Determination Order will issue in due course after claimant is found medically stationary in relation to his current aggravation claim. This is consistent with our decision in Gary A. Freier, 34 Van Natta 543 (1982).

ORDER

The Referee's order dated December 9, 1982 is reversed in part and vacated in part. Those portions of the Referee's order which upheld the SAIF Corporation's August 26, 1982 aggravation claim denial are reversed. SAIF's denial is set aside and this claim is remanded to SAIF for processing in accordance with ORS 656.273. Claimant's attorney is awarded a reasonable attorney's fee of $1,000 for services performed at the hearing and $500 for services performed at the Board in overcoming that denial, to be paid by the SAIF Corporation. The remainder of the Referee's order is vacated.

ROY J. LANE, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11128
October 27, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee McCullough's order which awarded 128° for 40% unscheduled permanent disability, thereby modifying the Determination Order of November 30, 1982 which awarded no permanent disability. SAIF contends that the 40% permanent disability award is excessive.

Claimant is a 33 year old iron worker who injured his low back in January 1982 when he slipped on some ice while carrying a piece of iron. He has received conservative medical and chiropractic treatment since his injury and has not returned to work. Claimant's treating doctor, Dr. Renquist, D.C., has diagnosed claimant's condition as thoraco-lumbar sprain with myositis and radicular

syndrome in both lower extremities. Dr. Renquist stated that claimant cannot return to his work as an iron worker. Dr. Poulson diagnosed chronic lumbosacral strain and, in August 1982, stated that claimant could return to medium level work. The BBV Medical Services panel of doctors diagnosed chronic low back strain superimposed on spondylolysis at L5/S1 and recommended in October 1982 that claimant gradually return to his work. While the BBV doctors did not anticipate any permanent impairment, Dr. Renquist stated that claimant's impairment is moderate.

The Referee found claimant limited to light work. After considering all the relevant factors, the Referee concluded that claimant's loss of earning capacity due to his low back injury entitled him to an award of 40% permanent disability. We find the Referee's award to be excessive and modify as follows.

Claimant was 33 years old at the time of hearing and he has a high school education and some vocational schooling. We find that claimant is now limited to medium work, whereas he previously performed heavy work, and that his impairment is in the mild range.

Applying the guidelines in OAR 436-65-600, et seq., and combining the factors as provided in these rules yields a disability rating of 15%. Comparing that rating with other similar cases, we conclude that an award of 15% permanent disability is appropriate in this case. Accordingly, we modify the Referee's order.

ORDER

The Referee's order dated May 6, 1983 is modified. In lieu of the Referee's award of permanent disability claimant is awarded 48° for 15% unscheduled permanent partial disability for injury to his back. Claimant's attorney's fee should be adjusted accordingly.

DUANE E. MADDY, Claimant
Evohl F. Malagon, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 82-08939
October 27, 1983
Order Denying Approval of Disputed Claim Settlement

Claimant and the employer/insurer, by and through their respective counsel, have submitted a document entitled "Stipulation" to the Board for approval. This document appears to be a disputed claim settlement pursuant to ORS 656.289(4), disposing of an alleged bona fide dispute concerning compensability. The settlement agreement recites that claimant's original low back injury was accepted and processed to claim closure; that claimant received a stipulated permanent disability award; that claimant thereafter sought further medical care and treatment, including surgery; that claimant requested a hearing raising multiple issues, including the insurer's alleged failure to process and pay a claim for medical benefits; and that claimant has requested that the Board exercise its discretionary authority pursuant to ORS 656.278 to reopen claimant's claim. The stipulation further recites:

> "Argonaut on behalf of Cuddeback hereby gives notice to claimant that it denies any and all responsibility for claimant's condition subsequent to September 26, 1976, on the ground:

"(a) Claimant's later employment with Cuddeback, whom Argonaut ceased to insure after July 1, 1975, materially contributed to claimant's pre-existing condition and necessitated subsequent medical treatment.

"(b) Argonaut expressly denies responsibility for any arthritic condition identified and treated by Drs. Cassell and Filarski since June 1980 on the grounds that the condition bears no causal relationship to the injury for which the claim was filed.

"(c) Argonaut also takes the position that all of claimant's current medical condition is attributable to his arthritic condition.

* * *

"In particular, claimant fully understands that neither Argonaut nor Cuddeback will be responsible in this claim after September 26, 1976, for any time loss, medical or other expenses or permanent disability which claimant has alleged, alleges or may hereafter allege is related to his February 22, 1972, injury or his employment prior to July 1, 1975, when Argonaut ceased to insure Cuddeback."

This agreement would extinguish claimant's right to claim workers' compensation benefits in the future in relation to this claim. We have considered a similar settlement agreement in Arnold Androes, WCB Case Nos. 82-08873, 82-04339, 35 Van Natta 1619 (decided this date), in which we concluded that the parties' proffered settlement agreement violated the prohibition against releases and, therefore, was not subject to approval. ORS 656.236(1). We find that the settlement agreement entered into by the parties to this proceeding suffers from the same defect.

We have an additional concern in this case. The stipulation recites that one of the reasons that Argonaut denies further responsibility for claimant's condition is that the condition has been worsened by subsequent work activity. In J. C. Compton Company v. DeGraff, 52 Or App 317, 323 (1981), the court held that where there is a dispute concerning employer/insurer responsibility, any settlement entered into by one of the employers/insurers and the claimant concerning the issue of responsibility is invalid after an order has issued pursuant to ORS 656.307 designating one of the employers/insurers as a paying agent. The court agreed with the Board that "such a situation has all the potential for creating prejudice." 52 Or App at 323. See Robert DeGraff, 29 Van Natta 893, 894 (1980). From the terms of the settlement agreement presently before us and the information contained in the "record" of this case, it does not appear that any insurer on the risk subsequent to Argonaut has been joined in a proceeding under ORS 656.307; however, it would seem that this settlement agreement may

have the same potential for creating prejudice as did the settlement in DeGraff. Indeed, if claimant has filed a claim with a subsequent employer/insurer for the same benefits which he has sought in this claim with Cuddeback/Argonaut, it is conceivable that claimant could be paid twice for the same disability. On the other hand, if claimant has failed to file any such claim with another employer/insurer, this settlement agreement suffers from the same defect which led us to conclude in Arnold Androes, supra, that the settlement agreement was a prohibited release of claimant's rights under the Workers' Compensation Act. If the subsequent employer/insurer vaguely referred to in the settlement agreement were made a party to this agreement and stated its willingness to assume future responsibility for claimant's compensation, this DeGraff problem would be eliminated. As it now stands, however, we find that this settlement agreement cannot be approved.

ORDER

The disputed claim settlement submitted to the Board, being in violation of the statutory prohibition against releases, is not approved.

MICHAEL MINSKER, Claimant
Des Connall, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-06561
October 27, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Podnar's order which upheld the insurer's partial denial of claimant's knee injury claim. (The insurer accepted claimant's back injury claim at the same time that it partially denied claimant's knee injury claim.) The insurer cross-requests review of that portion of the Referee's order that found that claimant had good cause for requesting this hearing more than 60 days after the partial denial.

The Board affirms and adopts those portions of the Referee's order concerning the merits of whether claimant's knee condition is work-related. We agree with the Referee that the preponderance of the evidence establishes that it is not.

We disagree, however, with the Referee's good-cause finding. The insurer's partial denial, in the usual and proper form, was issued on April 15, 1982. Claimant did not request a hearing on that partial denial until July 23, 1982. In these circumstances, ORS 656.319(1)(b) requires claimant to establish "good cause for failure to file the [hearing] request by the 60th day after notification of denial." Claimant's excuse for his late filing in this case is that he was in contact with the insurer following the denial, that the insurer agreed to investigate his knee claim further, including arranging for independent medical examinations, and that claimant thus assumed that the partial denial was not final. Recently, since the Referee issued his order in this case, we considered an almost identical situation in Margaret J. Sugden, 35 Van Natta 1251 (1983), and concluded that a claimant's subjective belief or understanding that a written denial in usual and proper form means something other than a denial is not sufficient to establish good cause. We find that our analysis in Sugden is applicable and controlling in this case.

Thus, although we disagree with part of the Referee's analysis, we agree with the Referee's ultimate conclusion upholding the insurer's partial denial of claimant's knee claim.

ORDER

The Referee's order dated March 30, 1983 is affirmed.

KAREN M. POTTS, Claimant
Wiswall, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-00174
October 27, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Howell's order which awarded claimant additional compensation for temporary total disability between November 18, 1981 and April 2, 1982 and 64° for 20% unscheduled disability. SAIF argues that claimant has not established that she was other than medically stationary on November 17, 1981 and that the permanent disability award granted by the Referee is excessive. Claimant suggests that her permanent disability award should be increased.

Claimant is a 24-year-old grocery clerk who compensably injured her right shoulder and back while lifting freight in July 1980. She was diagnosed as having muscle and ligament strain. In September 1980 she attempted to return to work but experienced increased pain and was taken off work. In October 1980 Dr. Hockey stated:

> "This patient has no objective evidence of any problems with her low back although she states she has some low back pain. I would assume that she may have had a mild lumbosacral strain.
>
> "In regards to her shoulder, she has a little strain to the right trapezius muscle which is increased with pushing down on the arm in abduction. I do not find any evidence of a cervical herniated disc."

Dr. Hockey released claimant to return to modified work.

Claimant worked for about a month but again began complaining of pain in her upper back. Claimant continued to complain of pain and continued to see various doctors including Dr. Nagel, an orthopedist, and Dr. Wasner, a rheumatologist, none of whom were able to document objective findings. Dr. Wasner felt that claimant might be suffering from fibrositis.

In September 1981 Dr. Wasner reported that claimant felt about the best she had in two years under his treatment. When Dr. Wong first saw claimant on October 2, 1981, he reported that claimant had recently discovered that she was pregnant:

> "At this time I would not attempt to treat the patient with any medication because of

her pregnancy. I believe what we can offer her is to put her on a generalized muscle strengthening exercise program."

On November 17, 1981 claimant was evaluated by Orthopaedic Consultants. They opined:

> "In our opinion this patient's condition is medically stationary at this time. Her subjective symptoms are not supported by objective physical findings of abnormalities. We are of the opinion that claim closure is justified and treatment is only palliative temporarily as now being received. We feel that she could return to her previous occupation or some other occupation but at the present time is in her first trimester of pregnancy....
>
> "We find no evidence of permanent impairment in the cervical region, the doral spinal region or in the extremities."

Dr. Wong refused to concur entirely with the Orthopaedic Consultant's report because he did not agree that claimant was medically stationary: "Until the pregnancy is terminated, I have difficulty fully assessing the patient and whether she is medically stationary at this time."

On January 4, 1982 a Determination Order issued which found claimant was medically stationary on November 17, 1981 and which did not award any benefits for permanent disability. In March 1982 Dr. Wong noted claimant was complaining of increased pain but attributed it to her pregnancy. On April 2, 1982, Dr. Wong reported that claimant was then medically stationary. Claimant gave birth about the first of June 1982.

The Referee found that the claim was prematurely closed and that claimant was not medically stationary until April 2, 1982. We disagree. Claimant suffered a soft tissue injury in July 1980 with no subsequent objective medical findings of impairment; just as a matter of common sense, it would seem that 16 months later it would be expected "that no further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). Indeed, Dr. Wasner reported in September 1981 that claimant was greatly improved and Orthopaedic Consultants reported in November 1981 that claimant was stationary. We believe that Dr. Wong's opinion to the contrary is weakened by two considerations: (1) He first reported that claimant's pregnancy prevented him from forming an opinion about whether claimant was stationary, but subsequently, in a later stage of pregnancy, declared that she was stationary; and (2) the nature of Dr. Wong's treatments are far from clear, but apparently primarily involved something in the nature of physical therapy and exercise; at least at the point of 16 months post-injury, it would seem that this treatment was palliative rather than curative in nature. For all of these reasons, we conclude that claimant has not established that she was

other than medically stationary on November 17, 1981, as found by the January 4, 1982 Determination Order.

We also disagree with the Referee on the issue of extent of disability. As previously noted, no doctor has been able to find any objective indication of any form of impairment. The Referee based the award of 20% unscheduled disability on claimant's testimony, finding that claimant was a "generally credible witness" albeit with some tendency to exaggerate her symptoms, and that some of those symptoms were enhanced by non-injury-related factors like claimant's weight. We agree with the Referee that there is sufficient evidence (although just barely) to conclude that claimant's pain complaints are basically real and are caused in some part by her compensable injury. However, we do not find that claimant's disability is as great as the Referee found.

Following the guidelines in OAR 436-65-600 we arrive at the following analysis. We assign claimant's impairment a +1 value based on her pain complaints but discounting those complaints because of her exaggeration and some noncompensable causation. We assign a -7 factor for her age of 24. We assign a -9 factor for labor market findings because we find that a significant portion of the labor market is still open to her. We assign a +3 factor based on the amount of training required for her grocery clerk job. We assign a +5 factor for adaptability because claimant's previous work was medium work and we conclude that she is now precluded from at least some medium work. Combining these factors, we conclude that claimant is entitled to an award of 16° for 5% unscheduled disability.

Our decisions on the principal issues requires noting another issue raised at hearing. SAIF requested authority to setoff its overpayment of time loss benefits. There was an off-the-record discussion of this issue before the hearing began which then resulted, at the start of the hearing, in both counsel agreeing with the Referee's summary: "Claimant indicated that she acknowledged the overpayment and dollar amount." We thus think that the parties have, in effect, resolved this issue by stipulation and that SAIF is entitled to setoff its overpayment against benefits awarded by this order or that become payable in the future.

ORDER

The Referee's order dated September 28, 1982 is reversed in part and modified in part. Those portions of the Referee's order concerning premature closure and awarding additional temporary total disability are reversed. The Determination Orders dated January 4, 1982 and February 10, 1982 are reinstated and affirmed as proper closure of claimant's claim. Those portions of the Referee's order concerning extent of disability are modified. Claimant is awarded 16° for 5% unscheduled disability in lieu of the award granted by the Referee. Claimant's attorney's fee should be adjusted accordingly.

RONALD A. RICHARD, Claimant
Christin Prescott, Claimant's Attorney
Miller, et al., Defense Attorneys

WCB 82-02380
October 27, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of Referee Braverman's order which overturned its denial of claimant's right leg injury.

On September 19, 1981 claimant sustained a non-disabling bruise to his right leg while climbing down the steps of the bus he drove for the employer. He filed an 801 claim form, and the employer initially accepted the incident as a disabling injury. Claimant did not seek help from a doctor for his problem but instead saw his cousin who is a registered nurse. Claimant's cousin told claimant to stay off his leg for a few days and to treat the bruise with ice. She said if it continued to trouble him, claimant should then see a doctor for an x-ray. The cousin did not charge claimant for her services.

On February 23, 1982 the employer issued a denial which stated:

> "The laws relating to the Worker's Compensation Department of Oregon, specifically ORS 656.005(8)(a) define a 'compensable injury' as an accidental injury...arising out of and in the course of employment requiring medical services or resulting in disability or death; . . .
>
> "Because you did not not seek medical services as a result of the September 18, 1981 accident wherein you fell, hitting your leg, we are denying your claim under the above statute."

At hearing, the Referee ruled that despite the fact that claimant was only treated by a registered nurse who did not charge him for his services, his on-the-job injury did require medical services. He, therefore, overturned the employer's denial.

We disagree with the Referee because we agree with the employer that claimant did not sustain a compensable injury. ORS 656.005(8)(a) defines a compensable injury:

> "A 'compensable injury' is an accidental injury...arising out of and in the course of employment requiring medical services or resulting in disability or death."

There is no question that claimant sustained an accidental injury arising out of and in the course of employment. The only question is whether the accidental injury is a "compensable injury" because it required medical services.

We conclude that claimant's injury did not require medical

services as that term is used in the statute. The statute does not define "medical services" per se. However, we find that what the statute contemplates in its use of the term "medical services" is treatment or evaluation for which claimant is charged money and, therefore, seeks compensation. "Compensation" is defined in the statute to include "all benefits, including medical services." Although the statute does not say so, what seems to be contemplated is that in order for a "compensable injury" to exist, there must be some compensation claimed, either in the form of reimbursement for medical services or time loss or permanent disability. It makes no sense to speak of "compensable injuries" or even "workers' compensation" unless "compensation" has some meaning. In this case there was no claim for reimbursement for medical services or any other form of compensation; therefore, there was no compensable injury. The employer's denial was proper.

We do not reach the question of whether nursing services would constitute "medical services" under the statute if compensation were claimed for them.

We also note that the employer does not contest whether an accident occurred on the job. In the event claimant's bruise became aggravated or required time loss or medical services in the future, we do not believe that claimant would be precluded under the terms of the denial or this order from bringing a new claim. That issue is not presented in this case, however, and we do not purport to decide it.

ORDER

The Referee's order dated January 13, 1983 is reversed. The denial of February 23, 1982 is reinstated.

JOSEPH SUIRE, Claimant
Howard Clyman, Claimant's Attorney
Lindsay, Hart, et al., Defense Attorneys
Richard C. Pearce, Defense Attorney

WCB 82-06126 & 82-04405
October 27, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Universal Underwriters, the insurer of Tower Motor Company, requests review of Referee Mulder's order which overturned its denial of claimant's aggravation claim. The issue on review is whether claimant established, by a preponderance of the evidence, a worsening of the medical condition resulting from his original injury.

We affirm the Referee's Order with the following comments.

Claimant suffered a right elbow hyperextension on October 4, 1977 when a transmission fell on his right arm and side. He was then employed by Tower Motor Company. Treatment was conservative. Ultimately, claimant was awarded 30% disability by a Determination Order dated September 13, 1978.

In April 1979, claimant suffered an exacerbation of the condition while changing a tire on his car. Originally denied, the claim was ultimately reopened and then closed by a Determination

Order dated December 3, 1979 which awarded time loss, but no additional permanent disability.

Claimant continued to have treatment, and his claim was subsequently reopened. Dr. Berselli, his treating physician, refined his diagnosis as a "chronic strain of the anterior capsule of the elbow joint." The doctor did not think there was additional permanent impairment. On April 29, 1980, a Determination Order closed the claim with additional temporary disability and no additional permanent disability.

Claimant was referred to the Callahan Center and the claim was reopened. On August 31, 1981, after vocational rehabilitation, the claim was again closed with additional temporary disability and no additional permanent disability.

On March 14, 1982, while employed by Tom Smith Trucking, claimant injured his elbow while unloading tires from a trailer. Soon after, he filed claims against both his first employer, Tower Motor Company, for an aggravation claim, and his second employer, Tom Smith Trucking, for a new injury claim.

Both employers denied benefits.

The Referee found that claimant had suffered an aggravation and not a new injury. Although not made abundantly clear in his order, the Referee felt that claimant had established, by a preponderance of the evidence, a worsening in the condition resulting from his original injury.

On review, Universal Underwriters argues only that claimant has not established a worsening caused by the original injury. It does not argue that the incident at Tom Smith constituted a new injury. We find that claimant's burden of proof has been met through the medical reports of his treating physician, the other doctors' reports, accompanying exhibits and through his own testimony.

Dr. Berselli, the treating physician, opines that claimant's condition has indeed worsened since the original incident. The doctor felt the existence of continued pressure on the median nerve in his forearm had caused further deterioration and function of that nerve. He viewed this worsening as an aggravation of the condition brought on by his original injury. The Referee found Dr. Berselli to be persuasive.

Dr. Ash, a neurologist, diagnosed claimant's condition as a right carpal tunnel syndrome plus additional pain of unknown etiology. Dr. Ash opined that a right carpal tunnel syndrome problem could be responsible for a great deal of claimant's pain. He felt that the "tunnel syndrome" was unrelated to the original injury. However, Dr. Ash stated that it was possible that permanent damage to claimant's elbow could have been caused by the original incident. He also conceded that claimant could have a median nerve problem as Dr. Berselli believed.

Neither Dr. Rosenbaum nor Dr. Wilson, neurologists, could find any neurological abnormalities to explain claimant's pain. Dr. Wilson found claimant's elbow extension limited about 20° with

restrictions in supination/pronation and increased pain to the arm when stress was applied to the biceps. This "about 20°" limitation was an increase from the 15° limitation recorded in April 1981 by Dr. Storino of the Callahan Center.

Although by no means overwhelming, we feel that claimant has "tipped the scale" in establishing a worsening in the condition resulting from his original injury. In reaching our decision, we feel that, as claimant's treating physician from the onset of his original injury and continuing throughout his case, Dr. Berselli was in the best position to judge claimant's condition and decide whether there had been a worsening. Although the other doctors' reports lack objective facts establishing a neurological reason for the worsening of claimant's condition, the fact remains that the doctor most familiar with claimant's condition from its origins has detected a worsening in that condition since this latest incident.

Claimant's testimony, which the Referee found to be credible, supports the conclusion that his condition has worsened. Claimant stated he could not extend his right arm as fully as he could in April 1981, before the latest incident. He also testified that he was experiencing an increase in pain. The increase in pain is supported by Dr. Berselli and somewhat reinforced by comparing Dr. Sorino "pre-incident" examination with Dr. Wilson's "post-incident" examination.

Based on our review of the record and considering claimant's credible testimony, the medical report from his treating physician, the other doctors' opinions, and the nature of the incident at Tower Motor's place of business, we find that the Referee correctly concluded that claimant experienced an aggravation of his original right elbow injury.

ORDER

The Referee's order dated January 31, 1983 is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee for services on Board Review, payable by Universal Underwriters.

SHARON S. WEBSTER, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-06400
October 27, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

This case involves questions of compliance or noncompliance with prior litigation orders in WCB Case No. 77-02895. In that prior proceeding, a Referee awarded claimant compensation for total disability, but on review the Board reversed the total disability award and instead granted claimant an additional 64° for 20% unscheduled disability. Sharon S. Webster, 27 Van Natta 687 (1979).

In this case, the SAIF Corporation requests review and claimant cross-requests review of Referee Braverman's order which: (1) Approved SAIF taking a "credit" for total disability benefits paid to claimant pending review in the prior proceeding against the increased 20% disability award ordered by the Board in that case;

(2) disapproved SAIF taking a "credit" for total disability benefits paid to claimant pending review in the prior proceeding against claimant's subsequent time loss benefits after claim reopening; and (3) denied claimant's request for penalties. SAIF argues that it should be entitled to setoff, one way or another, all excessive benefits paid pending the Board's decision on review in the prior proceeding. Claimant argues that SAIF cannot setoff any excessive benefits paid pending the Board's decision on review in the prior proceeding; claimant also renews her argument for penalties and attorney fees.

The parties stipulated to the relevant facts. In October 1978 claimant was awarded permanent total disability by a Referee's order in WCB Case No. 77-02895. SAIF requested Board review of that Referee's order. The Board reversed the Referee's award of permanent total disability and awarded claimant 20% unscheduled disability in addition to benefits previously awarded. 27 Van Natta 687 (1979). Between the date of the Referee's decision and the date of the Board's decision, SAIF had paid claimant $10,642.35 in total disability benefits.

The value of the additional 20% award granted by the Board in WCB Case No. 77-02895 was $4,480. SAIF did not pay any of this amount, but instead, applied this amount to the benefits paid pending review to reduce its "overpayment" to $6,162.35.

Thereafter, claimant's claim was reopened and time loss benefits paid to claimant. SAIF withheld 25% of each time loss payment until the remaining $6,162.35 "overpayment" was recouped.

The Referee concluded in this case that SAIF acted properly in not paying the 20% award granted by the Board in WCB Case No. 77-02895, instead "crediting" the amount of that award against the benefits for total disability it had paid pending review. We disagree with the Referee for the reasons stated in Glenn O. Hall, 35 Van Natta 275 (1983), a case we decided after the Referee issued his order in this case.

The Referee also concluded that SAIF acted improperly in paying claimant a reduced amount of time loss to recoup the balance of its "overpayment", reasoning that temporary disability and permanent disability should not be commingled. We agree with the Referee's conclusion but disagree with his reasoning.

ORS 656.313(2) states in unequivocal terms: "[C]laimant shall not be obligated to repay any such compensation which was paid pending the review or appeal." While Glenn O. Hall, supra, did not involve this exact issue -- a setoff of amounts paid pending review against compensation due in the future after claim reopening -- everything we said in Hall about ORS 656.313 and the implementing administrative rule, OAR 436-54-320, is equally applicable in the present context. For the same reasons that an employer/insurer cannot reduce permanent disability benefits to recover erroneously ordered compensation, an employer/insurer cannot reduce temporary disability benefits to recover erroneously ordered compensation.

Finally, we agree with the Referee and decline to award a penalty. Inasmuch as SAIF withheld and reduced claimant's benefits

before we decided Hall, inasmuch as there were prior Board decisions that could reasonably have been interpreted as inconsistent with the position we adopted in Hall and inasmuch as our position in Hall (now on review in the Court of Appeals) is certainly a matter about which reasonable persons could differ, we do not view SAIF's actions as so unreasonable as to warrant imposition of a penalty.

ORDER

The Referee's order dated February 28, 1983 is affirmed in part and reversed in part. That portion which permitted the SAIF Corporation to take a "credit" of $4,480.00 against its prior "overpayment" is reversed and, in lieu thereof, SAIF is ordered to pay $4,480.00 to the claimant. Claimant's attorney is awarded $600 for services rendered on Board review in prevailing on SAIF's request for review, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

EDDIE G. WHITE, Claimant
Coons & McKeown, Claimant's Attorneys
Macdonald, et al., Defense Attorneys

WCB 81-10811 & 82-01410
October 27, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Danner's order which upheld the SAIF Corporation's denials of claimant's aggravation claims against two of its insureds.

The Board affirms and adopts the order of the Referee with the following additional comment. Claimant argues that SAIF has issued a backup denial of his psychological condition in violation of Bauman v. SAIF, 62 Or App 323 (1983). The Referee did not separately discuss this contention, possibly because it was not very clearly raised at hearing.

Claimant sustained the more significant of his two industrial injuries in March 1978 while working for Tillamook County. That injury resulted in a strain or sprain type of condition in claimant's neck and back. Virtually all of the many doctors who have examined or treated claimant since 1978 have been unable to find any objective, organic explanation for claimant's pain complaints, that many doctors have referred to as exaggerated. Thus, the medical evidence is full of terms like psychopathology, psychogenic overlay, conversion reaction, conversion hysteria, etc. In context, we understand these references to mean: (1) Claimant's impairment consists of disabling pain; (2) there is no organic explanation for the level of reported pain; therefore (3) various terms have been used to suggest that the disabling pain must be largely psychological in origin.

SAIF's denial here in issue, dated February 5, 1982, states in part:

> "Medical information in file indicates your condition has not materially worsened since last arrangement of compensation, and therefore, aggravation must be denied. In addition we are at this time denying responsibility for any psychological problems. Medicals indicate your psychological problems are not causally related to your injury of March 23, 1978.

"Medical treatment required as a result of your March 23, 1978 injury will continue to be paid as indicated under ORS 656.245."

The first sentence is not inconsistent with Bauman; indeed, it is expressly permitted by Bauman. And the last sentence is unobjectionable. The problem involves the middle two sentences -- "denying responsibility for any psychological problems" because they are allegedly "not causally related to" the March 1978 injury.

It would seem that, before it can be said that an employer/insurer has issued a "backup" denial of a claim, it has to be ascertained what was previously in accepted status. As indicated above, it appears to us that, before the above denial was issued, claimant's "psychological problems" were in accepted status only in the sense that most medical opinion explained claimant's chronic pain in psychological rather than physiological terms. See Barrett v. Coast Range Plywood, 294 Or 641 (1983), order on remand, Phillip J. Barrett, 35 Van Natta 789 (1983); Mary J. Treanor, 35 Van Natta 31 (1983); Juanita M. DesJardins, 34 Van Natta 595 (1982).

Then, at some point in early 1982, claimant began receiving psychological treatment for conditions other than chronic pain for the first time since his 1978 injury. Apparently it was SAIF's receipt of reports about this new and different form of treatment that led to its issuance of the above-quoted denial. So interpreted, there is no backup denial and thus no Bauman problem. Claimant's "psychological problems" of disabling pain remain in accepted status and medical services will continue to be provided as stated in the denial. It is only the claim of additional and different "psychological problems" which has been denied, and we think rightly so.

ORDER

The Referee's order dated December 14, 1982 is affirmed.

ROBERT T. ARNOLD, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-04130
October 28, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of those portions of Referee Leahy's order which affirmed a Determination Order's award of 22.5° for 15% scheduled disability to the right forearm. The issue on review is extent of disability.

Claimant compensably injured his right wrist on July 6, 1981 while vacuuming floors in his capacity as a janitor for the employer. He was pushing a vacuum which was apparently virtually self-propelled when he struck his right wrist against the leg of a desk. There was an immediate onset of pain. Claimant testified that he had been pain free before this incident. He did admit to having had a "sprain" in his right wrist when he was about 13

years old. Claimant saw Dr. Khan who diagnosed a non-union of the carpal navicular. A bone graft was unsuccessfully attempted.

In February 1982 Dr. Nathan examined the x-rays which were taken shortly after the on-the-job incident. Dr. Nathan opined:

> "We have films from the Sunnyside Medical Center, 8/21/81 and at that time we note a navicular fracture, but this is quite longstanding, as evidenced by the fact that the proximal part is sclerotic around its rim and slightly wedged. There is also some eburnation to the fracture surfaces. I suspect this injury could well have been one or several years old, as of August '81.

Dr. Nathan believed that any pain which resulted from claimant's on-the-job incident was "secondary to soft tissue bruising only and not representative of either a fresh fracture or degeneration which was already occurring in the navicular bone."

In March 1982 Dr. Button evaluated claimant. He opined:

> "By history this individual sustained a fracture of the scaphoid years ago which probably resulted in a fibrous union which was asymptomatic until his more recent injury. The present radiographic picture would suggest a fibrous union with some avascular change."

On April 23, 1982, the insurer denied responsibility for further benefits on the grounds that claimant's condition was no longer the result of his on-the-job incident. A Determination Order issued on May 10, 1982 awarding 15% scheduled disability. An amended Determination Order issued May 21, 1982, taking away the disability award because the first Determination Order had failed to consider the insurer's denial.

The Referee affirmed the insurer's denial insofar as it denied responsibility for the bone graft surgery. He considered the second Determination Order to be a "reconsideration" under the meaning of ORS 656.268 and OAR 436-65-100 and held that under the circumstances the Evaluation Division was without authority to reconsider its first Determination Order because there is no evidence any party requested reconsideration and presented new medical evidence, the only circumstance in which reconsiderations are specifically authorized by the statute and regulation. He, therefore, held that claimant was entitled to an award for permanent disability.

We do not agree that the Amended Determination Order was a reconsideration. Both the statute and the regulation appear to contemplate that the Evaluation Division may reconsider Determination Orders when there is new evidence and when one of the parties requests the reconsideration. In other words, the statute and the regulation pertain only to reconsiderations on the merits of the Determination Order when there is new evidence which supports a

change in the Determination Order. The Evaluation Division may not make reconsiderations on the merits of a claim unless one of the parties requests reconsideration. This is not a case in which the Evaluation Division is making a reconsideration on the merits based on new evidence. Rather, it is a situation in which Evaluation made an error of fact. It did not consider the fact that a partial denial had been entered which limited its authority to make an award. Apparently, when Evaluation discovered its error, it issued an amended Determination Order which was consistent with the historical fact that a denial was in effect. We do not believe that either the statute or the regulation contemplates that Evaluation may not correct errors which are merely the result of a failure to recognize undisputed historical facts about claims processing. The agency should not be so bound that it cannot correct its own, easily ascertainable factual errors about claims processing, unless one of the parties requests reconsideration. Accordingly, we find that Evaluation had authority to amend its original Determination Order because the amended Determination Order merely corrected a mistake in historical fact concerning processing of the claim.

As an alternative basis of decision, the Referee held that there was sufficient medical evidence to support the conclusion that claimant had suffered some permanent disability as a result of his on-the-job incident. We agree.

The Referee apparently found claimant credible because the Referee relied on Dr. Button's report which is premised on claimant's history. It is clear from the medical evidence that claimant's right wrist was broken well before the on-the-job incident. However, only Dr. Button's opinion explains why claimant was asymptomatic prior to the incident and was in pain immediately thereafter. According to Dr. Button, claimant's previous break had been joined by fibrous tissue. The on-the-job injury damaged the fibrous tissue and thus required immediate medical care. Dr. Nathan's opinion does not explain how claimant could have been asymptomatic prior to the on-the-job incident. We find that claimant suffered some permanent disability as a result of his compensable injury.

The 22.5° for 15% scheduled disability to his right forearm which was granted by the original Determination Order adequately compensates claimant for his right forearm disability.

ORDER

The Referee's order dated January 5, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

NIKKI BERTHOLD-ILLIAS, Claimant
Wm. David Bailey, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 81-10928
October 28, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Williams' order which upheld the insurer's October 23, 1981 denial or partial denial (the exact scope of the denial being rather unclear) of claimant's undiagnosed right arm condition. That denial states in part: "It would appear, that at best, your employment as a dental/business manager may have caused your condition to become symptomatic, but it did not actually worsen your condition, which remains essentially undiagnosed. * * * Furthermore, it is just as likely that your disability may have been caused by activity away from employment, as activity at employment."

The Board affirms and adopts the order of the Referee with the following additional comment. If claimant's condition is compensable at all, it is compensable as an occupational disease. See Clarice Banks, 34 Van Natta 689 (1982), aff'd 64 Or App 644 (1983); O'Neal v. Sisters of Providence, 22 Or App 9 (1975). As such, claimant must establish that her work activity is the major contributing cause of her current condition. SAIF v. Gygi, 55 Or App 570 (1982). Claimant has failed to so establish by a preponderance of the persuasive evidence. Although the diagnosis of claimant's condition remains uncertain, this factor alone does not necessarily defeat the compensability of her claim, Connie Palmer, 35 Van Natta 1267, 1270 (1983), John Hart, 35 Van Natta 665, 666 (1983); however, considering the evidence of claimant's contemporaneous employment and non-employment activities, the absence of a definite diagnosis makes it impossible to identify claimant's employment activity as the major cause of her condition.

ORDER

The Referee's order dated April 20, 1983 is affirmed.

NANCY A. BINGAMAN, Claimant
Pozzi, et al., Claimant's Attorneys
Lindsay, Hart, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-09549 & 82-00634
October 28, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The employer, Johnson-Kelliher/Snow Mist Seafoods (Snow Mist), insured by Pacific Marine, requests review of Referee Mulder's order which assigned it responsibility for claimant's occupational disease claim, rather than claimant's earlier employer, New England Fish Company (New England), insured by INA. The sole issue on review is employer/insurer responsibility for claimant's occupational disease claim. No appearance has been made by claimant on review.

We adopt the Referee's findings, affirm his conclusion, and make the following additional comments. The Referee concluded that

claimant's more recent employment with Snow Mist contributed at least slightly to her condition in 1981. See generally Smith v. Ed's Pancake House, 27 Or App 361 (1976). New England, as respondent, contends that the proper standard for determining liability in this case is that enunciated by the court in Inkley v. Forest Fiber Products Company, 288 Or 337 (1980), and Bracke v. Baza'r, 293 Or 239 (1982), i.e., that claimant's more recent employer is responsible for her condition if the exposure at that place of employment was of a nature which could have contributed to claimant's disabling condition.

Counsel for Snow Mist astutely points out that this case is unlike most other cases in which the question of employer/insurer responsibility for a compensable occupational disease arises in that claimant has an accepted occupational disease claim with her earlier employer, New England, and that potential causation at the most recent place of employment is not sufficient to shift liability to that employer (Snow Mist). The cited case closest in point, procedurally, is SAIF v. Baer, 60 Or App 133 (1982). The significant difference between this case and Baer, however, is that in this case there is a dearth of medical evidence concerning the possible distinction between the disabling symptoms of claimant's condition in 1981 and the worsening of her pre-existing, underlying and apparently industrial condition. In Baer, there was evidence to support the court's conclusion that claimant's subsequent industrial exposure caused a mere recurrence of symptoms, as opposed to affecting the underlying condition itself.

The question of employer/insurer responsibility presented in the context of this complicated medical situation, where the various examining physicians appear to be at odds in their respective diagnoses, presents a difficult factual issue which can only be resolved by competent medical evidence. The only "medical opinions" in the record which come close to assisting us in making the determination of employer/insurer responsibility, are contained in the interrogatories provided to Dr. Nathan and Dr. Berkeley by counsel for New England. In light of an earlier report, Dr. Nathan's response to the interrogatories appear to raise compensability-type issues without really addressing the responsibility question; and Dr. Berkeley's response indicates that, in his opinion, claimant's work activity at Snow Mist in 1981 contributed, "at least slightly to the causation of her disability in the sense of worsening, at least temporarily, the bilateral ulnar nerve entrapment condition."

In light of Dr. Berkeley's opinion, to find, as counsel for Snow Mist urges, that claimant's employment exposure with her more recent employer caused the mere recurrence of symptoms of a previously accepted occupational disease would be conjecture on our part, without the support of any medical evidence in the record. We find, as the Referee essentially did, that claimant's more recent employment with Snow Mist contributed independently to the worsening of her pre-existing condition and that responsibility for the ensuing disability, therefore, lies with this employer. Cf Bracke v. Baza'r, supra.

ORDER

The Referee's order dated February 10, 1983, is affirmed.

OLIVER S. BROWN, Claimant
Carney, et al., Claimant's Attorneys
Miller, et al., Defense Attorneys
Reviewed by Board Members Barnes and Lewis.

WCB 81-10133
October 28, 1983
Order on Review

Claimant requests review of Referee Mulder's order which upheld the insurer's denial of claimant's injury claim. The issue is whether claimant's injuries arose out of and in the course of his employment.

Claimant, a truck driver, was injured by the explosion of dynamite in his truck that had been placed there by a co-worker. The injury occurred on the employer's premises at the start of claimant's work shift while he was warming up his truck. In criminal proceedings, the co-worker confessed that he had placed the dynamite in claimant's truck because he was angry about claimant's involvement with the co-worker's wife.

Although we disagree with portions of the Referee's analysis, we agree with his conclusion that this claim is not compensable.

The Referee discussed Rogers v. SAIF, 289 Or 633 (1980), and Jordan v. Western Electric, 1 Or App 441 (1970), at length. We think those cases offer, at most, limited and tangential guidance. Instead, we think the controlling precedents, also discussed by the Referee, are Robinson v. Felts, 23 Or App 126 (1975), and Kenneth Hollin, 27 Van Natta 837 (1979).

Robinson involved a claim for death benefits on behalf of a worker who was shot and killed, at her place of work, by her estranged lover who was despondent about being ignored by the worker and because the worker had returned to work. The Robinson court found the claim not compensable, relying on Blair v. State Ind. Acc. Comm., 133 Or 450, 455 (1930): "For a personal injury to arise out of and in the course of employment, there must be some connection between the injury and the employment other than the mere fact that the employment brought the injured party to the place of injury." The Robinson court concluded: "The 'risk' was not 'connected with employment' but instead arose out of a personal relationship with Symes [the killer]. To hold otherwise in a case like this would be to ignore the 'arising out of' requirement of the statute." 23 Or App at 133.

Likewise, in the present case, claimant's injuries arose out of a personal relationship, and the only connection with employment was the fact that employment brought claimant to the place of injury.

The only possible distinction between Robinson and the present facts is that the assailant in Robinson was not then an employe of the same employer as the victim (although he had been in the past), while the assailant in this case is an employe of the same employer and thus claimant's co-worker. We have previously concluded that this distinction does not produce a different result in Kenneth Hollin, supra. Hollin involved an at-work assault by a co-worker for purely personal reasons; following Blair v. State Ind. Acc. Comm., supra, we found that the claim was not compensable. We reach the same conclusion in this case.

ORDER

The Referee's order dated April 7, 1983 is affirmed.

RALPH CUTRIGHT, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-03933
October 28, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer requests review of Referee Thye's order which awarded claimant compensation for permanent total disability, awarded additional temporary total disability compensation and penalized the employer for unreasonably refusing to pay temporary total disability compensation. The employer contends that claimant has not proven that he is totally disabled and that claimant is not entitled to temporary disability compensation because he has retired from the labor market.

We affirm and adopt the Referee's findings and conclusions with respect to the extent of permanent disability. We also affirm the Referee's award of temporary total disability compensation and the penalty imposed for the employer's failure to pay such compensation. We agree with the Referee's statement that, despite the employer's continuing contention that it should not be required to pay claimant temporary total disability, the prior Referee's order of April 2, 1981 obligated the employer to make such payments until that order was reversed or otherwise modified on Board or judicial review. ORS 656.313(1).

ORDER

The Referee's order dated January 20, 1983 is affirmed. Claimant's attorney is awarded a fee of $500 for services rendered on Board review, to be paid by the employer.

ANITA GARZA, Claimant
Royce, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-05563
October 28, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Peterson's order which increased claimant's unscheduled permanent disability award from 10% (32°) awarded by Determination Order dated May 26, 1982 to a total award of 50% (160°). SAIF contends the Referee's award is excessive. We agree with SAIF and thus modify the Referee's order.

Claimant is a 35-year-old teacher's aide who injured her low back when she was struck by a student. Claimant's condition was diagnosed as a chronic low back strain. Claimant also suffered substantial emotional problems as a result of the confrontation with the student and was diagnosed as having significant depression related to the industrial injury. Also, because of right leg pain and weakness related to the low back strain, claimant fell several times, one time injuring her right shoulder.

The impairment of claimant's low back has been rated as mild, and we find the impairment of claimant's right shoulder to be minimum. Although claimant's treating psychiatrist, Dr. Buss, rated her psychological impairment in the mild to moderate range in April 1982, claimant's psychological condition seemed to improve after that appraisal. Claimant indicated to Orthopaedic Consultants in September 1982 that her nervousness and depression were somewhat better since being treated by Dr. Buss. Orthopaedic Consultants also noted that claimant had had episodes of crying during the previous examination, but such was not true at the September examination. In addition, claimant testified at hearing that she planned to apply for a teacher's aide job, whereas she previously seemed unwilling to return to that type of work.

Applying the factors outlined in OAR 436-65-600 et seq, including an impairment rating of 20%, claimant's age of 35 years, education including one year college, and other relevant factors yields a disability rating of 25%. We find that award to be appropriate and proper.

ORDER

The Referee's order dated March 2, 1983 is modified. Claimant is awarded 25% (80°) unscheduled permanent disability, an increase of 15% (48°) over the Determination Order of May 26, 1982 which awarded 10% (32°) unscheduled permanent disability. Claimant's attorney's fee shall be adjusted accordingly.

FRED A. JOHNSON, Claimant
Emmons, et al., Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 81-06812
October 28, 1983
Order of Remand

The self-insured employer requests review of those portions of Referee Daron's order which declined to reduce the award of 144° for 45% unscheduled permanent partial disability granted by a Determination Order. The employer has also moved to reopen the record to consider evidence which was not in existence at the time of hearing. Because we remand to have the Referee consider the new evidence, we do not reach the issue of extent of disability.

The central issue in this case is the extent of claimant's permanent shoulder disability resulting from his compensable bilateral shoulder condition. In a deposition and at the December 1982 hearing, claimant testified that he experiences continuous pain in his shoulders which prevents him from lifting heavy weights or lifting above his head. Claimant also testified that because of his shoulder pain he has trouble sleeping and is unable to sit or walk for long periods.

After the December 1982 compensation hearing, claimant filed a discrimination charge against the employer alleging that the employer had discriminated against him because he had filed workers' compensation claims. He alleged that the employer had refused to rehire him even though he had "recovered from the injury." During the course of litigation of that discrimination charge, claimant presented a full work release from his physician. He also made representations in a deposition to the effect that he no longer had any permanent disability as of March 1983. The

employer seeks to have the discrimination complaint, the physician's release and claimant's deposition from the discrimination proceeding considered in evidence in this compensation proceeding. We regard the employer's motion as a motion to remand.

Although the physician's release and claimant's statements to the effect that he no longer had pain in his shoulder in March 1983 are not necessarily inconsistent with his December 1982 testimony that he was in constant pain, the disparity between these two positions certainly raises questions about the December hearing testimony. The discrimination complaint was not filed until after the compensation hearing, and thus the evidence generated in connection with that complaint was not available at the time of the compensation hearing. Under these circumstances, we are satisfied that the employer has made a sufficient showing that the evidence in question could not have been obtained before the compensation hearing with due diligence. See Ora M. Conley, 34 Van Natta 1698, aff'd 65 Or App 232 (1983). We are also satisfied that this additional evidence is relevant and material -- perhaps even crucial -- to the extent of disability issue raised in this proceeding. We thus conclude that it would promote substantial justice to remand this case for introduction and consideration of the additional evidence now tendered by the employer.

ORDER

This case is remanded to the Hearings Division for further proceedings consistent with this order.

ROY D. PARKER, Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-11163
October 28, 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 claimant's aggravation claim and awarded penalties and attorney fees for SAIF's failure to pay interim compensation.

Claimant sustained separate industrial injuries in 1979 and 1980 while working for different employers which had different insurers. In May 1979 claimant was working as a lineman for a construction company insured by SAIF when a cross-arm from a power pole fell across his back and right shoulder. Dr. Strom diagnosed cervical sprain, bilateral brachial neuralgia and thoracic intercostal neuralgia. In July 1979 Dr. Strom noted low back pain which he also related to the industrial injury. Dr. Serbu examined claimant on referral from Dr. Strom and noted shoulder blade and low back pain. The last award of compensation for the 1979 injury is a June 1980 stipulated order which awarded claimant 2.5% unscheduled permanent disability.

In July 1980 claimant was working for a new employer, insured by USF&G, when he injured himself lifting an outrigger that weighed 80 to 100 pounds. Claimant sought chiropractic care from Dr. Ott complaining of low back, upper back and neck pain. Dr. Rochey also examined claimant and reported a history of lifting the outrigger

with immediate upper back, neck and low back pain. The July 1980 injury claim was initially accepted by USF&G. Subsequently, on August 13, 1982 claimant and USF&G entered into a disputed claim settlement in which USF&G denied responsibility for claimant's condition and claimant received $5,000.

One month later, Dr. Ott wrote SAIF that claimant continued under his care for injuries sustained in July 1980, that claimant had exhausted his USF&G benefits and that claimant wanted Dr. Ott to bill SAIF for his continued care. On October 5, 1982 claimant's attorney wrote Dr. Ott giving him the date of the 1979 injury, the SAIF claim number and the date of the stipulation that resulted in claimant's 2.5% disability award for the 1979 injury. Claimant's attorney also asked Dr. Ott to report to SAIF that claimant's neck condition had worsened since the date of the stipulation, that the condition was related to the 1979 injury and that time loss was authorized. Dr. Ott then sent SAIF a letter that fully complied with this request. SAIF denied the aggravation claim on November 24, 1982, not having paid interim compensation since receipt of Dr. Ott's letter.

The Referee found that claimant's condition had worsened since June 1980, and that the worsening was related to the 1979 industrial injury, on the basis of Dr. Ott's deposition testimony. The Referee stated:

> "On page 7 of Dr. Ott's deposition, he was asked:
>
> > 'Q. . . . do you have an opinion based upon a reasonable probability as to the cause of the cervical and thoracic condition?
> >
> > 'A. My opinion is that it was caused from when the cross arm hit him on the shoulder and the right side of the neck.'
>
> "Dr. Ott was asked about the basis for his letter of October 22, 1982 requesting reopening. The deposition reveals the following on page 17:
>
> > 'Q. . . . What were the physical findings upon which you based this request for reopening?
> >
> > 'A. Instability in the neck and a worsening of symptoms.
> >
> > 'Q. Worsening of what symptoms?
> >
> > 'A. The symptoms of hand and arm numbness, weakness and spasm, increased pain.
> >
> > 'Q. Spasm and increased pain where?
> >
> > 'A. In the neck and upper back and arms.'"

Despite this testimony, we disagree with the Referee's conclusion. Considering the entire record, we are not persuaded that claimant's condition has worsened due to the 1979 injury. First, the medical evidence and claimant's testimony do not convince us that claimant's condition has worsened as opposed to claimant experiencing continuing symptomatic complaints. Second, we are not convinced that claimant's present condition is related to the 1979 injury. Dr. Ott opines it is related, but he did not start treating claimant until after the July 1980 injury. Further, claimant's complaints following the 1979 injury were substantially the same as those following the 1980 injury. We cannot find any evidence that explains how claimant's present complaints are related to the 1979 injury, rather than the 1980 injury, when both injuries produced the same complaints. In this regard, we note that Dr. Ott was apparently providing the same or substantially the same treatment before and after the disputed claim settlement between claimant and USF&G, the insurer on the 1980 injury. After that settlement, Dr. Ott began billing SAIF, the insurer on the 1979 injury, for what appears to be a continuation of the same treatment. We find it impossible not to have doubts about a medical opinion that seems to be at least partially tailored to the circumstances of insurance coverage.

For all of these reasons, we conclude that claimant has not established that his condition has worsened or that his present condition is related to the 1979 injury. We agree with and adopt those portions of the Referee's order on the issue of penalties and attorney fees for SAIF's failure to pay interim compensation.

ORDER

The Referee's order dated February 23, 1983 is affirmed in part and reversed in part. That portion which set aside the SAIF Corporation's denial dated November 24, 1982 is reversed; that denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

CLEVE A. RETCHLESS, Claimant
Mercer, et al., Claimant's Attorneys
Cheney & Kelley, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 79-04418 & 79-08745
October 28, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The employer, Laurelhurst Thriftway (Laurelhurst), requests review of Referee Mulder's order which found that claimant sustained a new injury on December 4, 1978 while employed by Laurelhurst rather than an aggravation of his 1973 injury sustained while employed by Butler Village Marker (Butler), set aside Laurelhurst's September 13, 1979 denial and affirmed the January 19, 1981 denial issued on behalf of Butler. Laurelhurst contends that claimant suffered an aggravation rather than a new injury and that his new injury claim is barred for failure to give timely notice pursuant to ORS 656.265(4).

We adopt the Referee's findings of fact as our own and we affirm his order.

Despite the seemingly contrary opinion of Dr. Schmidt, the preponderance of the medical evidence indicates claimant sustained a new injury while employed by Laurelhurst in December 1978 rather than an aggravation of his 1973 injury. In his September 21, 1979 report Dr. Schuler stated that based mainly on the fact that claimant experienced more sciatic pain following the 1978 incident that, "I would lean towards the fact that this was a new injury which was more severe than those he had had in the past." Dr. Pasquesi reported on October 10, 1979 that all of claimant's injuries had an additive effect on his condition. Dr. Franks, who performed surgery on claimant in January 1980, reported on January 4, 1982 that:

> "It is my opinion that, even though he has had significant low back problems in the past, the number one overwhelming event that led to his further evaluation and eventual surgery that I performed on January 7, 1980, was the accident while lifting the pallet on December 4, 1978."

The course of events which followed claimant's 1978 incident is also supportive of the conclusion that a new injury was sustained.

With regard to Laurelhurst's contention that claimant failed to give timely notice pursuant to ORS 656.265(4), we agree with the Referee that claimant established good cause for his failure to give notice within 30 days after the accident. ORS 656.265(4)(c). Claimant, who had no knowledge of the legal distinction between new injury and aggravation, simply assumed that his difficulty in 1978 was a continuation of the same problem he had experienced intermittently since the 1973 injury. Moreover, the 1978 incident was initially accepted by Butler's insurer as an aggravation of the 1973 injury and compensation was paid. We additionally find that Laurelhurst was not prejudiced in its ability to defend this claim. In the context of this case, the question of whether claimant sustained a new injury or an aggravation is almost purely a medical question, and Laurelhurst's ability to solicit such evidence in this case was not impaired in the least.

ORDER

The Referee's order dated November 24, 1982 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by Laurelhurst.

JOHN C. ROOP, Claimant
Gary G. Jones, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-09072
October 28, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Wilson's order which: (1) Upheld SAIF's denials of two aggravation claims; (2) set aside SAIF's denial of claimant's new injury claim; and (3) awarded claimant's attorney a fee in the amount of $2,000 for having prevailed on a denied claim at hearing. SAIF argues that the new injury claim is not compensable and that the Referee's award of attorney fees is excessive. Claimant renews his request

for penalties for unreasonable denial and discusses the Referee's refusal to leave the record open for an anticipated report from Dr. Gallagher.

First, it is not clear what relief, if any, claimant seeks in connection with Dr. Gallagher's report that is not included in the record but has been tendered to us in connection with a motion to supplement the record. The only relief we could grant is to remand to the Referee. Brown v. SAIF, 51 Or App 389 (1981). We find no persuasive reason to do so. See Ora M. Conley, 34 Van Natta 1698 (1982), aff'd 65 Or App 232 (1983). We have thus limited our review to the evidence introduced at hearing.

Second, we turn to the merits. At all material times, claimant worked for the same employer which was insured by SAIF. Claimant sustained compensable right knee injuries in October 1977 and in February 1981 which SAIF accepted. The present "new injury" claim also involves claimant's right knee and arises from an at-work incident in June 1982. SAIF makes the rather startling argument that this most recent knee injury is not compensable because of claimant's prior knee injuries.

If SAIF intends to invoke the law governing employer/insurer responsibility, it is far from clear to us that any of that law can possibly be of more than marginal relevance when a worker has had a series of injuries while working for a single employer insured by a single insurer. In a one-employer/insurer situation, it would seem that the most recent incident should be accepted either as an aggravation or as a new injury; it would not seem that an aggravation claim can be denied on the basis that the claimant sustained a new injury, or that a new injury claim can be denied on the basis that the claimant sustained an aggravation.

In any event, we affirm and adopt those portions of the Referee's order finding the most recent, June 1982 incident compensable as a new injury.

Third, we find that the Referee's award of $2,000 in attorney fees is excessive. The general standards in our rules governing awards of attorney fees for prevailing on a denied claim are efforts expended and results obtained. OAR 438-47-010. Under this general standard, we have previously suggested fees in the range of $800 to $1,200 in denial cases. Clara M. Peoples, 31 Van Natta 134 (1981). The results obtained in this case involve setting aside a denial of a claim that included surgery and apparently quite a bit of time loss -- although to the extent that the defense to that claim was seemingly in the nature of a responsibility argument, such a result was certain to be obtained either on an aggravation or on a new injury theory. The record, which consists of only 13 exhibits and 41 pages of hearing transcript, does not suggest more than usual efforts expended. However, claimant's attorney has submitted an affidavit that, without itemizing time spent on specific activities, shows a total of slightly more than 17 hours expended at the hearing level. Considering all relevant factors, we conclude that a fee of $1,500 for services at the hearing level would be more appropriate.

Fourth and finally, we consider the penalty issue. As previously stated, claimant sustained compensable knee injuries in October 1977 and February 1981 while working for this employer

insured by this insurer; and then claimant contended he sustained a further knee injury in June 1982 while working for this employer insured by this insurer. The June 1982 incident was witnessed by a co-worker who fully substantiated claimant's story. There was not then nor is there now any evidence, medical or otherwise, that even remotely suggests that claimant's right knee condition after June 1982 was due to anything other than one, some or all three of the at-work incidents, two of which had previously been accepted. There may have then been some reasonable question whether the June 1982 incident should be accepted as an aggravation or as a new injury, but there can be no reasonable doubt that it should have been accepted as something and compensation benefits provided immediately. While a truly unreasonable denial may be rare, we conclude this is one of them.

ORDER

The Referee's order dated March 31, 1983 is affirmed in part and modified in part. In lieu of the fee awarded by the Referee, claimant's attorney is awarded $1,500 for services at the hearing level. In addition, claimant is awarded, as and for a penalty for unreasonable denial, 25% of the benefits for temporary total disability that were due and payable between the date of injury, June 7, 1982 and the date of the Referee's order, March 31, 1983. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $700 for services rendered on Board review, to be paid by the SAIF Corporation.

IRENE L. WRIGHT, Claimant
John C. O'Brien, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-06690
October 28, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Podnar's order which found claimant entitled to benefits for permanent total disability. An April 9, 1982 Determination Order awarded claimant 150° for 100% scheduled disability for loss of her right leg. The issue is the extent of claimant's disability.

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

SAIF's argument that the Referee incorrectly concluded that claimant was entitled to permanent total disability benefits relates solely to ORS 656.206(1)(a) (1971), the law in effect on the date of claimant's injury. That statute provided:

> "'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." (Emphasis added.)

SAIF argues that the Referee incorrectly interpreted the emphasized

language of that statute as meaning an award of permanent total disability could be made for any scheduled loss even though not specifically enumerated by the statute, so long as it permanently incapacitated a claimant from work at a gainful and suitable occupation. We agree with SAIF that certain language in the Referee's order leaves one with the impression that he so interpreted the statute.

We agree with SAIF, as does claimant, that Rencken v. SAIF, 17 Or App 210 (1974), clearly states that permanent total disability cannot be awarded under former ORS 656.206(1)(a) for any scheduled loss other than those specifically enumerated by the statute; rather, the "other condition" language of that statute relates solely to unscheduled disabilities. If the Referee intended to state that loss of a single leg, without unscheduled disability, qualifies under the statute as an "other condition" for purposes of permanent total disability, that would be incorrect.

Claimant argues, however, and we agree, that the record demonstrates that claimant's disability goes beyond her lost leg and involves unscheduled areas of her body as well. We also agree with claimant that the record unequivocally demonstrates that she is permanently and totally disabled. Therefore, despite the possibility that the Referee may have misinterpreted former ORS 656.206(1)(a), we agree completely with his otherwise well-reasoned order.

ORDER

The Referee's order dated February 28, 1983 is affirmed. Claimant's attorney is awarded $600 as a reasonable attorney's fee for services in connection with this review, to be paid by the SAIF Corporation.

CHARLES S. BOYLE, Claimant
Galton, et al., Claimant's Attorneys
Moscato & Meyers, Defense Attorneys

WCB 82-04631
October 31, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of that portion of Referee Leahy's order which awarded claimant a penalty and attorney's fee for the insurer's failure to pay temporary total disability benefits. The issue on review is whether a penalty and attorney's fee were justified when the insurer unilaterally terminated claimant's temporary total disability benefits after claimant was released from a vocational rehabilitation and pain treatment program, but before a redetermination by the Evaluation Division was obtained.

A portion of the Referee's order requires clarification. It is apparent that the Referee's order contains an obvious typographical error. The order reads that compensation should be paid from January 4, 1982. Clearly, the date should have been January 4, 1983. Throughout his opinion the Referee refers to January 4, 1983, including his summary of issues. Furthermore, the parties stipulated at hearing that the Referee should refer to January 4, 1983 when ruling upon the time loss compensation issue. We, therefore, find that compensation should have been paid from January 4, 1983.

On the merits of the penalty and attorney's fee issue, the facts are as follows. Claimant, who had been found medically stationary, had been involved in a vocational rehabilitation program followed by a pain center program until January 4, 1983. When the pain center program was completed on January 4, 1983, the insurer terminated time loss payments. Claimant requested a hearing asserting that he was entitled to time loss benefits until his claim was closed by Determination Order. He relied upon ORS 656.268(2), (4) and (5).

The insurer contends that a penalty and attorney's fee was not in order given prevailing law at the time of hearing, and that the Referee specifically found that the insurer's argument for terminating time loss was reasonable. The insurer argued that once a claimant is found medically stationary and then a Determination Order is issued, he is entitled to no further temporary total disability compensation (time loss). If vocational rehabilitation is thereafter authorized, time loss must be resumed, not because claimant is not medically stationary, but because of his maintenance while he is engaged in retraining. Therefore, the insurer argues it is unfair to require the continuation of those benefits beyond the termination date of the program.

This very issue has been addressed by the Board and the Court of Appeals. Billy Joe Jones, 34 Van Natta 655 (1982), aff'd., Jones v. Boise Cascade Corp., 63 Or App 194 (1983). At the time of hearing, the Jones case was pending before the Court of Appeals. In Jones, the court affirmed the Board's order which held that temporary total disability benefits must continue to be provided to a medically stationary claimant until issuance of a Determination Order pursuant to ORS 656.283(5). Thus, although the issue was pending before the Court of Appeals, the Board decision was in effect. The Board issued the Jones decision on May 21, 1982, before the insurer's unilateral termination of January 4, 1983. Failure to follow a Board order is sufficient basis for an award of penalties. Barbara Holder, 32 Van Natta 205 (1981).

We do not find the insurer's reasons for failing to continue to pay claimant temporary total disability benefits reasonable. Clearly, at the time of his release from the vocational rehabilitation and pain center program a redetermination of his claim by the Evaluation Division had not been made. When the insurer unilaterally terminated claimant's temporary total disability benefits, prevailing administrative, statutory and case law required just such an authorization from the Evaluation Division before benefits could be terminated. OAR 436-61-420, OAR 436-61-410(2), ORS 656.268(2), (4) and (5), and Billy Joe Jones, 34 Van Natta 655 (1983).

Under these circumstances a penalty and attorney's fee are warranted. See Mark L. Side, 34 Van Natta 661 (1982); ORS 656.262(9); Barbara Holder, supra.

ORDER

As corrected herein, the referee's order dated February 15, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

ERIK A. LANDIS, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-00536
October 31, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Foster's order which concluded that claimant was not a subject worker on the date he was injured, November 24, 1981, and thus upheld the SAIF Corporation's denial of his claim arising from that injury.

Claimant is a corporate officer who was injured while doing carpentry work. ORS 656.027(8) was enacted by Oregon Laws 1981, chapter 535, section 3, and went into effect on November 1, 1981, i.e., a little more than three weeks before claimant's injury. That statute describes one category of nonsubject workers as follows:

> "A corporate officer who is also a director of the corporation and has a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officer." (Emphasis added.)

The emphasized language of this statute constitutes a repudiation of the "dual capacity" doctrine previously recognized by the Board and upheld by the Court of Appeals in Erzen v. SAIF, 40 Or App 771 (1979). Under that doctrine, corporate officers were considered subject workers and thus entitled to compensation for injuries received when "engaged in performing the ordinary duties of a worker." There is thus no question that, under the pre-November 1, 1981 law claimant would have been entitled to compensation for injuries sustained while doing carpentry work; nor is there any question that, under post-November 1, 1981 law, claimant would not be entitled to compensation for injuries sustained while doing any work for the corporation. The question is which law should be applied.

Claimant contends that the dual capacity doctrine was incorporated into his insurance contract with SAIF before ORS 656.027(8) went into effect; it follows, claimant argues, that he has a contract right to compensation notwithstanding the existence of a statute in effect on the date of injury which provides that he has no statutory right to compensation for that injury. We substantially agree with the Referee's analysis and fully agree with the Referee's conclusion to the contrary.

Claimant alternatively argues that SAIF should be required to refund that portion of the premium paid to SAIF after ORS 656.027(8) went into effect that was based on claimant's wages for "performing the ordinary duties of a worker." This is a dispute between an insurer and its insured over which we have no jurisdiction. Derral D. Kelley, 34 Van Natta 73 (1982). If we did have jurisdiction, we would agree with claimant.

ORDER

The Referee's order dated March 4, 1983 is affirmed.

FREDERICK D. OXFORD, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-00287 & 82-00288
October 31, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Danner's order which permitted the record to be reopened for the taking of additional medical evidence, set aside SAIF's denial of aggravation and awarded additional temporary disability compensation. SAIF contends that the Referee erred in reopening the record, claimant failed to prove that he has suffered a worsening of his previous compensable low back injury, claimant has failed to prove that he is entitled to any additional temporary disability compensation and the Referee's award of attorney fees was excessive.

I. Reopening of the Record

The Referee issued his original order on June 28, 1982. On July 19, 1982 claimant's attorney requested that the record be reopened to allow a report from Dr. Jeppesen to be admitted into evidence. Claimant explained that the report was not available at the time of the hearing because Dr. Jeppeson had been transmitting the reports on claimant's case to the wrong insurer. The Referee reopened the record on July 22, 1982 for reconsideration. SAIF objected to the admission of Dr. Jeppesen's report, stating that it could have been obtained prior to the hearing. However, SAIF indicated in the same letter to the Referee that its rights would be protected if SAIF were to be given the opportunity to present rebuttal evidence to Dr. Jeppesen's report. Claimant's attorney agreed to reconvene for further evidence taking by both parties, and the Referee scheduled a new hearing for that purpose. At the second hearing, claimant offered two letters from Dr. Jeppesen and his report, as well as a report from Dr. Donald T. Smith. SAIF made no objection at the time these exhibits were offered, and they were admitted. A request was made to leave the record open at the conclusion of the second hearing for the admission of further reports from Dr. Smith and Dr. Birskovich. SAIF made no objection to this request, and the Referee left the record open for admission of those exhibits.

SAIF's brief on Board review asserts that the Referee erred in reopening the record after the first hearing because claimant had not shown that the medical reports in question could not have been made available at the time of the first hearing. Because of SAIF's apparent agreement with the proposal to hold a second hearing rather than just reopen the record, as the claimant had originally requested, and its failure to object to the reports admitted when the record was reopened, we find that SAIF has waived any objections it might have raised with respect to the reopening and the additional medical evidence.

II. The Denial of Aggravation

ORS 656.273 provides that an injured worker is entitled to additional compensation, including medical services for worsened conditions resulting from the original injury. We believe that claimant has proven that his condition has worsened, at least to

the extent that it requires further medical treatment, and that the 1978 injury is a material factor in that worsening. Claimant's increased pain in October of 1981 occurred after claimant had been transferred to a job requiring more physical exertion than the work he had been doing. SAIF contends that claimant's problems are due to a non-industrial degenerative rheumatoid condition and not to his prior low back strain. SAIF's theory is not supported by the report of their own examining physician, Dr. Degge, who diagnosed low back strain and opined that claimant was not medically stationary. Additionally, Dr. Birskovich, a rheumatologist, could find no evidence that claimant was suffering from a rheumatoid condition.

III. Temporary Disability Compensation

Claimant primarily relies on Dr. Jeppesen's report of May 24, 1982 as proof of claimant's entitlement to additional temporary disability compensation. This exhibit is a "fill in the blanks" type form and contains no explanation or rationale for Dr. Jeppesen's conclusion that claimant was unable to work from October 13, 1981 to March 31, 1982 and only able to do modified work from April 1, 1982 through August 1, 1982. Dr. Goluban's emergency room report of October 13, 1981 specifically indicates that claimant was released to return to his regular work. Claimant testified that he in fact returned to work and continued to work until he was laid off when the plant closed. Dr. Smith indicates that claimant was unable to work during the same period, but we give very little weight to his opinion due to the faulty history on which it is based. Given the fact that claimant was obviously able to work during at least part of the time in question and the lack of explanation from Dr. Jeppesen, we find that claimant has failed to prove entitlement to any additional temporary disabilty compensation.

IV. Attorney Fees

SAIF asserts that the Referee's award of $1,800 as an attorney's fee for services rendered at the two hearings was excessive. Certainly in light of our holding on Board review, that claimant has not established his entitlement to temporary disability benefits, $1,800 would appear to be an excessive fee.

ORDER

The Referee's order dated June 28, 1982 as amended on January 21, 1983 is reversed in part. That portion of the Referee's order which awarded additional temporary disability compensation is reversed. In lieu of the fee awarded by the Referee, claimant's attorney is awarded $1,200 for services at hearing, to be paid by the SAIF Corporation.

The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $400 for prevailing on the denial of aggravation and the propriety of reopening issues on Board review, to be paid by the SAIF Corporation.

DONALD E. POND, Claimant
Alan Tuhy, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-09131
October 31, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests and claimant cross-requests review of Referee Thye's order which reversed SAIF's denial of claimant's 1981 cervical claim and which denied claimant's request for penalties and attorney fees for SAIF's failure to timely provide medical documents. SAIF contends that claimant's need for a cervical laminectomy and foraminotomy in August 1981 was due to a natural progression of claimant's pre-existing degenerative disc disease and was not an aggravation of his compensable 1979 injury. Claimant contends he is entitled to penalties and attorney fees for SAIF's failure to provide medical documents in a timely manner.

The Board affirms and adopts the portion of the Referee's order which reversed SAIF's denial of claimant's 1981 cervical claim. Regarding the penalty issue, however, the Board finds the claimant entitled to penalties and attorney fees for SAIF's tardy provision of documents to claimant's attorney.

On October 15, 1981 claimant's attorney wrote SAIF asking that SAIF consider claimant's request for production to be continuing in nature. Thereafter, Dr. Brown, SAIF's neurological consultant, sent three interoffice memo reports to SAIF's legal department dated November 5, 1982, December 9, 1982 and January 13, 1983. SAIF's attorney stated that he forwarded copies of these three reports to claimant's attorney on February 24, 1983. Claimant's attorney stated he received them on March 2, 1983, seven days before the scheduled hearing.

The Referee refused to award penalties because OAR 436-83-460 does not specify the period of time within which an insurer must forward documents after receipt when the documents are not held by the insurer at the time of claimant's request for production. In addition, the Referee found no evidence of prejudice to the claimant resulting from the delayed receipt of the documents. We differ with the Referee on both points.

OAR 436-83-460 provides:

> "Upon demand of any claimant requesting a hearing, the DRE/SAIF and its representatives shall within 15 days of mailing said demand furnish to claimant or his representative, without cost, copies of all medical or vocational reports . . . which are then or come to be in the possession of the DRE/SAIF or its representatives . . ."

We interpret this rule to mean that when a claimant has requested production, the insurer must forward to claimant copies of medical and vocational reports within 15 days of mailing of claimant's request or within 15 days of the insurer's receipt of documents received after claimant's request. Kathryn P. English, 34 Van Natta 1469 (1982). Therefore, in this case where claimant requested production prior to SAIF's receipt of Dr. Brown's three

reports, SAIF was obligated to forward each report to claimant within 15 days of its receipt of each report. SAIF's failure to do so entitles claimant to penalties and attorney fees. Moreover, claimant is not required to show prejudice resulting from the insurer's delayed provision of the documents. The Board orders SAIF to pay claimant a penalty of $300 and an attorney fee of $300 for its failure to comply with OAR 436-83-460. Stella Phillips, 35 Van Natta 1276 (1983).

ORDER

The Referee's order dated April 11, 1983 is affirmed in part and reversed in part. The Referee's denial of claimant's request for penalties and attorney fees is reversed. SAIF shall pay claimant $300 as and for a penalty and claimant's attorney an associated fee of $300 for failure to comply with OAR 436-83-460.

The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $600 as a reasonable attorney's fee on Board review for prevailing on a denied claim, to be paid by the SAIF Corporation.

CASIMER WITKOWSKI, Claimant
Galton, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorney
Allen & Vick, Attorneys

WCB 81-05395 & 81-05678
October 31, 1983
Order on Review (Remanding)

Reviewed by the Board en banc.

Claimant requests review of Referee St. Martin's order upholding the self-insured employer's denial of an alleged aggravation claim and his order refusing to reopen the claim to consider evidence developed after the hearing but before the original order became final. The issue on review is whether the Referee should have considered the new evidence and whether the case should be remanded to the Referee to consider the new evidence.

Claimant sustained compensable injuries on August 26, 1980 and again on October 24, 1980. These injuries were in the nature of slip and fall injuries in which claimant may have struck his shoulders or neck. Claimant began to develop left side paresthesia shortly after the injuries, however the claim was closed with no permanent disability award on April 20, 1981.

Claimant continued to experience left side paresthesia which continued to worsen. He began missing work. He filed an aggravation claim which was denied by the employer. The aggravation claim was heard by the Referee on January 20, 1982. At that time the only evidence which supported claimant's argument that the worsening of his paresthesia was caused by his compensable injuries was the opinion of his chiropractor that the left side paresthesia was caused by cervical problems which were the result of the industrial injuries. All other medical evidence at that time indicated that claimant had suffered a stroke and that his left side paresthesia was unrelated to the industrial injury.

On February 12, 1982 claimant saw an orthopedist, Dr. Todd, who referred him to a neurologist, Dr. Silver. Dr. Todd suspected cervical problems. Dr. Todd's report as well as all reports by Dr. Silver have not been admitted into evidence by the Referee. The

dissent castigates the majority because it "relies rather heavily on evidence that is not yet admitted." We have considered this evidence and recite it here for the limited purpose of deciding whether the case should be remanded, not for its substantive value.

On March 3, 1982 the Referee issued his order finding that the left side paresthesia was unrelated to claimant's industrial injuries. He discounted the chiropractor's opinion and relied on the opinions of the other doctors that claimant had suffered a stroke.

On March 17, 1982 Dr. Silver performed a myelogram which revealed obstructions at C3-4 and C4-5. Dr. Silver felt that the myelographic findings were consistent with either a cervical spondylotic myelopathy or lateral sclerosis. He opined that if it were revealed to be cervical spondylotic myelopathy then it was probable that the paresthesia was caused by the industrial injuries.

On April 2, 1982 the Referee abated his order "to enable the litigants to clarify their respective medical positions and/or to obtain additional medicals and/or to take a responsive position to the claimant's contention on the merits."

On April 7, 1982 Dr. Silver operated on claimant despite the fact that the employer had mailed a letter the day before requesting that the surgery be delayed for an independent medical examination. The doctor later noted that he felt it would be medically infeasible to delay surgery while the employer sought more independent medical examinations.

The surgery revealed that claimant indeed suffered from cervical myelopathy which was secondary to cervical spondylosis and disc degeneration. Dr. Silver performed a discectomy at C3-4, C4-5 and C5-6 as well as a fusion. The later medical reports indicate that claimant improved markedly following this surgery.

On September 8, 1982 the Referee issued an order reinstating his previous order and specifically refusing to consider the evidence which was developed after the hearing. He reasoned that considering that evidence would be "giving [claimant] two bites at the apple." He also noted that the employer would be prejudiced because it had been denied an independent medical examination prior to the surgery.

In addition to assigning as error the Referee's refusal to consider the subsequently developed evidence, claimant has moved to remand the claim to the Referee to consider another report from Dr. Silver which was generated after the Referee's last order.

In Robert Barnett, 31 Van Natta 172 (1981), we described the rationale behind our restrictive policy on remands.

> "Given all these circumstances--significant control by the parties over when a case is docketed for hearing, the possibility of a postponement and the possibility of keeping the record open--the Board concludes that a restrictive policy toward remands is appropriate." 31 Van Natta at 174.

In essence, we apply a restrictive policy toward remands because there are numerous mechanisms for keeping the record open, but once the record closes it is in the interests of administrative economy that the record be as final as possible. Consequently we allow remands only in very narrow circumstances. Those circumstances are presented when relevant evidence is discovered which could not reasonably have been produced and discovered prior to the hearing.

It is undoubtedly from this policy that the Referee developed the notion that the additional evidence should not be considered because claimant should not get more than one bite at the apple. While we agree in principle with the Referee, in this case the first bite at the apple was not completely chewed because by abating his order, the Referee in essence kept the record open for that evidence until he issued a final order.

The central issue in this case is whether claimant's condition attributable to his compensable injuries has worsened. Claimant saw Dr. Silver after the hearing but before the order issued. Dr. Silver diagnosed claimant's cervical problems after the order issued but before it became final. Dr. Silver's reports bear on the issue of whether claimant's worsened left side paresthesia was caused by his compensable injuries. As soon as it became apparent that the basis for the order might be in error, claimant moved to abate the order.

We have no doubt the Referee had the authority to abate his order and jurisdiction to consider Dr. Silver's reports so long as no party had requested Board review. Until the time for requesting review passed or until a request for review was filed the Referee continued to have jurisdiction over the claim. See ORS 656.289(3), OAR 436-83-480. The order of abatement was not an appealable order because it was not "one which determines the rights of the parties so that no further questions can arise before the tribunal hearing the matter." Mendenhall v. SAIF, 16 Or App 136 (1974).

Once the Referee found that it was appropriate to abate the order to "enable the litigants to clarify their respective medical positions and/or to obtain medicals and/or to take a responsive position to the claimant's contention on the merits," we believe he should have allowed them to do so and then considered the developed record on the merits. The dissent considers it "shocking" that we consider the Referee's order of abatement in the nature of an order keeping the record open for additional evidence. While it is true that the legal effect of the Referee's order was merely to abate his previous order, the practical effect was to encourage the parties to fully develop their position and the evidence on the issue raised by Dr. Silver's reports. In such a circumstance where the Referee's order of abatement encourages developing evidence and legal positions, it is certainly reasonable to expect that when those positions and that evidence have been fully developed the Referee will consider them. We note that the Board has previously said that Referees have a duty to suspend proceedings until a claimant submits to an independent medical examination requested by the employer/insurer. Victoria Napier, 34 Van Natta 1042 (1982). Certainly by analogy, when a Referee, in essence, reopens a record to allow the parties to develop evidence on a particular issue, then it is reasonable to expect that he would then consider that evidence.

The real issue in this case is whether the claimant has established that the new evidence he seeks to have considered was unobtainable prior to the hearing. We believe that the Court of Appeals has already disposed of that issue. In Egge v. Nu-Steel, 57 Or App 327 (1982), the Court of Appeals remanded a claim to the Referee to consider a medical report which was generated the day after the hearing. The only excuse for the late generation of that claim was that the claimant had moved to a different state and was continuing to seek medical evaluation and treatment because his Oregon physicians had been unable to discover the cause of his pain. The court noted "the record furnishes a reasonable explanation [of why the evidence had not been obtained earlier]." 57 Or App at 329. Like the claimant in Egge, no doctors had been able to discover the cause of this claimant's paresthesia until he saw Dr. Silver after the hearing.

We believe that Egge controls. If the court found it appropriate in Egge to remand to the Referee to consider evidence developed after the hearing which was unavailable because the claimant had not previously seen the doctor who generated the evidence, then a fortiori, it is appropriate for us to require the Referee to consider similar evidence which was not produced at hearing for similar reasons after he had abated his order for the express purpose of allowing the parties to fully develop the evidence on that issue.

Although the dissent cites numerous Board cases, it does not explain how this case differs in any material way from Egge. We believe that Egge requires a finding that claimant could not have obtained the newly developed evidence in this circumstance. We do not believe we are, as the dissent implies, opening the door for a remand every time a claimant obtains a new medical opinion. Both this case and Egge involve the rare situation of a claimant who has never obtained a satisfactory explanation of the cause of a medical problem. Both cases also involve a claimant who continues to seek that explanation and is finally rewarded for his diligence with an objective medical explanation of the problem shortly after a hearing but before a final order is issued. It is only in those circumstances that we are saying today that remand is appropriate.

In summary, the Referee continued to have jurisdiction over this claim because he abated his original order before it became final or was appealed. Dr. Silver's reports bear on the central issue in this case, whether claimant's worsening is caused by his compensable injuries. It was appropriate to consider those reports because they were not available because claimant had not seen Dr. Silver prior to the hearing and was merely continuing to attempt to get medical evaluation and treatment as was the claimant in Egge. This is sufficient explanation on the record of why claimant was not able to obtain this evidence prior to the hearing.

We also note that the employer has denied compensability of the surgery performed by Dr. Silver. A hearing on that denial is pending. It is certainly in the interests of administrative economy to combine the hearing on the denial with the question of the cause of claimant's paresthesia.

Accordingly, we remand this case to the Referee to consider a fully developed record consistent with this order.

ORDER

The Referee's orders of March 3, 1982 and September 8, 1982 are reversed. The claim is remanded to the Referee for consideration consistent with this order.

Board Member Barnes Dissenting:

It is not apparent from the majority's decision, but motions to Referees to reconsider on the grounds of newly discovered evidence and motions to the Board to remand on the grounds of newly discovered evidence are both covered by the Board's rules of practice and procedure. OAR 436-83-480(2) states:

> "A motion [for a Referee] to reconsider shall be served on the opposite parties by the movant and, if based on newly discovered evidence, shall state:
>
> "(a) The nature of the new evidence; and
>
> (b) An explanation why the evidence could not reasonably have been discovered and produced at the hearing."

OAR 436-83-700(5) makes the same standards applicable to motions to the Board to remand:

> "If Board review is sought on newly-discovered evidence, the request should conform to Rule 83-480(2)."

There are literally dozens of Board decisions interpreting and applying these provision from our procedural rules. The majority ignores all of these prior decisions, which is convenient because most of them are inconsistent with the result the majority reaches today.

I.

Before discussing the policy considerations I think are applicable to Referee reconsideration and Board remand, I begin by stating my understanding of the facts. In this vein, I first note that the majority's statement of the facts relies rather heavily on evidence that is not yet admitted -- the evidence that claimant wants admitted on remand. I suggest it is appropriate to consider this not-yet-admitted "evidence" solely for purposes of determining whether to remand; I think it is inappropriate to rely on this not-yet-admitted "evidence" in reciting the facts now before us.

The facts actually before us can best be stated chronologically:

August 1980 and October 1980: Claimant sustained compensable injuries. These injuries were thought to be quite minor and claimant continued to work.

April 20, 1981: A Determination Order issued which awarded no compensation for either temporary or permanent disability. This

was apparently intended to close both the August 1980 and the October 1980 claims, although the Determination Order recites only an October 1980 date of injury.

April 27, 1981: Immediately after receiving the Determination Order, claimant began treating with a chiropractor, Dr. Robinson, who submitted what the employer interpreted as an aggravation claim, i.e., that claimant's condition worsened immediately after he got the April 20 Determination Order.

May 27, 1981: The employer denied claimant's aggravation claim.

June 10, 1981, June 18, 1981 and January 2, 1982: Claimant filed requests for hearing. The principal issue raised was whether claimant's injury-related condition worsened after the April 20 Determination Order such that he was entitled to aggravation reopening pursuant to ORS 656.273.

June 18, 1981 and June 19, 1981: Claimant filed Applications to the Presiding Referee to Schedule Hearing. Both of these applications certified: "The claimant is ready for hearing and prepared with all medical reports and other evidence."

January 20, 1982: A hearing was held before Referee St. Martin. Based on standard Board procedures, this hearing was scheduled solely in reliance on claimant's prior certifications that he was "ready for hearing."

March 3, 1982: Referee St. Martin issued an order which upheld the employer's May 27, 1981 denial of claimant's aggravation claim.

March 19, 1982: Claimant moved that the record be reopened for receipt of two additional exhibits. (The actual wording of claimant's requests was "that the record in this case remain open"; but since the record obviously closed before the Referee issued his March 3 order, all parties have treated this as a request to reopen the record.) These exhibits involved treatment claimant received in February 1982, after the January 1982 hearing.

March 24, 1982: The employer objected to reopening the record.

April 2, 1982: Referee St. Martin issued an order captioned "Order Granting Motion for Reconsideration." Regardless of the caption, it is clear to me that the actual substance of this order was merely to abate the Referee's March 3 order and to keep the question of whether to reopen the record under advisement. Specifically, the April 2 order states:

> "IT IS HEREBY ORDERED that the said Opinion and Order of the above-entitled case published March 3, 1982 is hereby set aside and shall be abated to enable the litigants to clarify their respective medical positions and/or to obtain additional medicals and/or to take a responsive position to the claimant's contentions on the merits;

"IT FURTHER BEING ORDERED that this order being granted while the Referee still has jurisdiction, the time for appeal shall likewise be abated."

Early April 1982: The parties were aware by this time, although there were not yet any documents to this effect tendered to the Referee, that Dr. Silver proposed to perform cervical surgery and that Dr. Silver believed that the proposed surgery was causally related to claimant's August 1980 and/or October 1980 industrial injuries.

April 6, 1982: The employer issued a denial of the surgery proposed by Dr. Silver.

June 3, 1982: Claimant filed a request for hearing protesting the employer's April 6 denial. That hearing request is currently pending as WCB Case No. 82-04843.

(Neither the employer's April 6 denial of surgery nor claimant's June 3 hearing request on that denial are in the record now before us. However, both parties have represented to the Board that the employer issued such a denial on April 6; and the records of this agency, which I believe we can officially notice, Dennis Fraser, 35 Van Natta 271 (1983), reflect that claimant filed a hearing request challenging an April 6 denial and that request is now pending as WCB Case No. 82-04843.)

July 28, 1982: Claimant tendered 14 additional exhibits to the Referee for possible inclusion in the record in this case. These exhibits involved treatment claimant had received starting in April 1982, after the January 1982 hearing, primarily surgery performed by Dr. Silver in April.

August 2, 1982: The employer objected again to reopening the record.

September 8, 1982: Referee St. Martin issued an order which denied reopening of the evidentiary record and thus denied admission of all of the post-hearing exhibits offered by claimant. Any doubt about the intended effect of Referee St. Martin's April 2 abatement of his March 3 order was clearly resolved in his September 8 order:

"On April 2, 1982, an Order granting motion for reconsideration without prejudice to either party was issued in the above-entitled case to give claimant an opportunity to submit medical documentation to support a motion to re-open the case and to give the employer an opportunity to take a responsive position to claimant's contentions. The Order setting aside the Opinion and Order published on March 3, 1982 was granted without prejudice after oral argument by respective counsel in order for the Referee to retain jurisdiction of the case in that the 30 days was about to expire."

On the merits of whether to reopen the record, Referee St. Martin's analysis was:

> "The record shows that claimant elected to go to hearing on January 20, 1982 after having seen several competent physicians. He relied on the evidence then in existence. There was a failure of proof and the denial for re-opening was affirmed. Having elected to proceed to hearing with the evidence then in hand and observing the proceedings, claimant then, post hearing, sought additional medical attention. I am of the opinion that granting the claimant's motion would be giving him two bites of the apple."

I agree with this analysis wholeheartedly and would affirm the Referee.

II.

The Board majority's first reason for reversing is built on a foundation that, in my opinion, is a complete misstatement of the record. The majority interprets the Referee's April 2 abatement as follows: "[T]he Referee in essence kept the record open for [additional] evidence...." Building on that fallacious foundation, the majority then volunteers a cheap shot: "...when a Referee, in essence, reopens a record to allow the parties to develop evidence on a particular issue, then it is reasonable to expect that he would then consider that evidence."

The majority's interpretation of the Referee's April 2 order is erroneous to the point of being shocking. It is crystal clear to me that the Referee never decided that the record would be reopened for admission of additional evidence. Rather, in response to claimant's March 19 motion to reopen the record, on April 2 the Referee only abated his March 3 order so that he could keep the question of whether to reopen under advisement without losing jurisdiction on the thirtieth day after his March 3 order. No party to this proceeding contends otherwise. Referees and this Board issue orders of abatement virtually every week to be able to consider post-order motions without losing jurisdiction. Never before has such an order of abatement been interpreted as, "in essence" or in any other way, a ruling on the merits of the pending motion. I refuse to join in the first grossly erroneous interpretation to that effect.

III.

As stated above, in his March 19 and July 28 motions, claimant tendered a total of sixteen exhibits to the Referee for admission as part of the January 20 hearing record. In addition, on Board review, claimant has moved to remand for admission of two additional reports from Dr. Silver generated after the Referee's ultimate order. All 18 of these proposed exhibits involve medical examination or treatment of claimant after the January 20 hearing.

As also stated above, under the Board's rules, motions for a

Referee to reopen a record and motions for the Board to remand are judged by the same standard: Whether the evidence could "reasonably have been discovered and produced at the hearing." OAR 436-83-480(2).

There is, of course, an ambiguity lurking in that standard. No evidence about post-hearing medical examination or treatment can ever be "produced" at a hearing. Does this mean that hearings should be regarded as merely dress rehearsals, with the party that loses after the dress rehearsal then generating additional evidence about post-hearing examination or treatment that should then always be admitted under OAR 436-83-480(2)? Until today, the Board consistently said "no."

We have previously interpreted OAR 436-83-480(2) in the context of procedural reality. In reality, no hearings are scheduled by this agency until the party that requested the hearing files an application to schedule which certifies readiness for hearing. In this case, claimant filed two such certifications of readiness in June 1981, well before the January 1982 hearing. I do not think it is fair to the thousands of claimants, employers or insurers waiting for their cases to be heard for this claimant to treat the certifications he filed as meaningless.

In a variety of ways, the Board has previously and repeatedly so stated. In Robert A. Barnett, 31 Van Natta 172, 174 (1981) we stated:

> "Under current practice, no hearing is scheduled until the parties file an application to schedule. Thus, the parties more than the Board now control when a hearing is held. 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."

In Ruth M. Case, 33 Van Natta 490, 191 (1981), we stated:

> "Claimant's attorney has yet to offer any explanation why the testimony of claimant's co-worker could not have been discovered before the hearing and produced at the hearing. All that has been contended is that claimant was unaware, until after the hearing, that her co-worker had overheard her report of injury. However, the reason clients retain and pay attorneys is to investigate the facts and marshal the evidence. * * * In an agency that has received an average of over 1,000 hearing requests per month through the first nine months of this year, the alternative of allowing attorneys to prepare for hearings

> after they are conducted does a greater harm to a greater number of people who must then be forced to wait longer for their own hearings."

In William A. McKenney, 33 Van Natta 542 (1981), we observed:

> "The hearing that was already held in this case was not merely a dress rehearsal or the highest form of discovery. The Referee's order that was issued in this case is not just a roadmap to guide the parties in presenting the evidence that should have been presented at the first hearing."

And in Charles Berry, 34 Van Natta 44 (1982), we pointed out the practical problems:

> "We decline to allow a remand every time that a claimant, whose claim is being reviewed by this Board, is referred to a different physician for an examination after the record of the hearing has been closed. If we held otherwise, the hearing process would never end."

In summary: (1) The parties, not this agency, control when they are ready to proceed to hearing on the then-available evidence; (2) this agency has no particular interest in when any individual case is heard but has a significant interest, I submit, in keeping the thousands of pending hearing requests moving toward resolution; (3) protracting the resolution of any one case by reopening the record or remanding for further evidence taking necessarily slows down the resolution of one case and, in my opinion, also necessarily extends the delay in getting other pending cases resolved; and (4) for all of these reasons, the prior emphasis in Board decisions applying OAR 436-83-480(2) has been on whether evidence in question could have been "discovered" pre-hearing by attorneys doing what attorneys are supposed to do, marshalling the evidence necessary to prevail.

Thus, we have affirmed the Referees who did not reopen the evidentiary record and/or ourselves denied remand for introduction of new medical evidence generated post-hearing in Dick L. Babcock, 35 Van Natta 325 (1983), Elbert E. Qualles, 35 Van Natta 112 (1983), Robert Delepine, 35 Van Natta 72 (1983), Lorri L. Widman, 34 Van Natta 1646 (1982), Erma Grahma, 34 Van Natta 1467 (1982), and Ray Armstrong, 32 Van Natta 245 (1981), just to cite some of the many cases in which the Board has reached that result. Likewise, we have affirmed Referees who did not reopen the record and/or ourselves denied remand for introduction of new lay-testimony evidence generated post-hearing in Ora M. Conley, 34 Van Natta 1698 (1982), aff'd 65 Or App 232 (1983), and Ruth M. Case, supra. How does the Board majority now explain how this case differs from those prior cases? By ignoring the prior cases.

What guidance does the Board majority now give our Referees for how to handle future requests to reopen the record? None, except that it appears ill-advised for a Referee to invoke the

metaphor about multiple bites at an apple. In Charles E. Parr, 35 Van Natta 896 (1983), a party moved the Referee to reopen the record on facts quite similar to those in the current case. In Parr Referee Pferdner refused to grant that motion and, in affirming him, our Order on Review even quoted from his order denying reopening: "'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.'" 35 Van Natta at 896-97. Is that not substantially what Referee St. Martin said in his ultimate September 8, 1982 order in this case? But Referee Pferdner was affirmed in Parr and Referee St. Martin is reversed in this case.

Looking specifically to the facts of this case, I again note that claimant's first hearing request was filed in June 1981 and that also, that same month, claimant twice certified that he was "ready for hearing and prepared with all medical reports and other evidence." Throughout the remainder of 1981, up until the time of the January 1982 hearing, claimant had the right to consult the physicians of his choice. ORS 656.245. And we see cases every week in which a claimant is referred to a physician by his attorney as part of preparation for hearing. Under OAR 436-83-460 the employer disclosed all evidence in its possession to claimant. Claimant thus had ample opportunity pre-hearing to know what all the medical evidence would be and had virtually unlimited opportunity to generate additional evidence. Claimant nevertheless elected to proceed to hearing on January 1982 on the basis of the evidence that was introduced at that time. After the Referee's order adverse to his position was issued, claimant changed doctors. Claimant's March 19 and July 28, 1982 motions to reopen the record do not contain a single word of explanation of why the post-hearing evidence could not have been obtained pre-hearing; the March 19 motion states only that the additional evidence was "unavailable" at the time of hearing -- an explanation that we have found insufficient in all of the above-cited cases.

I suspect that the reason the Board majority does not attempt to reconcile the result in this case with the contrary result in numerous prior similar cases is that the results cannot be reconciled. It seems to me that, increasingly, the decisions of this Board are becoming subjective and standardless. I could not disagree more strongly with that ad hoc approach.

IV.

There is a final reason why remand is inappropriate in this case, a reason that involves an issue this Board has obliquely touched on several times but apparently never directly addressed as a distinct issue. We all know that the "starting point" from which to measure an aggravation claim is the last award or arrangement of compensation. Do aggravation claims have an "ending point" -- a time up to which any worsening of a claimant's condition is assessed?

That question is quite relevant in this case. Immediately after receiving the April 20, 1981 Determination Order, claimant began treating with Dr. Robinson who submitted what the employer interpreted as an aggravation claim and promptly denied in May 1981. This case went to hearing in January 1982 as a challenge to that May 1981 denial. In other words, it would appear to me that

the issue before the Referee in January 1982 was whether claimant's injury-related condition worsened at any time between the April 20, 1981 Determination Order (the last award of compensation) and the time of the hearing. Stated differently, it would appear that the hearing date (or the closure of the hearing record) is the "ending point," the time up to which worsening is measured.

The majority must disagree because it remands this case for introduction of evidence about claimant's post-hearing medical treatment and surgery as presumably in some ways relevant to the issue of claimant's April 1981 aggravation claim and the employer's May 1981 denial of that claim. Again, however, the majority's apparent position is inconsistent with prior Board decisions.

The facts in Lewis Twist, 34 Van Natta 52, 34 Van Natta 290 (1982), aff'd 62 Or App 602 (1983), were as follows: Claimant went to a hearing on what we called his "first aggravation claim" on March 11, 1980; the Referee, Board and Court of Appeals all upheld the insurer's denial of that aggravation claim; the very next day, March 12, 1980, claimant first consulted a new physician who performed surgery in July 1980; we referred to that surgery as claimant's "second aggravation claim." On these facts, we held that the denial of claimant's first aggravation claim was not "the last award or arrangement of compensation"; nor was it res judicata. We at least implicitly approved the claimant's act of filing a second aggravation claim based on medical developments after the hearing on the first aggravation claim: "Here the claimant was involved in on-going medical treatment at the time of the first aggravation hearing and as a consequence of that treatment it was subsequently discovered that claimant required surgery and surgery was performed." 34 Van Natta at 292. The same is, of course, true in this case.

In Benjamin O. Hockema, 35 Van Natta 299 (1983), the claimant's aggravation rights had expired by the time an extent-of-disability hearing was held. On Board review of the Referee's decision on extent of disability, claimant requested remand to the Referee for introduction of additional evidence. We stated:

> "The nature of this additional evidence is ambiguous. To the extent that it relates to what claimant's condition was at the time of the hearing, we find that the evidence could, with due diligence, have been obtained and offered before the record closed * * *. Alternatively, the additional evidence claimant wants to introduce may relate to a worsening of his condition after the present hearing record closed. Because claimant's aggravation rights expired in 1980, claimant cannot now assert an aggravation claim in connection with this pending case. Claude Allen, 34 Van Natta 769 (1982); Wilma Kim Buhman, 34 Van Natta 252 (1982). Rather, if claimant believes his condition has worsened, his proper remedy at this point is to submit the additional evidence in question to the

> Board in connection with a request for own motion relief pursuant to ORS 656.278." 35 Van Natta at 299-300.

In other words, in Hockema we suggested that post-hearing medical developments were to be regarded as a separate and distinct claim.

We said the same thing in Mary Offutt-Littell, 35 Van Natta 536 (1983). That case, exactly like this case, involved a claimant who had surgery after a hearing on a denial of an aggravation claim. That case, exactly like this case, involved a motion for the Board to remand to the Referee for introduction of the post-hearing evidence about the claimant's surgery. The only difference I can see between this case and Offutt-Littell is that the Board reached the exact opposite conclusion in Offutt-Littell:

> "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." 35 Van Natta at 537.

And George Brasky, 34 Van Natta 453, aff'd 61 Or App 226 (1982), indicates that even some pre-hearing matters can and should be viewed as separate and distinct claims. Brasky went to hearing on the issue of a January 1981 denial of a December 1980 aggravation claim. In June 1981, apparently just before the hearing, claimant was involved in another incident that arguably was an aggravation of his compensable condition. Apparently also, when the hearing convened, the insurer's time in which to accept or deny the latter, June 1981, aggravation claim had not yet expired. Claimant's attorney thus stated to the Referee that the issue was limited to the earlier aggravation claim and denial. Overlooking this limitation, the Referee found the latter aggravation claim compensable. We reversed because that decision went beyond the issues raised.

I submit that the clear implication of the above case is that, subject to a claimant's right to more narrowly limit the issues as in Brasky, alleged post-hearing worsening of a claimant's condition should be treated as a new, separate and distinct claim and I would so hold. Indeed, the parties to this case must share that understanding. As stated above, the employer felt it appropriate to

issue a new post-hearing denial on April 6, 1982 and claimant felt it appropriate to file a new hearing request on that denial. Therefore, the question of whether claimant's condition worsened after the January 1982 hearing in this case and specifically the question of the compensability of claimant's April 1982 surgery are pending for resolution in WCB Case No. 82-04843; there is absolutely no need to inject those issues into this case when those issues were not presented and could not have been presented at the time of the January 1982 hearing.

I would deny claimant's motion to remand and affirm the Referee's order. I, therefore, respectfully dissent.

HARRIS E. JACKSON, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03742
November 3, 1983
Order of Dismissal

The SAIF Corporation has requested review of Referee Galton's order, designated as an "Interim Order," which denied SAIF's motion to dismiss claimant's request for hearing. Claimant has moved to dismiss SAIF's request for Board review on the grounds that the Referee's order is not a final, appealable order presently subject to Board review.

Claimant's hearing request, received by the Board on April 21, 1983, designates several issues for hearing, including medical services, premature claim closure, claim reopening for further medical treatment and temporary total disability benefits, and extent of disability. The last claim closure herein was by Determination Order dated April 14, 1983, which awarded temporary total disability from November 12, 1980 through December 12, 1980 in accordance with a Stipulated Order dated November 8, 1982. The Determination Order awards no permanent disability in excess of that previously awarded claimant.

In response to claimant's request for hearing, by letter dated June 3, 1983 addressed to the Presiding Referee, counsel for SAIF objected to scheduling a hearing on any issues other than those arising under ORS 656.245. That letter, which reasonably may be construed as a motion to dismiss claimant's hearing request, states in pertinent part:

> "The basis for this objection is that under ORS 656.278 jurisdiction as to all matters other than ORS 656.245 is with the Workers' Compensation Board under its own motion jurisdiction. Therefore, the stipulation of December 1, 1981 and the Determination Order of April 14, 1983 should be construed as a nullity and as such, the Hearings Division
>
> does not now have the authority to hold a hearing concerning premature claim closure, reopening of the claim, or permanent impairment."

Although it should be obvious and elementary that copies of correspondence with this agency about pending cases should be sent to opposing counsel, SAIF did not send a copy of this letter/motion to claimant's attorney.

The hearing convened on September 1, 1983. The Referee's interim order states the issues, in addition to the jurisdictional issue raised by SAIF's motion to dismiss, as follows:

> "Claimant protested the Determination Order entered April 14, 1983, which had allowed him temporary total disability benefits from November 12 through December 12, 1980. He requested time loss benefits from December 13, 1980 to January 1981, and thereafter, and an increased permanent partial disability award over the 25% of the maximum allowed by statute previously awarded. Finally, claimant protested the de facto denial of his left eye melanoma."

The Referee's order recites claimant's counsel's assertion that he did not see SAIF's motion to dismiss until the date of hearing. "Therefore, claimant was unprepared to present evidence, if any there be, of his seeking medical care and treatment and/or attempting to perfect an aggravation claim between the 1979 Stipulation and April 26, 1980," the day after claimant's aggravation rights expired.

By statute a hearing request is filed with the Board, and the Board refers the hearing request, "to a Referee for determination as expeditiously as possible." ORS 656.283(2), (3). The statutory and regulatory scheme generally contemplates Board review of Referee's orders which are final, as opposed to interlocutory orders, which is consistent with the most efficient utilization of limited administrative resources. However, the Referee's designation of his order as an "Interim Order" is not dispositive of the issue of its reviewability by the Board at the present time. Board review of a Referee's order is not necessarily controlled by the same principles applicable to judicial review of a Board order.

A definition of "finality" is elusive. The Court of Appeals has remarked, for purposes of deciding whether a city's approval of a tentative plan under its subdivision ordinance is a final order reviewable in writ of review proceedings: "The administrative process necessarily must retain a degree of flexibility. The question is not whether the decision is absolutely final, but whether there is sufficient finality to be appropriate for judicial review." Bienz v. City of Dayton, 29 Or App 761, 770 (1977).

The Court of Appeals decisions presenting the court's definition of a "final" Board order for purposes of judicial review are summarized in Beck v. Oregon Steel Mills, 36 Or App 581 (1978). Hammond v. Albina Engine & Mach., 13 Or App 156 (1973); Hiles v. Compenstion Department, 2 Or App 506 (1970); Barr v. Compensation Department, 1 Or App 432 (1970). See also Mendenhall v. SAIF, 16 Or App 136 (1974). Our review of those decisions discloses that the considerations relevant to a determination of the finality of

a particular order include the effect of the order in determining the parties' respective rights so that no further questions arise before the lower tribunal, and whether the order adjudicates a substantial right or imposes a duty or obligation. We believe that another relevant factor is the advantages and disadvantages to the reviewing forum in considering the propriety of a particular ruling which may adjudicate a substantial right and/or impose a significant obligation or duty but which, nevertheless, does not completely resolve the issues before the lower tribunal. In other words, the question of finality is answered, at least to some extent, by considerations pertaining to the reviewing body's interest in avoiding piecemeal review of multiple issues arising in a single case.

Considering the differences in the respective relationships between the court and the Board vis-a-vis a petition for judicial review, and the Board and the Hearings Division vis-a-vis a request for Board review, we do not deem the court's definition of finality of a Board order necessarily binding upon the Board in deciding whether a Referee's order is final for purposes of Board review. Similar considerations are present, however, and the Court of Appeals decisions concerning the subject of finality, although not binding, are persuasive authority. See, e.g., Larry J. Barnett, 33 Van Natta 655 (1981).

We have in the past considered procedural rulings by a Referee as interim orders not subject to Board review. In David Bartell, 29 Van Natta 876 (1980), we stated that a Referee's order granting a motion to set aside an order of dismissal was not reviewable. The same conclusion was reached in Richard Wehr, 29 Van Natta 656 (1980), involving a request for review of a Referee's order requiring a party to produce certain witnesses for cross-examination; John Swearinger, 29 Van Natta 269 (1980), involving a request for review of a Referee's order directing the claimant to undergo a myelogram; and Derral D. Kelley, 28 Van Natta 793 (1980), which involved a Referee's order denying a party's motion for a deposition.

In Larry J. Barnett, supra, the claimant had requested a hearing contesting a Determination Order's award of permanent disability. After filing the hearing request, claimant became enrolled in a vocational rehabilitation program. Prior to the date of the scheduled hearing, SAIF moved to defer the hearing until a post-rehabilitation redetermination of permanent disability was made pursuant to ORS 656.268(5). The Referee granted SAIF's motion. On review of that order, we concluded that the Referee's order was similar to an order of postponement, was in the nature of an interim order and, therefore, was not sufficiently final to then be reviewed. 33 Van Natta at 656.

The order in this case is similar to the orders involved in the above cases in the sense that it disposes of a preliminary issue in the case without rendering a decision on the merits of the claim for relief which was before the Referee, i.e., the issues raised by claimant's hearing request. It is like the orders considered by the court in Hammond v. Albina Engine & Mach., supra, and Barr v. Compensation Department, supra, in the sense that the Referee's order in this case merely determines that further pro-

ceedings will be held on the merits of claimant's hearing request. In this sense it also is like the Referee's order in David Bartell, supra. It would appear, however, in deciding that a hearing on the merits of claimant's request can be held pursuant to ORS 656.283, a substantial right has been adjudicated -- the claimant's right to a hearing; and, similarly, an obligation has been imposed upon the SAIF Corporation to litigate the merits of claimant's hearing request. Of course, the same right/duty analysis might be made of a Referee's order requiring a party to submit to a deposition, or a claimant to undergo a myelogram, or an order vacating a prior dismissal. Considering this order in the context of the proceeding that led up to it, we conclude that it is closer to the interim end of the interim-final continuum.

It is apparent that there was a lack of notice to claimant that SAIF was raising a jurisdictional issue. Claimant should have an opportunity to marshal evidence in support of his contention that the Hearings Division has jurisdiction over the issues raised by his request for hearing. For example, there is some indication that claimant may have perfected an aggravation claim prior to the expiration of his aggravation rights, although the parties subsequently entered into a stipulation which makes no mention of such a claim. We believe that a proper ruling, one which finally addresses the issue, cannot be made in the absence of a more complete development of the record. We do not regard the Referee's "Interim Order" as a final disposition of the issue raised by SAIF's motion; we, therefore, do not deem it appropriate to proceed with review at the present time. After the parties have had the opportunity to more completely develop a record, the Referee will be in a better position to finally rule on the jurisdictional issue and, with the benefit of a more complete record, the Board will be in a better position to review the Referee's ruling should any party so desire. In the event that the Referee ultimately finds that SAIF's motion is well-taken, he should rule on the merits of whatever claim for relief is properly before the Hearings Division, e.g., a claim for medical services pursuant to ORS 656.245.

ORDER

The SAIF Corporation's request for review of the Referee's September 7, 1983 order is dismissed as premature.

LYNDA HOLMES, Claimant
David Force, Claimant's Attorney
John Snarskis, Defense Attorney

WCB 81-04594
November 3, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Foster's order which upheld the insurer's partial denial of claimant's recurrent corneal erosion. Compensability is the only issue on review.

Claimant compensably injured her left eye when something flew into the eye and got stuck under the eyelid on April 7, 1977. The emergency room physician, Dr. Cornog, noted "abrasion of conjunctiva -and to a lesser degree to the L. cornea." Claimant saw a Dr. Spradling in June 1980. His diagnosis was recurrent corneal erosion which was possibly the result of a previous abrasion of the cornea.

Claimant saw Dr. Fine in April 1981. He too diagnosed a recurrent corneal erosion. He noted that he had obtained no history of a previous injury to the left eye. He opined:

> "It is impossible for me to relate this to any previous injury. It is true that recurrent corneal erosion syndrome sometimes follows traumatic abrasion of the cornea, but there are certainly an equal or larger number of cases that are spontaneous in occurrence and unrelated to injury."

On May 5, 1981 the insurer issued a partial denial of claimant's recurrent corneal erosion syndrome.

On January 31, 1983 Dr. O'Dell reported that he had been caring for claimant since May 1981. He noted that she had a history of an injury in 1977 to the conjunctiva with slight abrasions to the left cornea. He opined:

> "It is definitely possible for a recurrent erosion to be caused from the type of injury Ms. Holmes sustained."

On the basis of this record, we agree with the Referee that claimant has failed to sustain her burden of proving a causal connection between her compensable injury and her recurrent corneal erosion. Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated May 31, 1983 is affirmed.

Board Member Barnes Dissenting:

In a compensable April 1977 incident, some unknown foreign body entered claimant's left eye and caused an abrasion of the cornea. In 1981 claimant was diagnosed as having left eye corneal erosion. The question in connection with this denied aggravation claim is whether the former materially caused the latter.

I find myself in complete agreement with the discussion and analysis at pages 5 to 7 of claimant's brief and, for the reasons stated therein, I would answer the above question in the affirmative and thus reverse the Referee's order. See also Volk v. Birdseye Division, 16 Or App 349 (1974); Linda L. Reining, 35 Van Natta 620 (1983) (dissenting opinion).

RONALD E. BASS, Claimant
PATRICIA S. BASS, Claimant
Leonard Pearlman, Dept. of Justice

WCB CV-83009
WCB CV-83008
November 7, 1983
Crime Victim Order

The applicants, Patricia and Ronald Bass, requested Board review pursuant to ORS 147.155. They appeal from the Department of Justice's June 3, 1982 and July 28, 1982 orders which denied them benefits pursuant to the Compensation of Crime Victims Act, ORS Chapter 147. A combined hearing of both applicants' claims was heard on August 16, 1983 before Hearings Officer Kay Kinsley. The Hearings Officer made findings and recommendations which we set forth in pertinent part:

"1. The applicants were victims of a crime on June 22, 1980.

"2. The applicants incurred medical costs and loss of earnings due to injuries stemming from that crime.

"3. The applicants were not provided with cards by the investigating law enforcement officials stating the procedure to be followed in obtaining compensation under the Compensation of Crime Victims Act as required by ORS 147.365.

"4. Patricia Bass contacted the Clackamas County District Attorney's Office during the summer of 1980 and was given incorrect information regarding the benefits available under the Act and, as a result of that contact, neither Patricia Bass nor Ronald Bass filed for benefits under the Act because of the incorrect information given.

"5. The applicants later obtained further information through a television program on April 25, 1982 which caused them to believe they would be eligible for benefits under the Act and, as a result of that program, the applicants filed for benefits under the Act on April 27, 1982.

"6. The Department of Justice denied the applicants' application for benefits pursuant to ORS 147.015(6) in that the applications had not been filed within six months of the date of their injuries and, in the Department's judgment, the circumstances did not constitute 'good cause' for which an extension of time would be allowed.

"7. In reaching its decision, the Department relied on 'administrative policy' as set out in a proposed rule, OAR 137-760-105, which stated:

> 'In the interests of orderly and consistent administration no extension of time within which the claim must be filed will be granted beyond one year from the date of the criminal injury for any cause except for mental or physical incapacity resulting from the injury sustained from the criminal act.'

"8. The applicants were not prevented from filing within the one year period due to mental or physical incapacity resulting from the injury sustained from the criminal act.

" 9. The applicants had no actual or legal notice of the above 'administrative policy' which placed upon them an absolute limit of one year for filing of an application for benefits under the Act.

"10. The Department's June 3, 1982 orders denying benefits stated it was 'severely prejudiced in its ability to pursue a civil action against the alleged assailants or recover any compensation awards by way of subrogation rights concerning any restitution possibly ordered by the court.'

"11. There was no evidence presented showing that the Department of Justice was prejudiced in its processing of the claim due to the late filing.

"12. The applicants testified at hearing and both were credible witnesses.

"OPINION AND RECOMMENDATION

"In its written argument the Department contends: (1) that only it, and not the Board, has the authority to determine whether or not a particular set of circumstances constitute good cause for extending the time for filing under ORS 147.015(6)(b); and (2) assuming that the rationale underlying the one year time limit policy is that the Department might be prejudiced . . . in processing older claims, the Board has no authority to question that on a case by case basis.

"The Department has analogized the Board's ability to determine the meaning of "good cause" to the court's limited ability in Sayers v. Employment Division, 59 Or App 270 (1982) and Springfield Education Assn. v. School District, 290 Or 217 (1980).

In Sayers, the Court of Appeals held that while an '. . . agency must exercise its judgment in determining the meaning of 'good cause,' 'the court's role' . . . is merely to determine whether the agency's policy decision is within its scope of delegative authority. 59 Or App at 279. The court then proceeded to determine whether the agency had the statutory authority to properly promulgate an administrative rule defining 'good cause' and whether that rule was properly applied by them in the particular case at hand. The court did not go further and examine whether the agency's actual definition of 'good cause' was a reasonable definition.

"The Sayers limited review of an agency's actual definition of 'good cause' is not analogous for two reasons: First, the Workers' Compensation Board is not in the same position as the reviewing court in Sayers. Rather, it is a reviewing administrative agency which has been granted broad powers in these cases by the Legislature. ORS 147.155(5). The Board has

previously considered what its scope of review is to be in this type of case and has determined that its review is de novo, which is consistent with its scope of review generally. ORS 656.295(5). Jill M. Gabriel, WCB Case No. CV-83010 (August 23, 1983). De novo review on the record means that the reviewing body '. . . has not only the right, but the duty to arrive at a result based on its independent judgment.' Hannan v. Good Samaritan Hospital, 4 Or App 178 (1970). Therefore, the Board may independently determine, with appropriate deference to applicable law, whether the facts in the above captioned cases constitute 'good cause.'

"Second, the Sayers court had before it a properly promulgated rule which set forth the agency policy for limiting the definition of 'good cause.' There is no such agency rule in this case. The Department cited 'administrative policy' as its authority for denying compensation in the original June 3, 1982 orders. In its July 28, 1982 orders (which reconsidered and affirmed the June 3, 1982 orders), the Department cited the proposed rule OAR 137-760-105 (quoted above) as authority for denying the applicants' compensation. Although we agree with the Department that it has the power to adopt such rules to define 'good cause,' in the absence of properly promulgated rules to that effect, we decline to limit our review on the basis of 'administrative policy' and proposed rules.

"The facts in this case are on all fours with the facts in Jill M. Gabriel, WCB Case No. CV-83010 (August 23, 1983). In Gabriel, as here, the only reason the applicant was denied benefits was due to her failure to apply for benefits within one year of the crime. Gabriel was not given a card explaining the Compensation of Crime Victims Act as is required under ORS 147.365. Upon learning of the benefits fourteen months after the crime through a newspaper article, Gabriel applied for benefits with the Department of Justice. Citing Ivan Ouchinnikov, 34 Van Natta 579 (1982), the Board held that Gabriel had made a prima facie showing of good cause for late filing due to the failure of the police to provide Gabriel with a card informing her of her rights under the Act. The Board found that there was no indication that the Department was prejudiced in its ability to process the claim due to the late filing. The Board then held:

> 'We believe that the denial of a claim because of late filing (where good cause has been shown) without first making a showing that it was prejudiced by the late filing is an abuse of discretion. We hold, therefore, that the Department abused its descretion in denying this claim.'

"Similarly, the applicants in this case have made a prima facie showing of good cause for late filing. The Department of Justice has not shown it was prejudiced in processing the claim due to the late filings. Under Gabriel, the Department abused its discretion in denying the applicants' requests for benefits under the Act.

"Based on the above, I recommend that the Board reverse the Department's June 3, 1982 and July 28, 1982 orders denying the applicants' benefits under the Compensation of Crime Victims Act and that their applications be remanded to the Department for processing."

We adopt the above findings and, in conformity therewith, order that the Department of Justice accept the applicants' claims for compensation under the Compensation of Crime Victims Act.

ORDER

The Department of Justice's June 3, 1982 and July 28, 1982 orders denying the applicants benefits under the Compensation of Crime Victims Act are reversed and their claims are remanded to the Department of Justice for processing in accordance with this order.

DIANA BINFORD, Claimant

WCB CV 83011
November 7, 1983
Crime Victim Order

Applicant, Diana L. Binford, requests Board review pursuant to ORS 147.155. She appeals from a Department of Justice (Department) decision on review which affirmed the Department's original order denying applicant compensation under the Crime Victim's Compensation Act (the Act), ORS 147.005, et seq. A hearing was held on September 30, 1983 before a hearings officer appointed by the Board pursuant to ORS 147.155(5). The claimant was present at the hearing and was unrepresented by counsel. John Unwin, an administrator for the Department, was present at the hearing. The Department was represented by Assistant Attorney General Pearlman.

The Department concedes that applicant has satisfied all requirements for compensation under the Act with the exception of ORS 147.015(1) which requires that "he is a victim, or is a dependent of a deceased victim of a compensable crime . . ." The Department argues that claimant is not a "dependent" of the deceased victim of a crime as that word is defined in ORS 147.005(5):

> "'Dependent' means such relatives of a deceased victim who wholly or partially were dependent upon the victim's income at the time of death or would have been so dependent but for the victim's incapacity due to the injury from which death resulted."

The Department's argument is two pronged. It first argues that because Bruce Binford was unemployed and not receiving unemployment compensation, he had no income to contribute so he could not have been contributing to his wife's support. It also argues that even prior to Bruce Binford's loss of his job, applicant was not dependent on him for her support.

We review de novo. Jill Gabriel, 35 Van Natta 1224 (August 23, 1983). Our decision is based on the Findings and Recommendations of the Hearing Officer.

I. FINDINGS OF FACT

Applicant is the widow of Bruce Binford who was the victim of a homicide which occured in Portland, Oregon on October 5, 1982. His death occurred on October 8, 1982.

During calendar year 1982 Bruce Binford was employed by various employers. According to W-2 forms supplied by applicant, his total income for 1982 prior to his death was $9,395.60. The applicant's income for the entire year of 1982 was $9,307.84.

Bruce Binford was terminated from his job on September 25, 1982. He had applied for unemployment benefits prior to his death but had not yet begun to receive such benefits.

OPINION

Based on the preceeding findings of fact together with the arguments and explanations offered by applicant and the Department at hearing, we conclude that applicant was at least partially dependent on Bruce Binford at the time of his death and is, therefore, entitled to compensation under the Act.

The Department's first argument focuses on the language "at the time of death" and concludes that, because Bruce Binford was unemployed at the time of his death and had not yet begun to receive unemployment benefits, he had no income at the time of his death, so applicant could not have been dependent on him. The Department focuses on the time of death in the interests of administrative efficiency:

> "According to the record before the Department, the victim, claimant's spouse, was unemployed at the time of his death. Therefore the requirement of dependency "upon the victim's income at the time of death" cannot be met, because at that time he had none. The statute by requiring this test to be made as of "the time of death" is designed to ease the burden of administration under which the Department might otherwise be required to reconstruct evidence of dependency over prior months or years." Department's Argument at 1.

Rather than applying the Department's strict interpretation which focuses on the victim's employment status at the moment of the crime, we believe that the question of whether an applicant is a "dependent" of a victim of a crime at the time of death is best answered by applying a totality of the circumstances test:

> "Dependency does not necessarily require total financial support by one family member of another. Partial support may suffice. There is no mathematical test for the requisite support. Rather, the test should be a circumstantial one under the particular facts of each case." Hines v. Hines, 32 Or App 209, 216 (1978).

The two were husband and wife and were living together. At hearing the applicant explained that her husband contributed his income to their common living expenses. Although he was without a job on the day of his death, Bruce Binford had only lost his job a few days previously. He had applied for unemployment compensation prior to his death. The Department concedes that had he begun to receive unemployment compensation it would have been considered in determining his income. We believe it is reasonable to conclude under these facts that had Bruce Binford lived he would have continued contributing money to the marital partnership. However, that finding does not fully answer the question of whether applicant was a dependent of Bruce Binford.

The Department also argues that under the circumstances, applicant was not dependent on Bruce Binford at the time of his death:

> "There is nothing, therefore, in the evidence to show . . . that the claimant was dependent upon his earnings, i.e. relying on the spouse's income for support. It can be assumed that each in this two-person family was essentially contributing his own support, much as they would have done had they lived independently."

The term "dependent" as used in ORS 147.015(1) has not been construed in our cases. The statutory definition does not help to resolve the issues before us. We look to the Oregon Appellate court decisions in other areas to guide us. In Hines v. Hines, supra, the Court of Appeals construed the term "dependent" as used in the wrongful death statute:

> "[W]e conclude that dependency in the present context requires . . . actual support in the nature of financial contributions or valuable services flowing from the decedent to the purported dependent."

In support of this definition, the Court of Appeals quoted an early worker's compensation case, Paul, et al v. Industrial Acc. Com., 127 Or 599 (1928).

> "In order for relatives to be dependents of an unmarried decedent they must be dependent in fact on his contributions in order to continue to live in comfort according to the manner of living of people in their class and condition." Id at 604.

The thrust of these opinions is the idea that the decedent actually contributed money or services to the alleged dependent and that without these contributions the alleged dependent would not have been able to maintain the style of living maintained prior to the decedent's death.

According to the evidence on record, applicant's income for the entire year 1982 was less than Bruce Binford's income for the

first nine months of 1982. Applicant alleged that Bruce Binford was the "main financial support of the household." As previously noted, applicant explained that Bruce Binford contributed his salary which was historically greater than applicant's to the couple's common fund. Applicant explained that her standard of living was better while she was married to Bruce Binford. She explained that the couple made purchases as well as incurring debts which she would not have done had she lived alone:

> "If I had been single, I'd have had a different life style. I'd have lived in a different place. I may have been living at home. But this was a joint effort, he earned more than I did, his paycheck went to rent, to the major bills. I helped pay the grocery and smaller bills. I'm looking at a Visa bill, a large department store bill that he incurred because he--because of his job he had the clothes for it, and it was a joint effort, but I think if either one of us were single we wouldn't have had the same life style. I can assume any of you if you're single, you adjust your life style. You're married it's a little different, and this is a joint effort."

We conclude under these circumstance that applicant was dependent upon Bruce Binford. Bruce Binford contributed money to the applicant, and applicant's standard of living was dependent on money Bruce Binford contributed to her.

We are not unmindful of the Department's interest in determining the amount of compensation for loss of support to which applicant is entitled. ORS 147.035(b)(C). We suggest that a fair way to determine the compensation under this section would be to determine the average amount of support Bruce Binford could have supplied to claimant per week based on the income he brought in during 1982 prior to his death. The evidence needed to make this computation is easily available in this record.

ORDER

The Department of Justice's decision on review dated May 9, 1983 is reversed. The claim is remanded to the Department for processing in accordance with this order.

EARL W. ANDREWS, Claimant
Rolf Olson, Claimant's Attorney
Lindsay, Hart, et al., Defense Attorneys

WCB 82-08563
November 10, 1983
Order on Reconsideration

The Board issued its Order on Review herein on October 21, 1983. 35 Van Natta 1582 (1983). Claimant has requested that the Board award an attorney's a fee pursuant to ORS 656.386(1) in addition to the fee awarded pursuant to ORS 656.382(1) in our Order on Review.

The sole issue on Board review was whether the Referee erred in refusing to impose a penalty and associated attorney's fee for the insurer's failure to pay claimant temporary total disability at the correct rate. We found that the rate at which claimant's temporary disability benefits was computed was inconsistent with our prior decision in Eldon Britt, 31 Van Natta 141 (1981); that in a similar case we had found the insurer's conduct in violation of a prior Board decision to be unreasonable, Barbara Holder, 32 Van Natta 205 (1981); and that, therefore, imposition of a penalty and attorney's fee was appropriate. We imposed a penalty and ordered the insurer to pay claimant's attorney a fee of $500 in association with that penalty, in addition to the fee allowed by the Referee's order. The Referee had allowed claimant's attorney a fee equal to 25% of the increased temporary disability compensation awarded by the Referee's order.

Claimant contends that the insurer's failure to pay claimant's temporary disability benefits at the correct rate amounted to a refusal to do so and a "de facto" denial of compensation, which provides the basis for an award of an insurer-paid fee pursuant to ORS 656.386.

Insurer-paid fees are authorized in denied or "rejected" cases "where the claimant prevails finally in a hearing before the referee or in a review by the board," or on appeal to the court. ORS 656.386(1). See generally OAR 438-47-020, 438-47-040(2), 438-47-045(2). On the other hand, an attorney's fee is paid out of the claimant's compensation when the attorney is instrumental in obtaining additional compensation in the claimant's behalf. See, e.g. OAR 438-47-025, 438-47-030, 438-47-040(1), 438-47-045(1). Thus, generally fees are payable out of a claimant's award in extent of disability cases; and fees are paid by the employer/insurer in addition to compensation in denied cases. There are situations in which the usually clear distinction between an extent case and a case involving a denied claim becomes obscure. The issue in this case falls into that gray area.

The facts of this case are that the insurer paid claimant temporary total disability benefits for the correct period of time, i.e., the period during which claimant was temporarily disabled; but that the rate of temporary disability was incorrectly calculated under ORS 656.210. We believe this type of issue more closely resembles an extent of disability issue than a question concerning a denied or "rejected" claim within the meaning of ORS 656.386(1). Eldon Britt, supra, 31 Van Natta at 143. Cf Vandehey v. Pumilite Glass & Building Co., 35 Or App 187, 193 (1978); Grudle v. SAIF, 4 Or App 326, 333 (1971). Accordingly, we decline to award claimant's attorney a fee pursuant to ORS 656.386(1) for prevailing on the issue of the correct calculation of claimant's temporary total disability compensation.

Claimant appears to contend that, having "finally prevailed" before the Board on the issue of a penalty for the insurer's failure to properly calculate his temporary disability benefits, he is entitled to an insurer-paid fee pursuant to ORS 656.386(1). Although attorney fees associated with a penalty are imposed, in significant part, as a measure of the relative unreasonableness of

the employer/insurer's claims processing action, other factors to be considered are the efforts expended and results obtained in relation to the penalty issue. The attorney's fee which the insurer is required to pay claimant's attorney pursuant to our Order on Review reflects these considerations. Claimant's attorney is not entitled to an additional fee under the provisions of ORS 656.386(1). Cf Van DerZanden v. SAIF, 60 Or App 316, 321 (1982); Korter v. EBI Companies, Inc., 46 Or App 43, 54 (1980).

ORDER

On reconsideration the Board adheres to its Order on Review dated October 21, 1983.

BENJAMIN O. HOCKEMA, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-09555
November 10, 1983
Order of Remand

The Board issued its Order on Review herein on March 23, 1983. 35 Van Natta 299 (1983). Claimant thereafter petitioned the Court of Appeals for judicial review, and by an order dated August 24, 1983, the court remanded to the Board "for additional evidence." The Board is without authority to consider additional evidence not made of record before the Referee. ORS 656.295(5), OAR 436-83-720(1). Accordingly, it is necessary to remand this case to the Hearings Division for further proceedings.

ORDER

This case is remanded to the Hearings Division for further proceedings consistent with the court's order dated August 24, 1983.

THOMAS R. GREGG, Claimant
Bischoff, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-03925
November 15, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of those portions of Referee Foster's orders which set aside its denial of claimant's aggravation claim and refused to grant its motion to dismiss claimant's request for hearing. The issues are jurisdiction and the compensability of claimant's aggravation claim.

Claimant first injured his low back in 1975 while employed by Central Lane Building Supply, which was insured by SAIF. That claim was accepted by SAIF and closed by Determination Order dated September 18, 1975 with an award of three days of temporary total disability benefits.

In August 1977 claimant began receiving chiropractic treatment from Dr. Fechtel for low back pain. Dr. Fechtel indicated in his report of November 18, 1977 that claimant had continuous low back pain and radiation to the right knee, and that claimant began noticing increased pain associated with his job and activities such

as jogging. Dr. Fechtel diagnosed chronic moderate lumbosacral strain associated with the 1975 injury and stated claimant was medically stationary with no permanent impairment.

Sometime in 1977 claimant went to work as a forklift operator for Timberline Lumber Company, which was also insured by SAIF.

In 1978 claimant was examined by Dr. Matteri, who reported claimant was complaining of back and thigh pain. Dr. Matteri found little objective evidence to verify claimant's complaints and concluded claimant was suffering from a lumbar strain syndrome that was largely attributable to muscular irritation. Dr. Matteri felt claimant was medically stationary. We infer that claimant's 1978 back difficulties were accepted by Timberline/SAIF as a new injury because a Determination Order issued on September 25, 1978 which listed Timberline as the employer and listed an injury date of March 31, 1978. That Determination Order awarded claimant three days of temporary total disability benefits.

Claimant returned to Dr. Fechtel in August 1979 with further complaints of back and leg pain. Claimant completed an 801 form indicating that his activities at Timberline were constantly irritating his back. In September 1979 Dr. Hockey reported that claimant injured his back while lifting heavy timber at work on August 6, 1979 and that he had quit work on August 28, 1979. Dr. Hockey diagnosed lumbosacral strain, advised that claimant could not yet return to work and instituted physical therapy. On November 8, 1979 Dr. Hockey reported that claimant was medically stationary and released to return to work as of November 19, 1979 with minimal impairment. Dr. Hockey indicated claimant's condition was a result of a new injury.

Another Determination Order issued on December 18, 1979. It awarded claimant approximately three months of temporary total disability benefits and listed the date of injury as July 27, 1979.

In October 1980 claimant was seen by Dr. Craig with complaints of low back pain. Dr. Craig reported claimant's then current problem "began several weeks ago when he was deer hunting." Dr. Craig diagnosed a low back strain. Dr. Fechtel examined claimant in November 1980, not having seen claimant since August 1979. Dr. Fechtel noted there was no new trauma associated with claimant's current back symptoms and that:

> "In my examination, I could find no evidence that would directly tie his current symptoms to his old work injury. [It is not clear which of the prior three work injuries Dr. Fechtel was referring to.] By the same token, I could find no evidence that would directly deny that they were related. It seems in most medical probability that current symptoms are more related to the current lifestyle and activities of this patient."

On March 13, 1981 SAIF issued a denial which indicated that claimant's July 27, 1979 Timberline injury remained accepted, but denied that claimant's current symptoms were a result of that injury.

Claimant was examined on November 11, 1981 by Dr. Rocky, who noted claimant began to experience increasing back pain in November or December of 1980. At that time claimant was playing drums for a band and practicing two to four hours per day, five days per week, with at least one engagement per week. After examining claimant and reviewing his history, Dr. Rocky opined:

> "I find no specific evidence of injury residual in this man to explain his present complaints. His back range of motion is moderately severely restricted. This is a non-specific finding which may be present after any prolonged period of inactivity for any reason."

Claimant thereafter began treating with Dr. Smith. On November 2, 1982 Dr. Smith reported claimant had evidence of chronic lumbosacral and/or thoracic back problems, and that a review of the records "suggest[ed]" that his condition had worsened. Dr. Smith believed claimant could have a herniated disc. However, a myelogram performed on December 1, 1982 was interpreted as showing no evidence of any abnormality.

As stated previously, SAIF issued a denial on March 13, 1981. On April 29, 1981 claimant filed a request for hearing listing the issues to be: medical benefits, temporary disability and total disability.

When the hearing convened on January 19, 1983 counsel for SAIF moved that claimant's request for hearing be dismissed on the basis that claimant "did not appeal the denial of March 13, 1981 within 60 days." SAIF's argument was based on the fact that claimant's request for hearing, although obviously filed within 60 days of the denial, did not specifically refer to the denial, and that the request for hearing was, therefore, not an effective appeal of the denial. The Referee issued an interim order on January 21, 1983 denying SAIF's motion. SAIF, relying on our decision in Lucy (Froyer) Anderson, 34 Van Natta 1249, aff'd without opinion, 63 Or App 675 (1983), argues that the Referee erred in not dismissing claimant's request for hearing. Without repeating everything we have said in the past concerning Anderson, see Tom E. Dobbs, 35 Van Natta 1332 (1983), we find no error in the Referee's decision. As noted by the Referee, there was simply nothing else that claimant could possibly have been requesting a hearing on in April 1981 other than the March 1981 denial. By contrast, in Anderson there were both an outstanding Determination Order and an outstanding denial, and there was a genuine question as to whether claimant requested a hearing in relation to the Determination Order alone.

There can be no such uncertainty in this case. All of the previously issued Determination Orders were final by operation of law; the only outstanding document was the March 1981 denial; and claimant's request for hearing, although somewhat general, did state issues relevant to that denial. Anderson is thus distinguishable and we agree with the Referee's refusal to grant SAIF's motion to dismiss.

The question of the compensability of claimant's aggravation claim, however, is another matter. The Referee's order could be read to imply that he may have thought the issue was responsibility for claimant's 1980 aggravation as between claimant's 1975 employer and his 1979 employer. The Referee stated:

> "There is some question as to whether [claimant's] present condition is related to his 1975 or 1979 injury. The evidence strongly suggests that a new injury occurred in 1979. * * * The medical evidence indicates that the claim was properly accepted by SAIF, and the denial must therefore be set aside."

However, the issue was the compensability of claimant's aggravation claim in relation to claimant's 1979 injury only.

As our summary of the medical evidence makes clear, although there is some evidence which could be read as indicating claimant suffered a worsening of his back condition, there is absolutely no evidence which indicates any relationship between claimant's 1979 injury and his condition in 1980-81, and there is some strong evidence which indicates that there is no connection between the 1979 injury and claimant's current condition. Dr. Fechtel, who treated claimant both before and after the 1979 injury, opined that claimant's symptoms in 1980 were due to his particular lifestyle rather than his previous injury. Similarly, Dr. Rocky could find no evidence of any injury residuals that would explain claimant's symptoms. Dr. Craig noted that claimant's back symptoms began when he was deer hunting. None of Dr. Smith's reports express any opinion about the cause of claimant's back difficulties. In short, there is no medical evidence of any kind which indicates that claimant's 1979 Timberline/SAIF injury is a material contributing cause of his current condition, and we are at a loss to understand what evidence the Referee could have relied upon in finding to the contrary.

ORDER

The Referee's interim order dated January 21, 1983 is affirmed. The Referee's order dated March 11, 1983 is reversed. SAIF's denial dated March 13, 1981 is reinstated and affirmed.

KENNETH SURRATT, Claimant
Galton, Popick, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Lindsay, Hart, et al., Defense Attorneys

Own Motion 83-0206M & 83-0207M
November 15, 1983
Own Motion Order

Claimant, by and through his attorney, requested the Board exercise its own motion authority and reopen his claim for a worsened condition allegedly related to his May 9, 1966 industrial injury. The insurer on the risk at the time of claimant's 1966 injury was Liberty Mutual Insurance Company. Attached to this request was a report from Dr. Aversano, dated October 21, 1981, in support of claimant's contention that his condition was related to the 1966 injury. The Board acknowledged claimant's request.

Nothing is in the Board file between the date of the Board's acknowledgment letter and claimant's attorney's letter of April 29, 1983 to Argonaut Insurance Company. On this date, claimant requested that Argonaut reopen his claim for worsened conditions related to his September 9, 1976 industrial injury. Argonaut, by letter of May 11, 1983 indicated it was not willing to voluntarily reopen claimant's claim.

On May 23, 1983, the attorney for Liberty asked the Board what action was taken on the 1966 injury claim. The Board responded on June 7, 1983 that there was an indication from claimant's attorney that all the information had not yet been submitted to the Board. All parties were allowed a further opportunity to supplement the record. Both insurers promptly responded with pertinent medical documents.

On July 12, 1983 claimant requested that the Board exercise its own motion relief in both the 1966 and 1976 injury claims. On July 25, 1983, Argonaut (1976 claim) responded to claimant's request indicating that since Dr. Silver had the wrong history of claimant's physical condition, it did not feel his report should be relied upon by the Board. (Dr. Silver had related claimant's condition to Argonaut's claim.) Argonaut also did not feel claimant's condition had actually worsened. Liberty subsequently responded to claimant's own motion request and stated that the Board should not rely on Dr. Aversano (who related claimant's condition to the 1966 injury) as he was unaware of the superseding incident in 1976. Liberty went on to advise the Board that it had issued a formal denial of claimant's request to reopen on September 25, 1981 and claimant had failed to appeal this denial.

By letter of August 4, 1983, the Board inquired of claimant's attorney whether there were presently any issues regarding claimant's entitlement to medical services under ORS 656.245. Also noted was a June 23, 1983 denial and inquiry was made regarding claimant's pursuit of the issues raised in this denial. Claimant responded, indicating that the medical bills of Dr. Aversano and Dr. Silver had been rejected by both carriers.

On August 10, 1983 Liberty forwarded to the Board a copy of its June 23, 1982 denial. On August 16, 1983, Argonaut advised the Board that it had not denied medical care under ORS 656.245 as no claim had, as yet, been made on claimant's behalf. The only request for payment from the claimant was relative to a $50 litigation report. Claimant responded that the report in question was not for litigation purposes, as was obvious from the face of the report. Argonaut immediately responded that there was no claim for .245 services before it, and it was appropriate that the Board now consider claimant's request for own motion relief.

After a thorough review of the evidence before us, the Board reaches the following conclusions:

(1) A denial issued on June 23, 1982 from Liberty Mutual (1966 claim) which denied responsibility for claimant's current medical condition. Because of the superseding 1976 injury, Liberty would pay no further benefits to claimant for its 1966 claim. Attached to this denial was a proper appeal notice

which gave claimant 60 days to request a hearing if he was not satisfied with the denial. No appeal was taken from this denial. As far as the Board is concerned, claimant's possible entitlement to medical services for conditions allegedly related to his 1966 industrial injury remains in a denied status. The Board is not willing, under the authority granted it in ORS 656.278, to consider claimant's request for own motion relief with respect to the May 9, 1966 injury.

(2) Claimant contends a $50 report fee was a claim for medical services against the Argonaut 1976 injury claim under ORS 656.245. Dr. Silver, the author of the report in question, examined the claimant thoroughly in August 1981 and continued to see claimant through 1982. In December 1982, he referred claimant to Dr. Aversano for evaluation of claimant's leg complaints. It appears that Dr. Silver had not seen claimant for at least two months when he was asked to respond to questions posed by claimant's attorney. The report of Dr. Silver, dated March 3, 1983, was definitely for litigation purposes and, therefore, a request for payment of same was not a claim for medical services under ORS 656.245.

(3) The Board generally considers a medical services question under ORS 656.245 to be the "forerunner" of a request for own motion relief. Before the Board will consider an own motion request, it expects that a claimant's medical bills are either being paid voluntarily by the insurer or have been ordered paid by a Referee as a result of a hearing. In this particular case, i.e., the 1976 injury claim, there has been no claim for medical services by claimant. Under ORS 656.278, the Board may open a claim for that period of time the claimant is not medically stationary and is undergoing treatment of some type in order to return his condition to a stationary status. (This assumes that all other factors are in claimant's favor, such as his work status. Vernon Michael, 34 Van Natta 1212 (1982).) However, if a claimant is not seeing a doctor and undergoing some type of treatment, it is generally assumed by the Board that his condition is stationary. In light of the fact that the claimant is not seeing a doctor in this case, the Board is uncertain what remedy claimant is seeking. We take note of the fact that claimant has advised the Board that he cannot afford the services of a doctor unless, and until, his claim is reopened. However, especially in a case involving two injury dates and two insurers, the Board is not willing to make a ruling on own motion reopening until the medical services question is resolved. Were the Board to reopen claimant's 1976 claim at this time, it is quite obvious from the record that Argonaut would deny claimant's medical expenses. This could result in the necessity for a hearing with the final result being that claimant's claim would be in an open status in what might be found by the Referee to be a noncompensable medical claim. In the Board's opinion, this is not the way to proceed. We conclude, based on the record before us that claimant's request for own motion relief in the 1976 injury claim should be denied.

ORDER

Claimant's request for own motion relief involving both his May 9, 1966 injury and his September 9, 1976 injury is hereby denied.

JOSEPH F. WECKERLE, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 81-0221M
November 15, 1983
Own Motion Order

Claimant sustained a compensable injury on April 5, 1956 which resulted in injuries to his head, ribs and both shoulders. For some time, SAIF Corporation paid claimant's related medical expenses for related conditions. SAIF now contends that claimant is not entitled to continued medical expenses as his injury happened prior to the enactment of ORS 656.245. Claimant requested a hearing on the issue of his entitlement to medical expenses. The Board decided to consolidate the Hearings Division case with its own motion case. The Referee ruled that claimant was not entitled to medical benefits under ORS 656.245 and recommended to the Board that it exercise its own motion authority pursuant to ORS 656.278 and "allow for resumption of medical benefits."

After review of the evidence before us, there is no question that claimant's current condition is related to his 1956 industrial injury. With respect to the legal aspect of this particular case, the Board ruled in William Newell, 35 Van Natta 629 (1983), that it could consider a worker's entitlement to medical benefits under the provisions of ORS 656.278 when his/her injury occurred prior to 1966 and where permanent total disability is not an issue.

Although the Board can, and will, consider claimant's entitlement to continuing medical benefits when claimant does not have a statutory "right" to said benefits, the Board generally will grant medical benefits only during a period of time when a claimant is non-medically stationary.

It is evident that claimant has been seeing several doctors for a period of time. Apparently, sometime around mid-1981, claimant heard about a new pain clinic opening up at Douglas Community Hospital and his treating doctor made arrangements for claimant to be examined there. As a result of initially seeing Dr. Bathurst, claimant was referred first to Dr. Norris-Pearce, then Dr. Andersen, and lastly, Dr. Brown. In July 1981 claimant requested own motion relief which was denied by Board order in October based on the Board's finding that claimant's condition had not worsened. The more recent evidence still indicates that most of claimant's condition remains medically stationary and that he is mainly trying to find some type of treatment modality to improve his condition. It is apparent that claimant has undergone numerous tests and evaluations, with the only "treatment" being medication to help maintain his present status.

However, Dr. Charles Brown, by a report of July 27, 1982, indicated that claimant had been subject to moods of depression due to worry about his physical condition. Over a period of time, Dr. Brown was able to significantly improve claimant's depressive state. We conclude that SAIF should accept responsibility for the treatment (which was apparently mostly antidepressants) and office visits of Dr. Brown up to the time claimant's depressive condition became stationary. The medical evidence is not complete on this

subject, but it appears that Dr. Brown was working with claimant from sometime in January 1982 through at least July of the same year. Claimant's attorney is entitled to a fee equal to 25% of these medical benefits, not to exceed $500. This fee is to be paid out of the benefits, not in addition to them.

IT IS SO ORDERED.

DAVID T. ADAMS, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-05781
November 16, 1983
Order on Remand

On review of the Board's order dated August 23, 1982 the Court of Appeals reversed that portion of the Board's order which failed to impose a penalty and associated attorney's fee for the SAIF Corporation's failure to issue a denial of claimant's claim for medical services. The court remanded to the Board for imposition of an appropriate penalty and attorney's fee. The Board has been advised by the parties that they have reached an agreement concerning an appropriate amount for a penalty and attorney's fee.

NOW, THEREFORE, that portion of the above-noted Board order which failed to impose a penalty and attorney's fee is vacated, and the SAIF Corporation is directed to pay claimant a penalty in the amount of $200, and to pay claimant's attorney a fee in the amount of $1,000, in accordance with the parties' agreement, for SAIF's unreasonable delay in acceptance or denial of claimant's medical services claim. ORS 656.245; 656.262(9); 656.382(1).

IT IS SO ORDERED.

WARREN C. BACON, Claimant
Carney, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 80-00875
November 16, 1983
Order Denying Approval of Stipulation/Disputed Claim Settlement

Claimant and the employer/insurer, by and through their respective counsel, have submitted a stipulated settlement agreement to the Board for approval. The agreement has some characteristics of a disputed claim settlement, and by its terms purports to absolve the employer/insurer from further liability in connection with claimant's 1979 industrial injury claim. See ORS 656.289(4).

Claimant sustained an industrial injury to his right shoulder in February of 1979. The injury resulted in a rotator cuff tear. The claim was accepted and first closed by Determination Order in August of 1979, which awarded compensation for temporary total disability only. After the claim was later reopened, it was again closed by a second Determination Order dated January 9, 1980, which awarded claimant additional temporary total disability and 19.2° of scheduled permanent partial disability for a 10% loss of claimant's right arm. Claimant requested a hearing contesting the permanent disability awarded by this Determination Order. He claimed that as a result of this industrial injury and pre-existing disabilities,

he was entitled to an award for permanent total disability. ORS 656.206(1)(a). By a Referee's order dated July 14, 1981, claimant was awarded compensation for permanent total disability. The employer/insurer requested Board review, contending that claimant had not established permanent total disability status. One of the issues raised by the employer/insurer was whether a 1976 Determination Order (which closed a separate May 1976 low back injury claim), which had awarded claimant no permanent disability and which had become final by operation of law, conclusively established that claimant had no pre-existing low back disability. We found it appropriate to consider evidence of claimant's low back impairment as a pre-existing disability contributing to his overall disability, and affirmed the Referee's award of permanent total disability. Warren C. Bacon, 35 Van Natta 41 (1983).

The employer/insurer petitioned for judicial review of the Board's order. While the case was pending before the court, the parties entered into the agreement which has been tendered for approval. An Order of Remand was entered by the court in order to allow the Board to consider the parties' proposed settlement.

This stipulation recites:

> "The parties have agreed there is a bona fide dispute between them regarding the issues raised by the employer. Particularly, there is a dispute regarding whether claimant has any additional permanent disability beyond that awarded by the Determination Order of August 8, 1979, and further whether the claimant is permanently and totally disabled. In regard to the latter, the parties are in dispute as to the application of, and involvement in, prior alleged injuries and the computation of claimant's award of permanent and total disability based upon alleged other injuries. Therefore, the parties have agreed that a disputed claim settlement of these issues would be appropriate. * * *"

The stipulation recites claimant's position that he is entitled to an award for permanent total disability, as found by the Referee and the Board. The employer/insurer's position is stated as being that claimant suffered no permanent disability as a result of his February 1979 injury; that claimant's disability, if any, is related to an arthritic condition of his cervical spine which is unrelated to his accepted industrial injury; that "claimant should not be allowed to include in the computation or equation of obtaining permanent total disability prior on-the-job injuries where there was no indication of permanent disability, and the claimant is barred by the doctrine of res judicata from asserting these matters;" and that claimant has had subsequent non-industrial "aggravations" of his right shoulder condition, which have independently and materially contributed to his need for any further medical treatment.

The terms of the stipulation, set forth under the heading, "Terms of the Disputed Claim Settlement," are that in consideration for the receipt of a substantial lump sum payment, which is to be considered, "an advance on any future permanent partial disability, temporary total disability, temporary partial disability, or permanent total disability, and further, an advance against any future medical benefits payable to the claimant on the entire claim," the August 1979 Determination Order awarding 10% scheduled disability, "shall remain in effect," claimant's request for hearing and the appeal of the employer/insurer from the Board's Order on Review may be dismissed with the understanding that claimant has permanent disability as a result of the February 2, 1979 injury which equals 10% scheduled disability for loss of his right arm; that claimant did suffer from pre-existing and noncompensable conditions, particularly in the cervical spine, which were not aggravated or worsened by his industrial injury or injuries; and that:

> ". . . there is a dispute between [the parties] regarding the affect [sic] of previous industrial injuries (other than the one in question as relates to the right shoulder), and that for purposes of this settlement, they shall not be and should not be considered in the computation of permanent partial disability . . . ."

The stipulation further recites the parties' understanding that by acceptance of the lump sum payment under the terms of the stipulation, claimant agrees that, "this is to be construed as an advance on any and all benefits payable . . . including medical benefits, reasonably related to the accepted industrial injury."

Finally, the stipulation recites the parties' understanding and agreement that:

> "[T]hese monies are paid as an advance on the compensable injury and as a disputed claim on the other issues raised by the claimant. However, it is to be construed as an advance for all benefits allowable under the accepted claim. Further, that if this agreement is held to be illegal, unenforceable, or the claimant makes claim for further benefits, that the carrier or employer shall be entitled to 100% setoff against any such claim for benefits the
>
> claimant may make or that the Workers' Compensation Board of the State of Oregon or any court may order payable to the claimant."

The issue in these proceedings, which the parties are attempting to settle, is the extent of claimant's permanent disability resulting from his compensable February 1979 industrial injury. The Referee and the Board have determined that claimant is permanently and totally disabled as that term is defined in ORS 656.206(1)(a), which includes consideration of any disability pre-existing the injury in question. There is no issue concerning

the compensability of the underlying claim. Because there is no issue concerning compensability, there cannot be a bona fide dispute within the meaning of ORS 656.289(4). The issue in this case is whether claimant is entitled to an award for permanent total disability. This is an extent-of-disability issue, one which does not present any issues capable of resolution pursuant to the statutory provision allowing disputed claim settlement agreements. Compare Greenwade v. SAIF, 41 Or App 697 (1979), with Schultz v. Compensation Department, 252 Or 211 (1968).

We conclude this agreement constitutes a prohibited release in violation of ORS 656.236(1), which provides: "No release by a worker or his beneficiary of any rights under ORS 656.001 to 656.794 is valid." See William R. Whitt, 25 Van Natta 192 (1978). By the terms of this agreement claimant releases all of his rights under the Workers' Compensation Act, including his right to receive compensation for medical services for reasonable and necessary treatment of conditions related to his original injury, a release that is specifically objectionable under the reasoning of SAIF v. Parker, 61 Or App 47 (1982).

Although the parties have attempted to structure their settlement agreement in order to make it appear as though a bona fide dispute exists concerning compensability, we believe the real purpose of the agreement is to settle the issue which was decided by the Referee and the Board, i.e., the extent of claimant's permanent disability. The obvious effect of the agreement is to release claimant's right to future workers' compensation benefits in consideration of claimant's present receipt of a substantial sum of money. Although the parties may believe that their agreement represents a reasonable disposition of this compensable industrial injury claim, in ORS 656.236(1) the legislature has prohibited some private dispositions of workers compensation claims regardless of reasonableness. See Arnold Androes, 35 Van Natta 1619 (October 27, 1983); Duane E. Maddy, 35 Van Natta 1629 (October 27, 1983); Donald T. Campbell, 35 Van Natta 1622 (October 27, 1983).

ORDER

The stipulated settlement agreement submitted to the Board for approval, being in violation of the statutory prohibition against releases, is not approved.

RICK D. CLEMENS, Claimant
Ringle, et al., Claimant's Attorneys
Schwenn, et al., Defense Attorneys

WCB 82-05882
November 16, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of those portions of Referee Mulder's order which affirmed the May 21, 1982 Determination Order which awarded claimant 7.5° for 5% scheduled permanent partial right leg disability. The issues are the extent of claimant's permanent partial disability and claimant's entitlement to temporary disability benefits beyond August 3, 1981.

With regard to the permanent disability issue, we agree completely with the Referee and we affirm and adopt the relevant portions of his order.

We turn to the question raised by the insurer: Claimant's entitlement to temporary partial disability benefits beyond August 3, 1981. On that date Dr. Baldwin released claimant to return to his regular work. Claimant was thereafter examined by Dr. Zimmerman who reported on September 1, 1981 that claimant had an inadequately rehabilitated knee. Dr. Zimmerman felt claimant could benefit from supervised therapy to increase his quadriceps strength but he advised claimant to return to Dr. Baldwin for continued care.

Claimant was reexamined by Dr. Baldwin on September 28, 1981. Dr. Baldwin reported:

> "He was released as of August 3, 1981. This date has not been changed, and time loss between August 3 and the present date was not authorized. I have advised him to return to the current position that he is being offered by Weiler Chevrolet . . ."

Claimant was thereafter examined by Dr. Beals who was of the opinion that claimant was not medically stationary, felt that an exercise program would be beneficial and referred claimant to a physical therapist.

Claimant was reexamined by Dr. Baldwin on February 22, 1982. Dr. Baldwin reported that claimant was working eight to ten hours per day for Ron Tonkin Chevrolet (claimant had been working for Ron Tonkin on a full time basis since November 1981). Dr. Baldwin opined: "It is my feeling that his condition continues to be medically stationary and that there should be no change in his current treatment or medical status.

A Determination Order issued on May 21, 1981 awarding claimant benefits for temporary total disability from October 14, 1980 through August 3, 1981 and, inexplicably, temporary partial disability from August 3, 1981 through February 22, 1982.

We are uncertain why the Determination Order awarded claimant any temporary disability benefits beyond the August 3, 1981 work release date. Dr. Baldwin, claimant's treating physician, made it abundantly clear on three occasions that no time loss was authorized beyond that date. Dr. Beals' statement that claimant was not medically stationary upon examination in November 1981, appears to be nothing more than the caution often exhibited by physicians when examining a patient for the first time. In fact, claimant testified that he never followed through with Dr. Beals' physical therapy recommendation because he had been working full time since November 1981 and was putting in so much overtime that he could not fit appointments with a physical therapist into his schedule.

We agree with the insurer that the Determination Order must be modified to delete any provision for temporary disability benefits beyond August 3, 1981.

ORDER

The Referee's order dated March 14, 1983 is affirmed in part

and reversed in part. Those portions of the Referee's order which affirmed the May 21, 1981 Determination Order's provision of temporary partial disability benefits from August 3, 1981 through February 22, 1982 are reversed. The Determination Order is modified to eliminate its provision of temporary disability benefits from August 3, 1981 through February 22, 1982. The remainder of the Referee's order is affirmed.

GERALDINE M. MAURER, Claimant
Robert E. Brasch, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-11668
November 16, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Seifert's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim. On review, the sole issue is compensability.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated May 26, 1983 is affirmed.

Board Member Barnes Concurring:

There is now a philosophy and trend within this Board to the effect that our Orders on Review should not state the reasons for our decisions. I disagree with that philosophy and trend because I think we have "discretion to make policies for even application, not discretion to treat each case on an ad hoc basis." Sun Ray Dairy v. OLCC, 16 Or App 63, 72 (1973). As the court has also said, an agency's order should

> "state what it found to be the facts and fully explain why those facts lead it to the decision it makes. Brevity is not always a virture." Home Plate, Inc. v. OLCC, 20 Or App 188, 190 (1975).

Thus, in order to at least individually be doing what I think the Board should be doing, I state my own reasons for my position in this case.

I am not certain exactly what is being claimed. Apparently the claim is primarily to the effect that claimant's work as a swimming teacher was the major cause of the origin or worsening of a staphylococci infection which spread to claimant's eyes. However, the record also contains reference to other ocular diseases.

What is now being claimed is potentially important because in 1973 a prior claim claimant made for "staph. infection" was resolved on a disputed claim basis pursuant to ORS 656.289(4). Although the parties have not developed the point, I have serious doubts that any claim can now be made for the progression of exactly the same disease that was previously "disputed out."

What is now being claimed is also important in assessing the evidence regarding causation. Although circumstantial evidence and some qualified medical opinions suggest the possibility of some connection between claimant's work and the disease(s) here in issue, I find the situation sufficiently complex that I am not persuaded that claimant has established that her work exposure was the major cause of her disease(s) in the absence of more definitive medical evidence.

JAMES COURTNEY, Claimant
Pippin, et al., Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB 78-06677
November 17, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Williver's order which found that claimant is permanently and totally disabled. Extent of disability is the issue on review. In addition, SAIF has moved to remand for additional evidence.

Claimant is a 40 year old former mill worker who compensably injured his right hand in July 1976 when it was caught in the blades of a planer head. His hand was severely mangled and he lost two fingers. The medical evidence establishes that claimant has very limited use of his dominant right hand, and he was awarded compensation of 120° for 80% loss of the right hand by Determination Order in June 1978.

Claimant has an eighth grade education but is functionally illiterate. He had polio as a child, and as a result one leg is shorter than the other. However, he testified that before the industrial injury the effects of his polio did not prevent him from working on his feet all day long. Claimant's work history consists mainly of manual laboring jobs.

His treating physician, Dr. Donahoo, opined that because of his hand injury claimant would be restricted to "administrative" jobs. He also opined: "He is in school at this time and I strongly urge that he remain there for a 'clean job.' That is, some non-manual work would be in his best interests." Orthopaedic Consultants evaluated claimant and opined that claimant is capable of doing light work.

ORS 656.206(3) provides:

> "The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

There is no doubt that claimant's right hand is seriously impaired. However, claimant has failed to convince us that his right hand impairment, even when coupled with his preexisting functional illiteracy and orthopedic problems prevent him from

"performing work at a gainful and suitable occupation." ORS 656.206(1). By claimant's own testimony he was capable of working on his feet prior to his compensable hand injury. He has provided no evidence that he is not now capable of working on his feet all day. Exhibit 45 and claimant's testimony refer to his ability to ride a bike, fish, wash dishes and operate a vacuum cleaner, despite his severe right hand impairment. There are certainly light jobs that require little or no more use of one's hands than do these activities.

Claimant has briefly tried one job since his 1976 hand injury. That job involved driving a tractor. Claimant testified that he quit that job after one week because the vibrations were hurting his hand too much; a subsequent report from claimant's doctor suggests another reason for quitting -- "he does not feel he can live on the salary he is making." Claimant subsequently entered a vocational rehabilitation program to be trained as a log truck driver, presumably indicating claimant's belief that he was probably able to do such work despite having been unable to operate a tractor. Claimant successfully completed the retraining program, although there are some indications of less than complete cooperation on claimant's part (exhibits 16, 20A and 39).

In summary, the disabling effects of this industrial injury are confined to claimant's right hand. No doctor has opined that claimant is physically incapable of working. Claimant's successful completion of his retraining program would support an inference that claimant would be capable of working in a hypothetically normal labor market. Under all of these circumstances, we do not think that claimant's limited seek-work efforts were reasonable under ORS 656.206(3).

Claimant does not argue that he is entitled to an increase in his scheduled award for his right hand, so we decline to increase that award.

We decline to remand the case to the Referee because SAIF has failed to demonstrate why the proffered evidence was not obtainable prior to the hearing in this case. Ora M. Conley, 34 Van Natta 1698 (1982); Casimer Witkowski, 35 Van Natta 1661 (October 31, 1983).

ORDER

The Referee's order dated October 11, 1982 is reversed. The Determination Orders dated June 16, 1978 and July 3, 1979 are reinstated and affirmed.

MAX D. CUTLER, Claimant
Jay W. Whipple, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 82-0224M
November 17, 1983
Own Motion Order

Claimant, by and through his treating physician, submitted a claim for medical services to the SAIF Corporation. The claim was treated by SAIF as a request for own motion relief pursuant to ORS 656.278. SAIF elected not to pay the benefits claimed and submitted the matter to the Board for possible own motion relief. We determined that the ostensible own motion matter included a claim for medical services pursuant to ORS 656.245 and, therefore, construed the request for own motion relief as a request for hearing pursuant to ORS 656.283; we also deferred consideration of any issues arising under ORS 656.278 pending the outcome of the medical services litigation. Max D. Cutler, 34 Van Natta 1480 (1982).

A Referee's order has issued in WCB Case No. 83-00908, finding that the claim for medical services is not causally related to claimant's original industrial injury. We have this day issued an Order on Review affirming that Referee's order. The determination that the claim for medical services is not related to claimant's original injury is dispositive of claimant's request for additional temporary and/or permanent disability compensation pursuant to ORS 656.278. Accordingly, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

WALTER T. VanMETRE, Claimant
Danner & Scott, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-07464
November 18, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Gemmell's order which upheld the insurer's backup denial of claimant's left hand injury claim.

Subsequent to the Referee's order, the Supreme Court concluded that backup denials are not permitted, subject to limited exceptions not applicable here. Bauman v. SAIF, 295 Or 788 (1983).

ORDER

The Referee's order dated April 22, 1983 is reversed and the insurer's backup denial is set aside. Claimant's attorney is awarded $1,200 for services at hearing and on Board review in prevailing on a denied claim, to be paid by the insurer.

GEORGE T. DAVID, Claimant
Gilbertson, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-06361
November 21, 1983
Order on Review (Remanding)

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Knapp's order which dismissed claimant's request for hearing on the grounds that the Hearings Division does not have jurisdiction to review the propriety of a stipulated settlement. Claimant contends that the Referee should have taken evidence and determined whether the stipulated settlement should be set aside. We agree with claimant and thus reverse.

Claimant suffered a compensable injury in 1977 for which a Determination Order issued October 29, 1981. This Determination Order awarded no permanent disability over that previously awarded. Claimant, unrepresented by legal counsel, and his employer entered into a stipulated settlement which was approved by a Referee on March 17, 1982. That stipulation awarded claimant additional permanent disability and provided that claimant waived his right to a hearing on the October 29, 1981 Determination Order.

Thereafter, claimant obtained legal counsel and requested a hearing raising issues related to the October 1981 Determination Order. At the hearing the employer moved for dismissal on the basis of the stipulation. Claimant contended the stipulation should be set aside. The Referee refused to accept evidence, reasoning that the Board, not the Hearings Division, is the proper forum for review of the stipulation.

First, although claimant did not raise the stipulation issue in his request for hearing, the issue was raised at hearing by the employer and by claimant. Therefore, the issue was properly before the Referee.

Second, this stipulation is controlled by Lawrence Woods, 34 Van Natta 1671 (1982), in which we held that if a party seeks to have a disputed claim settlement set aside, the proper remedy is to request a hearing before the Hearings Division. That same remedy is the proper one when a party seeks to set aside a stipulation. In Woods, we cited James Leppe, 31 Van Natta 130 (1981), and Mary Lou Claypool, 34 Van Natta 943 (1982), which were requests for Board review of Referees' orders refusing to set aside a stipulation, Leppe, and a disputed claim settlement, Claypool. In both cases we sanctioned the hearing request procedure as the proper means of contesting the validity of stipulations and disputed claim settlements. In Woods, we directed the aggrieved party to follow that procedure. See also Timothy D. Martinez, 35 Van Natta 1315 (1983).

Accordingly, we remand to the Hearings Division for proceedings to determine whether the stipulation should be set aside. That determination, of course, must be made in consideration of our admonition in Leppe that stipulations are to be set aside "very sparingly, only in the most unconscionable of situations." 31 Van Natta at 131.

ORDER

The Referee's order dated February 25, 1983 is reversed. This matter is remanded to the Hearings Division for proceedings pursuant to this order.

PAUL A. KLEE, Claimant
Keane, et al., Claimant's Attorneys
Beers & Zimmerman, Defense Attorneys

WCB 83-04852
November 21, 1983
Order of Dismissal

Claimant requested a hearing because EBI Companies refused to approve a settlement of a third party action entered into between claimant and a third party defendant. Questions concerning settlement of a third party action brought by a claimant, and the proper distribution of the proceeds of any such third party recovery, are originally resolved by the Board. ORS 656.593(1)(d), 656.593(3). Issues arising under the statutes governing third party recovery, ORS 656.576 et seq., are not properly the subject of a request for hearing pursuant to ORS 656.283. Marvin Thornton, 34 Van Natta 999 (1982). Moreover, we are advised that the parties have since resolved their dispute concerning the third party settlement distribution issue. Accordingly, we dismiss claimant's request for hearing.

ORDER

Claimant's request for hearing is dismissed.

JACK W. PETERSON, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-07937
November 21, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Pferdner's order which upheld the SAIF Corporation's denial of compensability of his left knee condition.

A hearing on this matter was originally held on March 5, 1981. On March 12, 1981 Referee Pferdner ordered SAIF's denial set aside. We reversed that order on October 21, 1981. Jack W. Peterson, 33 Van Natta 469 (1981). Claimant thereafter petitioned the Court of Appeals for judicial review and, on claimant's motion, the matter was remanded to the Referee on January 29, 1982 for consideration of additional evidence. ORS 656.298(6). A second hearing was held on December 20, 1982. After considering the additional evidence submitted by claimant, the Referee concluded that claimant had failed to establish the compensability of his left knee condition and thus upheld SAIF's denial.

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

Claimant argues that the Referee, in spite of quoting from Clayton v. Compensation Department, 253 Or 397 (1969), to the effect that no "magic words" are required to establish causation, nevertheless upheld SAIF's denial on the basis that the medical evidence did "not contain the 'magic words' that claimant's work

was the 'underlying major contributing cause' of claimant's torn meniscus." Claimant also argues no adverse inference should be drawn from the fact that he may have originally attributed his knee difficulties to an off-the-job injury sustained in 1978 because he is not qualified to offer an opinion with regard to the cause of his knee condition.

We agree with claimant that the fact he may have initially attributed his left knee difficulties to the 1978 off-the-job incident does not give rise to any adverse inference in relation to the medical cause of claimant's condition. The causation of claimant's knee difficulties is a complex medical question which requires expert evidence. Uris v. Compensation Department, 247 Or 420 (1967). Just as lay evidence in favor of a causal relation is normally insufficient to establish causation in such situations, lay evidence attributing a claimant's condition to a non-work cause will not necessarily defeat compensability, although it may be relevant to other issues, such as credibility.

However, this is of little aid to the claimant in the current case for we agree with the Referee that claimant failed to produce sufficient evidence to establish that his work activities were the major cause of his knee condition. Gygi v. SAIF, 55 Or App 570 (1982). Even though no such particular words are required, Clayton, supra, we find the evidence insufficient to rise to the level of establishing major work causation.

ORDER

The Referee's order dated January 7, 1983 is affirmed.

TRACEY WAGONER, Claimant
Elliott Lynn, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-05274
November 21, 1983
Order on Review (Remanding)

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Mulder's order which upheld the insurer's denial of claimant's industrial injury claim. We reverse.

Claimant allegedly injured her low back on October 3, 1980 when lifting bags of coins while performing her duties as a bank teller. Her claim was accepted, processed and closed by Determination Order dated June 9, 1982. Thereafter, on November 8, 1982 the insurer issued a backup denial. The insurer contended that circumstances occurring during the three days following claimant's alleged October 1980 work incident persuaded the insurer that claimant's need for medical treatment and disability were not related to her employment. The insurer attempted to show at hearing that during those three days claimant had injured her back at home moving a refrigerator.

After the issuance of the Referee's order the Oregon Supreme Court ruled in Bauman v. SAIF, 295 Or 788 (1983) that, once an insurer has accepted a claim, the insurer may not subsequently deny the compensability of the original claim unless there is a showing

of fraud, misrepresentation or other illegal activity. Although we agree with the Referee that claimant's testimony contained some inconsistencies, we attribute those inconsistencies to loss of memory over a two year period rather than to any fraud, misrepresentation or other illegal activity. We conclude the backup denial is invalid under Bauman.

Since claimant raised issues of entitlement to medical care and extent of disability which were not addressed by the Referee due to his finding of non-compensability, we remand this case for further proceedings on those issues.

ORDER

The Referee's order dated March 2, 1983 is reversed. This matter is remanded for further proceedings consistent with this order. Claimant's attorney is awarded $1000 for services rendered at hearing and an additional $500 for services before the Board, to be paid by the insurer.

MARGARET L. GRAY, Claimant
Kenneth D. Peterson, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-10199
November 22, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of those portions of Referee Shebley's order which found claimant entitled to benefits for temporary total disability from December 1, 1981 through April 30, 1982 and temporary partial disability from May 1, 1982 through May 18, 1982, and imposed a penalty against SAIF in the amount of 20% of such amounts. Claimant cross-requests review of those portions of the Referee's order which awarded her 10% unscheduled permanent partial disability, that being an increase of 10% over and above the October 20, 1982 Determination Order, and those portions of the order which failed to award claimant's attorney a fee pursuant to ORS 656.382(1).

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

Claimant contends she is entitled to a greater award of permanent partial disability than that allowed by the Referee, and that the Referee should have awarded her attorney a separate attorney's fee for prevailing on the issue of penalties. We disagree with claimant's contentions and affirm and adopt those portions of the Referee's order relevant to these issues.

SAIF contends, and claimant seems to concede, that the Referee erred in awarding claimant benefits for temporary total disability from December 1, 1981 through April 30, 1982 and for temporary partial disability from May 1, 1982 through May 18, 1982. SAIF argues that because claimant received unemployment benefits after being laid off from her modified job at C & B Livestock, that she was not entitled to receive temporary disability benefits as a claimant is not entitled to receive temporary disability benefits and benefits for unemployment compensation simultaneously. Subsequent to the hearing in this case we addressed this issue in Daniel J. Cannon, 35 Van Natta 1181, 35 Van Natta 1623, (1983). We stated:

> "In Edwards v. Employment Division, 63 Or App 521 (1983), the Court of Appeals recognized the possibility that post-injury receipt of unemployment compensation could be treated the same way as post-injury receipt of wages. * * * Such a worker, as we understand the Edwards decision, may be entitled to receive both unemployment compensation and workers' compensation in the form of temporary partial disability benefits . . ." 35 Van Natta at 1186.

We concluded that if post-injury wages or unemployment benefits are equal to or greater than the wage earnings at the time of injury, no temporary disability compensation is due, and that if post-injury wages or unemployment benefits are less than wages at the time of injury, temporary partial disability should be paid to make up the difference based on the formula in OAR 436-54-222(1).

Cannon is applicable to the current case. Claimant was laid off from her modified job at C & B Livestock on the last working day in November 1981, and was found medically stationary by Dr. Peterson on February 18, 1982. In the interim claimant collected unemployment benefits and earned some wages as a result of her working for Simplot and St. Anthony's Nursing Home. Therefore, claimant is entitled to benefits for temporary partial disability from December 1, 1981 through May 18, 1982. These temporary partial disability benefits are to be calculated in accordance with the formula set forth in the above paragraph.

With regard to the issue raised by SAIF concerning the penalty assessed by the Referee, we affirm and adopt those portions of the Referee's order relevant to this issue. However, since we have found claimant entitled to benefits for temporary partial disability, the 20% penalty assessed by the Referee should be calculated on the amount of temporary partial disability benefits owed from December 1, 1981 through May 18, 1982.

Although claimant appears to agree that she was entitled to benefits for temporary partial disability from December 1, 1981 through April 30, 1982, rather than temporary total disability as awarded by the Referee, she contends that the Referee actually intended to award temporary partial disability benefits and that his reference to these benefits as temporary total disability was "inadvertent." If this argument is correct, it would mean that claimant's attorney is entitled to a fee for services on Board review because compensation would not have been reduced on SAIF's appeal. However, a close reading of the Referee's order and the transcript convinces us that there was no inadvertence on the part of the Referee, and that he did just what he intended to do; that is, he awarded temporary total disability benefits with no consideration given for claimant's receipt of unemployment benefits. That being the case, compensation has been reduced on this appeal and claimant's attorney is, therefore, not entitled to an attorney fee for services before the Board.

ORDER

The Referee's order dated May 24, 1983 is affirmed in part and modified in part. Those portions of the Referee's order which found claimant entitled to benefits for temporary total disability from December 1, 1981 through May 18, 1982, and to benefits for temporary partial disability from May 1, 1982 through May 18, 1982, and assessed a 20% penalty on such amounts are modified. Claimant is entitled to benefits for temporary partial disability from December 1, 1981 through May 18, 1982, together with a 20% penalty on such amounts. The attorney's fee awarded by the Referee for prevailing on this issue should be adjusted accordingly. The remainder of the Referee's order is affirmed.

NORBERT A. LAROUX, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-06087
November 22, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of that portion of Referee Johnson's order which upheld the SAIF Corporation's denial of claimant's right inguinal hernia claim. Claimant contends that the medical evidence from his treating physicians is adequate to prove by a preponderance of the evidence that an at-work incident of May 10, 1982 caused or contributed to his recurrent right inguinal hernia.

Although claimant had a noncompensable right inguinal hernia and surgery in 1979, he was asymptomatic up until May 10, 1982. On that date, claimant, while mopping a tile floor at work, slipped and fell. He went down on his left knee with his right leg extended in front of him. Claimant experienced immediate burning pain in the right groin area. Within a few minutes a bulge appeared in the right groin area which was about the size of a golf ball. He immediately reported the injury to his supervisor and sought medical treatment. His condition was diagnosed as a recurrent right inguinal hernia. The Referee found that claimant's testimony was credible.

Regarding the medical opinions of Drs. Bice and Bond, the treating physicians, the Referee made the following findings:

> "Dr. Bice examined claimant on May 10, 1982. Dr. Bice was aware of the historical facts surrounding the alleged industrial accident of May 10, 1982. Dr. Bice was also aware the claimant had injured that part of the body before, i.e., a right inguinal hernia. Dr. Bice diagnosed claimant's condition as an inguinal hernia. Dr. Bice causally related claimant's condition to the industrial accident of May 10, 1982 (Ex. 10) [827 form]. Dr. Bice later opined, in effect, that a slip and fall incident with the onset of symptoms sounded like a logical way for a hernia to recur (Ex. 22).

"Dr. Bond examined claimant on May 12, 1982. Dr. Bond was aware of the historical facts surrounding the alleged May 10, 1982 industrial accident. Dr. Bond was also aware that claimant was injured before, i.e., a right inguinal hernia. Dr. Bond diagnosed claimant's condition as a right inguinal hernia, recurrent, subsequent to job injury of May 10, 1982. He performed the corrective surgery. Dr. Bond causally related claimant's condition to the industrial accident of May 10, 1982 (Ex. 11) [827 form]. Dr. Bond later reported that the recurrence 'apparently' was caused by a work injury as described in the history and physical (Ex. 14)."

The Referee concluded:

". . . [T]he reports of Dr. Bice and Dr. Bond do not establish causal relationship, between claimant's condition diagnosed as a right inguinal hernia and his job accident of May 10, 1982, by a reasonable medical probability. Dr. Bice, when he filled in the block on the Form 827, established causal relationship. However, by report of August 30, 1982, Dr. Bice, when referrring to the slip and fall incident of May 10, 1982 and the onset of pain, opined that this sounds like a logical way for the hernia to recur. That statement is not consistent with an opinion expressed in terms of a reasonable medical probability. Dr. Bond, when he filled in the block on the Form 827, established causal relationship. Later, when reporting about claimant's case on May 28, 1982, the doctor opined 'The recurrence apparently was caused by work injuries described in the history and physical'. The Referee does not consider 'apparently was caused' to be consistent with an opinion expressed in terms of a reasonable medical probability."

Although we are not even sure that medical evidence is essential given the claimant's credible testimony about his fall and the immediate onset of symptoms, we find the opinions of Drs. Bick and Bond sufficiently relate claimant's hernia to the May 10, 1982 work incident when considered in the context of all the evidence, specifically, the facts that claimant was asymptomatic before falling at work, the immediate onset of symptoms, the immediate reporting of the incident and the immediate hernia diagnosis. We thus reverse that portion of the Referee's order which upheld SAIF's denial.

ORDER

The Referee's order dated May 12, 1983 is affirmed in part and

reversed in part. The SAIF Corporation's denial dated June 29, 1982 is set aside and claimant's claim for his recurrent right inguinal hernia is remanded to SAIF for acceptance and processing. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,500 as a reasonable attorney's fee for prevailing on a denied claim, for services rendered at hearing and on Board review, to be paid by the SAIF Corporation.

GARY O. SODERSTROM, Claimant
FRED and SONJA SHEWEY dba FRED'S PLACE, Employers
Garry Kahn, Attorney
Macdonald, et al., Attorneys
Carl M. Davis, Ass't Atty. Gen.

WCB 81-05426
November 22, 1983
Order of Dismissal

The putative non-complying employer requests Board review of Referee Mulder's order upholding an order of the Worker's Compensation Department finding that the employer was a non-complying employer. We dismiss the request for review for lack of jurisdiction.

ORS 656.740(4) provides:

> "Notwithstanding ORS 183.315(1), the issuance of orders declaring a person to be a noncomplying employer or assessing civil penalties pursuant to this chapter, the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.550, except that:
>
> "(a) The order of a referee in a contested case shall be deemed to be a final order of the director.
>
> * * *
>
> "(c) When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim."

Because there are no issues in this case concerning a claim pursuant to ORS 656.283 or 656.704, appeal from the Referee's order is only available pursuant to the Administrative Procedures Act, ORS 183.310 to ORS 183.550. Accordingly, we are without jurisdiction to review the Referee's order and the request for review must be dismissed. It is unfortunate if the statement that appeal should be to the Board, stated at the conclusion of the Referee's order, misled the employer. However, our jurisdiction is statutory and incorrect statements of appeal rights cannot expand or contract that jurisdiction.

ORDER

The employer's request for review is dismissed.

ELFRIEDE E. RICHARDS, Claimant
Nick Chaivoe, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Frank J. Susak, Defense Attorney

WCB 82-00181 & 82-01440
November 23, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of that portion of Referee Quillinan's order which awarded claimant 48° for 15% unscheduled permanent partial disability for her low back injury. SAIF contends that claimant has not suffered any permanent disability as a result of her May 6, 1981 injury. Claimant has also filed a request for review of the Referee's order but has not filed a brief with the Board.

On de novo review, we affirm and adopt the Referee's findings and conclusions with the exception of the award of permanent disability compensation. The Referee upheld SAIF's denial of compensability for claimant's continuing symptoms. SAIF argues that the effects of claimant's compensable back strain have resolved and her continuing problems are due to her underlying degenerative arthritis which has not been worsened by the injury. We believe that SAIF's denials were correct. However, it was inconsistent for the Referee to uphold the denials and then find that claimant has suffered permanent disability as a result of the injury. We, therefore, must reverse the Referee's award of 15% unscheduled permanent partial disability.

ORDER

The Referee's order dated January 27, 1983, as amended on March 8, 1983, is reversed in part. That portion which awarded additional permanent partial disability compensation and an attorney's fee based on this award is reversed. The remainder of the Referee's award is affirmed.

SHERMAN R. THOMPSON, Claimant
Rolf Olson, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 82-10847
November 23, 1983
Order on Review (Remanding)

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Foster's order which dismissed his request for hearing. The issue is whether a 1979 disputed claim settlement precludes claimant from asserting a claim for aggravation in relation to his 1975 compensable injury.

Claimant suffered a compensable injury to his back in August 1975 while employed by Gordon Ball, Inc., which was insured by Globe Indemnity. This claim was eventually closed by Determination Order dated December 8, 1978 which awarded claimant benefits for temporary total disability and 10% unscheduled permanent partial disability. In October 1978 the insurer denied further responsibility for claimant's back condition on the grounds that claimant had suffered an intervening off-the-job injury in July 1978. Claimant requested a hearing.

In April 1979 a disputed claimant settlement between claimant

and the insurer was approved by a Referee. That settlement provides:

> "WHEREAS . . . claimant contends that he suffered a compensable injury on August 15, 1975, while working for the subject employer, Gordon H. Ball.
>
> "WHEREAS, claimant's claim was denied on October 19, 1978 on the basis that the claimant suffered a separate, intervening accident and further denied that the claimant was entitled to any further benefits under the Workers' Compensation Law after July 13, 1978 when the claimant suffered a supervening incident which, in itself, eliminated any further responsibility by the employer/insurer for payment of benefits as a result of the subject industrial accident of August 15, 1975.
>
> * * *
>
> "NOW, THEREFORE, IT IS HEREBY STIPULATED TO AND AGREED by and between the parties hereto that, in consideration of the payment of $2,240, claimant's Request for Hearing shall be withdrawn and dismissed and the employer's denial shall be affirmed. * * *
>
> "It is understood by the parties, and agreed, that said payment is in full and final settlement of all claims which claimant has or may have against the employer for injuries or diseases claimed or their results, relating to the alleged incident of August 15, 1975, and all benefits under the Workers' Compensation Law or otherwise, and this settlement is of a doubtful and disputed claim and is not an admission of liability on the part of the employer, who denies that the claimant has suffered any compensable disability from the incident of August 15, 1975, and that this settlement is of any and all claims whether specifically mentioned herein or not, under the Workers' Compensation Law or otherwise, and that claimant agrees that an Order may issue approving this Settlement."

The present proceeding arose in 1982 when claimant asserted an aggravation claim. The insurer issued a letter on November 17, 1982 that the parties have treated as a denial of that aggravation claim. Claimant requested a hearing. At the hearing, the insurer moved to dismiss claimant's hearing request on the ground that the 1979 disputed claim settlement precluded claimant from asserting an aggravation claim. The Referee agreed and granted the insurer's motion.

On review, claimant argues that the disputed claim settlement, if interpreted to preclude his present aggravation claim, is void because it would be a release prohibited by ORS 656.236(1). We agree. Since the hearing in this case, we considered the validity of disputed claim settlements substantially similar to that in the current case. Arnold Androes, 35 Van Natta 1619 (October 27, 1983); Duane E. Maddy, 35 Van Natta 1629 (October 27, 1983); Donald T. Campbell, 35 Van Natta 1622 (October 27, 1983). We concluded that the settlements in those cases were in violation of the statutory prohibition against releases and denied the requests for approval.

We think it follows that the disputed claim settlement here in question could not and does not preclude claimant from filing a claim for aggravation in relation to his compensable 1975 injury. This case, therefore, is remanded to the Referee for a hearing on the merits.

ORDER

The Referee's order dated April 13, 1983 is reversed and this matter is remanded to the Referee for further proceedings consistent with this order.

EDWARD E. WINKLER, Claimant
Jim Slothower, Claimant's Attorney
Minturn, et al., Defense Attorneys

WCB 82-09330
November 23, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Seymour's order which set aside SAIF's denial of claimant's hemorrhoid condition insofar as that denial purported to deny compensability of claimant's fistula in ano and perianal abscess. SAIF contends claimant has not met his burden of proving that truck driving was the major cause of his fistula in ano and perianal abscess. We agree with SAIF and thus reverse.

Claimant is a truck driver who has had problems with hemorrhoids since 1958. In July 1982, after claimant had been driving dump trucks to and from a rock pit, his hemorrhoid problem became worse, and he filed a claim for compensation. In August 1982 Dr. Koning surgically treated claimant for a perianal abscess, a fistula in ano and removed some chronic hemorrhoids.

Dr. Koning stated that hemorrhoids are commonly seen in truck drivers, who by the nature of their jobs, do a lot of straining in a sitting position, which is a predisposing condition to hemorrhoid formation. Dr. Koning described the development of fistula in ano as the result of superficial inflammation in the anal canal which subsequently burrows through the anal mucosa and underneath through the tissues to the skin near the anus. Dr. Koning stated: "This again can be aggravated by a condition similar to the ones described above [truck drivers who by the nature of their jobs do a lot of straining in a sitting position]." Dr. Koning stated that perianal abscess is a common result of fistula in ano, but whether truck driving could cause such an abscess to form is debatable.

The Referee stated he did not consider this a claim for hemorrhoids as such. Without the fistula and abscess in the fistula, reasoned the Referee, there would have been no operation. Further, the Referee construed "Dr. Koning's report as showing an aggravation of the hemorrhoids resulted in the fistula, which resulted in the abscess, which gave rise to the operation." This analysis seems internally inconsistent to us. The Referee stated that he did not regard this as a claim for hemorrhoids, but then he found a compensable aggravation of the hemorrhoid condition.

We also disagree with the Referee's interpretation of Dr. Koning's report as showing that the fistula was an aggravation of the hemorrhoids. Dr. Koning describes the development of fistula in ano, but he does not state that a fistula is an aggravation of the hemorrhoids or describe how the fistula is related to the hemorrhoids, if at all. Moreover, the Referee found that a fistula in ano is more than an increase in hemorrhoidal symptoms -- it is a change in the underlying condition. We find no medical opinion in the record to support this finding.

Furthermore, assuming arguendo that the evidence establishes that a fistula is an aggravation of the hemorrhoids and can be compensable separate from the hemorrhoids, we are not convinced that claimant's work activities were the major cause of the fistula. Dr. Koning indicated that the fistula in ano can be aggravated by doing a lot of straining in a sitting position. No medical report suggests that a fistula can be caused by such activity. In any event, the doctor's "can be" statement is too equivocal to prove that claimant's truck driving worsened his underlying fistula condition.

Finally, even in this equivocal opinion, Dr. Koning only relates hemorrhoids and a fistula to straining while sitting associated with truck driving. However, claimant's testimony indicated that there was little straining involved in his driving; that the trucks had power steering, air brakes and hydraulic dumps that were easy to operate. Claimant attributed the cause of his problems to bumping in the dump trucks, which had shorter wheel bases, were driven off-road around rock pits and many of which did not have air seats. But no medical opinion relates any of claimant's problems in any way to "bumping" while truck driving.

ORDER

The Referee's order dated April 15, 1983 is reversed. The SAIF Corporation's denial dated September 17, 1982 is reinstated and affirmed.

WILLIAM R. FIELDS, Claimant
Doblie & Francesconi, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-01300
November 25, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Galton's order which: (1) Set aside SAIF's denial of claimant's myocardial infarction claim; and (2) awarded claimant's attorney a fee in the amount of $3,000.

We affirm and adopt that portion of the Referee's order which set aside the denial but modify the portion which awarded the $3,000 attorney fee. This record consists of 20 exhibits comprising 66 pages, plus a 76-page transcript of the hearing. There were two witnesses who testified at hearing -- claimant and a cardiologist. Three other witnesses were prepared to testify on behalf of claimant, but the parties stipulated as to the content of their testimony, obviating the need for them to take the stand. There were no depositions taken in preparation for this case. Although cases regarding claims for myocardial infarctions can involve more extensive preparation and hearings, we conclude that the relatively modest amounts of medical opinion, exhibits and testimony in this case only justifies a fee of $1,500 for claimant's attorney's services at hearing.

ORDER

The Referee's order dated February 8, 1983 is modified in part and affirmed in part. Claimant's attorney is awarded $1,500 as a reasonable attorney's fee for services at hearing. The remainder of the order is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee for services on Board review, to be paid by the SAIF Corporation.

MARGARET L. HARRIS, Claimant
Pozzi, et al., Claimant's Attorneys
Brian Pocock, Defense Attorney
Steven Frank, Defense Attorney

WCB 80-02418 & 80-06627
November 25, 1983
Order on Remand

On review of the Board's orders dated April 30, 1982 and May 14, 1982, the Court of Appeals reversed the Board's orders and found Aetna Insurance Company responsible for claimant's compensable occupational disease.

Now, therefore, the above-noted Board orders are vacated, and this claim is remanded to Aetna Insurance Company for acceptance and payment of benefits in accordance with law. Aetna shall reimburse United Pacific Insurance Company for benefits paid to claimant pursuant to the prior Referee and Board orders.

IT IS SO ORDERED.

ROGER A. VIELMETTI, Claimant
Patrick K. Mackin, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-08664
November 25, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Pferdner's order which upheld the SAIF Corporation's denial of claimant's industrial injury for a broken fifth metacarpal in his left hand.

On July 27, 1982 claimant was employed as a press operator. That morning claimant had a dispute with his supervisor who ordered him to leave work. Claimant became angry and struck a cardboard box and a door with his fists. There is no indication that his

hand was injured at that time. Rather than leaving work, claimant stayed on the premises and, shortly after the dispute with the supervisor, assisted several co-workers in moving a large office machine up three flights of stairs. The Referee found, and we agree, that the employer acquiesced in claimant's continuing at work, so if an injury occurred during the moving incident, it was within the course of claimant's employment.

Claimant alleges that during the move of the office machine his hand was injured. He testified that his hand was caught between the handle of the machine and the stairs when the machine slipped. The Referee stated that he did not believe that claimant had injured his hand in the manner alleged. The Referee specifically stated: "These conclusions are achieved solely on the basis of the evidence presented, including the demonstration, and is not based on the appearance, attitude or demeanor of any witness."

Had the Referee based his finding that the incident did not occur on claimant's demeanor, we would be inclined to defer to such a credibility finding. However, the Referee's analysis appears to go somewhat beyond the record. The Referee concluded that the incline of the stairs was probably greater than 30° because "the incline of most stairs is greater than 30°." He also stated that the hand truck would have had to be operated so that the angle between it and the floor would be about 30° because that is where the Referee calculated the center of gravity would be based on the dimensions of the machine. But there is nothing in the record to indicate the actual incline of the stairs nor the center of gravity of a hand truck used to move a particular office machine.

On this record, we conclude that the stair incident occurred as alleged. The evidence indicates that claimant worked without apparent hand problems prior to the stair incident. There is no dispute that claimant assisted in moving the office machine up the stairs and that the move was troublesome for all concerned. There is no evidence which specifically corroborates claimant's story that he hurt his hand during the move, but no evidence contradicts it. Claimant reported the incident two days later and saw a doctor for it at the same time. In short, claimant's testimony is consistent with several nondisputed facts and we find no evidence which gives us any reason to disbelieve that testimony.

ORDER

The Referee's order dated April 20, 1983 is reversed. The SAIF Corporation's denial dated September 1, 1982 is set aside. The claim is remanded to SAIF for processing. Claimant's attorney is awarded $1,000 for services at hearing and on Board review, to be paid by the SAIF Corporation.

HOWARD M. YEAGER (Deceased), Claimant
Carney, et al., Claimant's Attorneys
Spears, et al., Defense Attorneys

WCB 79-04381
November 25, 1983
Order Denying Application for Attorney's Fee

The Board issued its Order on Review herein on December 18, 1981. 33 Van Natta 640 (1981). The Board affirmed the Referee's order which had affirmed two Determination Orders dated March 28, 1979, one of which awarded claimant 52.5° for a 35% loss of the left leg for an injury sustained in 1974; and one of which awarded claimant permanent total disability in connection with a subsequent injury in 1977. The employer petitioned for judicial review of the Board's order, contending that claimant was not permanently and totally disabled, but that if he was, he was not entitled to receive an additional award for permanent partial disability. The court held that claimant was permanently and totally disabled, but that he was not entitled to receive separate, additional payments for permanent partial disability while in receipt of payments for permanent total disability. Pacific Motor Trucking Co. v. Yeager, 64 Or App 28, 30, 32 (1983). The court's final order issued on October 12, 1983. The cost sheet attached to the final order designates the employer-petitioner as the prevailing party before the court, and costs are awarded to the employer-petitioner. We presently have before us claimant's attorney's application for an allowance/award of attorney fees for efforts expended in claimant's behalf before the Court of Appeals. Claimant invokes the Board's authority pursuant to ORS 656.382(2) and Morris v. Denny's Restaurant, 53 Or App 863 (1981).

This Board lacks authority to award attorney fees for services performed before the Court of Appeals in all but two situations. See Kristie Paresi, 34 Van Natta 37 (1982); SAIF v. Paresi, 62 Or App 139, 143 (1983). The first situation arises under Morris v. Denny's, supra, wherein the court construed OAR 438-47-045 as a grant of authority to the Board by which the Board awards an attorney's fee for services performed before the Court of Appeals in cases in which the issue is extent of disability and the court increases the claimant's award. Secondly, as a result of recent legislation, the Board presently has authority to award or allow a reasonable attorney's fee in cases in which a claimant "finally prevails after remand from the Supreme Court," or the Court of Appeals. ORS 656.388(1).

This case does not fall into either one of the two categories mentioned above. Claimant's compensation was not increased by the court; indeed, the court held that claimant was not entitled to receive the permanent partial disability award in addition to his award for permanent total disability. Nor has claimant "finally prevailed" on remand.

Even if we had authority to grant claimant's request, it does not appear that claimant's attorney would be entitled to a fee for services rendered before the court. Judicial review was initiated by the employer. The applicable statute and rule are ORS 656.382(2) and OAR 438-47-060. The statute provides that in the event of an employer-initiated petition for judicial review claimant's attorney is entitled to a reasonable attorney's fee if the court finds that "the compensation awarded . . . claimant

should not be disallowed or reduced . . . ." The court, in fact, reduced claimant's compensation by holding that claimant was not entitled to simultaneous payments for permanent total and permanent partial disability. As indicated by the cost sheet attached to the court's final order, the court did not consider claimant the "prevailing party," and costs were awarded to the employer-petitioner. But see Kociemba v. SAIF, 63 Or App 557 (1983); Humeland v. SAIF, 64 Or App 71 (1983).

ORDER

Claimant's application for an award or allowance of a reasonable attorney's fee for services rendered before the Court of Appeals is denied.

PATRICIA M. ANDERSON, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-07388
November 30, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Danner's order which set aside the insurer's denial of compensability of claimant's occupational disease claim and which awarded claimant $3,518, representing $2,490 in attorney fees and $1,028 in advanced expenses. The insurer contends that claimant's nasal/respiratory condition is not compensable, that the award of attorney fees is excessive and that advanced expenses are not recoverable.

Claimant began working for the employer as a sawyer where she was exposed to wood and wood dust. In 1978 claimant began having nasal obstruction symptoms which were diagnosed by Dr. Lee in 1979 as chronic sinusitis. In 1980 claimant was referred to Dr. Anderson at the University of Oregon Health Sciences Center. Dr. Anderson was struck by claimant's history that her symptoms were worse at work and better when she was not at work. Dr. Anderson opined that it was reasonably possible that claimant had a chronic problem caused by or exacerbated by dust at work. Claimant then filed a claim for occupational disease, the compensability of which was later denied by the insurer.

By the time of hearing, medical opinions regarding causation of claimant's nasal symptoms could be divided into two groups. Supporting the insurer's contention that claimant's occupational disease was not compensable were Drs. Bardana, Smith and Anderson. These three doctors essentially agreed that claimant's nasal problems are caused by sarcoidosis, or more generally, a granulomatous process, which is an inflammatory disease process of unknown cause.

Drs. Mettler, Lee and Korn generally supported claimant's contention that her claim was compensable. These three doctors agreed that claimant was suffering from an allergy. Dr. Mettler testified that claimant's allergy is inborn, but that her work environment "triggered it" and was a material contributing factor to claimant developing the sensitivity she now has. Dr. Lee stated that claimant's allergic disease to wood dust was work-related. Dr. Korn

stated that claimant's disease and nasal symptoms were caused by wood dust exposure at her place of employment.

The Referee, in finding the claim compensable, gave more credence to Dr. Mettler's opinion because Dr. Mettler diagnosed allergy and successfully treated claimant with allergy shots. We cannot agree with the Referee's conclusion because we are not persuaded that claimant has carried her burden of proving that her nasal condition was caused by her work environment.

First, we cannot find any persuasive basis for choosing one diagnosis over the other. Many of the medical reports are conclusory or contradictory, and they give us little guidance. The doctors who concluded that claimant's problems are caused by sarcoidosis -- Bardana, Smith and Anderson -- all base their opinions on a mistaken history of nasal problems since childhood. Dr. Mettler's opinion, on the other hand, is questionable inasmuch as allergy tests performed on claimant while she was working were negative, while Dr. Mettler's positive allergy tests were performed after claimant left her job. Drs. Korn's and Lee's opinions were also conclusory and were based upon Dr. Mettler's findings.

Second, assuming for sake of discussion that claimant is suffering from an allergy, we have even greater difficulty identifying what is the supposed allergen. In September 1980 Dr. Mettler reported he had scratch-tested claimant with birch, alder and a tree mixture with pine, and that all tests were positive. In November 1981 Dr. Mettler reported that claimant reacted to all weeds, grasses, trees and dust. At the hearing Dr. Mettler testified that claimant was allergic to trees. The insurer's attorney asked Dr. Mettler if his panel of testing was a pollen panel and Dr. Mettler replied, "Yes." Dr. Mettler answered other questions about claimant's "pollen allergy."

We cannot determine whether pollen was involved in all allergy tests or only in the birch-alder-pine series. If tree pollen is the only allergen, we find no evidence that claimant was exposed to tree pollen at her work. If claimant is allergic to trees, pollen, weeds, grasses and dusts, we find no evidence that her work exposure to these allergens, when compared to her off-work exposure, was a major cause of her allergic reactions. SAIF v. Gygi, 55 Or App 570 (1982); see also Thompson v. SAIF, 51 Or App 395 (1981).

Therefore, we find that claimant has failed to carry her burden of proving that she has suffered an occupational disease. Accordingly, we reverse the Referee and affirm the insurer's denial of February 18, 1982.

The Referee also ordered the insurer to pay claimant's attorney $3,518, representing $2,490 in attorney fees and $1,028 in advanced expenses. Since we reverse the finding of compensability, we likewise reverse the award of attorney fees. We note, however, that the advanced expenses would not have been recoverable if claimant had prevailed on the compensability question. It is well settled that a claimant's litigation costs are not compensable.

ORDER

The Referee's order dated March 18, 1983 is reversed. The insurer's denial dated February 18, 1982 is reinstated and affirmed.

MARY R. BURDICK, Claimant
Bottini & Bottini, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 82-08804
November 30, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Mason's order which awarded claimant 35% (112°) unscheduled permanent disability, thereby modifying the Determination Order of October 19, 1983 which awarded 10% (32°) permanent disability. The insurer contends that the disability award is excessive.

Claimant is a 42-year-old housekeeper and rental property manager. Claimant injured her low back when she fell off a chair onto a concrete floor. She also has suffered neck and headache problems. A myelogram showed a herniated disc at L4-5. Claimant has declined surgery.

Claimant's treating neurologist and orthopedist agreed that claimant cannot return to housekeeping work and that she should avoid bending, lifting, twisting and carrying heavy objects. Accordingly, claimant entered a vocational program in accounting and clerical work. Claimant offered convincing testimony from her daughter and a fellow student regarding claimant's problems at school and at home with regard to her back.

Claimant has not returned to housekeeping work, and she has not been able to find a job since successfully completing her vocational program. Claimant's vocational counselor testified as to claimant's extensive job search efforts, and claimant appears to be highly motivated. The Referee found, and we agree, that claimant is able to perform entry level accounting and clerical duties which pay about the same as she received in her previous employment. The Referee also correctly noted that, although claimant has not yet found work, the normal availability of occupational opportunities must be considered without adjustment for periodic cycles. We disagree, however, with the Referee's permanent disability award of 35%.

Claimant has not had surgery, and she has been sucessfully retrained. We conclude that a more appropriate award is 25% permanent disability.

ORDER

The Referee's order dated March 21, 1983 is modified. Claimant is awarded 25% (80°) unscheduled permanent disability, an increase of 15% (48°) over the Determination Order of October 19, 1982, which awarded 10% (32°) unscheduled permanent disability. Claimant's attorney's fee is to be adjusted accordingly.

CAROL A. CAUGHRAM, Claimant
Coons & McKeown, Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 81-03155
November 30, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of that portion of Referee Foster's order which set aside the February 11, 1981 and November 3, 1982 Determination Orders as premature and ordered the

claim be resubmitted to the Evaluation Division for redetermination of permanent partial disability benefits. SAIF argues that the Referee should not have required that the claim be resubmitted on the issue of permanent partial disability benefits in the face of the claimant's clear assertion at the hearing that she did not contest the amounts of permanent disability benefits awarded by those orders.

We understand that this was an unusual situation in that claimant was not represented at hearing and, even after the Referee explained to her what issues she could raise at the hearing, claimant contended her issues were temporary disability benefits and medical services benefits not paid, rather than the extent of the permanent disability award.

The Referee made an assumption that certain medical reports were not considered in the evaluation of claimant's disability. However, there is simply no evidence to that effect. On the other hand, there is evidence that the November 3, 1982 Determination Order correctly terminated claimant's temporary total disability as of October 7, 1982 and that the February 11, 1981 Determination Order was premature. Therefore, we affirm the November 3, 1982 Determination Order with the modification, in line with the Referee's order, that time loss was due continuously from May 10, 1980 through October 7, 1982, less time worked. This matter shall not be resubmitted to the Evaluation Division for an additional evaluation of claimant's permanent disability.

ORDER

The Referee's order dated January 31, 1983 is modified. The February 11, 1981 Determination Order is set aside. The November 3, 1982 Determination Order is affirmed, except in that temporary total disability benefits are due continuously from May 10, 1980 through October 7, 1982, less time worked. The remainder of the Referee's order is affirmed.

THOMAS L. CLARK, Claimant
Welch, Bruun et al., Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB 82-07391
November 30, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Williver's orders which set aside a Determination Order and reopened claimant's claim, ostensibly for a worsened condition related to claimant's original injury. The parties' understanding of the Referee's orders, which is consistent with our own, is that the Referee intended to reopen the claim effective September 16, 1982, pursuant to ORS 656.273; that he did not intend to reopen the claim on the basis of premature closure; and that those portions of his order setting aside the Determination Order, therefore, are without legal effect. Claimant concedes the propriety of that portion of the Referee's order finding that the claim was not prematurely closed. Therefore, the issue on review is whether claimant has established a worsening of his injury-related condition since the last award of compensation, which is the August 20, 1982 Determination Order.

Claimant was compensably injured on November 5, 1978 when he slipped and fell, injuring his lower back. His claim initially was closed by a Determination Order in March of 1979, which awarded temporary disability only. Claimant thereafter sought claim reopening, and SAIF issued a denial alleging a new injury with a more recent employer. In November 1980 claimant was hospitalized by Dr. Kendrick for a lumbar laminectomy at L4-5. The question of employer/insurer responsibility for claimant's 1980 surgery was decided adversely to SAIF in prior proceedings in which it was concluded that claimant had suffered a compensable worsening of his 1978 industrial injury, as opposed to a new industrial injury. Thomas Clark, 33 Van Natta 471 (1981).

Claimant completed a three term industrial mechanics program under the auspices of the Vocational Rehabilitation Division in June of 1982. Prior to completion of the training program, it was observed by claimant's counselor that he was experiencing physical difficulties with regard to the condition of his back and that claimant was "in obvious physical stress." Claimant's physical problems, however, did not cause him to miss class, and he was capable of traveling to various locations in and out of the State of Oregon in order to make job contacts.

On July 2, 1982 claimant was examined by Dr. Kendrick, at which time Dr. Kendrick observed that claimant continued to experience pain, mainly in the back, without much in the way of leg pain. He stated his opinion that claimant's condition remained stationary, "although he remains with significant physical limitations, as noted. He tells me that he is returning to work in a mill, and I think the success or failure of that will depend on how heavy the work is."

A Determination Order issued on August 5, 1982, which established a medically stationary date of June 3, 1981, a medically non-stationary date of April 13, 1982, and a subsequent medically stationary date of June 3, 1982. Claimant was awarded compensation for temporary total disability from November 18, 1982 through June 11, 1982, and an award for unscheduled permanent disability equal to 80° or 25% of the maximum allowable. Another Determination Order issued August 20, 1982, which modified the August 5, 1982 order by granting claimant compensation for temporary total disability inclusively from June 20, 1979 through June 11, 1982. Claimant requested a hearing contesting these Determination Orders.

A progress report dated August 10, 1982 from claimant's vocational rehabilitation counselor, notes that claimant was making little progress in his job seeking efforts, due to the combination of his disability and the poor job market. Later that month, arrangements were made for claimant to travel to Oklahoma in an attempt to obtain employment.

An August 24, 1982 report from Dr. Kendrick describes an incident which had occurred recently while claimant was bending over in his garden. Claimant had been unable to straighten up and had experienced tingling in his left leg with weakness of the right leg. Dr. Kendrick states in this report:

"The leg problems of which he complains

> bother me a bit and I think, can easily be explained on the severe foramenal stenosis that he has. I think nothing but time will tell us whether or not we will have to do something about that surgically, but if he worsens particularly with regard to leg symptoms, I suspect strongly that it will be on that basis and that decompression of that foramen will be required."

On September 7, 1982 Dr. Kendrick reported that claimant "really has continued to worsen," that claimant was experiencing low back pain, progressive stiffness, numbness and give-way of the legs, particularly when he stood. Dr. Kendrick stated that claimant's condition was "just progressively worsened, not starting any particular time, but just gradually." He noted that claimant's back motion had become increasingly abnormal. "He does not show any signs on x-ray, etc. particularly of mechanical instability, but shows severe foramenal stenosis as previously mentioned." Dr. Kendrick stated that he did not believe claimant's condition justified a stabilization procedure such as a fusion, but he believed claimant could benefit from a decompression of the foramen at L4-5, which procedure he recommended.

Claimant was referred for examination by Dr. Raaf, who stated that according to claimant's history, claimant was experiencing as much or more discomfort in his back as in his legs. Dr. Raaf did not find claimant suffering from severe radicular nerve root pain. He stated:

> "I think the preferable solution would be for him to get a job in maintenance supervision which does not require any heavy lifting. I agree he cannot go back to heavy work as a millwright. If he finds he is unable to do light work, then possibly decompression of nerve roots bilaterally at the L4-5 level would be justified although I do not think exploration and decompression of nerve roots at the L4-5 level will solve his problem. If another exploration is to be done I believe a fusion at the same time should be strongly considered."

In response to an inquiry from SAIF, by a handwritten notation dated December 7, 1982, Dr. Kendrick expressed his agreement with Dr. Raaf, i.e., that if claimant was capable of performing light-duty work, he should not have anything further, presumably surgically, done.

By letter of January 10, 1983, Dr. Kendrick reiterated his opinion that claimant would require further decompression, but that if claimant was capable of performing some type of gainful employment, then it would not be appropriate to do anything further and, thus, "no further curative treatment would be appropriate." Dr. Kendrick went on to state, however, that if claimant was not capable of engaging in any gainful employment, then some type of curative treatment would be indicated. Dr. Kendrick had stated

earlier, in a December 1982 report to SAIF, that a foramenal decompression was not a guaranteed solution to all of claimant's problems, that claimant would be left with some back pain no matter what was done, and that, "if as Dr. Raaf indicates, he is unable to work and unable to get along, then I think, and only then, surgery should be considered."

When the hearing convened before Referee Williver, claimant's attorney stated the issues to be claim reopening, either on the basis of premature closure or worsening of claimant's condition pursuant to ORS 656.273; and, alternatively, extent of permanent disability. Claimant's attorney also identified an issue concerning SAIF's failure to respond to Dr. Kendrick's September 7, 1982 letter to SAIF by promptly paying interim compensation benefits. As previously stated, the Referee found claimant entitled to claim reopening as of September 16, 1982 on the basis of a worsened condition.

On review SAIF contends that claimant is not entitled to reopening of his claim unless and until he undergoes the decompression surgery that has been suggested by Dr. Kendrick, and that claimant's condition remains medically stationary. We agree, and, therefore, reverse the Referee's order reopening the claim.

Claimant suffers from a significant disability which makes it difficult for him to obtain gainful employment in his field of work, industrial maintenance. However, no physician has opined that claimant presently is incapable of performing gainful employment subject to restrictions compatible with his physical impairment, if such employment were available. Claimant is obviously motivated to obtain employment, as evidenced by his active job search efforts. Although further surgical intervention may be considered in the future, presently no such treatment is anticipated, and claimant testified that he is not particularly anxious to undergo further surgery. SAIF concedes that, in the event that claimant eventually undergoes the decompression surgery recommended by Dr. Kendrick, claimant will at that time be entitled to claim reopening. The inquiry now, however, is whether claimant's condition has worsened since the last award of compensation, i.e., since the Determination Orders which issued in August 1982.

When Dr. Kendrick examined claimant on July 2, 1982 and found his condition medically stationary, claimant was able to perform forward flexion to approximately 30°. He previously had been experiencing fairly constant back pain with intermittent radiating leg pain. At that time, Dr. Kendrick noted that claimant clearly would experience recurring problems because of the narrowing of the foramen. Dr. Kendrick's August 24, 1982 report noted that claimant had been having trouble with his legs, "off and on." The report of examination on September 7, 1982 noted that claimant was able to perform forward flexion to 25° to 30°. The incident in claimant's garden which apparently precipitated Dr. Kendrick's consideration of surgery represented nothing more, in our opinion, than an episodic recurrence of a chronic low back problem that had reached a point of stability prior to issuance of the August 1982 Determination Orders. The Referee found that claimant's claim had not been closed prematurely. Claimant does not contend that this finding is in error, nor would the record appear to support any such contention. Claimant's testimony, insofar as it bears some relevance to

the question before us, supports the conclusion that claimant's condition has been stable during the entire period of time in question, i.e., since August of 1982. By December 14, 1982, three months after stating that claimant's condition was "just progressively worsened," Dr. Kendrick found claimant's complaints, "basically the same as they have been. He is not having quite as much leg pain now unless he extends his back. His back does continue to bother him intermittently in much the same way."

For the foregoing reasons, we reverse the Referee's order. It, therefore, is necessary to consider the extent of claimant's permanent disability. We find no reason to remand this case to the Referee for that purpose in view of the fact that the issue of permanent disability was stated in the alternative to the request for claim reopening, and claimant presented sufficient evidence to make a determination concerning extent of disability.

The Determination Order awarded claimant 80° for 25% unscheduled permanent partial disability. We find claimant is entitled to an increased permanent disability award. Based upon the surgical procedure which claimant has undergone, and the residual impairment which is apparent, we consider claimant's impairment in the mildly moderate category and have assigned a value of +31 to this factor. Claimant was 44 years of age at the time of hearing. He obtained his graduate equivalency degree. His employment at the time of the injury was millwright, which is considered heavy labor. Claimant has been relegated to light work. Considering claimant's vocational retraining, which has prepared him for a supervisory position in industrial maintenance, in light of his residual functional capacity, we find that 41% of the labor market remains available to claimant. Utilizing the guidelines for evaluating permanent disability, OAR 436-65-600, et seq., and considering this case in light of other cases involving similarly situated injured workers, we find claimant is entitled to an award of 112° for 35% unscheduled permanent partial disability.

ORDER

The Referee's orders dated February 8, 1983 and March 2, 1983 are reversed. The Determination Orders dated August 5, 1982 and August 20, 1982, to the extent that there is any confusion arising from the Referee's order, are reinstated and modified. The Determination Orders' award of 80° for 25% unscheduled disability is increased to award claimant an additional 32° or 10%, for a total unscheduled award of 112° for 35% of the maximum allowable. In lieu of the attorney's fee allowed by the Referee's orders, claimant's attorney is allowed 25% of the increased permanent disability award made payable by this order, not to exceed $3,000, for services before the Referee and the Board.

MICHAEL COCHRAN, Claimant
Willner, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-03827
November 30, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of those portions of Referee Fink's orders which upheld the SAIF Corporation's denial of his low back claim and which awarded claimant interim compensation only between April 2, 1982 and April 23, 1982. Claimant also moves for remand to consider additional evidence. The issues for review are: (1) Whether the claim is barred because it was not timely filed; (2) whether the Referee erred in refusing to admit two exhibits; (3) whether claimant has proven the compensability of his claim by a preponderance of the evidence; (4) whether claimant is entitled to more interim compensation than awarded by the Referee; and (5) whether remand is appropriate.

Claimant is a welder who was 29 years old at the time of hearing. In October 1981 he suffered an on-the-job injury which apparently was found compensable under the Federal Longshore and Harbor Workers' Compensation Act. Claimant returned to work for the employer in early February 1982. Claimant went off work again on March 1, 1982. Claimant phoned the employer and reported that he would not be at work. The evidence in this record indicates that claimant did not inform the employer of any alleged job connected injury until he filed an 801 form on April 2, 1982.

Claimant sought treatment for radiating left leg pain on March 19, 1982. A discectomy was performed on March 25, 1982. Dr. Neufield and Dr. Franks, who treated claimant, related his problems to the "very heavy work" which claimant described to them.

The 801 form filed on April 2, 1982 alleged that claimant's back problems were caused by picking up steel during the week of February 22, 1982. SAIF denied the claim on April 23, 1982.

Claimant requested an expedited hearing. The hearing notice issued on May 6, 1982 and a hearing was held on May 21, 1982. At the close of hearing the Referee left the record open to allow SAIF to conclude its direct examination of Dr. Norton and for claimant to cross-examine Dr. Norton. Prior to closure of the record, claimant's attorney tendered two additional exhibits. The Referee refused to admit these two exhibits.

The Referee concluded that the claim was barred because it was not timely filed. In the alternative, the Referee concluded that claimant had failed to prove by a preponderance of the evidence that the claim is compensable. In his original order, the Referee awarded interim compensation benefits from the date of the alleged injury until the date of the denial. In his amended order the Referee reduced the period during which he found SAIF liable for time loss to include only the period between when the claim was filed and when it was denied.

We disagree with the Referee's timeliness conclusion. However, on the merits, we agree with the Referee that claimant

has failed to prove compensability even considering the evidence which we find the Referee erroneously excluded. We agree with the Referee's ultimate holding on the interim compensation issue. Finally, we decline to remand for consideration of additional evidence.

I.

Claimant's injury allegedly occurred during the week of February 22, 1982. Claimant argues that his claim might be considered an occupational disease. However, we find that because his alleged exposure occurred within a one week period, and supposedly caused the sudden onset of pain, the claim should be classified as an injury.

Claimant did not file a claim or provide notice to the employer within 30 days of his injury as required by ORS 656.265. Failure to give notice within 30 days bars a claim unless one of several conditions are met, one being if the employer/insurer was not prejudiced. SAIF has the burden of proving it was prejudiced. Satterfield v. Compensation Department, 1 Or App 524 (1970). SAIF argues that it was prejudiced because the passage of time dimmed memories. However, there is no indication in the record that SAIF was prejudiced in its ability to gather information concerning the claim except that it was unable to obtain an independent medical examination prior to claimant's surgery. Under these circumstances, we find that SAIF has failed to prove prejudice. It follows that the claim is not barred for lack of timeliness.

II.

The Referee left the record open at the close of hearing in order to allow SAIF to continue its examination of Dr. Norton and to allow claimant to cross-examine Dr. Norton. Dr. Norton's testimony directly bore on the issue of compensability. Before the record closed claimant's attorney offered a letter from himself to Dr. Franks and Dr. Franks' reply for inclusion in the record. Dr. Franks' letter also bore on the question of compensability. We believe that once the Referee left the record open to allow submission of additional evidence on the issue of compensability, he should have admitted similar evidence on the same issue. See Edward Morgan, 34 Van Natta 1590 (1982). Accordingly, we find that the Referee erred in excluding the exhibits offered by claimant while the record was open. Consequently, we consider them as part of our review of the record.

III.

The Referee held that claimant had failed to prove by a preponderance of the evidence that his claim is compensable. In essence, he predicated that decision on the fact that the compensability of the claim rests on claimant's version of the facts; specifically, that the medical reports which support the compensability of this claim, including Dr. Franks' report which was erroneously excluded, all rest on the history of lifting extremely heavy weights recited by claimant. However, the Referee found the claimant not credible. After a review of the evidence, we agree with the Referee.

IV.

In his original order the Referee held that SAIF was liable for interim compensation from the date of the alleged injury until the date of denial. On reconsideration, the Referee held that claimant is entitled to interim compensation only from the date of notice of the injury until the denial. We agree. Stone v. SAIF, 57 Or App 808 (1982); Donald Wischnofske, 34 Van Natta 664 (1982). We affirm and adopt the Referee's amended order on the issue of interim compensation.

V.

Claimant moves to remand the claim to the Referee to consider additional evidence on the issue of what date claimant actually gave notice of his claim. The proffered evidence is the employer's telephone log which allegedly establishes that claimant actually gave notice of the claim on March 31, 1983, three days prior to his filing the 801 form.

We decline to remand because we find claimant has failed to make a sufficient showing that this telephone log was not obtainable through the exercise of due diligence prior to the closure of the record. Ora M. Conley, 34 Van Natta 1968 (1982), aff'd 65 Or App 232 (1983).

ORDER

The Referee's orders dated August 13, 1982 and August 24, 1982 are affirmed in part and reversed in part. Those portions refusing to admit Exhibits 27 and 28 and finding that the claim is barred for lack of timeliness are reversed. The remaining portions are affirmed. Claimant's motion to remand is denied.

MICHAEL G. CRAGUN, Claimant
Flaxel, et al., Claimant's Attorneys
Marcus Ward, Defense Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 81-08993, 81-10862 & 81-10863
November 30, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of those portions of Referee Nichols' orders which upheld denials by the SAIF Corporation (the aggravation insurer) and Crawford and Company (the new injury insurer) and which declined to award temporary total disability benefits and penalties from both insurers. Compensability, responsibility, temporary total disability benefits and penalties are the issues on review.

In May 1980 claimant slipped down some stairs while working for SAIF's insured, Special Security Investigators. Claimant's physician described claimant's problem at that time as a low back strain. SAIF paid time loss for four days and claimant was released to his regular work. The treating physician, Dr Albertson, stated: "He is practically well, released for work, no return needed." SAIF then closed the claim as a non-disabling injury.

Claimant worked for another employer, Burley Industries, during 1980. Burley is not a party to this appeal.

In June 1981 claimant was working for Crawford's insured, Oregon Aqua Food, scraping barnacles off a fish ladder. This job required heavy lifting. On June 10, 1981 claimant reported to his employer that he had "aggravated on old injury." He filed claims with Oregon Aqua Food and with SAIF. SAIF began paying interim compensation benefits, but Crawford did not.

Dr. Albertson reported that claimant was in pain and spasm and referred him to Dr. Smith, an orthopedist. On July 1, 1981 Dr. Smith reported that claimant had suffered a contusion with continuing discomfort.

> "In addition, he should avoid excessive stress on his low back. This would be best done by finding permanent relatively light work. I have no other treatment for him. His present condition is probably stationary and his claim could be closed on the basis of this report."

SAIF stopped paying interim compensation as of the date of this report but did not deny claimant's aggravation claim until September 10, 1982.

On July 28, 1981, Dr. Smith reported that claimant's pain

> "is a combination of many components such as his original work injury of May 1980, and heavy use of the back as when working for...Ore Aqua as well as probable functional component."

On November 3, 1981 Crawford wrote claimant's attorney a note indicating it was investigating the claim. On November 10, 1981 claimant's attorney transmitted a series of documents to Crawford and requested that Crawford inform him whether it intended to accept or deny the claim. The Referee found the November 10, 1981 letter to Crawford was Crawford's first notice of the claim. The Referee apparently disregarded the 801 form which was filed with Crawford's insured in June.

On November 19, 1981 Crawford wrote claimant's attorney a letter informing him that it was denying claimant's claim. It did not send the letter to claimant, nor did the letter contain a notice of claimant's right to appeal the denial.

On November 30, 1981 Dr. Smith wrote:

> "As you can see from my report, [claimant] told me that his original injury occurred in May 1980 while he was working as a security guard. There was no history of back trouble before that injury but according to his history he had intermittent trouble ever since that time. He had enough pain to cause him to miss a days work now and then ....I did not get any history of the effect of his work at Ore-Aqua...on his back pain.

> It is probable (if his history is accurate and complete) that his initial injury occurred when he fell while working as a security guard and that the heavy work for Burley Industries (and possibley for Ore-Aqua) are in part responsible for the continuation and persistence of his symptoms."

In January 1982 Dr. Smith reiterated his position:

> "It is my feeling that [claimant's] problem had its onset as a result of the June 1980 injuries. The work activities at Burley Industries and at Oregon-Aqua foods, resulted in temporary increase in disability requiring further medical services."

I

The Referee upheld the denials of both SAIF and Crawford because she found there was insufficient evidence to support either an aggravation or a new injury. We find that Dr. Smith's reports are sufficient to support a finding that the SAIF claim should have been reopened due to an aggravation. Dr. Smith's opinion is that the condition for which claimant sought medical treatment in 1981, while exacerbated by claimant's work at Oregon Aqua, was caused by his compensable injury at Special Security. We are convinced by his reports that claimant's condition was worse in June 1981 and that claimant's compensable injury at Special Security was a material cause of that worsening. Accordingly, we find that SAIF is responsible for claimant's aggravation claim.

II

The Referee, in her amended order, found that claimant was not entitled to interim compensation from either insurer and consequently did not impose a penalty on either insurer for late denial because there was nothing due upon which to base such a penalty. We disagree.

A.

As noted, SAIF properly paid time loss from the time it was notified of medical verification of the claim until Dr. Smith's, July 1, 1981 report. At that time it stopped paying time loss and paid no more, even though it did not deny the claim until September 10, 1981.

SAIF's action in terminating time loss would have been proper had Dr. Smith unconditionally released claimant to work. Anna Scheidemantel, 35 Van Natta 740 (1983). However, Dr. Smith did not unconditionally release claimant. He only released him to light work. SAIF, therefore, had an obligation to pay claimant interim compensation until full release or until it denied the claim. We also believe that a penalty is warranted for SAIF's failure to pay interim compensation. We impose a penalty of 10% of the interim compensation SAIF must pay under this order.

B.

Claimant filed an 801 with Crawford's insured for a new injury on June 12, 1981. Crawford was obligated under ORS 656.262(4) to begin paying interim compensation within 14 days. It never paid interim compensation. On review, Crawford argues that it was not liable for interim compensation because it would be unfair to allow claimant to collect interim compensation benefits from two insurers. We have previously resolved that issue contrary to Crawford's position. Darrell Messenger, 35 Van Natta 161 (1983). We conclude that claimant is entitled to receive interim compensation from Crawford from June 10, 1981 until Crawford's denial dated November 19, 1981.

Under these circumstances in which Crawford never paid interim compensation despite a clear statutory duty to do so, we impose a penalty on Crawford of 25% of the interim compensation due under this order.

ORDER

The Referee's orders dated November 5, 1982 and December 14, 1982 are affirmed in part and reversed in part. Those portions of the Referee's orders upholding Crawford's denial are affirmed. Those portions of the Referee's orders concerning Burley Industries are affirmed. Those portions of the Referee's orders upholding SAIF's denial are reversed. Those portions of the Referee's order concerning penalties and associated attorney's fees are reversed.

SAIF is ordered to pay claimant temporary total disability between July 1, 1981 and September 10, 1981. SAIF is ordered to pay claimant a penalty of 10% of the additional temporary disability benefits due under this order. SAIF is ordered to pay claimant's attorney $300 for prevailing on the penalty issue and $1,000 for prevailing on SAIF's denial.

Crawford is ordered to pay claimant temporary total disability benefits between June 12, 1981 and November 19, 1981. Crawford is ordered to pay claimant a penalty of 25% of the temporary disability benefits due under this order. Crawford is ordered to pay claimant's attorney $300 for prevailing on the penalty issue.

CURTIS E. CRAIG (Deceased), Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 77-01874
November 30, 1983
Order on Review (Remanding)

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Seifert's order which dismissed her request for hearing on a denial of widow's benefits. The Referee found that he lacked jurisdiction because the hearing request was not "filed within the statutory period." We find that the request for a hearing was timely and consequently reverse and remand to the Referee for a decision on the merits.

This claim has a long and complicated procedural history. Claimant's decedent, Curtis Craig, filed an 801 form on December 20, 1976 alleging that he was injured when a piece of plywood

struck him. Mr. Craig died due to lung cancer on February 1, 1977. On February 10, 1977 claimant filed this claim for widow's benefits alleging that claimant's industrial injury had rendered him permanently and totally disabled at the time of his death and had caused or accelerated his cancerous condition thus accelerating his death.

In a letter dated March 23, 1977 the SAIF Corporation denied claimant's claim for widow's benefits. That same day claimant filed a request for hearing alleging as issues temporary total disability, permanent partial disability and permanent total disability. The request for hearing was accompanied by a letter from claimant's then attorney dated March 18, 1977.

In 1980 claimant's present attorney became involved in the case. On December 24, 1980 claimant's present attorney filed a new 801 form alleging that decedent's death was caused by a compensable occupational disease. On January 23, 1981 SAIF denied the occupational disease claim. Claimant's attorney then amended the pending request for hearing to include a protest of the 1981 denial. SAIF then moved to dismiss the occupational disease claim for late filing. The Referee granted the motion and claimant

requested review. On July 9, 1982 we issued an order remanding the case to the Referee because we found that the Referee's order was not a final order because it did not determine the rights of the parties so that no further questions could arise before the Referee. We noted that the March 1977 request for hearing was still pending before the Referee. Curtis Craig, 34 Van Natta 971 (1982).

On remand SAIF moved to dismiss the March 1977 request for hearing because "[t]he Request for Hearing is dated March 18, 1977, five (5) days prior to the issuance of the denial." SAIF cited Syphers v. K-W Logging, Inc., 51 Or App 769 (1981), in support of its argument that the hearing request did not confer jurisdiction on the Referee to determine the validity of the denial because it preceded the denial. See also Thomas v. SAIF, 64 Or App 193 (1983).

The Referee correctly noted that the operative date is the date the request for hearing was received by the Board rather than the date on the accompanying letter. However, the Referee also noted that there was no evidence in the record to indicate when SAIF's denial dated March 23, 1977 was actually mailed or received by the claimant. However, SAIF apparently concedes that the denial was issued on March 23, 1977. Thus, in short, the evidence in this case is that the request for hearing was filed the same date the denial letter was issued. Under these circumstances, we conclude that the hearing request was not premature under Syphers.

ORDER

This case is remanded to the Referee for decision consistent with this order.

NOTICE TO ALL PARTIES: ORS 656.295(8) requires that Board orders contain "a statement explaining the rights of the parties under" ORS 656.298. ORS 656.298(1) provides that any party

affected by an order of the Board may, within 30 days after the date of the order, request judicial review of the order with the Court of Appeals. However, the Court of Appeals has held that this statute only contemplates judicial review of final Board orders. Beck v. Oregon Steel Mills, 36 Or App 581 (1978); Mendenhall v. SAIF, 16 Or App 136 (1974); Hammond v. Albina Engine & Mach., 13 Or App 156 (1973); Hiles v. Compensation Department, 2 Or App 506 (1970); Barr v. Compensation Department, 1 Or App 432 (1970). The court also has held that a Board order which remands to a Referee for further proceedings is not a final order for purposes of ORS 656.298 and, therefore, not presently subject to judicial review. Hammond v. Albina Engine & Machine, supra; Barr v. Compensation Department, supra.

CYNTHIA I. DOUGLAS, Claimant
Doblie & Francesconi, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-05187
November 30, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of those portions of Referee Seymour's order finding that her claim was not prematurely closed. The self-insured employer cross-requests review of those portions of the Referee's order which awarded claimant an additional 128° for 40% unscheduled disability for a total of 176° for 55% unscheduled disability. Premature closure and extent of disability are the issues on review.

The Board affirms and adopts those portions of the Referee's order finding that the claim was not prematurely closed. We disagree with the Referee, however, on the issue of extent of disability.

Claimant is 32 years old. According to the guidelines found in OAR 436-65-600 et seq, this yields a -2 factor. Her education, labor market findings and emotional factors all yield 0 factors. Her previous work was medium and we find that, based on the medical evidence, she is now capable of only light work. Thus, her adaptability factor yields a +5. Her previous work required up to six months training, so her work experience yields a +3 factor. Orthopaedic Consultants rates her impairment due to her compensable injury as mild. This yields a +20 factor for impairment. Even considering claimant's disabling pain, we conclude that the appropriate impairment factor is +30. Combining these factors and rounding to the nearest five, we arrive at a disability rating of 35%. We believe a rating of 35% compares favorably with other cases with similar disability.

ORDER

The Referee's order dated March 25, 1983 is affirmed in part and modified in part. Those portions of the Referee's order concerning premature closure are affirmed. The Referee's award of unscheduled disability is modified. Claimant is awarded an additional 64° for 20% unscheduled disability in lieu of the 128° for 40% awarded by the Referee. This award is in addition to the 15% previously awarded by Determination Order and Stipulation. Claimant's attorney's fee should be adjusted accordingly. Claimant's total permanent disability award to date equals 112° for 35% unscheduled permanent partial disability.

ROBERT HARRAL, Claimant
Charles Paulson, Claimant's Attorney
David O. Horne, Defense Attorney

WCB 82-04429
November 30, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review of Refereee Podner's order which set aside its denial of claimant's aggravation claim.

Claimant compensably injured his low back in July of 1977 while working as a construction laborer. His injury was diagnosed as a lumbosacral strain with some radiation of pain into the left hip. A Determination Order dated April 13, 1978 awarded claimant 5% unscheduled disability. Thereafter, claimant suffered increased problems in the way of bilateral leg numbness, tingling and pain, which was more severe on the left. Also, his left leg occasionally gave way. The parties' November 1978 stipulation increased claimant's award to 10%. Again, in May 1981, due to continued back and leg trouble, the parties stipulated to increase claimant's award by an additional 10% for a total of 20%.

On March 15, 1982 Dr. Connor reported that he had treated claimant on several occasions in November, December and January for lumbosacral strain. Treatment consisted of osteopathic manipulation, heat and aspirin.

On April 6, 1982 an incident occurred in which the claimant fell, causing greater low back and leg pain, requiring hospitalization and resulting in time loss. On May 4, 1982, the insurer denied the aggravation claim on the basis that it "does not appear that your condition was aggravated or arose out of and in the course of your employment . . ."

Claimant contends that on April 6, 1982 he was at home and was standing in his yard bending over to pick up a chainsaw when he experienced a sharp stabbing pain in his low back, causing his legs to give out and resulting in his falling down against a firewood log (or logs). Claimant further contends that this low back pain and leg weakness was one of many related incidents he has had since his compensable injury in 1977. Claimant contends that he was not drinking before the fall, but that on the way to the hospital his wife stopped to buy a bottle of wine for him to help ease the pain. Claimant's wife testified that she witnessed the fall and corroborated claimant's story regarding his alcohol consumption.

The insurer contends that the reason claimant fell on the day in question was due to alcohol consumption. It points to the evidence in the record indicating claimant's history of alcohol abuse and the hospital admission report stating claimant "appears intoxicated." At hearing claimant initially denied being intoxicated when he reported to the hospital emergency room, although later in the hearing he admitted to drinking quite a bit on the way to the hospital. The Referee did not make specific credibility findings with regard to the testimony of claimant and his wife. However, the Referee did state that he found the claimant's statements that his leg gave way and he fell consistent with the hospital admission record which stated: "At home in yard patient's back gave out. Patient fell against stack of logs and they fell

on him." The Referee also found claimant's story consistent with his entire history of low back weakness and leg give-away problems.

Unlike the Referee, we are not persuaded that claimant has proven that his worsened condition was caused in material part by his compensable injury. The evidence of intoxication raises serious doubts in our minds about the cause of the April 1982 off-the-job fall. We recognize that an off-the-job aggravation of a compensable injury can remain the responsibility of the on-the-job insurer under Grable v. Weyerhaeuser Co., 291 Or 387 (1981); however, the evidence of intoxication leaves us unable to conclude that claimant has met the Grable burden of proving that his 1977 compensable injury materially caused his 1982 worsened condition and that the worsened condition was not the result of an independent, intervening off-the-job cause. Grable, 291 Or at 400-401.

ORDER

The Referee's order dated December 28, 1982 is reversed. The insurer's denial dated May 4, 1982 denial is reinstated and affirmed.

HUGO HATZEL, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-10558
November 30, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Seymour's order which approved a Determination Order dated May 21, 1982, which awarded no permanent disability. Claimant contends he is entitled to an award of permanent disability. We agree with claimant and thus reverse the Referee.

Claimant suffered a compensable injury in October 1977 while driving a tractor trailer. Although his treating physician, Dr. Arthur Smith, stated claimant had some mild disability as a result of his injury, the Determination Order and Amended Determination Order issued in February 1979 awarded no permanent disability. Thereafter, claimant's claim was reopened for aggravation and closed by Determination Order dated May 21, 1982, which also awarded no permanent disability. That latter Determination Order is the subject of this case.

After his original injury, claimant was released to return to regular work with no restrictions on his work activity. Claimant testified that when he returned to work, even though his doctor did not restrict him, he did not go back to driving trucks because he did not think he could with his back injury. Instead, claimant bid on a job in the machine shop and began working as a machine shop helper in March 1978, and some time later, as an oiler.

In November 1980 Dr. Smith reported that claimant had continued to have low back pain since last seen in December 1978, that claimant had recently changed jobs from an oiler to a shop helper and that the shop helper job required a great deal of heavy lifting. As a result of the heavy lifting claimant's low back pain progressed to the point where he was unable to work. Dr. Smith

stated that claimant's present back pain is similar to that in 1978. Dr. Smith also recommended that claimant use his back at a lower level of activity such as that at his job as an oiler.

After a couple of weeks Dr. Smith released claimant to return to work as an oiler. He also arranged for claimant to be fitted with a back brace. Claimant returned to work and worked variously as an oiler, in the powerhouse, as a steam cleaner and as a machine shop helper. Dr. Smith reported that claimant had recurrent back pain when he returned to the machine shop and advised that claimant was not able to work in the machine shop but was capable of working in the powerhouse. In June 1981 Dr. Smith reported that claimant's condition was "not a great deal different from the time of his claim closure in December 1978." Further, Dr. Smith said, "I do not feel that the exacerbation of his problem due to the heavy lifting of late October or early November 1980 has resulted in any increased disability."

The Referee properly focused on claimant's changed circumstances from the time of the first Determination Order in February 1979 to the date of hearing. James Johnson, 35 Van Natta 47 (1983). After quoting Dr. Smith's opinion referenced above, the Referee concluded claimant had not worsened since the last rating of permanent disability. The Referee had reasonable grounds for making his determination. We find, however, that the work activity restrictions Dr. Smith placed on claimant after the November 1980 exacerbation, which were not placed on claimant at the time of the February 1979 determination, show an increase in claimant's loss of earning capacity over that period of time. Therefore, we find that since the February 1979 disability determination, claimant has suffered a further loss of earning capacity and is entitled to an award of 32° for 10% unscheduled permanent disability.

Besides arguing for increased unscheduled disability for his low back (WCB Case No. 82-10558), claimant also argues in his brief for a greater award of scheduled disability for his left knee (WCB Case No. 82-10557). Referee Seymour heard both of these cases at the same hearing but issued separate orders under their respective WCB numbers. Claimant only requested review of the back disability case, WCB Case No. 82-10558. Inasmuch as no request for review was filed for WCB Case No. 82-10557, the Board has no jurisdiction to review that left knee disability award.

ORDER

The Referee's order dated May 9, 1983 is reversed. Claimant is awarded 32° for 10% unscheduled permanent disability for injury to his low back. Claimant's attorney is allowed 25% of claimant's disability award, not to exceed $3,000.

HAROLD A. LESTER, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys
Reviewed by the Board en banc.

WCB 82-08239
November 30, 1983
Order on Review

Claimant requests review of Referee Seifert's order which: Awarded claimant a total of 20.25° for 15% scheduled permanent partial disability for his right foot (ankle) condition, which was an increase of 6.75° or 5% from the August 31, 1982 Determination Order which had awarded him 13.5° for 10%; and (2) did not assess penalties and attorney fees. On review, the issues are extent of disability and whether penalties and attorney fees are justified for the employer's allegedly unreasonable delay in responding to a request for medical reports from the Evaluation Division.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated April 25, 1983 is affirmed.

Board Member Barnes Dissenting in Part:

The penalty issue in this case arises from the following facts. Apparently some time before February 19, 1982 the employer first submitted this claim for closure; in any event, on that date the Evaluation Division requested additional medical information. It was not until August 10, 1982 that the employer requested the additional information from claimant's doctor. The doctor responded promptly, the claim was again submitted for closure and closed by Determination Order dated August 31, 1982. In short, the employer's inaction appears to have caused about a six month delay in the issuance of the Determination Order, and thus a six month delay in claimant's receipt of the compensation for permanent disability awarded by that Determination Order.

The Referee declined to impose a penalty under these circumstances, relying on the no-prejudice/no-intentional-delay reasoning in Newman v. Murphy Pacific Corp., 20 Or App 17, 23 (1975). However, the Referee did not have the benefit of the court's more recent analysis in Georgia Pacific v. Awmiller, 64 Or App 56, 59-60 (1983). The court in Awmiller, without citing Newman or mentioning prejudice, found that an unexplained delay in submitting a claim for closure was grounds for imposition of a penalty.

Reading Awmiller and Newman together, I am not sure whether prejudice or the lack thereof is relevant in this context. If the slate were blank, I would say that prejudice should be relevant. In virtually all claims, the worker receives compensation (temporary total disability) or wages and compensation (temporary partial disability) until a Determination Order is issued. While there is a "time value" to receipt of any money, including an award for permanent disability, I find it difficult to see much prejudice when delayed receipt of one benefit is accompanied by prolonged receipt of another benefit. Moreover, since a worker's aggravation rights run from the first claim closure, delayed closure has the effect of extending aggravation rights, which is beneficial, not prejudicial, for a claimant.

But the slate is not blank -- Awmiller is the last word. And I understand Awmiller as having eliminated any consideration of prejudice. I see no meaningful distinction between delay in submitting a claim for closure (as in Awmiller) and delay in following up a closure request with additional information required by the Evaluation Division (as in this case). For all of these reasons, I would assess a penalty in this case.

PATRICK McCORMICK, Claimant
Tamblyn & Bush, Claimant's Attorneys
Horne & Tenenbaum, Defense Attorneys

WCB 82-04884
November 30, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

The insurer requests review of Referee Mulder's order which granted claimant 80° for 25% unscheduled disability. Extent of disability is the only issue on review.

Claimant is a 36 year old former truck driver who compensably injured his neck and low back on January 6, 1982 jumping from his truck. He previously sustained a compensable injury to the same area in 1979. That earlier claim was closed with no award for permanent disability.

Claimant was evaluated in March 1982 by Orthopaedic Consultants who opined that he had chronic recurrent strain without radiculopathy. The Consultants opined:

> "We anticipate that he can return to his usual occupation with limitations such as he has already imposed upon himself or easily to some other occupation. It is our estimation that the degree of impairment as it exists today is none."

The limitations to which Orthopaedic Consultants referred were described in their report as ones which claimant had imposed on himself prior to the injury at issue here:

> ". . . largely because of his experiences with recurrent back pain which has been a problem for him ever since December, 1972 when the first of several reported on-the-job incidents occurred."

Claimant's treating physician, Dr. Dawson, concurred with Orthopaedic Consultants' report.

> "I agree with Orthopedic Consultants that [claimant] is physically able to return to work on a restricted basis. I would however suggest that his return to work may lead to a serious injury in the future. I still recommend a job change."

A May 27, 1982 Determination Order granted claimant no award for permanent disability. The Evaluation Division's worksheet indicates "no findings of permanent impairment due to this injury." Claimant requested a hearing to protest this Determination Order.

On November 22, 1982 Dr. Dawson stated:

> "At this time [claimant] has no objective impairment of his lower back. On occasion his left sacroiliac joint will become subluxated and respond to manipulative therapy. His impairment is that he can no longer perform his job as a truck driver and avoid future damage to his low back."

At hearing claimant testified to some limitations in activity including stiffness in the morning, bending limitations and sensitivity to the weather. It was not clear from his testimony whether these limitations predated his 1982 injury or not.

Claimant has the burden of proving the extent of his disability. We find that he has failed to prove that he has any impairment attributable to this compensable injury. Consequently, he has failed to prove that he is entitled to any award for permanent disability.

ORDER

The Referee's order dated January 7, 1983 is reversed. The Determination Order dated May 27, 1982 is reinstated and affirmed.

MICHAEL G. MELBYE, Claimant
Doblie & Francesconi, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-11334
November 30, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of that portion of Referee Foster's order which set aside its denial of claimant's aggravation claim for his "tennis elbow" (epicondylitis) condition. SAIF contends that claimant has not proven by a preponderance of evidence that his condition had worsened since the last arrangement of compensation. We agree and reverse.

Claimant, a construction worker, suffered a compensable injury to his right arm on September 2, 1978. After several Determination Orders and stipulations, a stipulation was entered into on January 17, 1981 which increased claimant's total award to 30% disability to his right arm. The general consensus for a diagnosis of his condition was lateral epicondylitis, or tennis elbow, on the right. It was recommended that he restrict his activities to light to medium work in order to reduce stress upon the elbow.

Claimant continued to have pain and consulted Dr. Takla, an orthopedist, in October 1982. Dr. Takla had first seen the claimant in May, 1982 and became claimant's treating physician shortly thereafter. On October 26, 1982, Dr. Takla reported that claimant had complained of pain in the right elbow since 1978. Claimant had experienced a recurrence of pain after splitting some wood. The doctor stated that he had placed claimant's arm in a sling and declared that with complete rest, claimant would recover.

On December 8, 1982, in response to a SAIF inquiry, Dr. Takla opined as follows:

> "Mr. Melbye came to see me for the first time on May 17, 1982 with a classical condition of right tennis elbow. There was no doubt about the condition being present in this patient. After several attempts to treat him by medical means, including heat and rest, he did improve, but the condition recurred at the least use of the arm. Finally on November 23, 1982, I put him in a full arm cast and he is still in the cast to this day.
>
> "To answer some of your questions; Mr. Melbye has worsened since your last arrangement of February 3, 1981. He has worsened to the extent that he cannot use his right arm for any purpose without pain. Mr. Melbye did admit that he pulled his arm lifting a freezer downstairs and certainly chopping wood does not help matters. However, he is a young man and he should be able to use his arm in any way he wishes to, in the future. I think the placing of a cast is a curative treatment if left on for a period of two to three weeks..."

SAIF paid time loss from December 13 to 16, 1982 and an additional two weeks through December 30, 1982.

Thereafter, SAIF requested that claimant be examined by Dr. Button, a hand and upper extremity surgeon. Dr. Button had seen claimant in March 1981 shortly after the last arrangement of compensation. At that time, Dr. Button had diagnosed claimant's condition as chronic epicondylitis.

By a report dated January 7, 1983, Dr. Button's diagnosis was chronic lateral epicondylitis right elbow and functional overlay. In answer to a number of questions concerning claimant's condition and Dr. Takla's treatment, Dr. Button replied as follows:

> "I. I do not feel that his condition has objectively changed or materially worsened, since being examined in 1981. There appears to be a strong element of a functional component and secondary gain, also mentioned in my original report. This would correlate with the findings of Mr. McElroy, vocational counselor.
>
> "II. Rarely is casting of an elbow for epicondylitis curative in nature, contrary to Dr. Takla's impression in his letter of December 8, 1982. After removal of the cast this patient has still remained symptomatic.

"III. I would consider him to be currently medically stationary and would have no further specific recommendations for treatment, other than perhaps avoiding heavy repetitive work. He has a wood stove at home and chops wood to heat his home. This is a significant aggravating factor."

The basis for the Referee's decision centers upon the opinion of Dr. Takla, the treating physician. The Referee felt claimant had aggravated his elbow condition even though it was questionable whether claimant's condition had improved as a result of having the cast on his arm. He concluded his analysis by stating claimant eventually was placed on temporary total disability and received medical care and treatment which Dr. Takla had considered curative.

With due deference to the treating physician's opinion, we are not persuaded that claimant's condition has worsened since the last arrangement of compensation. Dr. Takla first saw claimant in May 1982, some 15 months after the last arrangement of compensation. Dr. Takla's opinion of a worsened condition is based on claimant's contention that he cannot use his right arm for any activity without experiencing pain. Thus, the opinion is conclusory and is based on claimant's subjective complaints, not upon any objective findings.

Finally, we are more impressed by the opinions of the other doctors, particularly Dr. Button. The general diagnosis throughout the medical reports has steadfastly remained as right epicondylitis, or tennis elbow. Several of the reports have also found functional overlay as well. All doctors have reported significant pain. However, Dr. Takla's report is the only report that indicates claimant's condition has worsened since the last arrangement of compensation. Dr. Button's opinion is of particular interest to us in that he had seen claimant shortly after the last arrangement of compensation and following Dr. Takla's latest treatment. Dr. Button's opinion is clear. Claimant suffers from chronic epicondylitis, and his condition has not objectively changed or materially worsened since the last arrangement of compensation.

The record establishes that claimant suffers from a chronic loss of function which occurs whenever he exerts his right arm. This chronic loss of function which claimant suffers when he exerts his right arm is exactly what he was compensated for by his award of permanent partial disability. He is not entitled to reopening of his claim after each "woodsplitting" or other such exertion unless he establishes a worsening of his condition under ORS 656.273. Francis Knoblauch, 35 Van Natta 218, 219 (1983). Even though claimant may require medical treatment, reopening of the claim on an aggravation basis is unnecessary. Judy A. McAlpine, 35 Van Natta 62 (1983); ORS 656.245.

ORDER

The Referee's order dated January 31, 1983 is reversed. The SAIF Corporation's denial dated January 4, 1983 is reinstated and affirmed.

LUCILLE A. OPHEIM, Claimant
Rodriguez, et al., Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB 82-08155
November 30, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Seymour's order which affirmed the SAIF Corporation's denial of claimant's aggravation claim.

The Board affirms the Referee's order, but for different reasons than those discussed by the Referee.

Claimant compensably injured her low back in June 1980. A hearing on extent of disability was held prior to the hearing involved here. In an order dated January 19, 1982, Referee Nichols referred to the opinions of Drs. Miller and Thomas that claimant's degenerative disc disease was aggravated by her industrial fall. Although Referee Nichols made no specific finding as to aggravation of claimant's underlying condition, the Referee awarded claimant 160° for 50% unscheduled permanent disability. Neither party requested review of that order.

Then in June 1982, Dr. Thomas reported that claimant's condition had worsened considerably since January 1982. Dr. Thomas indicated claimant had arthritis in her back, that she had great difficulty walking and that she was very unsteady on her feet in that her knees almost bend backward and both hips rotate out. Dr. Thomas also indicated claimant had difficulty getting out of bed and up from a sitting position.

Dr. Kendrick, neurosurgeon, assumed claimant's care after Dr. Miller moved. Dr. Kendrick examined claimant in August 1982 and reported that he agreed that claimant probably was worse than when previously seen. Dr. Kendrick noted, as other doctors had noted, that claimant was markedly obese which has resulted in her legs opposing one another in a knock-kneed fashion with her inside ankle bones supporting much of her weight. Dr. Kendrick also noted claimant's history of hypertension. Then Dr. Kendrick stated, "The history of the condition is one of gradual worsening without any particular accidents, etc. . . . I don't think that there is any curative treatment for her other than a marked, indeed, massive weight loss."

Although Dr. Thomas later opined that claimant had a gradual deterioration of the lumbar spine, Dr. Kendrick discussed claimant's worsened condition in terms of her obesity, hypertension and lower extremity problems. Many of claimant's problems discussed by Dr. Thomas, such as walking, also seem related to claimant's obesity and leg problems rather than to her low back condition. Therefore, we disagree with the Referee's finding that claimant's degenerative disease has worsened.

We are more persuaded, however, by Dr. Kendrick's report which seems to relate claimant's worsened condition to her obesity, hypertension and leg problems. Accordingly, we affirm the Referee's ultimate finding that claimant has failed to prove that her present worsened condition is the result of her industrial injury.

ORDER

The Referee's order dated July 1, 1983 is affirmed.

GLENN J. PAYNE, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-01184
November 30, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Shebley's order which upheld the insurer's denials of claimant's claim for left ankle arthritis and a 1981 surgical fusion to correct that problem.

To the extent that claimant may be claiming that his 1981 condition is a compensable consequence of his 1968 compensable left ankle sprain, we note that claimant's aggravation rights on that old injury have expired, and a claim for compensation, other than medical services, would have to be made pursuant to ORS 656.278. We agree with the Referee's determination that a causal connection between claimant's 1968 injury and his 1981 condition is not substantiated by a preponderance of the evidence.

To the extent that claimant may now be asserting a new occupational disease claim, we agree with the Referee's analysis of the major-causation issue.

ORDER

The Referee's order dated January 4, 1983 is affirmed.

TERRY A. PETRIE, Claimant
Steven Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-07279
November 30, 1983
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Presiding Referee Daughtry's order which dismissed his request for hearing. The only issue is whether the claim should have been dismissed.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated June 27, 1983 is affirmed.

Board Member Barnes Dissenting:

Claimant changed attorneys twice between August 1980, when his hearing request was filed, and April 1983 -- which explains most of the rather extreme delay in getting this case to hearing. Then, on April 22, 1983, claimant's current (and third) attorney advised this agency of his involvement and requested additional time to investigate. The Presiding Referee's Orders of Dismissal here under review are dated June 9, 1983 and June 27, 1983.

In short, this agency allowed an attorney who took over the representation of a party in this rather "stale" case two months or less to investigate the situation. In my opinion, additional time for investigation should have been allowed and I would thus reverse the Presiding Referee's orders.

PHILLIP SCHMIEDEL, Claimant
Allen & Vick, Claimant's Attorneys
Cheney & Kelley, Defense Attorneys
Schwabe, et al., Defense Attorneys
Reviewed by the Board en banc.

WCB 82-05324
November 30, 1983
Order on Review

The employer, May Trucking Company, through its insurer, Industrial Indemnity Company, requests review of Referee Peterson's order which held that claimant was a subject worker under Oregon workers' compensation law and that claimant had suffered a compensable injury. The insurer contends that Oregon's workers' compensation law does not cover this claim.

We affirm and adopt the Referee's findings and conclusions. We believe the facts of this case are significantly different from previous cases involving drivers for May Trucking Company, including Hollingsworth v. May Trucking, 59 Or App 531 (1982), and subsequent Board orders. May Trucking has established a permanent terminal and place of business in Brooks, Oregon, and this establishment was the claimant's place of employment. Unlike the driver in the Hollingsworth case, claimant was injured in Oregon and not out of state. In addition, the Hollingsworth decision was based primarily on ORS 656.126(1) which is inapplicable when the injury has occurred in Oregon.

ORDER

The Referee's order dated January 28, 1983 is affirmed. Claimant's attorney is awarded a fee of $500 for services rendered on Board review, to be paid by the insurer.

Board Member Barnes Dissenting:

There have been four prior litigated cases involving the questions of whether this employer is a subject employer and whether its interstate truck drivers, like this claimant, are subject employes for purposes of the Oregon Workers' Compensation Law. In all four prior cases, those questions have been answered in the negative. Hollingsworth v. May Trucking, 59 Or App 531 (1982); Milo R. Reese, 35 Van Natta 539 (1983); Norman Wright, WCB Case Nos. 82-02772 and 82-01105 (Board Order on Review, May 5, 1983); Jonathan Wallace, WCB Case No. 81-11546 (Board Order On Review, May 13, 1983).

Now, in just a one-page order, the Board majority concludes that the facts of this case are "sufficiently different" from the facts of the prior cases to warrant the opposite conclusion to those questions. The majority's bald statement of a conclusion without supporting reasoning or analysis makes it hard to disagree, but I do not think there is any material distinction between this case and the prior cases.

Indeed, it is difficult to imagine how the facts of a specific employer's business operations relevant to whether it is an Oregon subject employer could vary much from one case to the next. About the only difference the majority mentions is that the employer has established a terminal in Brooks. In reality, that is no different from the facts of at least some of the prior cases. For example, in Wright the Referee found:

> "In early 1980 [the employer] opened a truck terminal in Brooks, Oregon and has maintained a facility there ever since. [The employer] has several full-time employees at the Brooks terminal, and approximately one-half of the 120 drivers, including claimant, store their trucks, and start and complete their trips there."

And in Wright the Board affirmed and adopted the Referee's order finding that claim not compensable because this employer was not a subject employer under Oregon law.

In my opinion, the explanation for today's different result has little to do with perceived (but unarticulated or erroneous) factual differences; rather, in my opinion, the explanation is that the commitment of the majority of this Board to decisional consistency does not now appear to be overwhelming.

Since I do not think there is any material distinction between this case and prior similar cases, and since I remain committed to trying to make our decisions consistent, I would reverse the Referee's order in this case.

ADLEY SMITH, Claimant
David Hollander, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 82-08685
November 30, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Thye's order which set aside its denial of August 18, 1981 and ordered the employer to process the claim on the basis of aggravation for the period prior to October 20, 1981 and as a new injury for the period subsequent to October 20, 1981.

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

The employer contends that the Referee erred in concluding that its denial of August 18, 1982 was barred by Bauman v. SAIF, 62 Or App 323 (1983), and that he erred in failing to decide the aggravation versus new injury issue on the merits. We disagree.

The employer has noted some concerns regarding the applicability to this case of the Court of Appeals decision in Bauman. However, any doubts the employer may have entertained in that regard have been totally resolved by the recent Supreme Court decision in that case. Bauman v. SAIF, 295 Or 788 (1983). Clearly the employer is prohibited from issuing a backup denial in a situation such as this where the new injury claim had been accepted by

the employer by stipulation for over six months. Even without benefit of the decisions in Bauman the employer would be prohibited from denying this claim. An employer or insurer may not deny a claim after it has signed a stipulation whereby it agreed to accept that claim. Clinkenbeard v. SAIF, 44 Or App 583 (1980). We, therefore, agree with the Referee that the employer's denial was barred and that it is, therefore, unnecessary to reach the merits of the aggravation versus new injury issue.

Our disposition of this case makes it unnecessary for us to address claimant's motion to supplement the record.

ORDER

The Referee's order dated April 13, 1983 is affirmed. Claimant's attorney is awarded a reasonable attorney's fee of $800 for services in connection with this review, payable by the employer.

ROBERT H. STIEGLER, Claimant
Willner, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-01908
November 30, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Leahy's order which upheld the insurer's denial, aggravation denial, partial denial or backup denial to the effect that claimant's psychological and drug related problems were not compensable consequences of his accepted October 1979 low back injury.

It is not clear to us whether the insurer had authority to issue the denial here in issue under Bauman v. SAIF, 295 Or 788 (1983). If it did have such authority, on the merits we agree with claimant's position that he has established that his October 1979 industrial injury was at least a material cause of his subsequent psychological and drug related problems.

ORDER

The Referee's order dated November 12, 1982 is reversed. The insurer's denial dated September 10, 1982 is set aside and the conditions denied therein are remanded to the insurer for acceptance and processing. Claimant's attorney is awarded $1,750 for services rendered at hearing and on Board review in prevailing on a denied claim, to be paid by the insurer.

HASTEN E. TUCKER, Claimant
Michael B. Dye, Claimant's Attorney
John Snarskis, Defense Attorney

WCB 82-10751
November 30, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of those portions of Referee Danner's order which granted claimant an additional award for unscheduled permanent disability of 48° for 15% for a total award of 96° for 30% unscheduled disability. Extent of disability is the only issue on review.

Claimant is a 47-year-old former restaurant manager. On January 17, 1982 a disgruntled patron of the restaurant claimant then managed threw a rock through the window of the restaurant. Claimant and another employee gave chase. Claimant tripped and fell so that his abdomen struck a curb. Claimant's kidney was ruptured in the fall. Claimant passed out and believes that he stopped breathing. He was taken to an emergency room and the kidney was removed. Claimant was discharged from the hospital on January 25, 1982 in good condition but with instructions to limit his activity.

On March 4, 1982 Dr. Drips, claimant's family doctor, noted that claimant had become quite depressed following his injury. On March 15, 1982 Dr. Weeber, the surgeon who removed the kidney, opined that claimant could return to work.

On May 3, 1982 Dr. Mead, a psychiatrist, opined that claimant was "manifesting a severe single episode depression." He also noted that claimant demonstrated free floating anxiety and a panic disorder. On May 14, 1982 Dr. Criss, PhD, whose specialty we are unable to ascertain from the record, reported that Dr. Drips had referred claimant to him for "concentration; memory retention; motivation; building self-image; etc." In July Dr. Criss opined that claimant was not physically able to work.

On July 14, 1982 Dr. Weeber opined: "I don't feel he has any physical impairment as a result of his industrial injury." On July 27, 1982 Dr. Mead released claimant to return to work. Dr. Mead noted that claimant continued to experience concerns of impending death and recurrence of his traumatic injury. On September 22, 1982 Dr. Mead noted that claimant continued to experience psychological residuals which included flashbacks of his injury. In February 1983 Dr. Mead reported that claimant should continue to visit him indefinitely.

A Determination Order issued on October 19, 1982 which granted claimant an award of 48° for 15% unscheduled disability. The evaluator's worksheet indicates that the Evaluation Division felt claimant was entitled to a 15% disability award based on his physical problems alone.

The Referee increased the award an additional 15%. He stated:

> "I find the award to have been in order with respect to claimant's physical residuals, but that an additional award is warranted, because of the psychiatric residuals."

We agree with the Referee's assessment that claimant is entitled to an award for loss of earning capacity due to his psychological problems. However, we do not agree that claimant is entitled to any award for unscheduled disability due to physical residuals of his compensable injury.

It is apparent that claimant has permanent psychological residuals and should be compensated for them. We believe that the 15% award granted by the Determination Order adequately compensates

him for those psychological residuals. However, the only indication that claimant has any physical residuals as a result of his compensable injury is the statement by Dr. Criss. Because Dr. Criss is not a medical doctor, his opinion on a medical question such as this carries no weight. Dr. Weeber, the treating surgeon, stated that claimant had no physical impairment. We defer to Dr. Weeber's uncontroverted opinion. Claimant has failed to prove that he has any loss of earning capacity as a result of any physical residuals from his compensable injury. Accordingly, we believe that claimant is entitled to no award for physical disability but is entitled to an award of 48° for 15% unscheduled disability for his psychological problems which resulted from the compensable injury.

ORDER

Those portions of the Referee's order dated April 25, 1983 concerning extent of disability are reversed. The Determination Order dated October 19, 1982 which awarded 48° for 15% unscheduled permanent disability is modified to reflect that the award is for a psychological disability, and, except as modified, is affirmed.

DALE WILLIAMS, Claimant
Robert Chapman, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-10666
November 30, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Johnson's order which upheld the SAIF Corporation's partial denial of November 10, 1982 by which SAIF denied that the current medical services being furnished claimant are related to his compensable injury of September 29, 1977.

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

Claimant first contends that his present symptoms are causally related to his compensable injury of 1977 and that he is entitled to continuing medical care for those symptoms pursuant to ORS 656.245. We disagree. We are in complete agreement with the Referee's conclusion that claimant's current symptoms are unrelated to his industrial injury, and we affirm and adopt those portions of his order relevant to this issue.

Claimant secondly contends that because he was specifically directed by a SAIF representative to Dr. Peterson, who then referred him to Dr. Saez, that at a minimum, SAIF should be required to pay the medical bills incurred as a result of his examinations and treatment by those doctors. Specifically, those bills are:

Dr. Peterson	$100.00
Dr. Saez	$193.00
Traction Device	$ 22.50
Prescription medications	$ 46.80

In support of this contention, claimant argues that the Referee erred in refusing to admit hearsay testimony from claimant's wife to the effect that she was instructed in a telephone conversation with an unidentified SAIF employe to have claimant return to Dr. Peterson for an examination. There is no documentary evidence in the record indicating that claimant was sent by SAIF to Dr. Peterson; admission of the testimony of claimant's wife would be the only means by which claimant could establish that such instructions were given.

Even if the disputed testimony had been allowed, the only medical bill which would have been relevant would be the bill for Dr. Peterson's examination. The remainder of the disputed bills were for treatment provided by Dr. Saez; treatment which was clearly unrelated to claimant's industrial injury. The fact that claimant may have been referred by Dr. Peterson to Dr. Saez did not necessarily give claimant or Dr. Saez a "blank check" for medical services unrelated to the compensable injury. Since the testimony of claimant's wife could only have been relevant to Dr. Peterson's bill, and since we find SAIF to be responsible for that bill in any event, it becomes irrelevant whether or not the hearsay testimony of claimant's wife was properly disallowed.

Whether claimant was instructed by a SAIF representative to be examined by Dr. Peterson, or whether claimant did so of his own accord, the cost of that examination is compensable. Dr. Peterson was claimant's initial treating physician at the time of the 1977 shoulder injury. Claimant is entitled to, and SAIF does not deny, continued medical benefits for this injury. Dr. Peterson's chart note of August 12, 1981 (which was authored following claimant's examination of the same date) states: "This 30-year-old man is seen for recheck regarding pain in his right shoulder involving pain in the supraspinatus area as well as some involvement of his neck." (Emphasis added.) We thus conclude that Dr. Peterson's examination of claimant on August 12, 1981 was done with the purpose of rechecking claimant with regard to the previous compensable injury for which he had provided treatment. Dr. Peterson's examination, therefore, was related to and stemmed from claimant's compensable shoulder injury. It follows that SAIF is responsible for payment of the $100 medical bill incurred in relation to that examination. See Brooks v. D & R Timber, 55 Or App 688 (1982).

ORDER

The Referee's order dated July 28, 1982 is affirmed in part and reversed in part. Those portions of the Referee's order which found SAIF not responsible for payment of Dr. Peterson's bill are reversed and SAIF is ordered to pay said bill. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an attorney's fee of $250 for services before the Referee and Board, to be paid by the SAIF Corporation.

HAZEL M. WILLIS, Claimant
W.D. Bates, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-00109
November 30, 1983
Order on Review (Remanding)

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Browne's order requiring it to reopen claimant's claim. SAIF raises the following issues on review: (1) Whether the Referee had jurisdiction to hear the claim because claimant's aggravation rights had elapsed; (2) whether the Referee was correct in finding that SAIF had voluntarily reopened and prematurely closed the claim; (3) whether the Referee erred in assessing a penalty against SAIF for premature closure; and (4) whether the Referee erred in refusing to allow SAIF to depose a doctor. The claimant raises the issue of whether the Referee erred in holding that claimant's claim for compensation for home nursing care was barred by the doctrine of res judicata.

Claimant initially filed a claim for bursitis in her left arm on February 9, 1976. The claim was first closed by a Determination Order dated July 2, 1976. Hence, claimant's aggravation rights expired on July 2, 1981. ORS 656.273(4)(a). On July 2, 1981 the claim was in open status following an aggravation reopening. On December 8, 1981 a Determination Order issued awarding claimant temporary total disability and permanent disability compensation. Claimant requested a hearing in January 1982 to protest the extent of disability awarded by that Determination Order. Claimant also alleged premature closure.

Claimant entered a vocational rehabilitation program on January 19, 1982. SAIF apparently began paying temporary total disability benefits while claimant was in the vocational rehabilitation program. A Determination Order issued on July 27, 1982 awarding claimant temporary total disability benefits for the period she was in the vocational rehabilitation program from January 19, 1982 through July 17, 1982.

Prior to the issuance of the July 1982 Determination Order, the parties had begun to discuss the possibility of sending claimant to a pain center for diagnostic testing. A SAIF attorney stated:

> "I am willing to refer Claimant to the Southern Oregon Pain Clinic or Dr. Joel Seres' Clinic in Portland on a diagnostic basis. We will pay time loss on a diagnostic basis while she is enrolled in the Center. In the event the referral led to further curative treatment (as opposed to pain management), we would be compelled to reopen fully."

Claimant entered a pain program on October 4, 1982. SAIF paid time loss benefits during the pain program. The pain center staff concluded that no surgical or aggressive medical approaches would be of assistance to claimant until her depression was relieved. SAIF then continued paying time loss pending a referral to Dr. Holland for a psychiatric evaluation. On November 23, 1982 Dr. Holland

wrote a report confirming that on November 17 he had informed SAIF that claimant would not benefit from psychiatric treatment. SAIF stopped paying time loss as of November 18, 1982.

Claimant filed two supplemental requests for hearing, one in December 1982 and one in January 1983, alleging, among other things, extent of scheduled permanent disability, premature claim closure, and "improper termination of temporary disability." It is fairly clear by our reading of the record that the issue being litigated is not whether the December 1981 and/or July 1982 Determination Orders prematurely closed claimant's claim, but whether the cessation of time loss in November 1982 was proper.

The Referee determined that she had jurisdiction to hear claimant's allegations that SAIF "prematurely closed" the claim by stopping time loss payments on November 18, 1982. We admit to some confusion as to why SAIF's termination of time loss is denominated a premature closure in this case. If SAIF's action in terminating payment of time loss was error, it was a unilateral termination, not a premature closure. In any event, the Referee said:

> "Under ORS 656.273(4) and Determination Order of July 2, 1976 claimant's aggravation rights would have expired July 2, 1981 had there been no further developments in the matter. However, the last Determination Order was entered July 27, 1982 and claimant had one year from that date to request a hearing in the matter of her compensable injury under ORS 656.268(6). Thus, jurisdiction continued in the Board until one year from the date of the last Determination Order or until July 27, 1983. I conclude this hearing was properly convened to entertain claimant's allegations of unreasonable claim closure or the extent of her permanent disability."

It is true that the Court of Appeals has held that, in some situations, a claimant has appeal rights even though it is more than five years after the first arrangement of compensation. In Coombs v. SAIF, 39 Or App 293, 300 (1979), the court said:

> "The legislature did not intend that a claimant's appeal rights granted by ORS 656.268(5) should prematurely terminate when his aggravation rights expire. When a claim is opened during the time claimant still has appeal rights, closure of that claim carries with it the right of appeal whenever issued."

In Carter v. SAIF, 52 Or App 1027 1032 (1981), the court quoted Coombs and then stated:

> "Similarly, because the claim in the present case was reopened, for whatever reason, during the time claimant still had the right to appeal the second determination order,

> ORS 656.268(6), the closing order entered by the Board could not be pursuant to its own motion jurisdiction. ORS 656.278. Thus the claim should have been closed pursuant to ORS 656.268 and, as such, is appealable."

Under these cases, if SAIF voluntarily reopened the claim when it paid time loss during the time claimant was in the pain center for diagnosis and was awaiting diagnosis by Dr. Holland, i.e., during October and November of 1982, then claimant was entitled to have the claim closed by a Determination Order, which would have carried with it appeal rights pursuant to ORS 656.268. However, we do not consider the payment of time loss under these circumstances to be a reopening which carries with it the right to closure and appeal rights.

ORS 656.018(4) provides:

> "Nothing in ORS 656.001 to 656.794 shall prohibit payment, voluntary or otherwise, to injured workers or their beneficiaries in excess of the compensation required to be paid under ORS 656.001 to 656.794."

After claimant's aggravation rights expired, claimant had no right to receive and SAIF had no obligation to pay time loss to claimant pending diagnostic evaluation at the pain center or by the psychiatrist. See Claude Allen, 34 Van Natta 769 (1982). Further, the evidence indicates that SAIF did not intend the payment of time loss to be a reopening. SAIF's attorney clearly stated prior to the pain center program that SAIF would only pay time loss for diagnosis. It is apparent from this letter that SAIF did not consider payment of time loss for diagnosis to be a full reopening. SAIF's senior claims examiner also testified that he did not consider payment of time loss on a diagnostic basis to be a reopening.

> "Q. Would you explain to the referee what you mean by a diagnostic basis.
>
> "A. The claim is not reopened and it's not formally submitted to the department as an opened claim."

Given the facts that SAIF was not obligated to reopen the claim and that it did not intend payment of time loss to be a reopening, we find that SAIF's payment of time loss in this circumstance was payment of excess compensation under ORS 656.018(4) rather than a reopening. As such, claimant was not entitled to closure under ORS 656.268. Therefore, the Referee was without jurisdiction to determine that SAIF's termination of time loss payments amounted to "premature closure."

Because we find that the Referee was without jurisdiction to hold that SAIF's termination of time loss payments amounted to "premature closure," it follows that the Referee erred in imposing a penalty and associated attorney's fee for "prematurely closing" the claim. In addition, the question of whether the Referee erred in refusing to allow SAIF to depose Dr. Holmes is moot because SAIF sought to depose Dr. Holmes to determine the basis of his opinion

that claimant was not medically stationary when SAIF stopped paying time loss. SAIF had no obligation to continue paying time loss or to open the claim pursuant to ORS 656.273; therefore, Dr. Holmes' opinion that claimant was not medically stationary is not material to any issue cognizable by the Referee or the Board in this matter.

Claimant argues that the Referee erred in refusing to order SAIF to pay for home health care services. The Referee held that the home health care services issue was disposed of pursuant to a stipulation and that claimant is barred by the doctrine of res judicata from now litigating that issue. We agree. We, therefore, affirm and adopt those portions of the Referee's order concerning payment for home health care services.

Because the Referee held that this claim was prematurely closed, she did not reach the issue of extent of disability raised by claimant's hearing requests contesting the two Determination Orders. We deem it appropriate to remand this case to the Hearings Division to determine the extent of claimant's permanent disability.

ORDER

The Referee's order dated February 24, 1983 is affirmed in part and reversed in part. That portion of the Referee's order concerning home health care services is affirmed. The remainder of the Referee's order is reversed, and this case is remanded to the Hearings Division for further proceedings consistent with this order.

NOTICE TO ALL PARTIES: ORS 656.295(8) requires that Board orders contain "a statement explaining the rights of the parties under" ORS 656.298. ORS 656.298(1) provides that any party affected by an order of the Board may, within 30 days after the date of the order, request judicial review of the order with the Court of Appeals. However, the Court of Appeals has held that this statute only contemplates judicial review of final Board orders. Beck v. Oregon Steel Mills, 36 Or App 581 (1978); Mendenhall v. SAIF, 16 Or App 136 (1974); Hammond v. Albina Engine & Mach., 13 Or App 156 (1973); Hiles v. Compensation Department, 2 Or App 506 (1970); Barr v. Compensation Department, 1 Or App 432 (1970). The court also has held that a Board order which remands to a Referee for further proceedings is not a final order for purposes of ORS 656.298 and, therefore, not presently subject to judicial review. Hammond v. Albina Engine & Machine, supra; Barr v. Compensation Department, supra.

DONNA L. HIETER, Claimant
Goodwin & Phelan, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-03404
December 8, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review of Referee Williams' order which set aside its partial denial of claimant's right carpal tunnel syndrome as a compensable consequence of claimant's July 1981 right hand/wrist injury.

In July 1981 claimant was attending a patient who suddenly grabbed her right hand and swung the back of her hand against a bed rail. Claimant continued to complain of pain in her right wrist. In October 1981 Dr. Melvin examined claimant and at first opined that claimant's problem was a combination of sympathetic dystrophy and carpal tunnel syndrome. Later that month, Dr. Melvin ruled out the sympathetic dystrophy component.

In November 1981 Dr. Schostal evaluated claimant at the insurer's request. He opined that claimant indeed had carpal tunnel syndrome but that it was unrelated to her July job injury. On December 3, 1981 the insurer issued a denial which states:

> "We are in receipt of Dr. Schostal's report from the nerve conduction studies. What he has found is that you do have some interruption of the nerve impulses caused by a carpel tunnel compression. His findings indicate, however, that this interruption is present in both hands, indicating that this problem was a congenital one rather than the result of your one hand injured at work.
>
> "We must, therefore, at this time deny your claim for carpal tunnel syndrome. We agree that the condition exists, but deny that it is related to your injury of July 16, 1981."

As discussed more fully below, claimant did not request a hearing on this denial within 60 days.

In January 1982 Dr. Nathan examined claimant for the insurer. Dr. Nathan noted that claimant's persistent pain in the dorsal aspect of the first intermetacarpal space was probably caused by her job injury. He opined, however, that her bilateral carpal tunnel syndrome was not work related. In March 1982 Dr. Nye evaluated claimant and concurred with Dr. Nathan's assessment that the bilateral carpal tunnel syndrome was not work related.

On March 11, 1982 the insurer issued a second denial. It states:

> "We are now in receipt of Dr. Nye's report which concurs with Drs. Nathan and Schostal's opinion that your bilateral carpal tunnel syndrome is not the result of

this industrial injury of last July. We are therefore denying your claim for any medical or other benefits related to the carpal tunnel syndrome.

"The severe bruising that you received in July, 1981 while at work will remain in an accepted status, and we will continue to provide assistance in trying to find a position for your return to work."

Claimant filed a request for hearing on April 19, 1982, challenging both the December and March denials.

The insurer argues that claimant's hearing request was not timely because she did not file it within 60 days of the December denial and she failed to show good cause for her late filing. Claimant counters that she has shown good cause for late filing of her request for hearing challenging the December denial and that, in any event, her request for a hearing challenging the March denial was filed within 60 days of that denial.

Claimant's only argument that there was good cause for her tardy hearing request in relation to the December denial is that the insurer asked claimant to submit to an independent medical examination after the denial issued. Claimant argues that this action together with the language in the denial that the claim is being denied "at this time" is sufficient to establish good cause for a claimant whom the Referee characterizes as "unsophisticated" and "ingenuous." Claimant testified that she did not believe that the denial was "final". We have recently considered and rejected this very contention and concluded that a claimant's subjective belief that a denial is not effective is not sufficient to establish good cause. Margaret J. Sugden, 35 Van Natta 1251 (1983). There was no good cause for failing to request a hearing within 60 days of the December denial.

The question of what effect, if any, the March denial has is closer. The insurer characterizes the December denial as a denial of right carpal tunnel and the March denial as a denial of bilateral carpal tunnel. Claimant characterizes both denials as denials of bilateral carpal tunnel. It is difficult to determine which characterization is correct. It appears from the history of this claim that claimant's right carpal tunnel syndrome was the clear issue in December 1981. The only reference prior to the December denial to the left hand was in Dr. Schostal's report which noted diminished nerve conduction in both hands. Apparently, the reason both hands were mentioned in the December denial is that the insurer believed that evidence of left carpal tunnel indicated that the right carpal tunnel was not work related.

During the next few months, the medical reports consistently discussed the fact that claimant had both left and right carpal tunnel syndrome. The March denial appears to have been issued as a clarification. The insurer was attempting to clarify that it was not responsible for either the right or the left carpal tunnel syndrome, but that it accepted responsibility for the bruising caused by claimant's on the job injury.

We believe that if claimant wished to challenge the March denial on the basis that her left carpal tunnel syndrome was caused by her job injury, her April request for a hearing would probably preserve that issue. However, claimant's only challenge is to the denial of her right carpal tunnel syndrome. The December denial clearly denied that condition. Claimant had the opportunity to challenge the December denial and did not do so in a timely manner.

Under these circumstances, we conclude that a "clarifying" denial such as the March denial is not sufficient to revive hearing rights on a condition that has previously been denied. We have consistently encouraged insurers and employers to issue denials in the interests of defining and refining the issues. Billy J. Eubanks, 35 Van Natta 131 (1983); see also Adams v. SAIF, 63 Or App 550 (1983). To now hold that a clarifying denial revives appeal rights on a condition which was previously denied could discourage insurers and employers from doing what we have previously encouraged.

In summary, claimant's challenge to the December denial is barred because it was not timely filed and the March denial did not revive claimant's rights to appeal the December denial of her right carpal tunnel syndrome.

Alternatively, if we were to reach the claim on its merits we would not find it compensable. The weight of the medical evidence is that claimant's right carpal tunnel syndrome was not caused by her compensable injury. Drs. Nathan, Schostal and Nye agree that claimant's carpal tunnel syndrome was not caused by her compensable injury. Only Dr. Melvin opines to the contrary. Claimant has failed to sustain her burden of proving by a preponderance of the evidence that her compensable injury was a material cause of her right carpal tunnel syndrome.

ORDER

The Referee's order dated November 30, 1982 is reversed. The insurer's denial dated December 3, 1981 is reinstated and affirmed.

ROY M. HOKE, Claimant
Burt, et al., Claimant's Attorneys
Moscato & Meyers, Defense Attorneys

WCB 82-09021
December 8, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of those portions of Referee Daron's order which set aside its denial of claimant's aggravation claim and awarded a penalty and attorney fee. Compensability of the aggravation claim and the propriety of the penalty and attorney's fees are the issues on review. The insurer also moves to strike references in claimant's brief to medical reports not in the record. We have not considered these extra-record materials in our review of this case.

Claimant has a long history of low back problems. Prior to 1979 he had had at least two spinal fusions. In September 1979 claimant compensably injured his low back. Another spinal fusion

was performed in January 1980, and a decompression laminectomy was performed in August 1981.

A Determination Order issued on April 21, 1982 awarding claimant 50% unscheduled disability. Claimant was hospitalized for back pain in July 1982. Initially there was some dispute over the insurer's responsibility for that hospitalization as an aggravation claim. The Referee found that circumstances surrounding that hospitalization were so "muddled that it is not worthy of consideration." He noted that the insurer had already paid for that hospitalization. Neither party challenges the Referee's analysis regarding the July hospitalization.

In December 1982 claimant again admitted himself to the hospital because of extreme back pain. The admission report recites claimant's long history of problems with back pain. It then noted:

> "I do not believe, from the standpoint of his physical examination today, that he is different. I would defer this opinion, however, until his x-rays are complete. If his x-rays show no changes, then I believe, clinically he is stable and then on the basis of his x-ray findings, also he is stable and I believe that he can be retrained."

On December 21, 1982 Dr. Buza, the treating physician, reported: "I do not see any significant changes in the x-rays to infer that this patient has deteriorated or changed. I believe that he is stable." On December 22, 1982 the insurer denied reopening the claim as an aggravation based on the December hospitalization.

At hearing, there was an issue of whether the insurer was responsible for the cost of the hospitalization under ORS 656.245. The Referee noted that the insurer had all but conceded as much, and ruled that the insurer was responsible under ORS 656.245. The insurer does not challenge that ruling on review.

The Referee also concluded that claimant had established a valid aggravation claim under ORS 656.273. We disagree. There is no medical evidence that claimant's condition in December 1982 was any worse than it had been in April 1982 when the last Determination Order was issued. Instead, both the hospital admission report and Dr. Buza indicate that claimant's condition was no different. The only indication that claimant's condition was any worse is that claimant himself felt that his pain was so bad that it required hospital admission. Of course, in a situation like this in which a claimant has had at least four back operations, his permanent disability award compensates him for disabling pain. It is reasonable to assume that the pain waxes and wanes at times. The fact that a claimant finds that his pain has fluctuated to the point that he feels the need for hospitalization does not necessarily establish a compensable worsening. The Court of Appeals recently held in Oakley v. SAIF, 63 Or App 433, 436 (1983):

> "An aggravation claim based solely on 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."

Judged by this standard, the aggravation claim here in issue must fail.

Because we reinstate the insurer's denial, the penalty and attorney's fee issues are moot. Claimant is not entitled to a penalty for unreasonable denial or an attorney's fee for overturning the denial.

ORDER

The Referee's order dated March 28, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order reopening the claim as an aggravation claim are reversed. The insurer's denial dated December 22, 1982 is reinstated and affirmed. Those portions of the Referee's order awarding a penalty for unreasonable denial and attorney fees for prevailing on the denial are reversed. The remainder of the Referee's order is affirmed.

ROBERT B. WILLIAMS, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Alan Viewig, Attorney
Carl M. Davis, Ass't A.G.

WCB 82-08105 & 82-07200
December 8, 1983
Order on Review (Remanding)

Reviewed by Board Members Lewis and Barnes.

The non-complying employer requests review of Referee Braverman's order which found claimant's low back claim compensable and which assessed a penalty and attorney's fee against the non-complying employer.

We affirm and adopt those portions of the Referee's order concerning the compensability of the claim. However, on the penalty and attorney's fee issue, we remand to the Referee to further develop the record. ORS 656.295(5).

At the outset of the hearing the Referee framed the issues:

> "The Referee is advised that there are four issues for resolution today. One is the question of whether or not the employer should be charged with penalty and attorney fees for allegedly failing to pay temporary total disability benefits within 14 days of notice...
>
> "The second issue is whether penalties or attorney fees should be affixed against the

employer for the alleged failure to accept or deny the claim within 60 days.

"Issue 3 is whether or not there has been bad faith appeal by the employer in this case, thereby statutory fees and attorney fees...."

Counsel for claimant, the employer and the SAIF Corporation agreed that those were the issues. The Referee in his order then assessed penalties and attorney fees against the employer.

In another context we have held that the statutory scheme does not contemplate penalties and attorney fees being assessed against the employer. Penalties and attorney fees are assessable only against the insurer. Roscoe Howard, 35 Van Natta 329 (1983). Howard involved a situation in which the employer was properly insured, but failed to promptly notify its insurer of a claim. In Howard we noted that if the employer's actions hindered the insurer in processing the claim and thus subjected the insurer to penalties, the insurer had a right to seek reimbursement from the employer pursuant to ORS 656.262(3). Similarly, in non-complying employer cases, ORS 656.054(1) provides that SAIF shall process the claim in the same manner it would process a claim against one of its insureds, except that it need not pay the first temporary total disability payment until the claim is referred to it by the director. ORS 656.054(3) further provides that costs of processing the claim are the liability of the non-complying employer, but that it is the director's responsibility to recover those costs from the non-complying employer. Although the statute does not specifically enumerate penalties as one of the costs of processing a claim, we believe that penalties are a part of the cost of processing a claim. We conclude that the Referee was without authority to assess penalties and attorney fees against the non-complying employer. If any penalties and fees are proper they should have been assessed against SAIF.

Because the case was heard and decided under the assumption that if any penalties or attorney fees were appropriate they would be assessed against the employer, SAIF did not have a real opportunity to defend against claimant's allegations that penalties and fees were appropriate. Consequently the record on that issue was not fully developed. We thus remand the case to the Referee to develop the penalty/attorney's fee issue more fully.

ORDER

The Referee's orders dated March 8, 1983 and March 21, 1983 are affirmed in part and vacated in part. Those portions of the Referee's order concerning compensability of the claim are affirmed. Those portions of the Referee's order concerning penalties and attorney fees are vacated, and this case is remanded to the Referee for further proceedings consistent with this order.

NOTICE TO ALL PARTIES: ORS 656.295(8) requires that Board orders contain "a statement explaining the rights of the parties under" ORS 656.298. ORS 656.298(1) provides that any party affected by an order of the Board may, within 30 days after the date of the order, request judicial review of the order with the Court of Appeals. However, the Court of Appeals has held that

this statute only contemplates judicial review of final Board orders. Beck v. Oregon Steel Mills, 36 Or App 581 (1978); Mendenhall v. SAIF, 16 Or App 136 (1974); Hammond v. Albina Engine & Mach., 13 Or App 156 (1973); Hiles v. Compensation Department, 2 Or App 506 (1970); Barr v. Compensation Department, 1 Or App 432 (1970). The court also has held that a Board order which remands to a Referee for further proceedings is not a final order for purposes of ORS 656.298 and, therefore, not presently subject to judicial review. Hammond v. Albina Engine & Machine, supra; Barr v. Compensation Department, supra.

DONNIE HARRISON, Claimant
Allen & Vick, Claimant's Attorneys
Brian Pocock, Defense Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-09100 & 82-01913
December 9, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of those portions of Referee Seymour's order which: (1) Set aside SAIF's backup denial dated March 22, 1982, which denied claimant's previously-accepted July 28, 1981 injury claim; (2) awarded claimant 16° for 5% unscheduled permanent disability as a result of his December 19, 1980 injury, the prior Determination Orders closing this claim having awarded no permanent disability; and (3) denied SAIF's motion to reopen the record to present additional evidence.

The Board affirms the order of the Referee, except that we conclude the backup denial was invalid under Bauman v. SAIF, 295 Or 788 (1983), and thus do not reach the merits of the denial.

ORDER

The Referee's order dated April 21, 1983 is affirmed. Claimant's attorney is awarded $400 for services rendered on Board review, to be paid by the SAIF Corporation.

PAULA F. KING, Claimant
Hansen & Wobbrock, Claimant's Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-04443 & 82-04442
December 9, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of those portions of Referee Braverman's order which assigned responsibility to it for claimant's current low back problems. Claimant cross-requests review of those portions of the Referee's order which declined to assess a penalty against Globe Indemnity for failure to pay certain medical bills.

The Board affirms and adopts those portions of the Referee's order which assigned responsibility to SAIF.

On the penalty issue, we find that while Globe was responsible under the .307 order it failed to pay four chiropractic bills. Although this failure may have been inadvertent, we find that it

was not reasonable. Accordingly we assess a penalty of 10% of the amount of those bills against Globe for its unreasonable delay in payment.

Claimant's attorney is entitled to no attorney's fee on the responsibility issue because claimant took no position on that issue on Board review.

ORDER

The Referee's order dated June 17, 1983 is affirmed in part and reversed in part. Those portions assigning responsibility to SAIF are affirmed. Globe Indemnity is ordered to pay claimant a penalty of 10% of the amount of the medical bills submitted to it but not paid while it was responsible for paying compensation. Claimant's attorney is awarded $200 payable by Globe in connection with the penalty issue.

GARY O. SODERSTROM, Claimant
FRED and SONJA SHEWEY dba FRED'S PLACE, Employers
Garry Kahn, Attorney
Macdonald, et al., Defense Attorneys
Carl M. Davis, Ass't A.G.

WCB 81-05426
December 13, 1983
Order of Abatement

The Board has received information which indicates that there may be a problem concerning the law which the Board applied in this matter. In order to give the Board time to determine whether such a problem exists, the Board sua sponte abates its order.

ORDER

The Board's Order of Dismissal dated November 22, 1983 is abated.

JEAN O. DENTON, Claimant
Myrick, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01660
December 14, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Brown's order which awarded claimant permanent total disability. SAIF contends claimant is not entitled to an award greater than the 30% permanent disability previously awarded. We find that claimant is not permanently and totally disabled and, therefore, reverse the Referee's order.

Claimant is a 52 year old waitress who compensably injured her low back in February 1979. Dr. Saez performed a microlumbar diskectomy in March 1980. In August 1980 Dr. Saez reported that claimant was medically stationary, not able to return to work as a waitress and should be retrained. Dr. Saez limited claimant to no bending, twisting or stooping and said she needed frequent changes in posture in an eight hour day. In February 1981 Dr. Saez limited claimant's lifting to ten pounds and rated her permanent impairment as moderate.

Claimant had repeated referrals to vocational rehabilitation including two assignments to authorized training programs. On a

few occasions claimant discontinued her participation in the vocational programs due to her back and leg pain. Although the vocational reports stated that claimant presented herself in a positive manner, her motivation to return to any type of employment was questioned.

Upon referral of Dr. Saez claimant began participating in the Northwest Pain Center program in September 1982. Although her motivation to return to work or to participate in a vocational rehabilitation program was again questioned, she was considered a good candidate for the pain center program. She made good progress at the pain center in that her flexibility increased, her pain behavior "was dropped," she discontinued use of prescription pain relievers and began using a TNS unit. On October 15, 1982 Dr. Seres reported in the discharge summary that the pain center personnel were in general agreement with claimant's own assessment of her physical limitations, i.e., that claimant should not do any significant lifting, no repetitive bending, stooping, twisting, turning or reaching and should be able to change her position frequently throughout her day's activities from sitting to standing to lying down if necessary. Claimant was portrayed as very cooperative and motivated to use the self help techniques taught at the pain center. However, the prognosis for her return to work was guarded.

In November 1982 claimant again began working with a vocational consultant at Crawford Rehabilitation Services. Her consultant reported that claimant felt much better as a result of the pain center program and was willing to try some limited work. Her consultant further reported that claimant felt she could work between four and eight hours a day if she could alternate between sitting and standing.

In December 1982, however, the Crawford consultant reported they would be holding off on the vocational program because Dr. Saez did not want to release claimant for work until she had been reevaluated at the pain center and by him. Claimant was reevaluated at the pain center in February 1983 at which time she reported significant improvement in subjective pain, limitations and mood, as well as good endurance, mobility and strength. The pain center reported that claimant had decided to retire so she could enjoy spending time with her retired husband, including some plans to travel. Claimant also indicated that her activity level had increased since her discharge from the pain center the prior October and she was making an effort to keep active with meetings and other activities.

The record contains no further vocational or medical reports after the February pain center follow-up evaluation. At the hearing claimant testified that she has learned to live with her pain, that she benefited greatly from her exercise program and that she was better physically and mentally since participating in the pain center program. Further, claimant testified that she continued to have sharp pain in her low back and hip and was able to perform household duties by lying down during the day. Claimant also stated that she plans to help her husband with some of his activities by acting as his secretary and attending meetings. Claimant has not looked for work since she was released from the pain center in October 1982.

In finding claimant to be totally disabled, the Referee observed that the Northwest Pain Center had indicated that claimant can work if she can lie down occasionally. The Referee could not conceive of any job in which claimant could be competitive with that restriction. Moreover, the Referee found that claimant is relieved of her obligation to make reasonable efforts to obtain employment under ORS 656.206(3) because of the severity of her impairment, including her pain level. The Referee additionally noted that claimant's treating doctor still had not released her for vocational rehabilitation and the vocational rehabilitation personnel had closed her file as medically unfeasible.

We disagree with the Referee's evaluation of the evidence. First, we note the Referee relied upon the October 1982 pain center report in finding that claimant could work only if she could lie down occasionally. However, subsequent pain center reports, not mentioned by the Referee, are considerably more sanguine in indicating that claimant's condition improved considerably after October 1982. Those more recent reports do not address claimant's ability to work solely because claimant reported that she had decided to retire.

Second, as we read the record, the failure to follow through with vocational rehabilitation was not based on lack of medical feasibility. As recently as November 1982 the efforts of Crawford Rehabilitation Services looked reasonably promising. The next month Dr. Saez called a halt to these vocational efforts, not because they were unfeasible, but solely for further evaluation of claimant's condition. That further evaluation consisted of the pain center follow-up reports summarized above. There is no further opinion from Dr. Saez or anybody else to the effect that the pain center's follow-up findings suggest any reason not to proceed with vocational rehabilitation, if claimant were interested.

Third, considering the pain center's follow-up findings and claimant's activity near the time of hearing, including housekeeping, attending meetings and plans to travel, we are not persuaded that her impairment is so great that she is relieved of the seek-work requirement of ORS 656.206(3).

For all of these reasons, we conclude that claimant has not established total disability. We thus turn to the question of partial disability. We find ourselves in substantial agreement with the Referee's analysis of the guidelines in OAR 436-65-600 et seq. and conclude that claimant would be appropriately compensated by an award for 50% unscheduled permanent disability.

ORDER

The Referee's order dated April 28, 1983 is reversed. In lieu of the Referee's award, claimant is awarded 160° for 50% unscheduled permanent disability. This is an increase of 64° (20%) over the total of 96° (30%) awarded claimant by Determination Orders dated February 11, 1982, August 20, 1980 and January 7, 1980. Claimant's attorney is allowed 25% of the increased compensation made payable by this order (64°), not to exceed $2,000, to be paid out of claimant's compensation and not in addition thereto.

JOHN D. FRESCHETTE, Claimant
David Hollander, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-05760
December 14, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Presiding Referee Daughtry's order which denied the parties' request for approval of a proposed Disputed Claim Settlement which provides, in part, "acceptance of this settlement means that no present or future compensation or medical benefits will be allowed under the Workers' Compensation Act after . . . January 22, 1982," the date on which claimant sustained an alleged intervening injury to his industrially injured right knee. Claimant concurs with the position taken by the insurer on review, requesting that the Board approve the parties' settlement agreement or remand this case to the Presiding Referee for that purpose.

Since the date of the Presiding Referee's order, we have considered the validity of settlement agreements submitted for approval pursuant to ORS 656.289(4) which are substantially similar to the agreement presented in this case. We have held that because the effect of such agreements is to extinguish any and all rights that a claimant has or may have under the Workers' Compensation Act in relation to an original, accepted industrial injury, they are in violation of the statutory prohibition against releases. ORS 656.236(2). Arnold Androes, 35 Van Natta 1619 (October 27, 1983); Duane E. Maddy, 35 Van Natta 1629 (October 27, 1983); Donald T. Campbell, 35 Van Natta 1622 (October 27, 1983). See also Sherman R. Thompson, 35 Van Natta 1711 (November 23, 1983).

The Board affirms and adopts the Presiding Referee's order denying approval of the parties' Disputed Claim Settlement. We note, in addition, that the case relied upon by the insurer in support of the validity of this settlement agreement, Seeber v. Marlett Homes, Inc., 30 Or App 233 (1977), is inapposite. The issue presented in that case was whether a claimant who had entered into an approved disputed claim settlement while the compensability of the claimant's original claim was in litigation could later file an aggravation claim pursuant to ORS 656.273.

ORDER

The Presiding Referee's order dated September 7, 1983 is affirmed.

VIOLET R. JONES, Claimant
Elliott Lynn, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07867
December 14, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Williams' order which found claimant entitled to compensation for permanent total disability. The only issue is the extent of claimant's disability.

Claimant suffered a compensable injury to her low back in March of 1980. The injury eventually resulted in two surgeries for recurrent disc extrusions at the L5-S1 level.

By progress note dated July 26, 1982, Dr. Berkeley, claimant's attending neurosurgeon, made the following assessment of claimant's condition:

> "...I think, however, the patient [claimant] has considerable degree of disability and her only type of chance of returning to work would be on a sedentary basis for brief periods of time during the day, say 3-4 hours, and with the opportunity of the patient to regulate her activities, particularly the periods of sitting and standing, or if necessary, even lying down. I think, on the other hand, that the patient is reaching maximum improvement and that she will be medically stationary from 8-1-82. I do not feel that any further curative care is available and that any further treatment is going to significantly alter this patient's present condition or future capabilities to work."

Dr. Berkeley prescribed a back brace to attempt to give claimant temporary relief. Dr. Skelley of the Callahan Center agreed that claimant was capable of sedentary work.

On August 16, 1982 a Determination Order issued awarding claimant 30% unscheduled permanent partial disability for her low back and 5% scheduled permanent partial disability for loss of her right leg (thigh). This award was in addition to a 10% unscheduled permanent partial disability award granted by Stipulation of January 14, 1981. Claimant has thus received a total of 40% disability for her low back condition.

The Orthopaedic Consultants examined claimant on December 14, 1982 and issued the following diagnosis:

> "1. Post laminectomy L-4/L-5 and L-5/S-1 with disc excision between L-5/S-1 on the left in 1972.
>
> "2. Status post laminectomy times two, L-5/S-1 on the right, 1981.

"3. Chronic lumbar strain with some radicular symptoms to the right."

The doctors felt that claimant could perform a light duty job which required no recurrent bending and stooping and with no lifting over approximately 10 pounds. They noted mild to moderate functional interference during the exam, but detected no gross interference. The doctors also mentioned that claimant had no specific goals for the future.

This apparent disinterest in setting future objectives also appears in notes recorded by claimant's vocational counselor. Eventually, rehabilitation services were terminated because claimant chose not to accept the services. The counselor did note that claimant wanted the opportunity to avail herself of the services at a later time.

The counselor's notes indicated that the reasons for claimant's termination from the program were primarily claimant's numerous physical maladies. However, claimant provided her own summarization for the termination. At the hearing claimant testified that: "I couldn't see any sense sitting in a chair getting uncomfortable, having her [the counselor] tell me to go out and get a job."

The Referee found claimant to be permanently and totally disabled. He reasoned that claimant's "somewhat perfunctory" participation in vocational rehabilitation was not indicative of work avoidance behavior in this particular case. He found claimant to be a credible witness and did not sense that her inability to remain still at the hearing for any substantial period of time was contrived.

Under the circumstances the Referee found that claimant had met her burden of demonstrating that she had made a reasonable effort to obtain gainful employment. Home Insurance vs. Hall, 60 Or App 750 (1982). He based this finding on claimant's three surgeries to her right mandible with extensive hospitalization and complications; a tubal ligation; treatment for a patella fracture; and two prior low back surgeries, in addition to the two surgeries for disc extrusion stemming from the compensable injury. Finally, the Referee noted that a psychiatric evaluation had indicated that the compensable injury had aggravated a prior psychiatric condition which resulted in a combination of physical and emotional impairments which were being met with a static defense. The Referee attributed claimant's apparent lack of motivation to this psychiatric condition.

We conclude that the evidence does not support an award of permanent total disability. Our summary of the relevant medical evidence establishes that not a single physician is of the opinion that claimant is totally disabled from a medical standpoint. Dr. Berkeley creates stringent limitations for claimant's prospective work activities, but he never indicates that claimant is totally disabled or physically incapacitated. Claimant has made little to no effort to establish that she is willing to seek regular gainful employment and has not made reasonable efforts to obtain employment. ORS 656.206 (3); Hall, supra.

The evidence also indicates that claimant has met rehabilitation efforts in a resistant manner. Her testimony at hearing, as noted above, is a clear indication of her attitude toward future employment. The Referee attributed this attitude to her psychiatric condition, based on a psychiatric evaluation performed by Dr. Janzer. We are not as persuaded by the evaluation. The evaluation was based on a one hour exam and a review of the medical records. Furthermore, Dr. Janzer admits the examination was incomplete and his diagnosis was tentative. Finally, he notes that it was difficult to establish a rapport with claimant.

Claimant is significantly impaired physically and is subject to severe restrictions, but she is not permanently and totally disabled. However, we do find that the Determination Order's award is inadequate.

Claimant is now 36. She has 11 years of schooling and no GED. Her overall general appearance is good and she possesses average to above average aptitudes. Her work experience consists of maid and laundry services, sandwich making, parts checker, cherry sorter and cashier. Her treating physician feels that she has a considerable degree of disability. Claimant experiences constant back pain which often radiates down her legs. It is difficult for her to sleep and to concentrate for any significant period of time. She can sit for an hour and one-half with effort and can stand for 40 minutes before the pain persists. She can drive a car for 20 minutes and can walk for 20-30 consecutive minutes. She can lift no more than 10 pounds and has been limited to sedentary-light duties.

Considering claimant's impairment, age, education and previous job experience pursuant to the guidelines of OAR 436-65-600 et seq, and comparing this case with similar cases, we find claimant has sustained a loss of earning capacity to the extent of 50% unscheduled permanent partial disability for her low back. We also find that claimant has sustained a permanent loss of use or function equal to 5% scheduled permanent partial disability for her right leg.

ORDER

The Referee's order dated April 15, 1983 is reversed. The Determination Order dated August 16, 1982 is modified in part to award claimant an additional 32° for 10% unscheduled permanent partial disability for injury to the low back, for a total unscheduled award to date of 160° or 50%. The award of 7.5° of scheduled permanent disability for a 5% loss of claimant's right leg (thigh) granted by the Determination Order is affirmed. In lieu of the fee allowed by the Referee, claimant's attorney is allowed 25% of the increased compensation made payable by this order (32°), not to exceed $2,000, to be paid out of claimant's compensation and not in addition thereto.

GREG METCALF (Deceased), Beneficiaries of
Hansen & Wobbrock, Attorneys
Roberts, et al., Attorneys

WCB 82-00783
December 14, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The deceased worker's putative beneficiaries request review of Referee Leahy's order which found that they were not dependents of the deceased worker and that they were, therefore, not entitled to benefits pursuant to ORS Chapter 656.

The issues for review are whether the deceased worker's mother and brother are dependents entitled to benefits pursuant to ORS 656.204(5) and ORS 656.005(11), and entitlement to penalties and attorney fees for the insurer's alleged failure to comply with the October 16, 1980 Determination Order.

Briefly, the facts are as follows.

The deceased worker died in a motor vehicle accident on March 25, 1980 while in the course and scope of his employment. A Form 801 was filed on June 27, 1980. The claim was accepted by the insurer. A Determination Order issued on October 14, 1980 finding that the decedent was fatally injured while a subject worker. The Determination Order ordered the insurer to pay the deceased worker's "beneficiaries," "an award of compensation for fatal injury."

Following the issuance of the Determination Order a somewhat prolonged period of confusion ensued during which the insurer attempted to obtain documentation from the deceased worker's mother and brother in order to establish dependency, and the amounts of support actually received from the decedent in the year preceding his death. ORS 656.204(5). A hearing was eventually requested and an interim order issued on September 14, 1982 ordering the production or release of all available and pertinent data to the insurer in relation to the question of dependency.

Following receipt of the additional evidence, the Referee entered a final order finding that the deceased worker's mother and brother had not established entitlement to dependent's benefits. Since the Determination Order ordered the insurer to provide benefits to the deceased worker's "beneficiaries," and, since he found that the deceased worker's mother and brother had not established dependency, the Referee concluded that the insurer had not failed to comply with the Determination Order. Although we do not agree with all of the statements in his order, we conclude that the Referee reached the right result.

ORS 656.005(11) states:

> "'Dependent' means any of the following-named relatives of a worker whose death results from any injury and who leaves surviving no widow, widower or child under the age of 18 years: Father, mother, grandfather, grandmother, stepfather, stepmother, grandson, granddaughter, brother, sister, half sister,

half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker. * * *" (Emphasis added.)

Evidence was presented which established that although the deceased worker maintained a residence separate from that of his mother and brother, he occasionally took his mother grocery shopping, and that he occasionally put money in library books around her house for her use. Apparently the deceased worker provided his mother with a car for her use and provided insurance coverage and repairs for the car. Further evidence was presented to the effect that the deceased worker kept a joint savings account with his mother and brother which they all used for their mutual support. There was testimony to the effect that the decedent did a substantial amount of work around his mother's house, including putting siding on the house, remodeling rooms, cutting brush, painting, plumbing, etc. The decedent's mother testified that her deceased son provided a total of $8,306.67 of direct support to herself and her other son in the year preceding his death. She arrived at this amount by calculating her yearly expenses and subtracting her income and her surviving son's income from their expenses. The deficit was alleged to represent money the deceased contributed to his family for support.

Although the evidence does establish that the decedent made some contribution to the support of his mother and brother, we are not convinced that the record establishes, as the statute requires, that they were dependent, in fact, on those contributions in whole or in part.

In 1979 the decedent's total income was $13,687, and he worked only one week in 1980 prior to his death. As the summary provided by the insurer indicates, the decedent's checking account record from March 1979 through March 1980 reveal that the decedent wrote checks amounting to over $9,000. In addition, the decedent's mother testified that the decedent was a "cash man," and that he preferred to conduct most of his transactions in cash.

Even though it appears that a few of the checks that the decedent wrote may have been for his mother's benefit, it appears that the decedent's personal living expenses totaled well in excess of $10,000 for the year preceding his death. It is, therefore, somewhat difficult to understand how the decedent could have provided over $8,000 in support to his mother and brother in the year preceding his death when his total income amounted to slightly more than $13,000. Further, it does not appear that the balance of that support could have come from the joint bank accounts established by the decedent. Although the records indicate that the decedent's mother made several withdrawals in the year preceding her son's death, it appears that she made deposits in amounts nearly equal to her withdrawals. The decedent's brother testified that he never made any withdrawals from the accounts.

Additional evidence indicates that although the decedent did a substantial amount of work on or around his mother's house, he was paid for at least part of this work by his mother. This fact seems somewhat inconsistent with the decedent's mother's claim that she was dependent on him. Moreover, although not necessarily conclusive, the decedent did not list his brother and mother as depen-

dents on his 1978 and 1979 income tax returns. The decedent's brother was claimed as a dependent by his mother on her 1979 income tax return. There was no testimony from the decedent's brother indicating that he ever received any money or other property from the decedent.

Although the decedent's mother and brother may have believed that they were dependent on the deceased's contributions in whole or in part for their support, the financial facts do not comport with that belief. As the insurer argues, what the somewhat vague evidence of this record shows is that the decedent took his mother grocery shopping on occasion, helped around her house (and with the family business in which he was a partner), and made other occasional gifts to her and his brother. The evidence does not establish that the decedent's contributions were by any means regular or that they were substantial enough in nature to render his mother or brother dependent on him in fact, "in whole or in part," for their support. Even if dependency had been established, the vagueness of the evidence would not allow us to make even a remotely accurate calculation of what benefits the decedent's mother and brother would be entitled to.

Since the deceased worker's mother and brother failed to establish entitlement to benefits as dependents, there was no failure on the part of the insurer to comply with the Determination Order, and no amounts upon which a penalty could be assessed.

ORDER

The Referee's order dated March 22, 1983 is affirmed.

ORVIL LEE MIDDLETON, Claimant
Rodriguez, et al., Claimant's Attorneys
Moscato & Meyers, Defense Attorneys

WCB 80-10663
December 14, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Howell's order which awarded claimant additional compensation equal to 30° (20%) scheduled right leg disability for a total award of 112.5° (75%) for loss of use of the right leg, thereby modifying the March 25, 1982 Determination Order. Claimant argues that he is permanently and totally disabled.

Based on the medical evidence in the record we find that claimant is severely disabled. Based on this record we also find that claimant is excused from the work search requirement of ORS 656.206(3), because we find it would be futile for him to search for work because he would not reasonably be expected to sell his services in a hypothetically normal labor market. Butcher v. SAIF, 45 Or App 313 (1980).

The Board reverses the order of the Referee.

ORDER

The Referee's orders dated November 3, 1982 and November 18, 1982 are reversed. Claimant is awarded compensation for permanent

and total disability effective October 15, 1982; this award is in lieu of that granted by the Referee, except that the insurer may credit compensation paid pursuant to the Referee's order against the additional compensation payable pursuant to this order. Claimant's attorney is allowed 25% of the increased compensation granted by this order as and for a reasonable attorney's fee, not to exceed $3,000.

DONALD K. SHAW, Claimant
Brown, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-05922
December 14, 1983
Order on Remand

This matter is before the Board pursuant to remand from the Court of Appeals. Shaw v. SAIF, 63 Or App 239 (1983). On review of the Board's order dated September 28, 1982, Donald K. Shaw, 34 Van Natta 1260 (1982), the Court of Appeals reversed our finding that claimant failed to request a timely hearing in relation to the October 28, 1980 Determination Order and remanded the matter for a determination on the merits. The only issue is the appropriate extent of claimant's unscheduled disability. SAIF contends that the Referee's award of 25% permanent partial psychological disability is excessive.

The Board affirms the order of the Referee.

It would appear that the Court of Appeals awarded claimant's attorney a fee for services rendered at the Board and court level in connection with the procedural issue in this case. Since the extent of disability issue had not previously been reached by either the Board or the court, it appears appropriate that claimant's attorney be awarded a fee for prevailing on the merits before the Board.

ORDER

The Referee's order dated February 19, 1982 is affirmed. Claimant's attorney is awarded a reasonable attorney's fee of $400 for services in connection with the review of the extent of disability portion of this case.

BIRDIE UMATHUM, Claimant
Doblie & Francesconi, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Rankin, et al., Defense Attorneys

WCB 82-03317 & 82-02912
December 14, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Williams' order which found SAIF responsible for claimant's 1982 thumb surgery and attendant disability as an aggravation, and ordered SAIF to pay a penalty for unreasonable delay in payment of time loss ordered pursuant to ORS 656.307. SAIF contends that the self-insured employer, Armour and Company, is responsible for claimant's 1982 surgery and disability as a new injury, and that the Referee's assessment of a penalty was inappropriate. We agree with SAIF's first contention but affirm on the penalty issue.

Claimant is a 62 year old "bacon arranger" for Armour and Company. Prior to January 1, 1977 Armour was insured by SAIF; since that date Armour has been self-insured. For the past 16 years claimant's duties at Armour required her to arrange slices of bacon in packages and press down with her hands and thumbs. In 1971 claimant made a claim for symptoms of arthritis in the carpal-metacarpal joints of both thumbs which SAIF accepted. Surgery was performed on her left thumb. Surgery was recommended on claimant's right hand as well, but claimant refused additional surgery. This claim was ultimately closed with an award of permanent disability for both hands.

Claimant's right hand problems continued and she filed a claim in 1975. Although SAIF could have processed this claim as an aggravation of the 1971 claim, SAIF instead processed it as a new claim. Claimant missed time from work in July and August of 1975. Surgery was again recommended on the right hand but claimant was adamant about refusing surgery until it was absolutely necessary. Her 1975 claim was closed by a March 11, 1977 Determination Order.

In November 1981 claimant saw Dr. Ragsdale and indicated she wished to have surgery for her progressive right hand pain. She reported that she continued to have pain in her right carpal-metacarpal joint and had been taking pain pills. She had continued working as a bacon arranger and had suffered no trauma to her right hand. Surgery was performed in March 1982.

The present question is whether this March 1982 surgery, associated time loss and possible disability should be viewed as an aggravation of claimant's 1971 and/or 1975 claim, for which SAIF would be responsible, or as a new claim, for which Armour would be responsible. Armour denied the claim, contending claimant's 1982 condition was an aggravation of her 1971 and 1975 claims. SAIF in turn denied the aggravation claim contending claimant's employment since January 1977, when Armour became self-insured, was responsible for her need for surgery and resulting disability. The Workers' Compensation Department issued an order pursuant to ORS 656.307 designating SAIF as the paying agent.

Prior to her 1981 treatment with Dr. Ragsdale, the last x-rays of claimant's right hand were taken in 1974 by her then treating physician, Dr. Bump. The 1974 x-rays showed marked degenerative change of the first carpal-metacarpal joint with narrowing, sclerosis and some cystic formation. In November 1981 Dr. Ragsdale reported that current x-rays of the right hand showed that the trapezial bone had become extensively eroded and elongated from osteoarthritic lipping, and cyst formation was present in the trapezium and first metacarpal space.

Dr. Rosenbaum examined claimant, reported his findings and testified at the hearing. Dr. Rosenbaum testified that claimant's work activity from 1973 until immediately before her 1982 surgery aggravated her underlying disease process. When Dr. Rosenbaum was asked if claimant's work activity merely produced symptoms, Dr. Rosenbaum clearly stated that the repetitive work aggravated the underlying disease. Dr. Rosenbaum testified, however, that in 1973 claimant had enough trouble with her right hand to contemplate surgery and that her major problem was in 1973. He also stated that claimant would have required surgery as previously recommended

regardless of whether she had been employed in recent years arranging bacon.

The Referee relied on this latter testimony that claimant would have required surgery anyway, concluding: "All of her problems relate to the degenerative condition which resulted from her compensable occupational disease, a condition which existed prior to Armour becoming a direct responsibility insurer and a condition which caused disability prior to Armour becoming a direct responsibility insurer." We disagree with the Referee's analysis.

We find that this case is controlled by Bracke v. Baza'r, 293 Or 239 (1982), which holds that full liability is assigned to the last employer/insurer that materially contributes to a worker's disabling condition. Under Bracke, Dr. Rosenbaum's testimony that the "major" problem arose in 1973 is not determinative. Rather, if the second employment, that is, employment from 1977 to 1982, materially contributed to the disabling condition, the fact that the "major cause" of her present disability is employment prior to 1977 does not matter under Bracke. Dr. Rosenbaum's testimony establishes that claimant's repetititve work activity prior to her disability in 1982 aggravated her underlying disease. This testimony is supported by a comparison of the 1974 and the 1981 x-ray findings. We conclude that claimant's employment subsequent to the period during which SAIF insured Armour aggravated claimant's underlying occupational disease resulting in disability in 1982. Armour, as a self-insured employer, is liable for claimant's right hand medical treatment in 1981 and thereafter and associated disability.

We agree with the Referee that SAIF unreasonably failed to pay temporary disability benefits after being ordered to do so pursuant to a 307 order and we affirm on the penalty issue.

ORDER

The Referee's order dated March 18, 1983 is affirmed in part and reversed in part. Armour and Company is found to be the responsible party for claimant's 1982 claim and is to reimburse the SAIF Corporation for benefits paid pursuant to the Workers' Compensation Department's June 1, 1982 order under ORS 656.307 and benefits paid pursuant to the Referee's March 19, 1983 order. That part of the Referee's order which assessed a penalty against SAIF is affirmed. Claimant's attorney is awarded $100 for services before the Board on review, to be paid by Armour and Company.

NELSON W. BAKER, Claimant
Charles Robinowitz, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 79-07010
December 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests and claimant cross-requests review of Referee Galton's order which: (1) Modified the August 25, 1978 Determination Order to provide claimant with benefits for temporary total disability from March 7, 1978 through June 29, 1978 but refused to set aside that Determination Order as premature; (2) ordered the employer to reopen the claim on the basis of an aggravation commencing November 30, 1978 and to pay all benefits until closure pursuant to ORS 656.268; (3) refused to determine the extent of claimant's disability in relation to the August 25, 1978 Determination Order as he found claimant not medically stationary at the time of the hearing; (4) dismissed claimant's request for hearing on the employer's partial denial of January 23, 1979 on the ground that the denial was "moot"; (5) ordered the employer to pay for all medical expenses in relation to claimant's respiratory and psychological condition; (6) denied claimant's request for penalties and related attorney fees; and (7) awarded claimant's attorney an "extraordinary" attorney fee of 25% of the additional temporary total disability compensation made payable by his order not to exceed $1,500.

I.

Claimant was 54 years of age and employed as a millwright on March 9, 1976 when he first consulted Dr. Faber with complaints of chest tightness and breathing difficulties. On April 6, 1978 Dr. Faber reported claimant was suffering from mild to moderate chronic obstructive pulmonary disease (COPD) and opined that claimant's employment environment, which was characterized by dusty and smokey conditions (particularly welding fumes), was a major cause of claimant's COPD. The employer accepted the COPD condition as a disabling occupational disease.

On May 23, 1978 Dr. Faber reported that:

> "[Claimant] is probably currently stable and could do some types of manual work in a non-polluted atmosphere. However, his lung reserve capacity is compromised to the extent that I do not feel he could do a great deal of heavy manual labor."

Claimant was examined by Dr. White on May 12 and June 9, 1978. Dr. White reported on June 29, 1978 that:

> "In answer to your question about whether his condition is medically stationary, I would have to say that further improvement is not likely from further treatment or passage of time."

Dr. Faber's June 29, 1978 chart note indicates that he was growing

concerned about claimant's "growing depression" and that claimant was having difficulty adjusting to the fact that he suffered from a disabling respiratory condition.

A Determination Order issued on August 25, 1978 awarding claimant temporary total disability benefits from March 7 through May 18, 1978 and 50% unscheduled permanent partial disability "resulting from injury to your respiratory system."

Claimant was also examined on several occasions by Dr. Vitums, a physician specializing in respiratory medicine. After reviewing claimant's medical history and performing pulmonary evaluations, Dr. Vitums concluded on August 9, 1978 that claimant suffered from reactive airway disease (reversible obstructive airway disease). Dr. Vitums reported that pulmonary tests confirmed only a slight abnormality which he believed could have been secondary to small airway dysfunction from claimant's previous history of cigarette smoking and/or associated with his reactive airway problem. Dr. Vitums believed that claimant should work in an environment which would not aggravate the problem, but felt that his work produced only a temporary aggravation of his respiratory disease and that no permanent damage was done to his lungs. Dr. Faber's December 28, 1978 chart note indicates that claimant's respiratory function had improved considerably and that claimant now had a forced vital capacity that was 85% of normal. He stated: "I feel that Dr. Vitums' diagnosis of reactive airway disease with improvement since being out of the polluted atmosphere at the shop is accurate."

On November 30, 1978 Dr. Faber reported that claimant's mental condition was deteriorating "as he feels that it is impossible to return to the jobs offered at Georgia-Pacific and he feels that he could not find any other type of work due to his physical condition and his age." Dr. Faber also noted that claimant was complaining of recurrent chest pain which he diagnosed as chest wall syndrome.

Claimant was thereafter treated at the Portland Clinic by Drs. Keppel and Dine. Dr. Dine reported that claimant admitted to being depressed and was having difficulty sleeping. Dr. Dine was of the opinion that claimant's insomnia, dizzy spells and chest pain were psychological in origin. Electroencephalograms taken in December 1978 were normal.

On January 23, 1979 the employer issued a partial denial which stated:

> "In reviewing Dr. Vitums' report of August 9, 1978 it was noted that the initial exposure to welding fumes only aggravated your underlying lung condition which effects are temporary in nature. Based on this opinion we will not be responsible for any further medical benefits."

On February 7, 1979 Dr. Faber reported that claimant had a difficult time adjusting to the fact that he had a lung condition and that his current complaints of chest pain and dizziness were most likely related to anxiety. He stated:

> "I personally feel that his occupation and

> lifestyle have contributed to his obstructive pulmonary disease, but I am unable to delineate the factors clearly responsible. I feel that [claimant] is not totally disabled and have discussed my feelings with [claimant] and his wife many times. I do, on the other hand, sympathize with the position and circumstances in which he finds himself."

On May 14, 1979 Dr. Davis conducted a psychiatric examination of claimant. Dr. Davis reported that claimant was extremely tense and was tearful at times when discussing his difficulties. Dr. Davis diagnosed depression. At a January 1981 deposition, Dr. Davis testified that she did not believe claimant was capable of working at the time of her May 1979 examination.

On March 1, 1980 Dr. Lindemann performed a psychological evaluation of claimant. Dr. Lindemann reported:

> "[Claimant] is an unsophisticated man with average manual-practical skills and low average verbal-academic skills. Originally a straightforward, steady, responsible person, he has been thrown by the train of events in his life, including his pulmonary problem, concern about his heart, and related feelings such as dizziness and numbness. He is now severely depressed and demoralized, manifesting a psychophysiological reaction.
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> * * *
>
> "A major causative factor appears to be the blow to Mr. Nelson of losing his long time work role, which was a large part of his total identity."

Dr. Lindemann additionally stated that claimant's emotional state clearly precluded employment.

On August 9, 1979 claimant's attorney filed a request for hearing indicating as issues: (1) Further medical care and treatment; (2) temporary disability; (3) permanent disability; (4) penalties and attorney fees; (5) permanent total disability; and (6) appeal from denial (no date specified).

A hearing was eventually held before Referee Ail in November 1980. Referee Ail passed away before he was able to issue an order, and a protracted period of procedural difficulties followed -- a complete summary of which is contained in Referee Galton's interim order of October 28, 1982, and will not be repeated herein.

When the hearing before Referee Ail convened, claimant's attorney indicated that he was contending claimant was not medically stationary at the time of the issuance of the August 25, 1978 Determination Order and that it was "inappropriate to award permanent partial disability when he (claimant) is unstable

medically." Additional issues concerned further medical benefits and related expenses and penalties and attorney fees. These issues were essentially restated in claimant's closing arguments to Referee Ail on February 27, 1981, with claimant arguing that his condition "had not reached maximum improvement."

Referee Galton concluded that the August 25, 1978 Determination Order did not issue prematurely. However, based on Dr. White's report of June 29, 1978, he did modify the Determination Order to provide that claimant receive temporary total disability benefits from March 7 through June 29, 1978. Referee Galton also concluded that claimant's psychological difficulties were a direct result of his compensable respiratory condition and ordered the claim to be reopened on an aggravation basis as of November 30, 1978. Based on William T. Lattion, 34 Van Natta 1518 (1982), the Referee concluded that since he had ordered the claim reopened, the employer's January 23, 1979 partial denial was "moot," and ordered the employer to pay for all medical and related expenses resulting from claimant's respiratory and psychological difficulties. Since he found claimant not medically stationary at the time of the hearing, the Referee refused to rate the extent of his permanent disability, if any. Additionally, the Referee denied claimant's request for penalties.

The employer contends: (1) That the Referee had no jurisdiction to decide any of the issues involved in this matter; (2) that even if he had jurisdiction, he erred in reopening the claim on the basis of aggravation; (3) that he erred in awarding claimant temporary total disability benefits from May 13, 1978 through June 29, 1980; and (4) that he erred in ordering the employer to pay for claimant's medical care and treatment. Claimant responds that, rather than finding an aggravation, the Referee should have set aside the August 25, 1978 Determinaton Order as premature and claimant should have been entitled to temporary total disability benefits through March 1, 1980, at which time he should have been found permanently and totally disabled.

II.

We address first the employer's argument that the Referee lacked jurisdiction to decide any issue involved in this litigation. As we understand it, the employer's argument is based entirely on its January 23, 1979 denial, which stated:

> "In viewing Dr. Vitums' report of August 9, 1978 it was noted that the initial exposure to welding fumes only aggravated your underlying lung condition which effects were temporary in nature. Based on this opinion, we will not be responsible for any further medical benefits."

The employer contends that this denial served to deny not only responsibility for payment of future medical benefits, but also served to deny the compensability of the entire claim. Since claimant failed to request a hearing in relation to the denial in a timely manner, the employer argues that the Referee had no jurisdiction over any issue.

We agree with the employer that there is nothing in the record

which would indicate that claimant filed a timely request for hearing in relation to the January 23, 1979 denial. Claimant was required to request a hearing in relation to that denial within 60 days, or not later than 180 days with good cause. ORS 656.319(1). Claimant, however, did not request a hearing until August 9, 1978, 198 days later. Claimant is thus outside even the "good cause" exception of the statute.

Claimant argues that the denial is invalid because it contains no indication that a copy was sent to the Director of the Workers' Compensation Department as required by ORS 656.262(7). This argument is simply not persuasive. Murphy v. SAIF, 13 Or App 105 (1973); cf Stroh v. SAIF, 261 Or 117 (1972); Angela V. Clow, 34 Van Natta 1632 (1982).

Although we agree with the employer that claimant failed to request a hearing in relation to the denial, we do not necessarily agree with the employer's argument that the denial served to deny the entire claim. This argument is very similar, if not identical to that made by the employer in Thomas C. Ray, 35 Van Natta 576 (1983). In that case the employer argued that an aggravation denial, which claimant had not requested a hearing on in a timely manner, foreclosed the Referee from considering the question of the extent of claimant's disability in relation to a timely request for hearing on a previously issued Determination Order. We rejected the employer's argument, concluding that such an unappealed denial could not foreclose a claimant's right to a hearing on a pending question of extent of disability. We find Ray to be dispositive. Although claimant in the current case did not request a hearing in a timely manner in relation to the employer's January 1979 denial, he did request a hearing in a timely manner in relation to the August 25, 1978 Determination Order. Thus, the denial could not serve to estop claimant from litigating any issue relevant to the Determination Order. See also Bauman v. SAIF, 295 Or 788 (1983).

In addition to the above, we find that the January 23, 1979 denial could hardly be more clear in its terms that it was only denying any continuing responsibility for medical benefits in relation to claimant's respiratory condition. In fact, the denial appears to concede that claimant did suffer a compensable aggravation of his lung condition, albeit temporary, as a result of his work exposure. We conclude that the denial was only a partial denial of continuing medical benefits in relation to claimant's respiratory condition. Since we have found that claimant failed to request a hearing in relation to that denial in a timely manner, it follows that that portion of the Referee's order finding the denial to be "moot" must be reversed, as well as that portion of his order which found the employer responsible for continuing medical benefits in relation to claimant's respiratory condition.

III.

Even if claimant had requested a hearing in relation to the denial in a timely manner, we would still conclude that the employer's denial of continuing responsibility for claimant's respiratory condition should be affirmed. Dr. Vitums' opinion is clearly to the effect tht claimant's employment only served to aggravate claimant's underlying lung condition temporarily. Dr.

Vitums reached this conclusion after comparing the results of various pulmonary function tests done over a period of time. The test results indicated that after claimant stopped working for a period of time, his lung function returned to a near normal status for a man of his age, and that any remaining deficiencies were likely the result of claimant's long history of cigarette smoking. After examining the pulmonary test results, Dr. Faber agreed with Dr. Vitums.

IV.

We next address the issue regarding aggravation versus premature closure and conclude that claimant is correct in his assertion that the August 25, 1978 Determination Order issued prematurely. It is obvious that the Determination Order was based on Dr. Faber's report of April 6, 1978, in which he reported that claimant's lung function was only 50% of normal for a man of his age, and Dr. Faber's report of May 23, 1978 in which he indicated that claimant was medically stationary. Dr. Faber issued these reports based on his conclusion that claimant suffered from COPD. However, this diagnosis subsequently proved either incorrect or premature as Dr. Vitums reported on August 9, 1978 that claimant's pulmonary function was improving, and that the condition claimant was suffering from was reactive airway disease which was temporarily aggravated by claimant's work exposure. Dr. Faber agreed with Dr. Vitums, and he noted continued improvement in claimant's pulmonary function until November 30, 1978, when he reported that: "I feel that he is somewhat improved over what he has been and perhaps will remain about this state . . . as long as he remains out of bad pulmonary environments." This continued improvement in respiratory function belies Dr. Faber's May 23, 1978 opinion that claimant was then medically stationary. Claimant did not reach a medically stationary status with regard to his respiratory condition until November 30, 1978.

However, we agree with the Referee that claimant was not stationary from a psychological standpoint at that time. Dr. Davis, in her deposition, and Dr. Lindemann, in his report of March 21, 1980 and his hearing testimony, all clearly relate claimant's psychological condition to his industrial exposure and we find no basis for disagreement with either doctor. Under Patitucci v. Boise Cascade Corp., 8 Or App 503 (1972), claimant has established the compensability of his psychological condition. Additionally, we agree with the Referee that a preponderance of the evidence indicates that claimant was not medically stationary from a psychological standpoint as of March 30, 1978. In fact, Dr. Faber indicated as early as June 29, 1978 that mentally, claimant was on the verge of an "acute break."

Claimant's contention that we should find him medically stationary as of March 1, 1980 (the date of Dr. Lindemann's examination) and award him permanent total disability as of that date is completely without foundation in the record. Even if that were a legitimate argument for claimant to make considering his position at the time of the hearing, there is nothing in the record indicating that claimant was medically stationary from a psychological standpoint at that time or any other time prior to the hearing. A complete determination of the extent of claimant's respiratory

disability (if any) and psychological disability will be made when claimant's psychological condition is found stationary. Gary A. Freier, 34 Van Natta 543 (1982).

V.

There are some additional difficulties presented by this case that need to be addressed. In its brief to the Board the employer states that the effect of the Referee's order was to make it immediately liable for four and one-half years of time loss benefits to claimant and "pursuant to ORS 656.313(1), all benefits for this four and one-half year period have been paid." The effect of our order serves to make the employer liable for an additional five months of time loss benefits that have not been paid, that is, for the periods from June 29 through November 30, 1978. In an undated hearing memorandum from claimant's attorney to Referee Ail, claimant stated:

> "Claimant contends he is medically unstationary and has been so since March 7, 1978, his last day of work. He should be entitled to temporary total disability benefits since that date with a credit for permanent partial disability paid to date." (Emphasis added.)

Since the Referee found an aggravation rather than premature closure, it follows that the employer was not able to offset any permanent partial disability paid under the August 25, 1978 Determination Order. Since we have found that that Determination Order issued prematurely, we will honor claimant's request that the employer should be allowed to offset permanent partial disability benefits paid pursuant to the Determination Order.

Another matter that must be addressed concerns attorney fees. Although the Referee ordered the claim reopened on the basis of aggravation, he awarded claimant's attorney a fee payable out of claimant's compensation, rather than an employer paid fee. Since we have concluded that there was a premature closure rather than an aggravation and since claimant has, therefore, prevailed on his cross-appeal of the Referee's order, claimant's attorney is entitled to an attorney's fee payable out of the increased compensation. Susan K. Spratt, 34 Van Natta 1028 (1982). OAR 438-47-040 allows a total hearing and Board attorney fee of up to $3,000 in such circumstances. Accordingly, we find claimant's attorney entitled to a total fee of $2,000, less any amounts already paid by the employer pursuant to the Referee's order, if any.

To summarize, we have concluded that: (1) The employer's partial denial of January 23, 1979 must be affirmed; (2) that the August 25, 1978 Determination Order issued prematurely; (3) that, although claimant was medically stationary with regard to his respiratory condition as of November 30, 1978, claimant also suffered a compensable psychological reaction as a result of his work exposure and that he was not and is not, based on this record, medically stationary with regard to the compensable psychological component of his claim; (4) that the employer is allowed to offset amounts of permanent partial disability paid pursuant to the premature August 25, 1978 Determination Order against the additional

temporary total disability benefits made payable by this order; and (5) claimant's attorney is entitled to an attorney's fee of $2,000 payable out of claimant's compensation, less amounts paid pursuant to the Referee's order, and in lieu of, not in addition to, that allowed by the Referee.

ORDER

The Referee's order dated December 29, 1982 is reversed. The August 25, 1978 Determination Order is set aside as premature and the employer is ordered to provide claimant benefits for his compensable psychological condition until closure pursuant to ORS 656.268. The employer is authorized to offset amounts of permanent partial disability paid pursuant to the Determination Order against the additional temporary total disability benefits made payable by this order. The employer's January 23, 1979 denial of continuing respiratory medical benefits is affirmed. Claimant's attorney is allowed an attorney's fee of 25% of the additional temporary total disability compensation made payable by this order, not to exceed $2,000, less any amounts already paid by the employer pursuant to the Referee's order. This attorney's fee is in lieu of and not in addition to that allowed by the Referee.

DARREL A. CHASTAIN, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 81-03963 & 81-03962
December 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

Frey's Thriftway and its insurer, U.G. Insurance, Inc./Fremont Indemnity, request review of Referee McCullough's order which set aside its denials for responsibility and compensability of claimant's present low back condition. Frey's contends either that claimant's present worsened low back condition is due to obesity, or that claimant suffered a new injury on November 10, 1980 while working for the Department of Energy, insured by the SAIF Corporation. We agree with Frey's that the evidence shows claimant's worsened back condition is due to his obesity and, therefore, that claimant has not proven by a preponderance of the evidence that his worsened back condition was due either to an aggravation of a prior industrial injury or to an alleged new industrial injury.

Claimant filed a workers' compensation claim on April 7, 1978 alleging that he had injured his low back on April 3, 1978 while working as a warehouse manager with Frey's Thriftway. The injury occurred while he was handling heavy freight. The claim was accepted as a disabling injury and claimant began treatment with Dr. Whitmire, chiropractor. Dr. Whitmire diagnosed claimant's injury as a lumbar strain. Claimant was off work through the rest of the year. He received continuing treatment from Dr. Whitmire during that time. A Determination Order issued on December 15, 1978 awarding claimant temporary disability benefits, but no permanent disability benefits. Claimant suffered a recurrence of low back pain while working at Frey's in early January 1979. This recurrence was treated as an aggravation of the April 1978 injury. Meanwhile, claimant continued to receive treatment from Dr. Whitmire. He was off work for about a week in January 1979 due to the aggravation. The claim was again closed by Determination Order on April 11, 1979 which again awarded claimant temporary disability

benefits only. On May 17, 1979 a third Determination Order awarded claimant some additional temporary disability in April 1979, but awarded no permanent disability benefits. On June 26, 1979 the parties entered into a stipulated order, whereby claimant was awarded 15% unscheduled permanent disability benefits as a result of the April 1978 low back injury.

In December 1979 claimant began working for the Oregon State Department of Energy as a mail room supervisor. About once a week he had to handle boxes of paper weighing up to 40 to 50 pounds, but the work was otherwise fairly light. Also in December 1979 claimant ended his chiropractic treatment with Dr. Whitmire. Throughout 1980 claimant worked for the Department of Energy. On November 10, 1980 he stepped out of his employer's van and experienced a catch in his back accompanied by substantial pain. As a result, claimant returned to see Dr. Whitmire on November 12, 1980, for the first time since December 1979.

Claimant filed both a claim for new injury with SAIF and an aggravation claim with Frey's. Both insurers denied responsibility and the Department designated a paying agent pursuant to ORS 656.307.

The responsibility issue was confused by Dr. Whitmire's reports. In January 1981 Dr. Whitmire opined that claimant's condition was related to his April 1978 injury as an aggravation. However, on May 12, 1981 Dr. Whitmire stated that he felt the November 1980 van episode contributed to claimant's back problems. Meanwhile, claimant was seen for independent medical examinations by Dr. Spady, orthopedist, and by Dr. Bolin, chiropractor. On May 20, 1981 Dr. Spady reported:

> "This man gives the history of having sustained an injury to his back in April 1978. I saw him for evaluation for the problem on the 13th of November, 1978. My opinion at that time was that the patient's condition was stationary and that he had made a satisfactory recovery from his back injury. It was my feeling that his impairment was minimal. At that time I made the statement that the patient was markedly obese and that he was likely to have further trouble with his back from time to time due to his poor physique and poor back hygiene."

Dr. Spady's report concludes:

> It appears to me that this patient's present symptoms are nothing more than what might be expected due to his general poor physique and poor back hygiene. I would not classify closing a van door as an injury. It is a very ordinary type of activity. The reason for recurrence of the patient's back pain with that incident was his underlying problem and not the activity itself. It would be my opinion that the present problem constitutes, neither an aggravation of a pre-

viously existing problem, nor a new injury, but rather a continuation of the patient's chronic back problem due to overweight and poor back hygiene."

On November 2, 1981 Dr. Bolin reported:

"[Claimant] is a 43 year-old caucasion male looking slightly older than his stated age due to his obesity. He is extremely obese standing 5 foot, 8 inches tall and weighing 257 pounds. His ambulation is quite awkward due to his obesity. * * * This patient probably did indeed suffer an aggravation of his obesogenic facet syndrome by stepping from the van causing a minor lumbar strain. * * * In answer to your Question No. 1, I do agree with Dr. Spady as related to the last paragraph [quoted above] of his May 20, 1981 report. I do not believe that his present condition is related to any previous injury but merely to his obesity. I would recommend that he lose 100 pounds at which time it would effect a cure."

As a result of those reports, on January 25, 1982 SAIF sent claimant a letter denying not only responsibility, but compensability, regarding claimant's low back condition. Frey's issued a similar denial on January 27, 1982. Thereafter, on January 29, 1982 claimant's most recent treating chiropractor, Dr. Young, reported:

"[Claimant] was first seen here on 11/19/81 with a complaint of chronic low back pain. He related that his original injury was on April 3, 1978 when pushing a pallet of groceries, he felt a tearing of the low back.

He reinjured his back in Nov. 1980 while stepping off a van. He has had 3 years of chiropractic care which has not relieved the pain consistently."

Although Dr. Young appears to be relating claimant's back condition to one or the other of the at-work incidents, his report concludes: "His prognosis is guarded in that if he failed to lose appreciable weight, he is likely to have recurring problems with the low back."

On July 8, 1982 Dr. Young reported:

"My initial impression [of claimant's condition] was of a chronic lumbar spine dysfunction initially brought on by the April 3, 1978 incident, reaggravated by the Nov. 1980 misstep and complicated by [claimant's] obesity.

"Treatment has been with ultrasound and spinal manipulation and [claimant] has been

> responding well. Except for a short flare-up in late May he has been completely asymptomatic. When reexamined on July 6, 1982 he had full range of motion and no pain in the low back. There is still an easy tiring condition in the low back which may represent a weakened lumbar mechanism complicated by obesity."

The Referee found that claimant's obesity was not the sole cause of his back problems since November 1980: "Claimant's obesity undoubtedly has been a complicating factor respecting his low back condition since his April 1978 injury, as recently suggested by Dr. Young * * *. But the fact that his obesity may make his low back problems worse does not render the low back condition non-compensable."

We have a somewhat different focus than the Referee as to claimant's burden of proof in this case.

> "In establishing an aggravation claim, the claimant must show that the worsening of his condition since the previous award is causally related to the industrial injury. It is not enough simply to show that the claimant, once injured, got worse; aggravation requires a connection with the industrial injury." Anderson v. West Union Village Square, 43 Or App 295, 197, modified 44 Or App 685 (1980).

Our review of: (1) Dr. Whitmire's conflicting reports; (2) Dr. Spady's and Dr. Bolin's conclusions that claimant's worsened condition is due to his obesity; (3) Dr. Young's mixed conclusion that claimant had possibly an aggravation or a new injury, but that his low back condition was complicated by obesity; (4) the lack of treatment for almost a year prior to the November 10, 1980 incident; and (5) the relatively nontraumatic incident of November 10, 1980, reveals that claimant has not met his burden of proving by a preponderance of the evidence that the worsening of his low back condition was due to either the 1978 injury or the November 1980 incident.

ORDER

The Referee's order dated November 22, 1982 is affirmed in part and reversed in part. That portion which upheld the SAIF Corporation's denials of claimant's new injury claim is affirmed. That portion which set aside the denials of claimant's aggravation claim issued by U. G. Insurance, Inc./Fremont Indemnity is reversed and those denials are reinstated and affirmed.

JESUS MOJICA, Claimant
Shepard & Stewart, Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB 82-11328
December 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer requests Board review of Referee Williver's order which granted claimant compensation equal to 112° for 35% unscheduled disability for injury to the low back. The employer contends the Determination Order awarding temporary total disability only should be affirmed, and that if claimant has any permanent disability, it is minimal.

At the time of the hearing, claimant was a 27-year-old Mexican worker who came to the United States at the age of ten. He had received a second grade education in Mexico. On June 27, 1981 claimant sustained a compensable back injury while working as a janitor for a potato processing plant. Dr. Kendrick initially diagnosed lumbar disc rupture with spondylolisthesis. Claimant was hospitalized for a myelogram in July 1981. Subsequently, surgery was considered but felt to be unfeasible at that time.

Claimant saw numerous doctors during the two years since his injury. The consensus was that claimant's subjective symptoms far exceeded any objective evidence. By February 1982 Dr. Kendrick felt claimant could return to his regular work as a janitor. He indicated claimant should limit his lifting to no greater than 25-30 pounds and should not do repetitive forward bending at the waist. Dr. Newby, an associate of Dr. Kendrick, saw claimant in March 1982 and indicated claimant was medically stationary at that time. He recommended claim closure with a permanent disability rating of mild to moderate.

In early 1982 the Field Services Division began working with claimant. It was finally determined that they could not assist claimant because he was not a documented worker in the United States.

Dr. Kemper, in March 1982, indicated claimant attempted to return to work but: (1) Claimant found himself in too much pain; and (2) he was apparently fired. (The employer has indicated they were not willing to rehire claimant because he was not a documented worker.) Dr. Kemper did not feel claimant was a malingerer, but he was unable to offer proof either way.

In April 1982 the Orthopaedic Consultants advised the insurer that claimant should participate in some supervised physical therapy. They also recommended claimant undergo a psychiatric examination. Claimant was hospitalized on May 28, 1982 in order to take part in a physical therapy program. It was apparently unsuccessful; claimant was discharged on June 1, 1982.

Dr. Kemper examined claimant in September 1982 and recommended pain center treatment. He felt claimant's attitude had changed sufficiently so as to make the pain center a reasonable option.

In October 1982 Dr. Stolzberg, a psychiatrist, felt claimant was overreacting to his back strain. She felt he was receiving a

great deal of secondary gain, both from his family and within the compensation situation. She concluded claimant would have no permanent psychiatric impairment due to this injury. In connection with the psychiatric examination, the Orthopaedic Consultants also saw claimant. Their final conclusion was that claimant's loss of function due to the injury was zero. They felt claimant could not work as a janitor due to the marked functional problems.

A Determination Order issued on November 23, 1982, which granted time loss compensation only.

Dr. Kemper, on February 11, 1983, advised claimant's attorney that he agreed with both Dr. Stolzberg and the Orthopaedic Consultants. Dr. Kendrick indicated he basically agreed with the Orthopaedic Consultants' report. He felt claimant was stationary and, from a medical point of view, was employable. He was in sympathy with the Consultants' finding that claimant had no permanent disability but felt claimant had some minimal disability which would preclude him from doing very heavy work or work which required him to use his back in an abnormal position for too long.

The Referee apparently based his conclusion on the premise that the doctors found claimant's disability to be in the mild to moderate category. We find to the contrary. The most recent comprehensive reports place claimant's permanent disability in the zero to minimal category.

Giving claimant the benefit of considerable doubt, we place his physical impairment at 5%. We do not feel claimant has shown permanent psychological impairment. Claimant is 27 years old (-5 value) and has a second grade education (+15 value). The specific vocational preparation required to do his job as janitor gives him a +3 impact. We find claimant can continue to do the medium level of work he was doing prior to his injury. Considering claimant's education, his residual functional capacity and his past work experience, we find he has 13% of the general labor market still open to him (+2 value). After a computation of the above values, we conclude claimant is entitled to an award for 20% unscheduled low back disability.

ORDER

The Referee's orders dated April 1, 1983 and April 19, 1983 are modified. In lieu of the Referee's award of 112° for 35% unscheduled disability, claimant is granted compensation equal to 64° for 20% unscheduled permanent disability for injury to his low back. Claimant's attorney's fee should be adjusted accordingly.

PEGGY S. PROCK, Claimant
Kirkpatrick & Pope, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-03605
December 16, 1983
Order on Review (Remanding)

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Leahy's order which set aside two Determination Orders as premature.

Claimant was compensably injured in March 1979. On September 2, 1980, following surgery on her low back, she was examined by Orthopaedic Consultants who found:

> "[T]his patient's condition is stationary from an orthopaedic and neurological point of view and her case should be closed. She is not at this time felt to be a candidate for aggressive potential surgical management of her low back. It is felt that improvement in her condition could be best achieved by case closure and settlement of her claim."

On November 30, 1980 a Determination Order issued finding claimant medically stationary on September 7, 1980 and awarding her 25% unscheduled disability. That Determination Order was affirmed by a Determination Order dated December 4, 1980. Claimant argues, and the Referee found, that those Determination Orders were premature because claimant was not medically stationary. We disagree.

The argument for premature closure is based on the fact that during this period between September 22, 1980 and November 30, 1981 claimant was treated for pain by Dr. Washington, an orthopedist. Claimant's argument is that while she may have been orthopedically stationary, a large portion of her disability consisted of pain and she was not stationary in terms of pain.

The medical evidence prior to claim closure indicates that claimant was then experiencing severe and, apparently, essentially constant pain. Dr. Specht reported in July 1980, "her pain remains severe and constant." Orthopaedic Consultants reported:

> "Otherwise she has continued to have pain in the low back, left worse than right, with radiation of pain to the left hip. She states that she has been essentially the same since the summer of 1979."

The treatment for pain which claimant received from Dr. Washington apparently was limited to physical therapy and pain medication. Dr. Washington in his deposition stated that claimant's pain condition fluctuated while she was under his care. Dr. Washington stated that the pain medication he provided claimant was not intended to improve her physical condition, but rather only to help her cope with her pain.

Oregon law defines medically stationary as meaning "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17) (emphasis added). We think the adjective "material" modifying "improvement" is particularly significant in this case. The most significant component of claimant's injury-related impairment consists of disabling pain. In the very nature of things, pain following back surgery can reasonably be expected to wax and wane. But when the level of pain is relatively constant for an extended period of time, and when no physician has curative treatment to offer, then we think it is reasonable and appropriate to conclude that "no material improvement" is likely.

We do not believe that claimant has proven by a preponderance of the evidence that she was other than medically stationary on

September 2, 1980. Orthopaedic Consultants, fully aware of her chronic pain problems, felt that she was medically stationary at that time. Dr. Washington said he felt claimant was orthopedically stationary, but that she was not stationary in terms of her management of pain, a rather fine distinction. However, during the course of Dr. Washington's treatment, claimant did not improve in her management of pain. By Dr. Washington's own testimony, claimant's ability to deal with pain initially seemed to improve but within a short time returned to the original status. The histories claimant gave to other physicians indicate that she did not believe she was improving under Dr. Washington's care. We do not believe that mere fluctuations in ability to manage pain are material changes in the sense contemplated by ORS 656.005(17).

Because we find that there was no premature closure, we remand to the Referee for a determination of the extent of claimant's disability.

ORDER

The Referee's order dated January 13, 1983 is reversed. The Determination Orders of November 3, 1980 and December 4, 1980 are reinstated. The claim is remanded to the Referee for determination on the issue of extent of disability.

CLEVE A. RETCHLESS, Claimant
Mercer, et al., Claimant's Attorneys
Cheney & Kelley, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 79-04418 & 79-08745
November 22, 1983
Order of Abatement

The Board has received a motion to reconsider our Order on Review dated October 28, 1983.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and respondents are requested to file a response to the motion for reconsideration within ten days.

IT IS SO ORDERED.

CLEVE A. RETCHLESS, Claimant
Mercer, et al., Claimant's Attorneys
Cheney & Kelley, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 79-04418 & 79-08745
December 16, 1983
Order on Reconsideration

The employer, Laurelhurst Thriftway, has moved for reconsideration of our Order on Review dated October 28, 1983. We abated that order on November 22, 1983 for the purpose of considering the motion. On reconsideration, we vacate our October 28, 1983 order and substitute the following in its stead.

In our prior order we affirmed the Referee's finding that the claimant sustained a new injury on December 4, 1978 while employed by Laurelhurst Thriftway. Therefore, Laurelhurst's September 13, 1979 denial was reversed, and the January 19, 1981 aggravation claim denial issued by Industrial Indemnity on behalf of Butler Village Market was affirmed.

Claimant originally sustained an industrial back injury in

1973 while employed by Butler. The claim was accepted and processed through closure. While employed by Laurelhurst in December 1978, claimant sustained a new injury to his back. The claim was accepted by Butler as an aggravation of the 1973 injury, and benefits were paid. The claim was closed by Determination Order of May 8, 1979. Claimant requested a hearing in relation to that Determination Order.

Subsequent to the issuance of the May 1979 Determination Order, claimant filed a claim against Laurelhurst alleging that he sustained a new injury in December 1978. Laurelhurst denied that claim on September 13, 1979. On January 19, 1981, Butler attempted to retroactively deny the claim that it had previously accepted and paid benefits for over two years. The denial letter stated:

> "As you know, we were the industrial carrier for Butler Village Market regarding your original industrial injury of May 3, 1973. That claim was closed in a Determination Order dated May 9, 1974.
>
> "Subsequently, a new incident occurred on December 4, 1978, during your employment with Laurelhurst Thriftway. That claim was, at that time, accepted by Industrial Indemnity as an aggravation of your earlier injury. However, you subsequently filed a new injury claim with Laurelhurst Thriftway on September 28, 1979. The preponderance of the factual and medical evidence received subsequent to this incident indicates that you suffered a new injury to the same area of your back resulting in a worsened condition, rather than an aggravation of your earlier 1973 injury.
>
> * * *
>
> "Accordingly, I must advise you . . . that your previously accepted claim for reopening due to the December 4, 1978 incident is hereby retroactively denied.
>
> * * *"

About the time we issued our Order on Review and prior to the time that order became final, the Supreme Court issued its decision in Bauman v. SAIF, 295 Or 788 (1983). In Bauman, the court concluded:

> "If, as in this case, the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. The insurer or self-insured employer is not at liberty to accept a claim, make payments over an

> extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate the issue of compensability." 295 Or at 794.

Laurelhurst contends that since Butler accepted the claim for aggravation and paid benefits in relation to that claim for approximately two years, under Bauman it is now barred from retroactively denying that claim. Based on the above-quoted portions of Bauman, we agree.

Butler argues that Bauman is not applicable to the present case for the reason that Bauman dealt with a denial of compensability, and the current case deals only with the issue of responsibility as between two insurers. Although that is a possible point of distinction between the current case and Bauman, we do not read the Supreme Court's opinion as making any differentiation between cases involving compensability and those involving responsibility.

Frasure v. Agripac, 290 Or 99 (1980), was a case involving responsibility between two potentially liable insurers. In Frasure, the first employer and its insurer accepted the claimant's aggravation claim and awarded time loss only. Between the time of the award and a requested hearing, the claimant's doctors changed their opinion and concluded the claimant's condition represented a new injury rather than an aggravation. The court concluded that the aggravation insurer was not barred from retroactively denying the claim for aggravation, even though it had accepted that claim nearly one and one-half years prior to the issuance of its denial. However, in Bauman, the court stated:

> "We must retreat slightly from what we said in Frasure. * * * In Frasure, we indicated that former ORS 656.262(7) allowed an employer to accept a claim and then subsequently to deny the right to compensation. This is not correct." 295 Or at 792, 793.

Thus, although the "bottom line" of the court's opinion in Bauman was phrased in terms of compensability, when read as a whole, it does not appear that the court actually intended to make any distinction between cases involving compensability and those involving responsibility. As the court noted, "To allow the employer or the employer's insurer to engage in such vacillating activity would encourage degrees of instability in the workers' compensation system that we do not believe the statute contemplates." 295 Or at 793. That reasoning is equally applicable to cases involving responsibility as well as compensability. Under Bauman, once a claim has been accepted and the statutory 60-day period within which an employer or insurer may deny a claim has elapsed, absent fraud, misrepresentation or other illegal activity, the claim may not be denied, period. The fact that this case involves an issue of responsibility rather than compensability is irrelevant.

Since Butler accepted the claim on the basis of aggravation of the 1973 injury, and since it failed to deny the claim until approximately two years subsequent to that acceptance, based on Bauman, it may not now attempt to retract its previous acceptance of the claim.

Claimant's attorney is entitled to no attorney's fee on Board review. Robert Heilman, 34 Van Natta 1487 (1982).

ORDER

The Referee's order dated November 24, 1982 is reversed. The September 13, 1979 denial issued by Laurelhurst is reinstated and affirmed. The January 19, 1981 denial issued by Butler is reversed. Butler, rather than Laurelhurst, is ordered to pay claimant's attorney the $1,500 fee awarded by the Referee.

VICKI J. STAV, Claimant
Robert Nelson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-02511
December 16, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Pferdner's order which modified the October 27, 1981 Determination Order by awarding claimant 22.5° for 15% scheduled right wrist disability. SAIF contends the Determination Order should have been affirmed. We agree with SAIF and reverse the Referee because, on this record, we do not find that claimant has proven that her right wrist tendinitis resulted in permanent disability.

On June 9, 1981 claimant was working for a saw chain company when she suffered a compensable strain of her right wrist. Her job involved repetitive lifting of 100 foot reels of chain and repetitive use of a staple gun. In reports dated July 2, 1981 and July 14, 1981, claimant's doctors indicated she would have no permanent impairment. Claimant subsequently developed or was diagnosed as having wrist tendinitis.

Claimant was examined by Dr. Button on July 24, 1981. Dr. Button thought that claimant should modify her work situation for approximately one to two months, but that, thereafter, she should be able to return to her regular job. On September 28, 1981 claimant was referred to the Callahan Center where she was examined by Dr. Storino, who reported that claimant had:

> ". . . tendinitis of the wrist, right more than left, with the only residual symptom today being mild tenderness over the volar aspect of the right wrist.
>
> "On examination today, the patient shows only minimal symptoms."

Dr. Storino recommended that claimant return to a modified job.

On October 2, 1981 Dr. Button wrote a second report recommending closure of the claimant's claim. He stated:

> "I consider her condition stationary and recommend closure of her case. There is no permanent impairment of function. I would

put no restrictions on her job activity, but if possible would advise she avoid strenuous repetitive assembly line type of situations."

At hearing, claimant's testimony reflected Dr. Button's observation that with heavy lifting she notes vague aching discomfort in her wrist.

Based on the above evidence, we find claimant has failed to prove she suffered any permanent disability due to her compensable wrist injuries.

ORDER

The Referee's order dated January 18, 1983 is reversed. The Determination Order dated October 27, 1981 is affirmed.

WALTER T. VanMETRE, Claimant
Danner & Scott, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-07464
December 16, 1983
Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review dated November 18, 1983.

The request is granted. On reconsideration, the Board adheres to its former order.

IT IS SO ORDERED.

BOARD MEMBER BARNES CONCURRING:

The insurer's request for reconsideration argues that we erred in applying the Supreme Court's recent decision in Bauman v. SAIF, 295 Or 788 (1983), to reverse the Referee's order in this case that had upheld the insurer's backup denial, because the Supreme Court's Bauman decision should not be applied retroactively.

There is certainly copious authority not to apply appellate court decisions retroactively, especially when the more recent decision overrules a prior decision. Most of that authority arises in the context of new common law or constitutional doctrine; little arises in the context of statutory construction.

And I understand the Supreme Court's Bauman decision to be based primarily on statutory construction. The court has concluded, in effect, that ORS chapter 656 never permitted an insurer to issue a backup denial after having previously accepted a claim. To the extent that the statutes have always said the same thing, application of the Bauman interpretation of those statutes in this case is hardly "retroactive" in the same sense as in a common law or constitutional context.

A complicating factor, as correctly pointed out by the insurer in this case, is that the Supreme Court's prior decision in Frasuer

v. Agripac, 290 Or 99 (1980), did say that an insurer was always permitted to issue a backup denial after previously having accepted a claim, and Bauman overrules that portion of Frasuer regardless of how politely the Supreme Court chose to phrase it ("We must retreat slightly from what we said in Frasuer." Bauman, 295 Or at 792.) The complication is that during the three year interval between Frasuer and Bauman, thousands of claims were accepted in reliance on the assumption that backup denials could be issued if subsequent investigation suggested they were appropriate. See Patricia C. Davis, 35 Van Natta 635, 641-42 (1983) (dissenting opinion):

> "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 be reasonably percieved as involving little exposure are very common in workers compensation.
> * * *
>
> " . . . Of about 111,000 claims filed in 1982, over 97,000 involved only payment of 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."

This widespread reliance on pre-Bauman law in the processing of claims is also indicated by the number of cases involving backup denials and were pending at one level or another of the litigation system when the Supreme Court decided Bauman.

As the insurer here argues, this extensive reliance on pre-Bauman law combined with simple notions of fairness and justice makes a rather compelling case for the proposition that Bauman should not be applied retroactively. I reluctantly conclude, however, that any holding to that effect should come from higher authority.

JAMES C. WELCH, Claimant
Brown, et al., Claimant's Attorneys
Brian Pocock, Defense Attorney

WCB 82-01160
December 16, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee McCullough's order which awarded claimant compensation for permanent and total disability for his low back injury. The insurer contends that the Referee's award is excessive because no physician has stated that claimant is unable to return to work and because there are some jobs in the light work category that claimant could presently perform such as gatekeeper, security guard, and light bartending. Our review of this case shows that a considerable amount of claimant's earning capacity has been significantly reduced as a result of his compensable injury. However, when we apply the guidelines at OAR 436-65-600 et seq and compare this case to other similar cases, we find that an award of compensation for permanent and total disability is excessive and that the claimant would be more properly compensated with an award of 192° for 60% unscheduled disability.

Claimant was hit in the back by a large rock on October 20, 1980 when a large quantity of dynamite unexpectedly exploded nearby while claimant was working at a job site laying pipe. As a result of the accident, claimant suffered a mild loss of hearing, double vision (which has been corrected by wearing eyeglasses) and a chronic low back strain. Claimant's orthopedic surgeon, Dr. Sulkosky, has limited claimant's lifting to approximately fifteen pounds with no repetitive bending or twisting and has recommended that he have a job where he is able to change positions frequently. Claimant has a full range of lumbar motion and an almost normal sensory examination. However, the chronic aching and throbbing lumbar pain, which increases to severe sharp pains at times, has been rated by Dr. Sulkosky as moderate impairment. All of claimant's prior work experience has been in the heavy work category. He is now limited to light work.

Claimant was 37 years old at the time of the hearing. He has a formal education to the ninth grade. However, he tested at the fifth or sixth grade level for reading, at the fourth grade level for math and at the low average level for clerical perception, dexterity and motor coordination. There has been considerable effort by vocational counselors to help claimant find a job with his residual abilities, but, thus far, all efforts have been unsuccessful.

The Referee reasoned that, pursuant to the holding in Gettman v. SAIF, 289 Or 609 (1980), claimant is entitled to an award of permanent and total disability compensation. The Referee found that there is no evidence that claimant can presently perform any jobs without retraining and that to speculate that claimant might be able to perform a job after retraining is impermissible under the holding of Gettman. Although we agree with the Referee that Gettman does not permit us to look to speculative retraining, we find that claimant has not proven he is permanently and totally disabled.

Claimant has presented evidence showing that he and his vocational counselors have had difficulty figuring out a light job to

which he could return. Claimant has been actively applying for light work jobs but, unfortunately, due to a scarcity of jobs in his geographical location, especially in the unskilled light work category, he has been unable to secure employment thus far. We find that continued diligent effort could yield a job for claimant, especially given claimant's young age of 37, his ability to handle light work, and the opinion of some vocational specialists that there are jobs that claimant can perform with his present skills.

ORDER

The Referee's order dated August 6, 1982 is reversed in part. In addition to the 48° for 15% unscheduled permanent partial disability awarded by the Determination Order dated January 18, 1982, claimant is awarded 144° for 45% for a total unscheduled award to date of 192° for 60% for injury to the low back. The remainder of the Referee's order is affirmed. In lieu of the fee allowed by the Referee's order, claimant's attorney is allowed 25% of the increased compensation made payable by this order (144°), not to exceed $2,000, to be paid out of claimant's compensation and not in addition thereto.

PATRICIA M. ANDERSON, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-07388
December 19, 1983
Order of Abatement

The Board has received a motion to reconsider our Order on Review dated November 30, 1983.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and the insurer is requested to file a response to the motion for reconsideration within ten days, specifically addressing the following questions:

(1) What conditions/diseases were in accepted status prior to the February 18, 1982 denial and thus, under Bauman v. SAIF, 295 Or 788 (1983), cannot now be denied?

(2) If in answer to the prior question, it is the position of the employer/insurer that the conditions/diseases denied in February 1982 were different from the conditions/diseases previously accepted, is the Bauman doctrine applicable to partial denials?

(3) If it is not possible to ascertain from the present record what was in accepted status prior to February 1982, would remand for additional evidence on this point be appropriate?

IT IS SO ORDERED.

TRACEY WAGONER, Claimant
Elliott Lynn, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-05274
December 20, 1983
Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review (Remanding) dated November 21, 1983.

The request is granted. On reconsideration, the Board adheres to its former order.

IT IS SO ORDERED.

Board Member Barnes, concurring:

The insurer's request for reconsideration argues that we erred in applying the Supreme Court's recent decision in Bauman v. SAIF, 295 Or 788 (1983), to reverse the Referee's order in this case that had upheld the insurer's backup denial, because the Supreme Court's Bauman decision should not be applied retroactively.

There is certainly copious authority not to apply appellate court decisions retroactively, especially when the more recent decision overrules a prior decision. Most of that authority arises in the context of new common law or constitutional doctrine; little arises in the context of statutory construction.

And I understand the Supreme Court's Bauman decision to be based primarily on statutory construction. The court has concluded, in effect, that ORS Chapter 656 never permitted an insurer to issue a backup denial after having previously accepted a claim. To the extent that the statutes have always said the same thing, application of the Bauman interpretation of those statutes in this case is hardly "retroactive" in the same sense as in a common law or constitutional context.

A complicating factor, as correctly pointed out by the insurer in this case, is that the Supreme Court's prior decision in Frasure v. Agripac, 290 Or 99 (1980), did say that an insurer was always permitted to issue a backup denial after previously having accepted a claim, and Bauman overrules that portion of Frasure regardless of how politely the Supreme Court chose to phrase it: "We must retreat slightly from what we said in Frasure." Bauman, 295 Or at 792. The complication is that during the three-year interval between Frasure and Bauman, thousands of claims were accepted in reliance on the assumption that backup denials could be issued if subsequent investigation suggested they were appropriate. See Patricia C. Davis, 35 Van Natta 635, 641-42 (1983), dissenting opinion:

> "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 be reasonably perceived as involving little exposure are very common in workers compensation.

* * *

". . . Of about 111,000 claims filed in 1982, over 97,000 involved only payment of 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."

This widespread reliance on pre-Bauman law in the processing of claims is also indicated by the number of cases involving backup denials that were pending at one level or another of the litigation system when the Supreme Court decided Bauman.

As the insurer here argues, this extensive reliance on pre-Bauman law combined with simple notions of fairness and justice makes a rather compelling case for the proposition that Bauman should not be applied retroactively. I relunctantly conclude, however, that any holding to that effect should come from higher authority.

MICHAEL A. BEACH, Claimant
Hansen & Wobbrock, Claimant's Attorneys
Horne & Tenenbaum, Defense Attorneys

WCB 83-00016
December 22, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The employer requests review of Referee Menashe's order which awarded claimant 25% unscheduled permanent partial disability for injury to the low back, that being an increase of 10% over and above the May 12, 1983 Determination Order. The employer contends that the Determination Order's award of 15% permanent partial disability was adequate compensation for claimant's injury. We agree.

Claimant suffered a compensable low back injury on May 13, 1982 while employed as a warehouseman. The injury was diagnosed as a lumbosacral sprain. Diagnostic testing failed to reveal any orthopedic or neurologic impairment. All of claimant's treatment to date has been conservative in nature, and there are numerous

medical reports indicating that claimant has a significant degree of functional overlay and has a tendency to "hyperreact" to minor stimuli. Claimant's impairment has been assessed to be in the minimal to mild range based solely on his complaints of pain. Although the Referee indicated that claimant was restricted to sedentary or very light duty work, claimant's treating physician indicated that there were few, if any, activities in which claimant could not engage. Moreover, at the time of the hearing claimant was employed by a supermarket service company and working five days per week, six to eight hours per day. Claimant's work involves driving to various supermarkets and using steam cleaning equipment to clean grocery shopping carts. It would appear that this work is at least in the medium category.

From a social/vocational standpoint, claimant is only 22 years of age and has a high school education. Testing at the Callahan Center indicated that claimant was qualified for 46 occupational patterns, and that he had superior abilities in spatial reasoning, perception and manual dexterity. Claimant is of at least average intelligence and has no psychological or emotional difficulties which would interfere with his ability to work.

Considering the guidelines of OAR 436-65-600 et seq, and other cases similar to this, we conlcude that claimant was adequately compensated for his disability by the Determination Order's award.

ORDER

The Referee's order dated July 5, 1983 is reversed. The May 12, 1983 Determination Order is affirmed.

RAYMOND H. BROWN, Claimant
Pozzi, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 81-08138
December 22, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee Shebley's order which modified the Determination Orders dated February 21, 1980 and August 20, 1981 by awarding claimant 50° for 33-1/3% loss of use of his right forearm. The Determination Orders had awarded no benefits for permanent disability.

We are in substantial agreement with the argument and analysis in the employer's brief and, based thereon, we modify claimant's award to 15° for 10% loss of use of his right forearm. We are particularly impressed by the findings of Drs. Kemple, Schuler and Graham of little or no physical impairment, with the latter finding "normal" grip in August 1981 and "good" grip in June 1982. We acknowledge claimant's testimony, which the Referee found to be credible, that claimant believes he has lost half his grip strength. While we do not doubt that this may be claimant's honest perception, we conclude that the more limited findings of all the doctors are likely more accurate.

ORDER

The Referee's order dated February 15, 1983 is modified. Claimant is awarded 15° for 10% loss of use of his right forearm; this award is in lieu of all prior awards. Claimant's attorney's fee should be adjusted accordingly.

WILLIAM DAY, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-06780
December 22, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee James' order which set aside its partial denial.

Claimant was compensably injured on February 4, 1981 when his chair tipped over backwards. On the claim form claimant executed, he noted muscle spasms in his back in the area of a previous on-the-job injury. The claim was accepted as nondisabling. The physician who initially saw claimant, Dr. Satyan, described his problem as "muscle strain, back." Claimant was advised to stay off work for two days. On April 2, 1981 claimant saw his regular physician, Dr. Anderson, who diagnosed "muscular strain aggravating osteoarthritis." In the portion of the form requesting a summary of the worker's complaint he wrote, "sacro-sprain-tendonitis left hip-Gen. back pain."

On April 26, 1981 claimant went out to dinner with some friends. During the course of the evening he had approximately four drinks. At the end of the evening the group returned to the home of Dr. Johnston. Claimant started down the basement stairs to the party room at Dr. Johnston's home. He suddenly fell down nearly the entire flight of stairs. There were no witnesses to the actual fall. Claimant was taken by ambulance to hospital. The emergency room report notes comminuted mildly impacted fractures of the humeral neck and old compression fractures at T11, T12 and L1. The report notes claimant's "inebriation."

The emergency room doctor later expanded on his report:

> "At the time I spoke with the patient, there was slurring of speech although he was indeed alert. There was a history of alcohol consumption prior to admission.
>
> * * *
>
> "My impression that the patient suffered from inebriation was purely clinical, based upon his history of alcohol consumption, plus slurring of speech. I cannot remember if at that time there was an odor of alcohol on the breath or not."

Two days after the fall, claimant saw Dr. Adlhoch who diagnosed a fracture of the left humoral neck, a contusion of the right hand and right sacroiliac sprain. In a later report, Dr. Adlhoch notes that he compared x-rays from before and after the fall and "found that there was a new compression fracture of the right side of the third lumbar vertebral body. I believe that this may be causing the symptoms suggestive of a right-sided herniated disc..."

Claimant was seen in July 1981 by Dr. Paxton for a neurological evaluation. Claimant indicated to Dr. Paxton that he was especially concerned that his left leg may have caused the April 26 fall. Dr. Paxton stated: "I can find no sensory or

motor loss. He stands on heel and toe. He has good posture and good muscularity in his lower extremities. I cannot really demonstrate any weakness."

Claimant was seen by Dr. Tilson in September 1981. Dr. Tilson opined:

> "I see at this point no reasonable connection between his back pathology and the fall of April 1981. That is to say, there is really no documentation that left lower extremity pain or weakness was brought to medical attention prior to the accident. However, [claimant] assures me this was in fact mentioned to Dr. Anderson on several occasions. There is no doubt in my mind that this patient has problems in his left lower extremity now, although they do not seem to be orthopedic."

Dr. Anderson in a letter to SAIF reported:

> "[Claimant] initially was evaluated...after he fell involving the chair in his office on February 4 with a diagnosis of muscle strain aggravated by osteoarthritis. He probably did mention some leg numbness and weakness at that time; however, he also had chronic back problems before. The patient also has old compression fractures of the lower thoracic and upper lumbar spine; in a fall such as he experienced when the chair collapsed, although his initial complaints were mostly upper thoracic and cervical, he certainly could have aggravated low back injuries and conditions in addition. I would have to assume that he probably had some leg weakness and numbness secondary to the fall...His mention of tendinitis in the hip at that time was probably not related to the direct cause for his weakness and numbness except for secondary relationships."

SAIF denied responsibility for further benefits and treatment on the basis that claimant's fall was an intervening injury which was not caused by claimant's compensable injury. The Referee found that the claimant had proven there was a causal relationship between the compensable injury and the April 26, 1981 fall. We disagree.

The only evidence which tends to link claimant's compensable injury to his tumble down stairs is his testimony that his leg gave way and Dr. Anderson's statement that claimant "probably" had mentioned leg give-way during the interval between his compensable injury and the fall. Dr. Anderson's memory is unsupported by any statement in the medical records. Furthermore, his statement is at best tentative. He states that claimant "probably" mentioned leg numbness and weakness. In the same sentence he refers to

claimant's earlier documented chronic problems. Dr. Anderson seems to be saying that claimant has mentioned a lot of complaints to him and that among those complaints he may have mentioned leg weakness and numbness. Dr. Anderson's statement does not indicate that he has an independent memory of claimant making such statements. Dr. Anderson appeared at hearing but was not closely questioned on this issue, so his report is the strongest evidence on the question of whether or not claimant mentioned the leg numbness and weakness.

Balanced against claimant's history and Dr. Anderson's report is the report in which Dr. Paxton states that he is unable to find any objective evidence of left leg sensory loss or weakness. In addition, the emergency room report and the testimony of claimant and his witnesses suggest the inference that claimant fell down the stairs not because of leg give way but because he was under the influence of alcohol.

We conclude that it is equally possible that claimant fell because of leg give way or because he was under the influence of alcohol. Therefore, claimant has failed to sustain his burden of proving that his compensable injury was a material cause of his April 26, 1981 fall and its sequalae. Accordingly, we reverse the Referee and reinstate SAIF's partial denial.

ORDER

The Referee's order dated July 21, 1982 is reversed. SAIF's partial denial dated June 25, 1981 is reinstated and affirmed.

GERARDO V. SOTO, JR., Claimant
Spears, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 83-03534
December 22, 1983
Corrected Order of Dismissal

Claimant contends that he requested review of Referee Podnar's order which upheld the insurer's denial of claimant's low back injury claim. The Referee issued his order on September 9, 1983. The facts are as follows.

On or before October 10, 1983, claimant, by and through his attorney, filed a document dated October 7, 1983 and captioned "Request for Hearing and Demand for Production," designating as issues: "Denial of September 9, 1983; penalties and attorney fees pursuant to ORS 656.269(9); temporary total disabilities; unscheduled permanent partial disability; and permanent total disability." Attached to this document, which was submitted under cover of a letter of the same date addressed to the Hearings Division, was an attorney retention agreement.

On October 19, 1983, the insurer's Motion to Dismiss claimant's "request for hearing" was received. The motion alleged that the Referee issued an order on September 9, 1983, upholding the insurer's denial; that the Referee's order became final by operation of law on October 9, 1983; that no timely request for Board review of the Referee's order had been filed by claimant; and that the issues raised by claimant's "hearing request," therefore, had been finally resolved adversely to claimant and could not be raised by way of an additional hearing request.

On October 20, 1983, the Presiding Referee entered an Order of Dismissal in WCB Case No. 83-09561, the case number assigned to claimant's Request for Hearing and Demand for Production upon receipt by the Hearings Division.

On or before October 21, 1983, claimant filed a response to the insurer's Motion to Dismiss, in which claimant's attorney stated that he had intended to request review of the Referee's September 9, 1983 order and mistakenly captioned his request for review as a request for hearing. By this response claimant asserts, in essence, that the Request for Hearing and Demand for Production sufficiently complies with the requirements for requesting Board review pursuant to ORS 656.289(3) and ORS 656.295 such that it should be accepted as a timely request for review of the Referee's order. Claimant's response relies upon and incorporates by reference a letter dated October 18, 1983, received by the Board the following day, confirming a telephone conversation between claimant's attorney and the Board's closing and appeals section supervisor, whereby claimant's attorney apparently attempted to rectify the error of filing a hearing request, rather than a request for Board review.

The Referee's order became final on October 10, 1983. Our records reflect that claimant's Request for Hearing and Demand for Production was filed within 30 days of the Referee's order. See OAR 436-83-700(2). The matter eventually was referred to the Board by the Presiding Referee's Order of Dismissal, but long after expiration of the 30-day period for requesting Board review. The question, therefore, is whether the documents received on October 10, 1983, filed with the Hearings Division, and designated as claimant's Request for Hearing and Demand for Production, sufficiently comply with the statutory and regulatory requirements for requesting Board review.

ORS 656.295(1) states: "The request for review by the board of an order of a referee need only state that the party requests a review of that order." The administrative rules regulating requests for Board review incorporate the statutory requirements with regard to the time and manner for requesting Board review. OAR 436-83-700(1). Claimant's attorney argues that the Request for Hearing and Demand for Production received on October 10, 1983 and originally processed as a request for hearing, substantially complies with the requirements for requesting Board review because: (a) It was filed within 30 days of the date of the Referee's order; (b) it correctly identifies the date of the document in issue, i.e. the Referee's order, although the document in issue is designated as a "denial of September 9, 1983," rather than a Referee's order; (c) no "magic words" such as "request for review" are required by the statute; and (d) claimant's "request for hearing" properly informed all parties of claimant's desire for Board review in this case.

The formal requirements for bringing a contested case before this agency are minimal. ORS 656.283(2) states:

> "A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, requesting the hearing, stating that

> a hearing is desired, and mailed to the Board."

Likewise, ORS 656.295 states that a party aggrieved by a Referee's order need only specify that the party "requests a review of the order." A minimum amount of information is necessary, however, in order to provide notice to all parties that Board review of the Referee's order is being requested.

A request for Board review satisfies the minimal requirements of ORS 656.289(3) and ORS 656.295 when the document gives timely notice to all other parties and this agency that it is the party's intent to request review of a Referee's order. Cf Argonaut Insurance v. King, 63 Or App 847 (1983). While it is certain that no "magic words" are required for compliance, it is equally certain that the statute contemplates a modicum of information sufficient to properly identify a document as a party's request for Board review of a Referee's order. The documents in question are prominently designated as a request for hearing and include the usual submissions that accompany such a request, including counsel's attorney retention agreement. See generally OAR 438-47-010(3). The document was processed as a new hearing request, and claimant's intent to request Board review was not clarified until after expiration of the statutory 30-day period.

We recently have been reminded in another context that: "It must be remembered that we are considering the actions of an administrative Board designed to be flexible in its search for accurate facts and just conclusions." Bailey v. SAIF, 296 Or 41, ___ (1983). Liberal interpretation and application of procedural requirements, particularly notice requirements, is not unlimited, however:

> "The whole idea is to get away from cumbersome procedures and technicalities of pleading, and to reach a right decision by the shortest and quickest possible route. On the other hand, as every lawyer knows, there is a point beyond which the sweeping-aside of 'technicalities' cannot go, since evidentiary and procedural rules usually have an irreducible hard core of necessary function that cannot be dispensed with in any orderly investigation of the merits of a case." 3 Larson, Workmen's Compensation Law, § 78.10 (1973); Nollen v. SAIF, 23 Or App 420, 423 (1975); Albiar v. Silvercrest Industries, 30 Or App 281, 284 (1977); Argonaut Insurance v. King, supra, 63 Or App at 850.

For the foregoing reasons, we hold that the document entitled "Request for Hearing and Demand for Production" does not constitute a request for review. Claimant has failed to timely request Board review of the Referee's September 9, 1983 order.

ORDER

This proceeding is dismissed, and the Referee's order dated September 9, 1983 is final by operation of law.

JOHN K. STORM, Claimant
Hansen, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-10264
December 22, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Fink's orders which set aside the August 25, 1982 Determination Order as premature. The insurer contends that the Referee erred in concluding that the Determination Order issued prematurely. The insurer also argues that the August 25, 1982 Determination Order improperly awarded claimant benefits for temporary disability for the period April 26 through July 15, 1982. Claimant asserts that the Referee correctly concluded that the Determination Order issued prematurely and, alternatively, that if there was no premature claim closure, he is entitled to an award of permanent partial disability. The insurer responds that if permanent partial disability is awarded, it is entitled to offset an overpayment of temporary total disability benefits in the amount of $2,376.90.

Claimant, who was 37 years of age at the time of the hearing, was employed as a machinist when he sustained a compensable left shoulder injury on or about March 1, 1982. Dr. Entena diagnosed a muscle strain of the left shoulder and referred claimant to a physical therapist for treatment.

On April 30, 1982 claimant was examined by Dr. Kaesche. Dr. Kaesche reported that claimant's physical findings were minimal and diagnosed left shoulder bursitis. Dr. Kaesche indicated that claimant could expect to experience some waxing and waning of his symptomatology.

On May 3, 1982 Dr. Entena reported that claimant was medically stationary on April 26, 1982 and released him to return to modified work with no heavy lifting and no hand-over-shoulder lifting or pushing. Dr. Entena indicated claimant's permanent impairment was "undetermined."

Dr. Entena reported on June 10, 1982 that claimant was still experiencing tenderness on his left shoulder in the area of the trapezius and latissimus dorsi muscle, and noted that claimant's employer did not have any modified work available when he was released in April 1982. Dr. Entena stated that claimant was basically unchanged since the time of his last examination, and that he was medically stationary and able to return to work. Dr. Entena expressed uncertainty with regard to claimant's permanent impairment.

Claimant was examined by Dr. Spady on July 15, 1982. Dr. Spady was of the opinion that claimant had some residual bursitis in his shoulder, but that it was only "very modestly symptomatic," and that he was capable of returning to moderately heavy work. Dr. Spady stated that a steroid injection of claimant's shoulder would probably have cured the problem, but that claimant refused such treatment. Dr. Spady concluded that claimant was medically stationary and that the claim should be closed with "an appropriate disability award commensurate with the existing impairment of function." Dr. Entena concurred.

A Determination Order issued on August 25, 1982 awarding claimant benefits for temporary total disability from March 1 through April 26, 1982, temporary partial disability from April 27 through April 29, 1982, and temporary total disability from April 30, 1982 through July 15, 1982 (the date of Dr. Spady's examination).

Claimant sought no further medical care or treatment for the next nine months.

At the suggestion of his attorney, claimant was examined by Dr. Bald on April 27, 1983. Dr. Bald reported that claimant exhibited a full range of motion in the left shoulder with no tenderness present. A sensory examination of the left shoulder was normal. Claimant's shoulder muscle reflexes were found to be normal and Dr. Bald stated that x-rays taken that day were entirely normal when compared to previous x-rays. Dr. Bald did find claimant to exhibit a significant strength impairment in the left shoulder. Dr. Bald concluded that claimant was suffering from mild residual rotator tendinitis and motor weakness of the left shoulder which should improve with a weight-lifting program.

Based on Dr. Bald's report the Referee initially concluded that claimant suffered a compensable aggravation, ordered the claim reopened effective April 27, 1983, authorized the insurer to offset excess time loss benefits paid claimant pending issuance of the August 1982 Determination Order and concluded that any issue with regard to extent of disability was premature. The insurer and claimant requested reconsideration of the Referee's order. On reconsideration, the Referee concluded that William Bunce, 33 Van Natta 546 (1981), was dispositive. The Referee set aside the Determination Order and ordered the insurer to pay claimant temporary total disability benefits from July 15, 1982 until closure pursuant to ORS 656.268. Since the Referee concluded the Determination Order issued prematurely, he found there to be no overpayment of temporary disability benefits. We disagree and reverse.

Claimant was found to be medically stationary by Dr. Entena, his treating physician, on April 26, 1982. Dr. Spady, who conducted an independent examination of claimant on July 15, 1982, also found claimant to be medically stationary. On August 5, 1982 Dr. Entena indicated that he concurred with Dr. Spady. In response to an inquiry from claimant's attorney on April 23, 1983, Dr. Entena reiterated his opinion that claimant was medically stationary as of April 26, 1982. Although claimant was examined by Dr. Bald on April 27, 1983, nowhere in his report does Dr. Bald indicate that claimant was not medically stationary at the time of the examination, and nowhere does he indicate any disagreement with Dr. Entena or Dr. Spady's conclusions with regard to claimant's medically stationary date. That is hardly surprising as Dr. Bald had never previously examined claimant.

The Referee's reliance on William Bunce was misplaced. The claimant in Bunce compensably injured his back in a motor vehicle accident. The claim was eventually closed after a course of conservative treatment. Claimant, however, was unable to return to work due to continued difficulties and he sought further medical care. Subsequently, a myelogram revealed that claimant was

suffering from a herniated disc, and had been suffering from a herniated disc ever since the motor vehicle accident. We concluded that the better approach in such situations was to treat the first Determination Order as premature.

Claimant argues that like Bunce, the current situation involves a case of misdiagnosis in that Drs. Entena and Spady diagnosed claimant as suffering from a pulled shoulder muscle and bursitis, whereas Dr. Bald "correctly" concluded that claimant had been suffering from rotator cuff strain and motor weakness in the shoulder ever since the original injury. This argument is not convincing. We are not certain whether Dr. Bald's diagnosis is correct, whether the diagnosis of Drs. Entena and Spady is correct, or whether all of the diagnoses are correct. Moreover, we do not understand there to be a significant difference between Dr. Entena's diagnosis of pulled shoulder muscle and Dr. Bald's diagnosis of a rotator cuff strain. "Misdiagnosis" is not a talismanic term that automatically results in a finding of premature closure. The facts of each case must speak for themselves. In this case claimant was found medically stationary with some minimal permanent disability by his treating physician and an independent examiner. Thereafter, claimant sought no further medical care for the next nine months until he was finally examined by Dr. Bald. However, Dr. Bald did not conclude that claimant was not medically stationary and recommended nothing other than conservative treatment in the form of muscle strengthening exercises. Thus, even if there was a misdiagnosis of claimant's condition, unlike Bunce, there is nothing in this case which would indicate that the previous conclusions that claimant was medically stationary and able to return to work with some minimal impairment were not correct. We, therefore, conclude that the August 25, 1982 Determination Order was not premature.

We next address the question of claimant's entitlement to temporary disability benefits from April 26, 1982, the date on which Dr. Entena indicated claimant was medically stationary, through July 15, 1982, the date claimant was examined by Dr. Spady. We conclude that the Determination Order's award of temporary disability benefits was incorrect. Dr. Entena indicated on April 26, 1982 that claimant was medically stationary and was released to return to modified work with no heavy lifting and no hand-over-shoulder lifting or pushing. On June 10, 1982 Dr. Entena stated that claimant's condition had not changed since his previous examination of April 26, 1982. In April 1983 Dr. Entena reiterated his opinion that claimant was medically stationary as of April 26, 1982 with the same work limitations previously noted. Dr. Spady did not voice any disagreement with Dr. Entena's medically stationary date, and basically agreed with Dr. Entena's conclusions regarding claimant's impairment. We conclude that the Determination Order's award of time loss benefits from April 26 through July 15, 1982 was incorrect. Time loss benefits should have terminated on April 26, 1982. The insurer is authorized to offset any time loss benefits paid between April 26 and July 15, 1982 from the award of permanent partial disability we make below.

With regard to the question concerning the extent of claimant's disability, we agree with claimant that the Determination Order should have included an award of permanent partial shoulder disability. Based on Drs. Entena and Spady's reports, we conclude that an award of 10% unscheduled permanent partial disability adequately compensates claimant for the loss of earning capacity he sustained as a result of his industrial injury.

With regard to the overpayment of time loss benefits in the amount of $2,376.90 paid claimant between July 16, 1982 and September 8, 1982, the insurer is authorized to offset this overpayment against the award of permanent partial disability made above. The insurer is not authorized to offset any additional time loss benefits paid as a result of the Referee's order. ORS 656.313. See also Sharon S. Webster, 35 Van Natta 1638 (1983).

ORDER

The Referee's orders dated May 31, 1983 and June 28, 1983 are reversed. The August 25, 1982 Determination Order is reinstated, but modified to delete the provision of time loss benefits from April 27, 1982 through July 15, 1982, and claimant is awarded 32° for 10% unscheduled permanent partial disability for injury to his left shoulder. The insurer is authorized to offset against claimant's award of permanent partial disability, all time loss benefits paid claimant between April 26, 1982 and July 15, 1982, and $2,376.90 in excess time loss benefits paid claimant between July 16, 1982 and September 8, 1982. Claimant's attorney is awarded an attorney's fee of 25% of the permanent partial disability made payable by this order, not to exceed $3,000.

ROY M. TREGASKIS, Claimant
Galton, et al., Claimant's Attorneys
Noreen K. Saltveit, Defense Attorney

WCB 82-05315
December 22, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Fink's order which affirmed the insurer's denial of claimant's heart attack claim. The sole issue is compensability.

The Board affirms the order of the Referee with these additional comments. Dr. Griswold opined that claimant's myocardial infarction was causally related to his heavy lifting employment activities on March 26, 1982 and during the entire week of March 22, 1982. Although the Referee considered Dr. Griswold's rationale more persuasive, the Referee found the reported histories so irreconcilable as to dictate affirmation of the denial.

We disagree with the Referee in that we find Dr. Rogers' rationale more persuasive. Dr. Rogers testified at the hearing that tests showed that claimant's myocardial infarction was preceded by ruptured plaque, which resulted in total occlusion of the artery by a blood clot. Dr. Rogers indicated that prevalent medical opinion does not relate plaque rupture to exertion. Had the myocardial infarction been preceded by narrowing arterial disease rather than by the ruptured plaque and blood clot occlusion, said Dr. Rogers, claimant's work activites would be a more probable cause of the infarct. Therefore, we affirm the denial on the basis of Dr. Rogers' opinion rather than on any finding of irreconcilable histories.

ORDER

The Referee's order dated March 15, 1983 is affirmed.

DONALD R. CLARK, Claimant
Welch, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 82-10257 & 82-11434
December 28, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

The insurer requests review of those portions of Referee Galton's order which: (1) Set aside the insurer's backup denial of claimant's back injury claim; (2) found that the denial was unreasonable and thus awarded an ORS 656.382(1) attorney fee of $300; and (3) awarded claimant 64° for 20% unscheduled disability, the October 8, 1982 Determination Order having awarded no permanent disability.

We do not reach the merits of the backup denial because we find it was not permissible for the insurer to deny this claim after having previously accepted it. Bauman v. SAIF, 295 Or 788 (1983). We affirm the Referee's permanent disability award.

And we reverse the Referee's award of an ORS 656.382(1) attorney fee. At the time the insurer issued its backup denial, such action was permitted by Frasure v. Agripac, 290 Or 99 (1980), which the Supreme Court subsequently overruled in Bauman. Moreover, the fact that the Referee chose to disbelieve the evidence that was the basis of the insurer's backup denial does not establish that the backup denial was unreasonable.

ORDER

The Referee's order dated January 12, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which awarded claimant's attorney an ORS 656.382(1) attorney fee of $300 is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a fee of $650 for services on Board review in connection with the issues of compensability and extent of disability, to be paid by the insurer.

TERRIE B. FRANSSEN, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01672
December 28, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Quillinan's order which affirmed the SAIF Corporation's February 16, 1983 partial denial of claimant's spondylolysis and spondylolisthesis conditions.

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

The issues to be decided in this case were set forth by the parties at the beginning of the hearing. The issues were stated as follows:

> "Mr. Strooband: The issue, of course, is the propriety of SAIF Corporation's denial of February 16, '83, which acknowledged that the claimant had sustained an injury to her back, but denied responsibility for

preexisting spondylolisthesis, and we contest that. * * *

"Referee: Okay. Mr. Nyberg?

"Mr. Nyberg: I think basically we agree about what we are disagreeing. I think the denial needs to be read carefully in that we have not denied treatment for the back, we denied the preexisting condition. * * *"

The issues having been so stated, the Referee concluded that the medical evidence failed to establish that claimant's November 3, 1982 compensable injury either caused or affected claimant's underlying conditions.

Claimant argues on review: "The main issue raised by SAIF's denial is whether there were consequences of claimant's accepted industrial injury which reached beyond the date of the denial." We perceive this to be a different issue than that which was submitted to the Referee for decision. The only issue set forth at the hearing was whether claimant established the compensability of her preexisting conditions in relation to her November 1982 injury. There being no evidence to that effect in the record, the Referee properly affirmed the denial. As noted by the court in Neely v. SAIF, 43 Or App 319 (1979), fundamental fairness dictates that the Board not decide a claim on the basis of evidence not contained in the record or on issues in regard to which no evidence has been presented.

Claimant additionally argues that the Referee erred in relying on Cochell v. SAIF, 59 Or App 391 (1982), which requires that a claimant establish that the underlying condition was actually worsened by the industrial injury. Although never explicitly stated recent court decisions do appear to cast substantial doubt on the continuing validity of Cochell. Jameson v. SAIF, 63 Or App 553 (1983), Harris v. Albertson's Inc., 65 Or App 254 (1983). Contra, Cooper v. SAIF, 54 Or App 659 (1981), Sheffield v. SAIF, 50 Or App 427 (1981), Weidman v. Union Carbide, 59 Or App 381 (1982). However, even under the standard set forth in Jameson and Harris, we find that the Referee reached the proper conclusion.

ORDER

The Referee's order dated June 29, 1983 is affirmed.

DARYL R. GABRIEL,II, Claimant
Willner, et al., Claimant's Attorneys
Moscato & Meyers, Defense Attorneys

WCB 82-00800
December 28, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee Pferdner's order which set aside its partial denial of claimant's occupational disease claim for pulmonary problems. The issue is compensability. We reverse.

Claimant is a 25-year-old man with a history of asthma dating

back to his youth. He started working for the employer as a painter in 1978. In May 1981 claimant experienced a severe asthma attack. His treating physician, Dr. Baker, an allergist, suspected sensitivity to the paints claimant encountered in his workplace. Testing found claimant to be sensitive to chemicals contained in the paints with which he worked. Claimant filed an occupational disease claim with the employer alleging that his respiratory problems were caused by paint exposure. At claimant's request, he was transferred out of his painting job into the employer's shipping department. Claimant was eventually laid off in a general layoff in October 1981.

Following his layoff, claimant returned to visit Dr. Baker in January 1982 complaining of nasal congestion, coughing, wheezing and shortness of breath which had lasted about two weeks. At that time, Dr. Baker performed lung function tests which indicated that claimant's condition was about the same as it had been when he was being exposed to paint fumes but was worse than it had been documented to be prior to claimant's occupational exposure. Based on these facts, Dr. Baker opined:

> "Basically, [claimant] had asthma prior to his exposure to the paint at the Hyster Company, however, the attack he had following paint exposure and with continuous paint exposure, I think, has definitely complicated his disease and made it worse. . . I do believe . . . his asthma has become worse as measured by his serial pulmonary functions. He is now showing persistent obstruction at roughly 2/3 of normal."

In May 1982 Dr. Baker again performed pulmonary function tests on claimant. Those tests revealed that his pulmonary functioning had returned to the level at which it existed prior to claimant's occupational exposure to paint. Dr. Baker voiced no further opinions concerning whether claimant's work exposure had worsened claimant's underlying asthma.

In June 1982 Dr. Lawyer, a pulmonary specialist, evaluated claimant at the employer's request. He too performed pulmonary function testing. His results were consistent with those obtained by Dr. Baker in May 1982. Claimant's lung functioning had returned to its pre-occupational exposure state. Based on this testing and his examination, Dr. Lawyer opined:

> "During the time that exposure was continuing, a prolonged exacerbation appears to be present. . . [W]hen his work exposures stopped . . . respiratory symptoms appeared to have resolved. Thus it would appear to me that a temporary exacerbation of symptoms had occurred without a material worsening or aggravation of the pre-existing asthma."

The self-insured employer's processing agent issued a "partial" denial:

> "It is our position the paint to which you

> were exposed on October 21, 1981 caused, at most, a temporary aggravation of your pre-existing, underlying, chronic, obstructive pulmonary disease. . . This is a partial denial, affecting only treatment of your condition after October 28, 1981. This partial denial does not affect the accepted portion of your claim . . . "

We think it is far from clear from this document alone exactly what was accepted and exactly what was denied. As this case has been tried and argued, however, it seems fairly clear that issue is joined on the question of whether claimant's industrial exposure caused any worsening of his pulmonary disease/asthma condition.

The Referee found that Dr. Baker's opinion, that the occupational exposure had worsened claimant's preexisting asthma, was more persuasive than Dr. Lawyer's opinion to the contrary. He discounted Dr. Lawyer's opinion based on alleged inconsistencies in the histories Dr. Lawyer recited compared with Dr. Baker's reports. The alleged inconsistency is that Dr. Lawyer stated in his report that claimant had not had respiratory problems since July 1981 when in fact he had asthma attacks in both September 1981 and January 1982. This alleged inconsistency is, of course, based on the history related to Dr. Lawyer by the claimant. Dr. Lawyer noted specifically in his report: "I should mention that he has difficulty being specific about dates and details on occasion." In addition, Dr. Lawyer was clearly aware of at least the January 1982 attack when he wrote his report because he explains that, according to Dr. Baker's chart notes, claimant had an upper respiratory infection which would explain the decreased lung functioning documented by Dr. Baker at that time.

Dr. Lawyer provides a cogent and consistent explanation for the diverse lung function testing documented in this record. He says that the reason claimant's lung functioning was reduced initially was exposure to paint. However, once claimant was no longer being exposed to paint, his condition returned to its pre-exposure state. He felt that the reason Dr. Baker thought there was a permanent worsening was that Dr. Baker performed lung function tests when claimant's lung functioning was temporarily impaired by upper respiratory infections, unrelated to his occupational exposure.

> "Well, he was relying on the pulmonary functions done when he was having the transient worsening. And I suspect that Doctor Baker, if he were to be responding to these same inquiries I am now, and knowing the history that [claimant] related to me in June of 1982; that he would agree that his serial pulmonary function test, at least of June '82, showed that he'd come back to normal . . . And he no longer would be persisting at two-thirds of normal."

We find Dr. Lawyer's opinion persuasive.

ORDER

The Referee's order dated September 15, 1982 is reversed. The partial denial dated February 4, 1982 is reinstated and affirmed.

BARBARA A. GILBERT, Claimant
Jolles, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-06508
December 28, 1983
Order on Review (Remanding)

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Galton's order which dismissed her request for hearing. We reverse.

Claimant compensably injured her right knee in February 1980. The self-insured employer initially accepted the claim as disabling. However, on April 28, 1982 the employer closed the claim as non-disabling. On July 28, 1982 claimant filed this request for hearing, raising the issue of extent of disability. At the hearing it was determined that there was no medical evidence to establish that claimant's knee injury had resulted in permanent impairment; claimant indicated that she intended to rely solely on her own testimony to establish permanent impairment. The employer then moved to dismiss, and the Referee granted that motion.

Even if medical evidence were essential to prove permanent impairment, it is far from clear why dismissal would be appropriate, as distinguished from a decision on the merits. See Patricia T. Bell, 11 Van Natta 50 (1973). However, since the Referee's decision, we have concluded that, although medical evidence is always preferred and sometimes required to prove physical impairment, it is not always essential. Juena K. McGuire, 35 Van Natta 1053 (1983). Based on McGuire, this case needs to be remanded for a decision on the merits.

Another issue has been raised by the employer for the first time on Board review -- that, to the extent that claimant may be protesting the employer's non-disabling classification of her claim, claimant has failed to exhaust her administrative remedies with the Workers' Compensation Department pursuant to ORS 656.268. See Anthony A. Bono, 35 Van Natta 1 (1983), reversed on other grounds 66 Or App 138 (1983). However, we find nothing in the record to indicate whether this administrative remedy has or has not been invoked. Since we are remanding this case anyway for other reasons, the parties are free to develop this additional issue before the Referee on remand.

ORDER

The Referee's order dated April 25, 1983 is reversed and this case is remanded to the Referee for further proceedings consistent with this order.

ROBERT J. HOPPES, Claimant
J. Gary McLain, Claimant's Attorney
Schwabe, et al., Defense Attorney

WCB 82-03954
December 28, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee Galton's order which set aside its denial of claimant's current chiropractic treatments. We agree with the Referee's findings and analysis.

We find the facts to be as follows:

Claimant was injured in a compensable motor vehicle accident in January 1974. The contemporary reports are not precise about the exact nature of those injuries, but we infer the most serious problem was soft tissue injury to the upper body/neck/shoulder area. After a period of recovery, claimant was able to return to work as a truck driver.

It was subsequently discovered that claimant has osteoarthritis and degenerative disc disease.

The current chiropractic treatment in issue is being provided by Dr. Pullella, who described the treatment as being for problems as diverse as pelvic-area spasm to inflammation of the elbow. Dr. Pallella stated, "The only reason that [claimant] would come in, 90 percent of the time, was because that elbow was swollen up so badly that he had a hard time climbing in that truck and just driving." It is far from obvious whether there is any connection between the body areas apparently injured in 1974 and the body areas currently being treated, but no issue is specifically raised along these lines. Rather, the employer argues that claimant's current treatment is necessitated solely by his osteoarthritis and degenerative disc disease, which were neither caused nor aggravated by the 1974 injury.

The Referee's order could be interpreted as concluding that claimant's osteoarthritis and degenerative disc disease were caused by the 1974 injury. Dr. Pullella's testimony could be interpreted as supporting this conclusion. However, we are not persuaded by Dr. Pullella's possible testimony and thus disagree with the Referee's possible conclusion. Dr. Pullella did not begin treating claimant until many years after both the 1974 injury and the diagnosis of claimant's spinal diseases. Dr. Pullella has not taken or examined x-rays that have been used by other doctors in diagnosing the spinal diseases. Most importantly, Dr. Pullella's reasoning does not withstand analysis: "degenerative disc disease and osteoarthritis can[not] occur without having some traumatic events occur causing it." If that is correct, then dozens of workers' compensation cases are incorrect in finding degenerative spinal conditions compensable as occupational diseases in the absence of identifiable trauma.

In summary, then, it appears to us that it is probable that Dr. Pullella is providing palliative treatment of both some residuals from claimant's 1974 injury which, of course, would be compensable, and also of spinal diseases, that we are not prepared to say on this record are compensable. Moreover, we do not see how the compensable and the noncompensable treatment can possibly be separated. Indeed, Dr. Pullella seems to take the same position in his December 29, 1979 report: "There is no valid way to discriminate between the effect of the industrial injury six years ago and the osteoarthritis and degenerative joint disease." In this kind of situation, the Board has concluded, and the Court of Appeals apparently agrees, that inseparable and incidental treatment of noncompensable conditions is compensable. Rebecca Hackett, 34 Van Natta 460, aff'd without opinion, 60 Or App 328 (1982). See also Aquillon v. CNA Insurance, 60 Or App 231 (1982). We thus agree with the Referee's conclusion in this case, but solely on the Hackett rationale.

ORDER

The Referee's orders dated November 17, 1982 and December 10, 1982 are affirmed. Claimant's attorney is awarded $450 for services rendered on Board review, to be paid by the self-insured employer.

CLINTON MADDOCK, Claimant
Lindsay, et al., Claimant's Attorneys
Donald D. Yokom, Attorney
Kottkamp & O'Rourke, Attorneys

WCB 81-07219
December 28, 1983
Order on Review (Remanding)

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Braverman's order which set aside its denial of claimant's injury claim. The broad issue is whether claimant was injured in the course and scope of his employment. Because we find one facet of that broad issue inadequately developed in the record, we remand.

Claimant sustained serious injuries in a motor vehicle accident on May 28, 1981 at about 4:20 p.m. Claimant was unable to testify due to his injuries, and thus the events leading up to that accident were pieced together from other sources.

On the day of the accident, claimant was employed as a "short haul" truck driver on a "will call" basis. Claimant's assignment that day was to drive a truck from the employer's place of business in Pendleton to a repair shop about 27 miles west of Pendleton and then to drive it back to the employer's place of business after repairs were completed. Claimant delivered the truck to the repair shop and spent most of the day, at least until the early afternoon, attending to a variety of personal matters. Claimant's sister-in-law testified that claimant telephoned her shortly before 4 p.m. that afternoon from a Pendleton restaurant and indicated the truck was ready and he was going to start out on the 27 mile trip to the west to pick it up and return it to Pendleton. Shortly thereafter, claimant was involved in a single-vehicle accident on the on-ramp to the eastbound lanes of Interstate 84. The insurer denied claimant's claim for his resulting injuries.

At the hearing, the principal focus was on the fact that claimant was headed east when the accident happened, whereas his only possible business destination (the truck repair shop) was to the west. Just as Christopher Columbus once sailed toward the west in an attempt to get to the east, the Referee found that there was a reasonable explanation for the route that claimant selected and that, under the circumstances, traveling east at the time of the accident was not inconsistent with claimant's destination being to the west. To the extent that the insurer may be renewing this compass-point argument on review, we agree with the Referee's analysis.

On review, the insurer's principal argument invokes the "coming and going rule," i.e., the doctrine that injuries sustained while traveling to and from work are not generally compensable. The insurer argues:

> "[Claimant's] work shift began when he picked up the truck in Pendleton. It ended

> when he left the truck at [the repair shop]. Claimant's work shift [would] not begin again until he arrived at [the repair shop] to retrieve the repaired truck. The break between claimant's two work shifts was free time for him."

Under this somewhat unusual, although theoretically possible, view of two work "shifts" on a single day, the insurer maintains that claimant was traveling back to work, i.e., to his second "shift," and that injuries sustained on this trip to work should no more be compensable than injuries sustained on any other trip to work.

There is a certain abstract appeal to the insurer's position, but we find the record inadequately developed to now reach this "coming and going" issue. When claimant's employer testified, the Referee asked about claimant's employment status during the interval between dropping the truck off for repairs and picking it up after repairs:

> "THE REFEREE: And was he being paid for the whole day?
>
> "THE WITNESS: No.
>
> "THE REFEREE: Just for the time he would drop it off and pick it up?
>
> THE WITNESS: Right."

Subsequently the employer described how truck drivers are paid: "Generally they are paid by the mile . . . unless its kind of an understanding if they don't make 200 miles in a day they are paid by the hour." Again the Referee asked for clarification about how this generalization applied to claimant:

> "THE REFEREE: How was the claimant being paid the day of the accident?
>
> "THE WITNESS: He was being paid by the hour.
>
> "THE REFEREE: And how would you determine his hours?
>
> "THE WITNESS: The time he turned in, the time he spent. They keep their own, what we call a pay sheet . . .
>
> "THE REFEREE: Was there a pay sheet that was recovered or came to your attention for the day that the claimant was injured?
>
> * * *
>
> "THE WITNESS: And I think I got it from his dad . . ."

Despite these efforts to develop the issue of claimant's employment status between the early morning and the late afternoon of May 28,

1981, neither the "pay sheet" nor any other documentary evidence on this subject was offered.

We deem it appropriate to remand for further development of this issue.

ORDER

The Referee's order dated September 28, 1982 is vacated and this case is remanded to the Referee for further proceedings consistent with this order.

MICHAEL A. McNAMER, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-02987
December 28, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests and the SAIF Corporation cross-requests review of Referee Brown's order which awarded claimant 7.5° of scheduled permanent partial disability for a 5% loss of the right leg on review of a Determination Order dated February 25, 1983, which awarded temporary total disability only. Claimant contends he is entitled to a greater award for permanent disability; SAIF contends that claimant is entitled to no award for permanent disability. Claimant raises an additional issue concerning that portion of the Referee's order which allows SAIF to recover overpaid temporary disability benefits. Our review of the record reflects that claimant was on notice of the amount of the overpayment claimed and did not contest the stated amount during the proceedings before the Referee. We, therefore, decline to consider this issue for the first time on Board review.

Claimant has moved to strike SAIF's brief on review, which is designated as SAIF's "cross-appellant brief." The basis for claimant's motion is the fact that SAIF failed to cross-request review within 10 days of the date of claimant's request for Board review.

The Referee's order was entered on June 2, 1983. Claimant timely requested Board review. Our records reflect that claimant's request was mailed on June 21, 1983. See OAR 436-83-700(2). The SAIF Corporation cross-requested review by mailing its cross-request on July 1, 1983, within 30 days of the date of the Referee's order. SAIF's cross-request for review was timely filed.

> "When one party requests a review by the board, the other party or parties shall have the remainder of the 30-day period, and in no case less than 10 days, in which to request board review in the same manner. The 10-day requirement may carry the period of time allowed for requests for board reviews [sic] beyond the 30th day." ORS 656.289(3). See Jimmie Parkerson, 35 Van Natta 1246 (1983).

Even if SAIF's cross-request for review had not been filed in a timely fashion, this would not provide the basis for striking SAIF's brief, as there is no requirement that a party cross-request

Board review in order to have particular issues considered on de novo review. Jimmie Parkerson, supra, 35 Van Natta at 1249. Accordingly, claimant's motion is denied.

On the merits of the extent of disability issue, we affirm the order of the Referee.

ORDER

The Referee's order dated June 2, 1983 is affirmed.

RODNEY A. VANDERLIN, Claimant
Robert Brasch, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-07869
December 28, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Brown's order which: (1) Determined claimant had not proven his condition had worsened after the May 14, 1982 Determination Order; (2) awarded claimant 16° for 5% unscheduled permanent disability, the Determination Order dated May 14, 1982 having awarded no permanent disability; and (3) awarded penalties and attorney fees for the employer's failure to pay interim compensation from September 3, 1982 through September 20, 1982. Claimant contends his aggravation claim is compensable, he is entitled to a greater award of permanent disability and he is entitled to interim compensation from July 28, 1982 through September 20, 1982, as well as additional penalties and attorney fees.

On the issues of the aggravation claim and the permanent disability award, we affirm the order of the Referee. On the issue of interim compensation, penalties and attorney fees, we modify the Referee's order.

The Referee found that interim compensation was due from September 3, 1982 through September 20, 1982, the date of the employer's denial of the aggravation claim. Claimant contends that the employer had notice of his medically verified inability to work on July 28, 1982. Claimant testified that he left work on that date during his shift and went to see Dr. Bert because of increased back pain. Claimant further testified that he took a work release from Dr. Bert back to his employer, specifically to the foreman and to the main office, that same day. When he did not receive a time loss check a couple of weeks later, claimant testified that he called the employer and inquired about his claim. The employer indicated they needed more information but also indicated they were going to deny the claim. Claimant stated

that he made attempts to obtain further information from the doctor and that his employer again verbally indicated it was denying the claim anyway. The record does not contain a copy of the work release slip that claimant said he took to his employer on July 28, 1982, but the Referee specifically found claimant's testimony to be credible. No evidence was offered to contradict claimant's testimony regarding the employer's notice of his medically verified inability to work on July 28, 1982.

The record contains chart notes of Dr. Bert (Exhibit 12), one

of which appears to show the date of July 28, 1982, rather than July 23, 1982 as stated in the Referee's order. That July 28, 1982 chart note indicates that claimant had had a recurrence of thoracic and cervical pain and that Dr. Bert would "hold him off work as of today because [the claimant] does not feel he can continue in his job."

Considering the Referee's finding that claimant was credible, the fact that no evidence was offered to refute claimant's testimony, and Dr. Bert's July 28, 1982 chart note which bolsters claimant's account of the events, we find that the employer had notice of the doctor's verification of claimant's inability to work on July 28, 1982. Therefore, the employer should have paid interim compensation from July 28, 1982 to September 20, 1982. The employer's failure to do so was unreasonable, therefore, penalties and attorney fees are appropriate.

ORDER

The Referee's orders dated December 10, 1982 and December 17, 1982 are affirmed in part and modified in part. Those portions of the Referee's order affirming the denial of the aggravation claim and awarding 16° for 5% unscheduled permanent disability are affirmed. That portion ordering the employer to pay claimant a penalty and associated attorney's fee is modified as follows. The employer shall pay claimant interim compensation from July 28, 1982 to September 20, 1982, a penalty equivalent to 25% of the compensation due for that period and an attorney fee of $250. This award of interim compensation, the penalty and ORS 656.382(1) attorney fee is in lieu of, not in addition to, that ordered by the Referee.

LILLIAN ABEL, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-05780
December 29, 1983
Order on Review (Remanding)

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Danner's order and Order on Reconsideration which affirmed the SAIF Corporation's June 6, 1980 denial, and dismissed claimant's request for hearing on the grounds that claimant's occupational disease claim was barred by a disputed claim settlement executed on March 6, 1980.

Claimant contends that the Referee erred in concluding that the March 6, 1980 disputed claim settlement barred the occupational disease claim for certain physical and/or psychological conditions filed by claimant on March 22, 1980, and requests the matter be remanded to the Referee for a ruling on the merits of her claim.

Briefly, the facts are as follows.

Claimant, who was employed as a nurse at Fairview Hospital, filed an occupational disease claim on January 22, 1979. Claimant alleged that she developed a severe sensitivity, allergy and toxicity as a result of fumes from various substances to which she was exposed during a remodeling project in the hospital. Claimant was treated for various symptoms which she alleged were a result of her exposure. On February 28, 1979, SAIF denied the claim, stating:

> "On January 22, 1979, you filed a claim for an injury to your whole body. Based on our thorough examination of all available information, we are unable to accept responsibility for your whole body, diagnosed as chronic anxiety--tension state, most likely from formaldehyde sensitivity, may be a possibility. * * *"

On March 6, 1980 claimant and SAIF executed a disputed claim settlement. The settlement provided:

> ". . . the claimant filed a claim alleging that on or about August 28, 1978, she suffered a condition of toxicity/poisoning to her whole body causing anorexia, nausea, headaches, vertigo, light headedness, palpitations, asthma, persistent taste of salt in her mouth, and other symptoms which she related to fumes present in her work environment." (Emphasis added.)

The settlement further provided that claimant was to receive $8,000, in exchange for which the claim remained denied and claimant's request for hearing was dismissed with prejudice.

On March 22, 1980, claimant filed a second occupational disease claim. Claimant alleged that she suffered from:

> "Refractory tension state with serious physical and emotional manifestations secondary to detrimental job transfer and repeated harassment with retaliation by Fairview Training Center management."

Specifically, claimant was alleging that her work exposure at Fairview (specifically, stress) caused certain conditions diagnosed as polymyalgia rheumatica, Collagen's disease, angioedema, labyrinthitis, Raynaud's phenomenon, certain emotional and/or psychological problems and a low back injury. This claim was also denied by SAIF.

The Referee concluded that the disputed claim settlement of March 1980 barred claimant from asserting the current claim. The Referee based his decision partially on the fact that the disputed claim settlement included the catch-all phrase, "other symptoms," and the fact that claimant's treating psychiatrist, Dr. Kimball, testified that claimant's current complaints, both physical and psychological, were all essentially psychological in nature, and were the same complaints in one form or another that claimant presented herself with prior to the time the disputed claim settlement was executed. Since claimant's current complaints existed prior to the date of the disputed claim settlement (albeit in different forms), and, since the disputed claim settlement included the phrase "other symptoms," the Referee concluded the disputed claim settlement barred the current claim.

Claimant argues that the disputed claim settlement could not have the effect of barring the current claim as her current conditions were neither known to her nor specifically diagnosed prior to the date of the disputed claim settlement, and that these condi-

tions were from a cause totally unrelated to the prior claim. Claimant contends that she is entitled to a ruling on the merits of her claim. We agree.

In Townsend v. Argonaut Ins. Co., 60 Or App 32 (1982), the claimant sustained a compensable low back injury in 1972. When the claim was reopened in 1977, a diagnosis of ankylosing spondylitis was made. The insurer then purported to deny the entire claim. The matter proceeded to hearing where the issue of the relationship between the injury and the ankylosing spondylitis was held open. A stipulation was entered between the parties which provided for reopening of the claim. A second stipulation was entered which provided that the insurer would comply with the previous stipulation. The insurer thereafter issued a partial denial with respect to benefits for disability resulting from claimant's ankylosing spondylitis. Citing Clinkenbeard v. SAIF, 44 Or App 583 (1980), claimant contended that the stipulations barred the insurer from denying the spondylitis since that condition was diagnosed prior to the dates of the stipulations. The court stated:

> ". . . unlike the stipulations in this case, the stipulation at issue in Clinkenbeard explicitly mentioned compensation for specific subsequently diagnosed diseases. Neither of the stipulations here specifically refers to the condition of ankylosing spondylitis, but each refers only to payment of all compensation due until closure is authorized. We will not interpret the stipulations as admitting what they do not clearly state." 60 Or App at 37.

The court concluded that the stipulation did not preclude the insurer from denying the compensability of claimant's ankylosing spondylitis.

We find Townsend dispositive of the current case. The disputed claim settlement in the current case specifically delineated exactly what conditions were being disposed of by the settlement; those conditions or alleged conditions being, anorexia, nausea, headaches, vertigo, light-headedness, palpitations, asthma, and persistent taste of salt in the mouth. Claimant is clearly barred by the settlement from attempting to assert a new claim in relation to those conditions, even if she asserts a new theory of causation. Cf Million v. SAIF, 45 Or App 197 (1980). However, under Townsend, claimant is not precluded from asserting a claim for conditions which the disputed claim settlement did not specifically dispose of, whether diagnosed pre-settlement or post-settlement (although the fact that the conditions may not have been diagnosed until after the stipulation was executed is obviously convincing evidence with regard to determining whether the stipulation was intended to dispose of those conditions).

Were the evidence to establish that claimant's current conditions are, in actuality, the same conditions which were disposed of by the disputed claim settlement, we would agree with the Referee that the settlement bars claimant from asserting a new claim in relation to those conditions. However, we are not convinced that the evidence does so establish in this case. The evidence only

establishes that many of claimant's current complaints and/or conditions are the same or similar to many complaints she voiced prior to the execution of the stipulation. Although there is a strong possibility that all of claimant's current complaints may be psychological in origin (as noted by Dr. Kimball), that is a finding which goes to the issue of compensability. However, it does not preclude claimant from asserting a claim in relation to those conditions where they were not previously disposed of. Townsend, supra.

Another question that must be addressed concerns the use of the phrase "other symptoms" in the disputed claim settlement. It is significant that the remainder of that sentence reads, "which she related to fumes present in her work environment." Claimant contends that she could not have related her current conditions to exposure to fumes at work as those conditions were not even known to her at the time. Even if the current conditions had been diagnosed, claimant argues that the settlement could not preclude the current claim unless she related her current conditions to her fume exposure, which she states, she did not.

A determination of what symptoms claimant was relating to exposure to fumes at work requires a close examination of the medical evidence. However, this is no easy matter as claimant's symptoms have been legion. With regard to the currently claimed conditions, it would appear that there is only one which was probably disposed of by the disputed claim settlement, that being labyrinthitis. It appears that claimant was suffering symptoms of labyrinthitis at or about the time she filed her first claim, and it does appear that she was relating those symptoms to her fume exposure. Although angioedema had been diagnosed prior to the time the disputed claim settlement was executed, it does not appear that claimant was contending this condition was related to her exposure to fumes. Thus, it appears that the only current condition precluded by the disputed claim settlement is labyrinthitis. As previously noted, the possibility that all of claimant's current conditions may in actuality be psychological in origin, is a compensability question which must be addressed by the Referee on remand.

We conclude that claimant is entitled to a ruling on the merits of her claim with regard to the issue of compensability of those conditions which have been variously diagnosed as angioedema, Raynaud's phenomenon, Collagen's disease, polymyalgia rheumatica, low back pain, and/or psychological difficulties.

ORDER

The Referee's order dated February 2, 1983 and Order on Reconsideration dated February 16, 1983 are reversed. This matter is remanded to the Referee for further proceedings consistent with this order.

ROBERT E. ALVAREZ, Claimant
Robert L. Chapman, Claimant's Attorney
Cowling, et al., Defense Attorneys

WCB 82-09965
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Brown's order which found that claimant's knee claim was prematurely closed and which assessed a penalty and attorney's fee for failure to respond to an aggravation claim.

Claimant compensably injured his right knee on July 22, 1980. He subsequently underwent two arthrotomies and a medial meniscectomy. Following claimant's second arthrotomy, Dr. Gilsdorf opined:

> "[H]is current condition has plateaued and will not materially improve with further time and treatment--may require further corrective surgery at a later date for continuing instability related to the articular changes in his right knee.

On September 14, 1982 Southern Oregon Medical Consultants performed a closing examination and opined:

> "The condition is considered stationary and claim closure at this time is recommended."

On October 1, 1982 Dr. Gilsdorf indicated that he agreed with the Consultants' findings.

On October 27, 1982 a Determination Order issued, finding claimant medically stationary on September 14, 1982, the date of the Consultants' examination.

On December 13, 1982 Dr. Gilsdorf indicated that, because claimant's symptoms had become more severe, he was contemplating doing a joint replacement on claimant's knee. He indicated that claimant was considering the possibility and wished to discuss it with his attorney before he decided whether to undergo the surgery.

On January 24, 1983 Dr. Gilsdorf wrote:

> "It has been my recommendation that Mr. Alvarez undergo knee replacement surgery. He has now informed me, through his attorney, that he wishes to proceed with the definitive knee surgery, that is knee replacement surgery...
>
> "In view of this man's symptomatic state, his condition cannot be and should not be considered stationary. Time loss should be reinstated and authorization to proceed, with this...knee replacement surgery, is requested."

The insurer authorized the surgery, but apparently time loss was never paid. Surgery was scheduled for March 6, 1983 but was never performed because of elevated blood sugar.

The Referee said that the opinions of Southern Oregon Medical Consultants and Dr. Gilsdorf that claimant was stationary in September 1982 were "tentative or precatory." The Referee concluded that in "20-20 hindsight" claimant was not medically stationary. We disagree. It is apparent that in September 1982 the unanimous medical opinion was that claimant's condition could not be expected to improve through treatment or the passage of time. It was only later when claimant's symptoms increased that his treating physician felt it advisable for the claimant to undergo the rather drastic measure of having the entire knee joint replaced. Consequently, we find that the claim was not prematurely closed because claimant was medically stationary in September 1982.

We agree with the Referee, however, that Dr. Gilsdorf's January 24, 1983 letter constitutes a valid aggravation claim. Accordingly, the insurer was under an obligation to respond to the request for time loss by either accepting or denying the aggravation claim. Because it did neither, the Referee was correct in assessing a penalty. However, under the circumstances, we feel a 15% penalty is more appropriate than the 25% imposed by the Referee. We also agree with the Referee that the issue of whether claimant is entitled to temporary total disability benefits after he was discharged from the hospital is not ripe for determination.

ORDER

The Referee's order dated May 4, 1983 is affirmed in part and reversed in part. That portion of the Referee's order setting aside the Determination Order of October 27, 1982 is reversed. That portion of the Referee's order concerning a penalty and attorney's fee is modified. The insurer is ordered to pay temporary total disability benefits from January 24, 1983 through at least March 6, 1983. The insurer is ordered to pay a penalty of 15% of the temporary total disability benefits ordered herein. The remainder of the Referee's order is affirmed.

MARIA G. ANGUIANO, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-03759
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Daron's order which awarded claimant 30° for 20% scheduled permanent partial disability for her left forearm condition and awarded her 15° for 10% scheduled permanent partial disability for her right forearm condition. The June 2, 1981 Determination Order awarded no permanent partial disability. On review the issues are extent of disability for the two forearm conditions.

The Referee found that despite the lack of medical evidence, claimant's uncontradicted testimony established a permanent limitation of functional use for both her forearms. We disagree; therefore, we modify and reverse.

This Board has recently held that, although it is theoretically possible that lay testimony can be found to be persuasive in the absence of supporting medical documentation,

permanent physical impairment must usually be supported by medical documentation. Juena K. McGuire, 35 Van Natta 1053, 1056 (1983). Further, when the medical evidence and the lay testimony are squarely inconsistent on issues of the permanency or extent of disability, we generally rely on the medical evidence. James G. Thomas, 35 Van Natta 714 (1983).

Claimant has undergone bilateral carpal tunnel release surgery. Her surgeon and treating physician, Dr. Fax, rated the permanent impairment to her left hand to be minimal. Dr. Fax concluded that claimant suffered no permanent impairment to her right hand. The doctor felt claimant could probably perform the type of work she had previously performed.

We have considered claimant's testimony about her physical limitations and loss of use to both her extremities. We are not persuaded to a point that would cause us to forsake the medical evidence and opinion of Dr. Fax.

We find claimant has suffered permanent partial disability to her left forearm in the amount of 15° for 10% and no permanent disability to her right forearm.

ORDER

The Referee's order dated June 22, 1983 is reversed in part and modified in part. That portion of the order which awarded claimant 15° for 10% scheduled permanent partial disability for her right forearm is reversed. Claimant shall receive no permanent partial disability for her right forearm condition. That portion of the order which awarded claimant 30° for 20% scheduled permanent partial disability for her left forearm is modified. Claimant is awarded 15° for 10% scheduled permanent partial disability for her left forearm condition. Claimant's attorney's fee should be adjusted accordingly.

SANDRA L. BEAR, Claimant
Peter Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-10655
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Pferdner's order which affirmed the SAIF Corporation's November 12, 1982 denial and refused to award penalties and attorney fees for SAIF's alleged failure to pay claimant benefits for interim compensation pending its denial of the claim. The issues for review are compensability, and claimant's entitlement to interim compensation benefits, penalties and attorney fees.

We adopt the Referee's findings of fact as our own, and we affirm and adopt those portions of the Referee's order relative to the issue of compensability.

With regard to the issues concerning interim compensation, penalties and attorney fees, we reverse. Claimant ceased working on December 4, 1981 as a result of her medical condition. On August 18, 1982 claimant filed a Form 801 alleging she had sustained an occupational disease or injury as a result of her work activities. The claim was denied by SAIF on November 12, 1982, 86

days after it was filed and 26 days late. ORS 656.262(4). Exhibit 23c establishes that SAIF paid claimant no interim compensation benefits pending denial of the claim. SAIF offered no excuse for its failure to pay such benefits. It follows that SAIF is responsible for payment of interim compensation benefits to claimant from August 18, 1982 through November 12, 1982, a 25% penalty on that compensation and an associated attorney's fee. Zelda M. Bahler, 33 Van Natta 478 (1981), reversed on other grounds 60 Or App 90 (1982).

ORDER

The Referee's order dated May 20, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which refused to award claimant interim compensation benefits, penalties and attorney fees are reversed. SAIF is ordered to pay claimant benefits for interim compensation from August 18, 1982 through November 12, 1982, a 25% penalty on such compensation and a $400 attorney's fee. The remainder of the Referee's order is affirmed.

ROY L. BIER, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-03293 & 81-01655
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Johnson's order sustaining the SAIF Corporation's denials of his claims for an industrial injury and an occupational disease, both of which allegedly caused his low back problems.

Claimant is a 65-year-old former working foreman for the Benton County Public Works Department. He has a long history of minor back injuries and complaints. The evidence shows no radiating pain into his left leg prior to July 2, 1980. On that day he injured his low back in a twisting incident while he was clearing brush. He then began experiencing low back pain and pain radiating down his left leg. A chiropractor diagnosed him as having a sacroiliac strain and degenerative disc disease aggravated by the twisting injury. Claimant then saw Dr. Armbrust who diagnosed him as having left sciatica, probably secondary to stenosis or foraminal narrowing.

In January 1981 SAIF denied claimant's injury claim on the basis that stenosis is a degenerative disease and, therefore, was not caused by the twisting incident in July 1980. Claimant then filed a second claim alleging that his low back problems were an occupational disease. SAIF likewise denied the occupational disease claim on March 6, 1981. Claimant left his job in April 1981 because of his chronic back and left leg problems.

On March 31, 1981 Dr. Degge examined the claimant at SAIF's request. He said:

> "I believe that his industrial injury of July 2, 1980, resulted in transient symptoms and sciatica on the left, which has responded to conservative treatment and appears to have run its course. His back

is, of course, susceptible to bending and twisting and he is prone to have recurrent attacks of low back symptoms when he exceeds his structural limitations. I believe his condition is long since stationary from the industrial accident of July 2, 1980, that his functional impairment could be considered minimal. Claim closure is recommended."

On October 30, 1981 Dr. Armbrust wrote claimant's attorney:

"In summary, I think that this patient's left sciatica is clearly related on the basis of his history to an on-the-job injury in July 1980. Although patient has had some degree of fluctuation of symptoms I do not consider him medically stationary and would consider him moderately disabled as a result of this pain. It is my current impression that this patient's history and radiographic findings suggest that the cause of his symptoms relates to an on-the-job aggravation of a pre-existing degenerative spondylitic change in the lumbar spine."

In April 1982, apparently in response to a report authored by Dr. Norton of SAIF which is not in the record, Dr. Armbrust reiterated his opinion.

"After review of Dr. Norton's textbook-like discussion of degenerative disc disease, I would certainly attempt to argue that this patient's degenerative disc disease is related to his occupation. My contention would be, however, that his radicular symptoms (i.e., pain) were precipitated by an on-the-job injury which aggravated a pre-existing condition. I think the important point with regard to Dr. Norton's discussion is that he is arguing that the natural history of disc and spondylitic disease is not modified by occupational or other activities. He, however, does not address the relevant point of precipitation of neurologic symptoms as a result of an acute injury occurring in the presence of a chronic and previously asymptomatic spondylitic state."

At the hearing Dr. Norton testified that in his opinion the on-the-job injury would not have caused any worsening of the underlying degenerative disease. However, he conceded that it could have caused the appearance of symptoms. He testified that the continued presence of the radicular left leg pain was caused not by the on-the-job injury but by the underlying disease or claimant's current activities.

The Referee upheld SAIF's denials on the basis of his finding

that claimant had failed to prove any worsening of the underlying degenerative condition. We agree with him on the occupational disease claim. Under Weller v. Union Carbide, 288 Or 27 (1979), a claimant must prove a worsening of an underlying disease for an occupational disease claim to be compensable. We agree that claimant has failed to prove a worsening of his degenerative disease.

However, although the signals from the Court of Appeals are not entirely clear to us, it appears that Weller does not apply to injury claims. Boise Cascade v. Wattenbarger, 63 Or App 447 (1983), and Jameson v. SAIF, 63 Or App 553 (1983). Even Dr. Norton and Dr. Degge agree that the twisting incident of July 2, 1980 caused an increase in claimant's symptoms. Accordingly, SAIF's denial of the industrial injury claim must be set aside.

We wish to make it clear, however, that we are not saying that SAIF is responsible for claimant's degenerative back condition. Because there is insufficient evidence to prove that the industrial injury worsened the degenerative condition, SAIF is not responsible for it. SAIF is only responsible for symptoms caused by the industrial injury. Although the evidence is contradictory, we find that there is sufficient evidence to prove that claimant's continuing left radicular pain is related to the compensable injury. Dr. Armbrust unequivocally relates the continuing pain to the compensable injury. We accept his opinion over those of Dr. Norton and Dr. Degge because claimant never had left radicular pain prior to the compensable injury and has had it continuously since that time.

There is insufficient evidence on this record to determine whether claimant has become medically stationary. Both Dr. Degge and Dr. Norton believe he is medically stationary, but they base that opinion on their belief that continuing left radicular pain is not related to the compensable injury. Dr. Armbrust, whose opinion we accept on the issue of whether the left leg pain is related to the compensable injury, has not stated that claimant is medically stationary. The claim is remanded to SAIF for processing.

ORDER

The Referee's order dated January 14, 1983 is affirmed in part and reversed in part. SAIF's denial of January 13, 1981 is reversed. SAIF's denial of March 6, 1981 is affirmed. Claimant's attorney is awarded $1,500, payable by SAIF for services at hearing and before the Board.

MICHAEL D. COOK, Claimant
David Force, Claimant's Attorney
Coons & McKeown, Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01819
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Quillinan's order which affirmed the SAIF Corporation's denial of treatment of claimant's back symptoms. Claimant contends that his coccyx pain is a continuing consequence of his August 1979 compensable injury and, therefore, he is entitled to medical care under ORS 656.245. We agree with claimant and reverse SAIF's denial to the extent it purports to deny treatment for claimant's coccyx injury. SAIF

contends that the Referee erred in admitting Dr. Givot's June 29, 1983 report, submitted within ten days of the hearing. We find that the Referee did not abuse her discretion in admitting the doctor's report in that the report's delay was due to the doctor's delay in preparing the report and not to the fault of either party.

Claimant compensably injured his coccyx in August 1978 when he fell on a log, which eventually resulted in the surgical removal of part of claimant's coccyx. In May 1981 claimant filed an aggravation claim on the 1978 coccyx injury, which SAIF denied. Then claimant filed a new injury claim against the employer employing him in May 1981, who was insured by SAIF, and SAIF denied the new injury claim. At the time of making these claims, claimant was complaining of low back pain as well as coccyx pain.

In June 1982 claimant and SAIF entered into a Disputed Claim Settlement, which referred to the aggravation claim filed by claimant but did not refer to the new injury claim. Thereafter, claimant sought medical treatment for his low back and coccyx pain. On June 1, 1983 SAIF issued its denial of further medical treatment, which is the subject of this case.

The Referee found that the pain for which claimant is presently receiving treatment is the low back pain which arose after May 1981 and which is different than the earlier back pain. Although claimant does have low back symptoms, the most recent medical reports clearly indicate that claimant is complaining of and being treated for coccyx pain also. The medical reports further indicate that the coccyx pain is related to the August 1978 injury and no medical report suggests otherwise. Therefore, we disagree with the Referee's conclusion that none of claimant's on-going complaints and treatment are related to his August 1978 compensable injury.

In addition, the Referee found that the Disputed Claim Settlement barred claimant from receiving further medical treatment at SAIF's expense. We disagree with this conclusion also inasmuch as entering into a disputed settlement regarding an aggravation claim does not bar further medical benefits when compensability of the original claim has already been established. Alex Watson, 32 Van Natta's 198 (1981). Therefore, we modify the Referee's order to reflect that SAIF's denial is affirmed only to the extent it purports to deny treatment for claimant's low back pain. Claimant continues to be entitled to medical treatment for conditions related to his compensable coccyx injury.

ORDER

The Referee's order dated July 21, 1983 is modified as discussed herein. Claimant's attorney is awarded $450 for his services on Board review and $500 for his services before the Referee, to be paid by the SAIF Corporation.

JAMES DODD, Claimant
Robert L. Chapman, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 82-11691
December 29, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

The employer requests review of those portions of Referee Brown's order which set aside its partial denial of claimant's right knee condition, found claimant entitled to 15% unscheduled permanent partial low back disability, that being an increase of 10% over and above the December 14, 1982 Determination Order, ordered the employer to pay claimant's prescription billings for the drug Persantine and refused the employer's motion to keep the hearing record open for admission of further evidence regarding claimant's "wage earning activities" prior to claim closure.

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

We agree with the employer's contention that the Referee erred in setting aside its denial of claimant's right knee condition. Claimant was injured on June 6, 1975 when the vehicle he was driving struck a ditch and power pole. Claimant reported that he bumped his head and left knee. There is no indication in any of the initial medical reports that claimant's right knee was injured in the accident, and there are no reported complaints of right knee difficulties until September 1976. Even then claimant informed Dr. Weinman that he did not recall striking his right knee in the June 1975 accident. By late 1977 claimant had changed his story and was reporting that he struck both knees in the accident. An examination of the record gives rise to serious credibility questions in relation to claimant's right knee claim.

Even if the credibility problem were ignored, the right knee claim would fail. Claimant's right knee condition has been diagnosed as chondromalacia secondary to a patellofemoral incongruity. Not only is this diagnosis inconsistent with a traumatic injury, but the Orthopaedic Consultants reported on November 2, 1982 that claimant's right knee condition was unrelated to his 1976 injury. There are no other medical reports in the record which address the issue of causation of the right knee condition.

With regard to the issue raised by the employer concerning the Referee's denial of the employer's motion to keep the record open for submission of additional evidence concerning claimant's "wage earning activities" prior to claim closure, and the issue concerning payment of claimant's prescription expenses for the drug Persantine, we agree with the Referee and affirm and adopt those portions of his order relevant to these issues. Although we share the employer's concern in relation to claimant's continued use of Persantine, it would have been (and still would be) a simple matter for the employer to send Dr. Stringer copies of Dr. Porter's reports and request Dr. Stringer's opinion as to the claimant's continued use of that drug. While we do not agree with all of his analysis, we also affirm the Referee's conclusion on the extent of disability issue.

ORDER

The Referee's order dated March 17, 1983 is affirmed in part

and reversed in part. Those portions of the Referee's order which set aside the employer's February 15, 1983 denial of claimant's right knee condition and awarded claimant's attorney a fee of $200 for overcoming that denial are reversed. The employer's denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

JOHN R. DOWELL, Claimant
Roll, et al., Claimant's Attorneys
Wolf, Griffith et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-10263
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Neal's order which upheld EBI Companies' denials issued in connection with claimant's July 16, 1979 industrial injury claim. Two of the three denials deny that claimant's condition has worsened. A third denial states that claimant's 1979 injury, "is no longer playing a material contributing role regarding [claimant's] current condition," and denies "all further medical treatments and benefits."

The Board referred a request for own motion relief relative to a May 31, 1974 industrial injury for which the SAIF Corporation is responsible, to the Referee for consolidation with claimant's pending hearing request contesting EBI's denials. The Referee issued a recommendation in that case, and we have this day issued a separate own motion order addressing the issues arising under ORS 656.278.

We adopt as our own the Referee's findings of fact. We agree with her determination that claimant's condition has not worsened and that EBI's two aggravation denials, therefore, should be upheld. We do not believe, however, that EBI's third denial denying all future workers compensation benefits was proper under the facts and circumstances of this case; and we, therefore, reverse that portion of the Referee's order upholding EBI's third denial.

The Referee concluded that claimant's 1979 injury represented nothing more than a temporary exacerbation of symptoms of a preexisting nonindustrial condition, although claimant had received an award for permanent disability as a result of this injury. There is evidence to support this conclusion; however, the third denial issued by EBI purports to terminate its responsibility for all future benefits, including medical services, as opposed to denying a specific claim for medical services. We generally have expressed dissatisfaction with denials of "hypothetical claims" for medical services and have stated that a denial of a claim for medical services generally will be interpreted as a denial of then-current treatment. Patricia M. Dees, 35 Van Natta 120 (1983); Anita Gilliam, 35 Van Natta 377 (1983); Gary E. Freshner, 35 Van Natta 528 (1983). See also Hettie M. Eagle, 33 Van Natta 671 (1981), wherein we held that an issue concerning entitlement to specific benefits does not arise and, therefore, cannot be litigated unless and until a claim for such benefits has been denied prior to a hearing. A claim for medical benefits generally takes the form of either a bill for medical services that have been

rendered or a request for authorization for future treatment. Billy J. Eubanks, 35 Van Natta 131 (1983). EBI's third denial does not appear to deny any such specific claim for medical services; rather it denies future responsibility for workers' compensation benefits, including medical services, which allegedly may be related to claimant's 1979 industrial injury. We find this denial a nullity and of no legal effect; therefore, it must be set aside. For reasons similar to those stated in Anita Gilliam, supra, 35 Van Natta at 379, we find it appropriate to award claimant's attorney a modest fee. ORS 656.386(1).

ORDER

The Referee's order dated January 12, 1983 is vacated in part. That portion of the order which upheld EBI Companies' November 8, 1982 denial is vacated, and that denial is declared to be a nullity and of no effect. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee for services rendered before the Referee and the Board in connection with EBI's November 8, 1982 denial.

CAROL A. DUREN, Claimant
Michael B. Dye, Claimant's Attorney
Keith Skelton, Defense Attorney

WCB 82-06304
December 29, 1983
Order on Review

Reviewed by the Board en banc.

The insurer requests review of Referee Nichols' order which set aside its denial of claimant's present complaints of left arm/shoulder/neck pain and headaches. The insurer contends that: (1) Claimant's compensable condition has not worsened; (2) claimant's headaches are not related to her compensable injury; and (3) the Referee erred in refusing to admit medical evidence which would have clarified some issues. We agree with the insurer that claimant has not proven a worsening of her compensable condition or that her headaches are related to her compensable condition. Because of our disposition of these issues, we do not reach the question of the admissibility of medical evidence not admitted into the record.

Claimant is a 47 year old fish processing worker who compensably injured her left arm, left shoulder and trapezius muscle when she fell in January 1980. Claimant received treatment from Dr. Cox, was off work for two weeks, then returned to work. No further work was missed and no further treatment was sought until November 1981. Claimant then first sought treatment from Dr. Cox who referred her to Dr. Freudenberg, who referred her to Dr. Bernstein.

Apparently, between the time claimant saw Dr. Freudenberg and saw Dr. Bernstein, she twice went to the Bay Area Hospital emergency room. Although the dates are somewhat obscure on the documents, it appears that claimant went to the emergency room complaining of headaches on April 16, 1982 and to the emergency room complaining of left shoulder and arm pain in early April 1982. The emergency room report regarding the left shoulder and arm referred to the January 1980 industrial injury and the emergency room doctor authorized time loss through April 11. The April 16 emergency room report regarding the headaches, however, made no mention of the industrial injury, and Blue Cross was named as the responsible insurer.

Thereafter, Dr. Bernstein reported that claimant was complaining of severe headaches, occipital and frontal, as well as left shoulder, left arm and neck pain. Dr. Bernstein eventually opined that claimant's headaches were related to her industrial injury and were a worsening of that injury. Drs. Cox and Bernstein agreed that claimant's arm, shoulder and neck complaints were related to her industrial injury, but no doctor opined that those conditions had worsened. Dr. Bernstein noted several inconsistencies in his examination of claimant.

The insurer sent claimant to Dr. Stolzberg who also noted marked discrepancies between claimant's performance on some tests. Dr. Stolzberg stated that claimant had made an uncomplicated recovery from her January 1980 injury. In addition, Dr. Stolzberg diagnosed migraine headaches based on a typical pattern of symptoms. That is, claimant has blurred vision with heat wave distortion, sees spots, has nausea, has suboccipital pain, has a family and personal history of migraines and has dizziness, all of which are quite typical of migraine headaches. Dr. Stolzberg stated that these headaches were not related to claimant's January 1980 injury.

Inasmuch as Dr. Bernstein did not examine claimant until almost two years after her seemingly minor injury in January 1980, we give little credence to his opinion that claimant's headaches are related to her January 1980 injury. Dr. Stolzberg's diagnosis of migraine headaches unrelated to the industrial injury seems better reasoned and we rely on his opinion. We find no other medical evidence pointing to a worsening of claimant's January 1980 injury.

Therefore, we find claimant has failed to prove that her headaches are related to the January 1980 compensable injury. Furthermore, we find claimant has not proven a worsening of her compensable condition under ORS 656.273. The insurer's denial is reinstated to the extent that the denial purports to deny claimant's aggravation claim and to deny claimant's headache condition. Claimant's January 1980 industrial injury remains compensable, and claimant continues to be entitled to medical care and aggravation rights related to that injury.

ORDER

The Referee's order dated May 25, 1983 is reversed. The insurer's denial dated July 6, 1982 is reinstated and affirmed in accordance with this order.

BOARD MEMBER BARNES CONCURRING:

We all agree on the result, but we apparently disagree on what evidence should be considered in arriving at that result. The insurer challenges both: (1) An evidentiary ruling of the Referee, refusing to admit Dr. Mang's January 1981 report; and (2) the Referee's decision on the merits. It seems to me that, as a matter of proper methodology, we should first resolve any questions about what evidence is before us for review before proceeding to the merits. Following that methodology, I conclude that Dr. Mang's January 1981 report was improperly excluded and have thus considered it in my review of the merits.

Claimant testified that she had never had problems with her neck and shoulders prior to the January 1980 industrial injury. She also testified that she had not had on-going problems with headaches before that injury. Claimant described a leg injury she sustained in a fall in a market about seven years ago, which would be in about 1975. Claimant also denied telling Dr. Stolzberg that she had severe headaches before the 1980 injury. Claimant's husband also testified that claimant did not have problems with her neck or shoulders prior to the 1980 injury, and specifically denied that she had neck/shoulder problems after the fall in the market in about 1976.

After all the testimony was presented, the record was left open for receipt of another report from Dr. Bernstein. When the insurer's attorney submitted Dr. Bernstein's report, he also submitted the report in question from Dr. Mang. Claimant objected to the admission of Dr. Mang's report and the Referee excluded it because it had not been submitted at least 10 days pre-hearing as required by OAR 436-83-400(3).

I disagree with the Referee's ruling. The requirement of pre-hearing submission of proposed exhibits stated in OAR 436-83-400(3) contains an exception: ". . .except that evidence offered solely for impeachment need not be so filed and provided." It seems obvious to me that Dr. Mang's report should have been admitted as impeachment of the sworn testimony of claimant and her husband, and certainly nothing in OAR 436-83-400(3) provides otherwise.

Dr. Mang's January 1981 report was written to a California attorney and discussed claimant's nonindustrial 1976 slip and fall injury. Dr. Mang notes that he first treated claimant in February 1978 and that, at that time, claimant was complaining of shoulder pain, neck pain and headaches. Dr. Mang at least implies that at least the shoulder and neck pain had been chronic since claimant's 1976 fall. This report casts considerable doubt, to say the least, on the sworn testimony of claimant and her husband to the effect that claimant only had shoulder pain, neck pain and headaches since the 1980 industrial injury.

My consideration of the impeaching impact of Dr. Mang's report, in addition to the other considerations identified by the Board majority, leads me to the same conclusion reached by the Board majority.

MICHAEL D. FARRIS, Claimant
Pozzi, et al., Claimant's Attorneys
Annala, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01458 & 82-02665
December 29, 1983
Order on Review (Remanding)

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Neal's order which found SAIF/Hood River Village Inn responsible for a new injury of November 13, 1981 as opposed to an aggravation of claimant's October 4, 1978 injury while employed with Diamond Fruit Growers, a self-insured employer. SAIF's defense to the new injury claim is not merely that claimant's condition is the responsibility of the self-insured employer; SAIF also denied the claim on compensability grounds, raising an issue of whether any injury-producing

accident or incident occurred while claimant was employed with Hood River Village Inn, SAIF's insured. SAIF produced two of claimant's co-workers at the hearing to support SAIF's defense that no accident or incident occurred on November 13, 1981 as alleged by claimant.

Diamond Fruit Growers, the self-insured employer, also denied compensability and not merely responsibility, although at the hearing, counsel for the self-insured employer seemed to rely primarily upon claimant's subsequent work activity for SAIF's insured as a defense to claimant's aggravation claim.

The Referee's order states: "The main issue, as established at the hearing is whether claimant sustained a new injury on November 13, 1981 while working as a maid at Hood River Village Inn or an aggravation of her October 4, 1978 left-hand injury at Diamond Fruit." The Referee's order reflects that she considered claimant's testimony and the medical evidence in arriving at the conclusion that claimant sustained a new injury as opposed to an aggravation under the last injurious exposure rule. We are unable to determine whether the Referee considered the testimony of claimant's co-workers and found their testimony less pursuasive than claimant's, or whether that testimony simply was not considered at all.

There are at least three possible resolutions of this case based upon the evidence presently of record: That claimant sustained a new injury as found by the Referee; that she sustained an aggravation of her prior compensable injury; or that she suffered an intervening superceding off-the-job injury to the same area of her body. Because the Referee's order jumps to the responsibility issue, without apparently considering what we believe to be the threshold issue of compensability, and because her order fails to disclose her assessment of the witnesses' respective reliability and credibility on the issue of whether an incident occurred as alleged while claimant was employed with Hood River Village Inn, we believe that this case has been "improperly, incompletely or otherwise insufficiently developed or heard by the Referee," and that it should be remanded to the Referee for further consideration. ORS 656.295(5). On remand the evidentiary record may be supplemented to the extent that the Referee determines it is appropriate.

ORDER

The Referee's order dated March 28, 1983 is vacated, and this case is remanded for further proceedings consistent with this order.

DOUGLAS A. FORD, Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-02892, 82-02893 & 82-03930
December 29, 1983
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests and claimant cross-requests review of Referee Foster's order which: (1) Found claimant is an Oregon employe and entitled to Oregon workers' compensation benefits, and thus set aside SAIF's denial of compensation in WCB Case Nos. 82-02892 and 82-02893; (2) refused to award penalties with regard to these cases; and (3) reversed SAIF's denials of claim-

ant's occupational disease claim for his rectal prolapse condition in WCB Case No. 82-03930. SAIF contends that claimant is not an Oregon employe and that his rectal prolapse condition is not compensable. Claimant contends he is entitled to penalties for failure to pay benefits under Oregon law.

We affirm the Referee with regard to the Oregon employe and penalty issues. As for the rectal prolapse claim, however, we reverse the finding of compensability.

Since childhood claimant has suffered from an intestinal problem known as rectal prolapse. With this condition, part of claimant's intestines would extrude when claimant strained. Claimant was able to pull the prolapse in at will. Within six weeks of beginning his second season of work as a tree planter, claimant saw Dr. Innes for his rectal prolapse, which claimant reported had become worse since he began planting trees. Claimant indicated to Dr. Innes that he had found it very difficult to retain the prolapse in his abdomen while carrying bags of trees around his waist and repeatedly bending to plant the trees. Dr. Innes performed surgery which corrected the problem.

When asked at deposition whether claimant's job activities worsened his prolapse condition, Dr. Innes answered, "That is possible but I would have to take [claimant's] word for that." Dr. Innes indicated that claimant's job activities could have accelerated or increased the prolapse. When asked if he thought that was probable, Dr. Innes answered: "I think it's possible."

We conclude that the medical evidence is too equivocal to support a finding that claimant's job activities were the major cause of a worsened underlying condition.

ORDER

The Referee's orders dated October 13, 1982 and November 3, 1982 are affirmed in part and reversed in part. That portion of the Referee's order which set aside SAIF's denial dated April 15, 1982, of claimant's occupational disease claim (WCB Case No. 82-03930) is reversed, and SAIF's denial is reinstated and affirmed. The balance of the Referee's order is affirmed. Claimant's attorney is awarded $450 for services before the Board on review in WCB Case Nos. 82-02892 and 82-02893.

Board Member Lewis Dissenting:

I respectfully dissent from the majority opinion that reversed the Referee's finding that claimant's rectal prolapse condition was compensable.

The reasons that I would affirm the Referee are: (1) Claimant was able to control the condition prior to doing this work; (2) claimant had to carry heavy bags of trees strapped around his waist which put pressure on his intestines; (3) it was not until he did this type of work that he required surgery to correct the problem; and (4) Dr. Innes testified that medical intervention was not necessary before the tree planting work and that it aggravated claimant's condition to the point that it would continue to worsen without medical intervention.

For these reasons, plus the credible testimony of claimant and the other witnesses, I believe claimant has carried his burden of proof, and I would affirm the Referee's order.

MICHAEL E. FRANKS, Claimant
Petersen, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-02593
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee McCullough's order which affirmed a Determination Order granting claimant no award for permanent disability to his hands. Extent of disability is the only issue on review.

Claimant developed a compensable contact dermatitis condition while working for a car dealership washing cars. After claimant became medically stationary, his treating physician stated that he thought claimant had no permanent impairment as a result of the dermatitis. However, the treating physician advised claimant to stay away from harsh chemicals and hot water. He released claimant only to work which did not involve exposure to these agents. He also stated that he felt claimant would continue to have flare-ups if he was exposed to chemicals and hot water. The Referee concluded that claimant was not entitled to an award for permanent disability. We disagree with the Referee's conclusion.

In Mark O'Hara, 35 Van Natta 587 (1983), we were faced with a similar situation. In O'Hara the claimant also had non-systemic contact dermatitis. The treating physician also felt that the claimant had no permanent impairment. However, he, too, placed restrictions on exposure to chemicals. On those facts we found that claimant was permanently sensitized to those chemicals. We said, "[W]e believe that permanent sensitization is a compensable form of impairment."

We conclude that, in this case, claimant is permanently sensitized to hot water and harsh chemicals. Consequently he is entitled to an award for permanent disability to his hands. Considering the guidelines in OAR 436-65-530(7), as we did in O'Hara, we conclude that claimant is entitled to an award of 7.5° for loss of his left hand and 7.5° for loss of his right hand for a total award of 15° (10%) scheduled disability for loss of both hands.

ORDER

The Referee's order dated May 18, 1983 is reversed. Claimant is awarded 7.5° for loss of his left hand and 7.5° for loss of his right hand for a total award of 15° (10%) scheduled disability for loss of both hands. Claimant's attorney is allowed 25% of this award, not to exceed $2000, as a reasonable attorney's fee.

LAWRENCE D. FRENCH, Claimant
Lyle C. Velure, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-02496
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Mongrain's order which affirmed the insurer's denial of compensability of his claim and determined the rate at which temporary total disability benefits are to be paid. Compensability and the temporary total disability rate are the issues on review.

The Board affirms the order of the Referee with these additional comments.

The insurer denied claimant's industrial injury claim almost a year after the claim was made, contending claimant's back condition was not work-related and raising the issue of claimant's credibility. In its brief to the Board the insurer contends the claim was fraudulent. The Referee found, "All the above factors lead me to question the reliability of the claimant's testimony to a degree that I feel I cannot conclude it is more probable than not that an incident occurred such as has been described." Accordingly, the Referee affirmed the insurer's "back-up" denial.

On review claimant argues that the Referee failed to impose on the insurer the burden of proving non-compensability as required by Patricia G. Davis, 35 Van Natta 635 (1983). Since the Referee's order issued and the Board briefs were filed, the Oregon Supreme Court has decided Bauman v. SAIF Corporation, ___ Or ___ (1983), which addresses back-up denials such as that involved in the present case. The Bauman court held that after an insurer accepts a claim it may not later deny compensability of the claim "unless there is a showing of fraud, misrepresentation or other illegal activity." We interpret Bauman to impose on the insurer the burden of proving fraud, misrepresentation or other illegal activity when it denies compensability on such grounds. Furthermore, our holding in Patricia G. Davis, supra, that the insurer has the burden of proving non-compensability in a back-up denial case was not altered by the Bauman decision.

In the present case, we agree that the Referee improperly imposed the burden of proof on the claimant. Therefore, we review the record to determine: 1) Whether the insurer has carried its burden of proving fraud, misrepresentation or other illegal activity in order to avoid the Bauman bar to back-up denials; and 2) whether the insurer has carried its burden of proving non-compensability of the claim. We find the insurer has carried its burden on both counts and affirm the decision of the Referee.

ORDER

The Referee's order dated December 12, 1982 is affirmed.

DAROL A. GILLILAND, Deceased
Pozzi, et al., Attorneys
SAIF Corp Legal, Attorney

WCB 82-02256
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of those portions of Referee Galton's order which: (1) Awarded claimant (the deceased worker's widow) interim compensation from December 22, 1981 until February 23, 1982; (2) awarded claimant a penalty of 25% of the above interim compensation due to SAIF's unreasonable resistance, delay and refusal to pay that compensation; and (3) awarded claimant's attorney an associated fee of $850 pursuant to ORS 656.382(1).

SAIF contends that the interim compensation should not have been awarded because SAIF's failure to pay it was not specifically raised by claimant. We conclude that SAIF was sufficiently on notice that claimant was seeking interim compensation benefits through specific definition of issues stated in colloquy between counsel and the Referee at hearing. If SAIF was surprised by the interim compensation issue when it was raised at hearing, it was entitled to request and receive a continuance on that issue. Robert G. Irving, 35 Van Natta 1363 (1983).

We further conclude, however, that claimant never raised the issue of a penalty for SAIF's failure to pay interim compensation. Claimant did seek a penalty on a different basis (unreasonable denial), but we have concluded that the claimed basis for a penalty must be raised with reasonable specificity. Richard Pick, 34 Van Natta 957 (1982). Since we must reverse the award of a penalty, the attorney fee must be modified to 25% of the interim compensation awarded claimant.

Claimant cross-requests review of that portion of Referee Galton's order which upheld SAIF's denial of death benefits. We agree with the Referee's conclusion, but for reasons other than the Referee's. The decedent died on December 22, 1981 of lung cancer that had metastasized to his brain and lymph nodes. The medical consensus is that the cancer was caused by a combination of asbestos fibers and cigarette smoking. The decedent was exposed to asbestos fibers with more than one employer. The Referee's analysis focused on the question of employer/insurer responsibility and the effect of the Board's order in Robert Luhrs, 34 Van Natta 1039 (1982). Our analysis in Luhrs was later modified in SAIF v. Luhrs, 63 Or App 78 (1983). In Luhrs the court concluded that, in the situation of a claimed occupational disease possibly caused by exposure with more than one employer, the claimant need not prove that any particular employment was the actual cause of the disease, but must be able to prove that employment exposure was the major cause of the disease. 63 Or App at 80-81. Only after resolving this threshold compensability issue favorable to the claimant's position, is it then appropriate to proceed to resolve the second issue of employer/insurer responsibility.

We conclude that claimant has failed to prove that asbestos

exposure at work was the major cause of decedent's disease and death.

At the time of his death, decedent was 42 years old. He had been smoking approximately one pack of cigarettes a day since he was a teenager. From 1962 until 1975, decedent was employed by Armstrong Construction and Supply and was continually exposed to raw asbestos. From June 1975 until May 1978, decedent was employed as an asbestos insulator or mechanic for McLaughlin Plumbing and Heating, where he worked only on new construction and was not exposed to raw asbestos. McLaughlin was purchased by E. J. Bartells, Inc. in May 1978. Decedent worked for Bartells, Inc. until October 1981 when he was forced to quit due to his cancer. While employed for Bartells, decedent was exposed to asbestos in 50% or more of his employment. This is a claim against only the most recent employer, Bartells.

On November 18, 1981 Dr. Richard Karchmer, hematologist and oncologist, reported:

> "Mr. Gilliland is a 41 year old gentleman with anaplastic carcinoma of the lung with lymph node and brain metastasis. Mr. Gilliland has been exposed for over 20 years to asbestos, various types of fibers, etc. He has also been a cigarette smoker. I feel the interaction between cigarette smoking and asbestos could have contributed to the development of his lung cancer."

On May 5, 1982 Dr. John Keppel, specialist in internal medicine and pulmonary diseases, reported:

> "The timing of the exposure and development of the carcinoma are quite crucial in terms of asbestos related tumors. Again, the peak incidence of tumors is from 30 to 35 years after exposure. Given the time as estimated from the reports that he had worked for [Armstrong Construction and Supply] beginning about 18 years ago, it would be unlikely that his exposures over that period of time contributed to an asbestos related carcinoma. However, the cocarcinogenesis of both asbestos and cigarette smoking may have been evident. His cigarette smoking throughout his lifetime would have increased his chance of lung cancer to 10 to 12 times that of baseline. Therefore, although I believe lung cancer in such a young individual is quite unusual and may be related to asbestos exposure, it would had to have been when he was in his late teens and would have been synergistic with his lifelong cigarette habit. I also do not feel that he had evidence of enough asbestos exposure to have caused any parenchymal reaction or asbestosis."

On June 11, 1982 Dr. Andrew Churg, pathologist, reported that post-mortem examination revealed that the asbestos count of

decedent's lung tissue indicated a very high level of exposure to commercial quality asbestos.

Dr. Keppel testified at hearing. The Referee found him to be a most persuasive witness. His testimony included discussion of the effect of cigarette smoking on the development of lung cancer when a worker is also exposed to asbestos:

> "Q. Now, there has been established, I understand, Dr. Keppel, a relationship between lung cancer and exposure to asbestos, has there not?
>
> "A. That's correct.
>
> "Q. Is asbestos considered a carcinogen?
>
> "A. Asbestos alone probably does carry some increased carcinogenic potential.
>
> "Q. In those persons who smoke cigarettes, there is an additional factor to be considered; is that right?
>
> "A. That's correct.
>
> "Q. Would you tell us, generally, what your opinion is in relationship to the carcinogenic effect of asbestos in persons who have a history of cigarette smoking such as that reflected in exhibit -- in the exhibits admitted here today relating to Mr. Gilliland.
>
> "A. There's a multiplication effect such that an asbestos worker who doesn't smoke may have a five times normal chance of developing carcinoma, and a smoking asbestos worker would multiply that almost twenty times, so that the estimate is 92-fold over base-line when an asbestos-exposed worker is also a smoker.
>
> * * *
>
> "Q. Now, you've had an opportunity to review the records of Mr. Gilliland, haven't you --
>
> "A. Yes, I have.
>
> "Q. -- and his autopsy report --
>
> "A. That is correct.
>
> "Q. -- Dr. Churg's report now?
>
> "A. That's correct.
>
> "Q. And you've been given some information, now, about his work history?

"A. That's correct.

"Q. Do you have an opinion as to whether there is a relationship between -- a material relationship or major relationship -- either of those -- between Mr. Gilliland's exposure to asbestos and his ultimate demise from cancer?

"A. Yes, I believe there's a relationship.

"Q. And is it a materially -- did his exposure to asbestos materially contribute to his ultimate demise from cancer?

"A. I believe it probably did.

"Q. Now, tell me why you believe that.

"A. In an asbestos worker, at a fairly young age of 41, developing a tumor that is related to smoking and asbestos working, and particularly developing that early in his life, the factor of being an asbestos worker and with his exposure is significant.

* * *

"Q. What is the effect of the cumulative exposure in a person who smokes, such as Mr. Gilliland did, and is exposed to asbestos such as he was?

"A. The -- as I understand the pathogenesis, or development of the tumor, the asbestos fiber, the one that causes the cancer irritates the cells within the lung such that they divide more frequently, and those dividing cells are further irritated or more likely to mutate because of the exposure to the coal tar in the cigarette. So, it takes the irritant factors of the asbestos fiber retained within the lung, then the carcinogenic potential of the tar being present, and the cells divide that leads to ultimate mutagenesis to a tumor.

* * *

"Q. As I understand your earlier testimony, there's no doubt in your mind that Mr. Gilliland's exposure to asbestos was a material contributing factor to his ultimate demise from cancer, right?

"A. That's correct.

"Q. As I understand your earlier testimony, there's no doubt in your mind that the conditions under which he labored during the

period that he worked for E. J. Bartell's were conditions that had the capacity to cause the cancer from which he ultimately deceased, right?

"A. That is correct.

From the above evidence, it appears that both cigarette smoking and asbestos exposure materially caused decedent's lung cancer and ultimate death. No doctor opines, however, that asbestos exposure was the major cause of decedent's disease. It may be simplistic to apply a legal test of "major contributing cause" to a medically complicated synergistic disease process of this type. But given the legal tests of causation set out in the cases of James v. SAIF, 290 Or 343 (1981), and Gygi v. SAIF, 55 Or App 570 (1982), and the absence of any medical opinion that asbestos exposure was the major contributing cause of decedent's disease, we must affirm the Bartells/SAIF denial of this claim. Cf Dethlefs v. Hyster Co., 295 Or 298 (1983).

ORDER

The Referee's order dated November 8, 1982 is affirmed in part and reversed in part. That portion which assessed a penalty against the SAIF Corporation for failure to pay interim compensation is reversed. That portion which awarded an ORS 656.382(1) attorney fee is reversed and, in lieu thereof, claimant's attorney is allowed a fee of 25% of the interim compensation awarded by the Referee, not to exceed $750. The remainder of the order is affirmed. Claimant's attorney is awarded $250 on Board review, to be paid by the SAIF Corporation, for prevailing on the issue of interim compensation.

LEONARD J. GOLTZ, Claimant
Burt, Swanson, et al., Claimant's Attorneys
Gila Tenenbaum, Defense Attorney

WCB 81-09549
December 29, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of that portion of Referee Mannix's order which found that a proposed surgical procedure was reasonable and necessary for treatment of claimant's condition and directed the insurer to authorize the recommended surgery. The insurer also assigns as error the Referee's refusal to consider the issue of the causal relationship between claimant's industrial injury and the proposed surgical treatment, the insurer contending that the proposed surgery is not compensable for this additional reason. We agree with the insurer's contention that the Referee erred in refusing to consider the additional issue raised on the day of hearing. Nevertheless, on the merits, we find that the proposed surgical procedure is both related to claimant's industrial injury and reasonable and necessary for treatment thereof.

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

Claimant originally filed a request for hearing in October of 1981 contesting a September 1981 Determination Order closing the claim. Claimant contended that his claim was prematurely closed or

that subsequent to claim closure, his condition ceased being stationary and he was entitled to claim reopening. Alternatively, claimant contended that his permanent disability exceeded that awarded by the Determination Order. In March of 1982, while claimant's hearing request was pending, claimant's treating physician, Dr. Buza, recommended the cervical fusion and sought authorization from the insurer. There is no written denial of the proposed surgery. See generally Billy J. Eubanks, 35 Van Natta 131 (1983). It apparently was agreed and understood by and between the parties that the insurer's defense to payment for the proposed surgery was that the surgery was neither reasonable nor necessary.

On the day of hearing, counsel for the insurer advised the Referee and counsel for claimant that the insurer intended to raise an issue concerning the causal relationship between the proposed surgery and claimant's industrial injury. Claimant's attorney objected to allowing the insurer to raise this new issue at such a late date and objected to any further continuances or postponement of the hearing. Counsel for the insurer offered to continue paying temporary disability benefits during the period of any additional delay occasioned by further postponement which might be necessary in order to allow claimant's attorney an opportunity to obtain further evidence. The Referee refused to allow the insurer to raise the issue of causal relationship "as a matter of equity." The Referee properly allowed the insurer to present its evidence on the question of causation by way of an offer of proof. The only issue addressed by the Referee in his order is the reasonableness and necessity of the proposed surgery.

In spite of the "equities" considered by the Referee, we find that the insurer should have been permitted to raise the issue of causation when the hearing convened. We recently considered the issue of whether an additional basis for denial may be raised orally at hearing. In Robert G. Irvin, 35 Van Natta 1363 (1983), we concluded that an employer was not foreclosed from raising the issue of whether the claimant suffered from a compensable occupational disease within the meaning of ORS 656.802(1)(a), where the terms of a written denial raised only the issue of the claimant's status as a subject worker:

> "There is no authority for some propositions because they are taken for granted. Whatever may have been the expectation when the requirement in ORS 656.262(7), that a written denial state 'the reason for the denial,' was first enacted in 1965, over the many years since then it has become commonplace for hearings to address and consider reasons in addition to and even different from those stated in the denials. * * * Furthermore, a denial does not terminate the right of an employer/insurer to investigate the claim further, and it is not unknown for additional investigation to result in shifts in the position of the employer/insurer, even to the point of revoking a prior denial and accepting a claim.
>
> "Moreover, if a hearing is requested on a denial of a claim, at some point the employer/insurer transfers control over the

> defense to its attorney, which often results in additional investigation of the claim, which can, in turn, lead to additional shifts in the position of the employer/insurer. Under present Board rules, there is no requirement that the exact position of any party be set out with the specificity of a civil-action pleading. For example, in Hughes v. Pacific Northwest Bell, 61 Or App 566, 571 (1983), the court quoted from the Board's order which had found that the claimant had made a claim for hearing loss only in one ear, but nevertheless concluded that claimant was entitled to a permanent disability award for binaural hearing loss. If there is that much latitude about any statement of what is being claimed, we think it necessarily follows that there has to be some latitude about what is being denied and the reasons therefor." 35 Van Natta at 1365-1366.

In addition to our analysis in Irvin, there is an even stronger reason to reach the same conclusion in this case. As previously noted, there is no written denial of the proposed surgery that is contested in this proceeding. The Court of Appeals has ruled that denial-type issues can be litigated in the absence of an actual denial. Thomas v. SAIF, 64 Or App 193 (1983). That ruling certainly makes it difficult to label any issue raised at the time of hearing an "additional" issue; such an issue certainly cannot be "additional" to the issues stated in a denial when, as in Thomas and in this case, there is no denial.

For all of these reasons, we conclude that the Referee should have allowed the insurer to raise the issue of causation orally at the hearing as an additional defense to the claim for medical services. When the insurer raised this additional issue and claimant indicated unwillingness to proceed with the hearing without the benefit of additional expert evidence bearing on this issue, the proper remedy was to further postpone or continue the hearing, particularly in view of the fact that counsel for the insurer offered to continue claimant's temporary disability benefits.

Although the Referee did not consider the issue of causation, he properly allowed counsel for the insurer to present evidence bearing upon this issue in the form of an offer of proof. Accordingly, it is not necessary for us to remand this case to the Referee for consideration of the issue of causation; we will consider as part of the record on review the evidence proffered in support of this defense. Edward Morgan, 34 Van Natta 1590 (1982).

We conclude that the surgery proposed by Dr. Buza is causally related to claimant's original industrial injury. The evidence bearing upon this issue consists of depositional testimony given by Dr. Dennis, a neurosurgeon, Dr. Gripekoven, an orthopedic surgeon who was one of the examining physicians on the panel of the Orthopaedic Consultants, and Dr. Buza, claimant's treating neurosurgeon. The insurer's causation defense is premised on the theory that the proposed surgical procedure, rather than being materially related to claimant's 1981 industrial injury, is due instead to a

preexisting degenerative disease process and/or a motor vehicle accident in which claimant was involved in October of 1980, as a result of which he suffered some injury to his neck.

In order to satisfy his burden of proving that the proposed surgery is compensably related to his industrial injury, claimant must establish that his injury is a material contributing cause to the condition which results in the need for surgery. Brooks v. D & R Timber, 55 Or App 688 (1982). If there are other causes of the condition requiring surgery, this does not defeat the compensability of the condition or relieve the insurer of the responsibility for payment of reasonable and necessary medical treatment of that condition so long as the industrial injury is a material contributing cause of the condition. See Grable v. Weyerhaueser Company, 291 Or 387 (1981).

After his industrial injury, claimant initially treated with Dr. Hogan, who referred claimant to Dr. White, a neurosurgeon, due to tingling in claimant's hands. Dr. White diagnosed a carpal tunnel problem, unrelated to claimant's industrial injury, and performed surgery in February of 1981. He noted continuing neck pain, directly related to claimant's January 1981 fall. A myelogram in February of 1981 revealed cervical spondylosis with right-sided nerve root irritation; however, Dr. White did not believe that the findings were sufficient to warrant surgical intervention. He expressed the opinion that claimant's cervical spondylosis was "work-aggravated."

When claimant's cervical problems persisted, Dr. White opined that claimant's symptoms might be consistent with a thoracic outlet syndrome, and he referred claimant for examination by Dr. Gaiser, who diagnosed such a condition and performed a rib resection in May of 1981. Even after this surgery, claimant's neck, hand, and arm symptoms persisted. Dr. White believed that some functional problems might be present, and referred claimant to Dr. Burr, an orthopedist. Dr. Burr diagnosed a chronic cervical strain. He did not discuss the prospect of surgery and felt that claimant might return to some form of light work. During this same period claimant began treating with Dr. Buza, who treated claimant conservatively, expressing the opinion that claimant could return to work at a reduced work schedule. On December 8, 1981 claimant was examined by Dr. Rosenbaum, a neurosurgeon, on referral by the insurer. Dr. Rosenbaum expressed the opinion that surgery would not benefit claimant, and that the best chance of returning claimant to the work force with limitation of his pain and complaints would be claim closure. Dr. Rosenbaum further stated: "I believe his current loss of function as it exists today with regards to the neck and upper extremities is in the realm of mildly moderate and this loss of function is due to this injury."

Claimant continued to treat regularly with Dr. Buza, and by March of 1982, Dr. Buza believed that a cervical fusion would benefit claimant's condition. He sought authorization from the insurer, but no response was forthcoming.

There is medical evidence suggesting that claimant's cervical problems might be the result of a natural degenerative condition. There also is evidence indicating that claimant's motor vehicle accident three months prior to his industrial injury may have

contributed to his overall condition. We find, however, in considering the record as a whole, the medical evidence establishes that claimant's January 1981 industrial injury materially contributes to his cervical condition and the need for surgery as recommended by Dr. Buza.

We affirm the Referee's order finding that the proposed surgical procedure is reasonable and necessary for treatment of claimant's compensable cervical condition.

ORDER

The Referee's order dated September 17, 1982 is affirmed. Claimant's attorney is awarded a fee of $600 for services rendered on Board review, to be paid by the insurer.

RALPH W. GURWELL, Claimant
Kenneth D. Peterson, Jr., Claimant's Attorney
Moscato & Meyers, Defense Attorneys

WCB 82-11071
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Seifert's order which excluded claimant's Exhibits 1 and 2 and found claimant's aggravation claim not compensable. Claimant moves for remand for inclusion and consideration of his Exhibits 1 and 2, which are reports from Dr. Weeks. In the alternative, claimant contends his aggravation is compensable.

Claimant argues that Dr. Weeks' reports are admissible in that about three weeks before the hearing claimant's attorney sent copies of the reports to the Hearings Division and to the employer's administrator, Diversified Risk Management Service (DRMS). At the hearing, the employer's attorney indicated that he had not seen the reports. The employer's attorney did not deny that DRMS had received the reports.

The Referee, relying on then-recent Board cases involving the 10-day rule in OAR 436-83-400(3), stated he felt compelled to exclude claimant's Exhibits 1 and 2. Since the Referee's order, however, the Board has decided Walter L. Hoskins, 35 Van Natta 885 (1983), and Thomas Ward, 35 Van Natta 1552 (1983), which somewhat soften the previous hard line approach to the 10-day rule. In any event, we find this case distinguishable from the Board cases that excluded exhibits because they were not offered in accordance with the 10-day rule.

Here, claimant's attorney provided copies of the offered exhibits to the employer's authorized representative and to the Referee more than 10 days prior to the hearing. OAR 436-83-400(3) requires a party offering medical reports to "file with the assigned Referee and provide all other parties with legible copies" not less than 10 days prior to hearing (emphasis added). We find that by providing the employer's representative with a copy of the offered reports, claimant has complied with this rule. The employer and its representative have an obligation to provide relevant information to their attorney. Furthermore, claimant's attorney was notified of the employer's attorney representation only shortly before sending the offered documents to the Referee

and to the employer's representative. Due to filing procedures in claimant's attorney's office, the letter regarding the employer's attorney representation was not in claimant's file when the offered reports were mailed. We would rule differently if claimant's attorney had been communicating with the employer's attorney but had sent the documents to the employer in an attempt to conceal the documents from the attorney. Finding no such "gamesmanship" here, we find that claimant's offered Exhibits 1 and 2, Dr. Weeks' reports dated December 16, 1982 and January 6, 1983, should have been admitted.

For the reasons cited in Edward Morgan, 34 Van Natta 1590 (1982), we deem a remand to the Referee unnecessary, and we have considered claimant's offered Exhibits 1 and 2 in our review of compensability of claimant's aggravation claim. Claimant's treating doctor since his original injury in June 1982 was Dr. Karmy. When claimant suffered a spontaneous onset of back pain in November 1982, claimant continued his treatment with Dr. Karmy. Dr. Karmy opined that claimant's November 1982 back problems were not related to his June 1982 industrial injury inasmuch as Dr. Karmey's examination of claimant in August and September 1982 revealed that claimant's symptoms had completely resolved. In December 1982 claimant saw Dr. Weeks, apparently for the first time, who opined that claimant's then-present condition was a direct result of claimant's June 1982 injury. We find Dr. Karmy's opinion to be more persuasive inasmuch as he gave a convincing explanation for his opinion, which Dr. Weeks failed to do. Furthermore, Dr. Karmy had the added benefit of having examined claimant at the time of his June 1982 injury and thereafter until claimant's symptoms resolved. Therefore, we find claimant's aggravation claim not compensable and affirm the Referee.

ORDER

The Referee's order dated February 9, 1983 is affirmed.

STEVEN J. JENNINGS, Claimant
Olson Law Firm, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01622
December 29, 1983
Order of Remand

Claimant requested review of Referee Seymour's order which upheld the SAIF Corporation's denial of claimant's back injury claim. SAIF has moved the Board to remand this case to the Referee for consideration of a medical report which apparently was in claimant's attorney's possession prior to the hearing but had not been disclosed to SAIF in spite of SAIF's request for production of medical reports authored by the physician in question. In response to SAIF's motion, claimant has indicated that he has "no objection."

Considering the facts and circumstances presented herein, we deem it appropriate to remand this case to the Referee for consideration of the additional evidence presented as part of SAIF's motion and for further proceedings deemed necessary and appropriate by the Referee.

IT IS SO ORDERED.

LUCILLE JORGENSEN, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-05937
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Peterson's order which set aside its denial of claimant's current chiropractic treatment. The issue is whether claimant has proven that her current treatment is causally related to her 1974 industrial injury.

Claimant suffered compensable cervical injuries in January 1973 and February 1974. The 1973 injury occurred when claimant slipped and caught herself without falling. Claimant received only chiropractic care, and the claim was closed by a May 1973 Determination Order that awarded about six weeks of time loss and no permanent disability.

The 1974 injury occurred when a disturbed patient at Fairview, where claimant was working, pressed down on the top of claimant's head several times. Claimant felt immediate pain and "grating and crunching." Again, claimant received only chiropractic care. The 1974 claim was closed by a November 1975 Determination Order that awarded neither temporary nor permanent disability benefits. Claimant testified that she has had chronic neck-area pain since the 1974 injury.

Claimant retired from her job at Fairview in 1975 and was 73 years old at the time of the hearing in this case. With one exception, all doctors who have expressed opinions state or imply that all or most of claimant's continuing cervical problems are due to osteoarthritis and/or osteoporosis, i.e., the natural aging process. (We do not understand claimant to be contending that her osteoarthritis and/or osteoporosis were caused or accelerated by her industrial injuries and, in any event, the medical evidence would not support such a contention.) The one exception is Dr. James Warner, who became claimant's treating chiropractor in 1981. Dr. Warner opines:

> "After doing a complete review of our records, two reports of Dr. Fechtel, as well as a [sic] x-ray report from Salem Radiology Consultants, P.C., T.T. Bollinger, M.D., It [sic] is our opinion the injuries sustained by Mrs. Jorgensen in 1974, are responsible for her condition at this time. Since we have found in our practice, that injuries if applied to the spine and severe mechanical stress will cause damage beyond what would normally be assumed. [sic] To state this simply, we find that in this case of a longitudinal stress to the spine, especially where part of the spine is under going compression as in a fall; and the other part of the spine is under traction, as in catching oneself; the stress is multiplied. This is especially true in Mrs. Jorgensen's case as she caught herself while falling. Yet she has been having trouble with her neck and

> shoulders ever since. We find the muscles of the cervical spine and the upper thoracic spine connect directly to the stimulizing muscles of the shoulder girdle as well as with the muscles that run longitudinally the length of the spine. Typically after an injury of this type, it is our experience that probability of the increased degeneration and increased arthritic activity is very high. Granted, Mrs. Jorgensen does have some degeneration of her cervical spine to a minimal degree. However, we have found many patients in our office who have had degeneration who were not in pain or suffering any symptoms, to that area. Mrs. Jorgensen's symptoms and her current problems and complaints started with the accident of February 21, 1974. For her history as well as her findings are consistant [sic] with her condition at this time. We do feel very strongly that osteoarthritis is not the cause of her pain. In the majority of americans [sic] osteo-arthritis is symptom free until we find it in our office or it is found in another office. Osteo-arthritis is simply a calus [sic] formation of the bone, similar to a calus [sic] formation of the skin implying that they have used [sic] for quite sometime, which in her case is true. It is not the cripling [sic] and painful type of arthritis that we associate with the narled [sic] hands and twiste [sic] fingers."

We are not at all sure we understand Dr. Warner's analysis. The details he discusses are the details of claimant's 1973 injury (when claimant caught herself while falling), not claimant's 1974 injury (when claimant was pressed on the top of her head), but Dr. Warner seems to be associating the details of the earlier injury with the date of the later injury. If Dr. Warner really intends to link current treatment with the 1973 injury, this is inconsistent with claimant's testimony that she fully recovered and was symptom free following the 1973 injury. If Dr. Warner instead intends to link current treatment with the 1974 injury, which is the link claimant argues she has established, the doctor's reasons for such a conclusion are difficult to comprehend.

Given the extremely minor nature of claimant's 1974 injury, an injury which produced neither temporary nor permanent disability, given the substantial evidence suggesting that claimant's current need for treatment is more likely related to noncompensable osteo-arthritis or osteoporosis and given our uncertainty about the basis of Dr. Warner's contrary opinion, we are not persuaded that claimant has proven entitlement to the disputed chiropractic treatment here in issue.

ORDER

The Referee's order dated April 20, 1983 is reversed. The SAIF Corporation's denial of medical treatment dated May 25, 1983 is reinstated and affirmed.

EARL MANCHESTER, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05667
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Seymour's order which overturned SAIF's denial of claimant's aggravation claim. The issues on review are compensability and whether the Referee erred under OAR 436-83-400(3) in admitting certain documents.

On March 14, 1983, claimant's attorney submitted a packet of exhibits for consideration at hearing. The hearing was held on March 23, 1983. The Referee held that the documents were submitted timely under OAR 436-83-400(3). That regulation states:

> "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."

At hearing, SAIF argued that the documents were submitted nine days prior to the hearing because of the rule enunciated by the Supreme Court in Beardsley v. Hill, 219 Or 440 (1959), which states that days are counted beginning with the first day after the precipitating event. The Referee acknowledged that Beardsley set out such a rule, but declined to apply it because he felt that the rule should be given a liberal construction in favor of the claimant.

We agree with SAIF that Beardsley applies to OAR 436-83-400(3). Claimant submitted the documents only nine days prior to the hearing. However, we conclude that the Referee did not abuse his discretion in admitting the documents. See OAR 436-83-400(4). SAIF had already seen all but two of the documents submitted by claimant. Furthermore, the Referee offered SAIF the opportunity to counter the two documents it had not seen and SAIF declined. Under these circumstances, we believe the Referee acted reasonably in admitting the exhibits which were filed nine days prior to the hearing.

On the merits of SAIF's denial of claimant's aggravation claim, we affirm and adopt the Referee's order.

ORDER

The Referee's order dated April 13, 1983 is affirmed. Claimant's attorney is awarded $550 for services on Board review.

STEPHANIE A. MARTIN, Claimant
Colombo & Scanlon, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 81-07345
December 29, 1983
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of that portion of Referee Thye's order which found that claimant's carpal tunnel syndrome claim was not compensable and that claimant was not entitled to penalties and attorney fees for an allegedly wrongful denial of her claim. The self-insured employer cross-requests review of that portion of the Referee's order which extended the closing date for temporary total disability benefits from July 6, 1981 to August 14, 1981 on claimant's accepted claim for musculo tendinitis.

The Board affirms that portion of the Referee's order which pertains to the compensability of claimant's carpal tunnel syndrome claim and her entitlement to penalties and attorney fees.

The Board reverses that portion of the Referee's order which awarded claimant additional benefits for temporary total disability. Dr. Button, claimant's treating physician, declared claimant medically stationary on July 6, 1981, and the August 3, 1981 Determination Order awarded claimant temporary total disability benefits up to that date. The Referee awarded additional temporary total disability benefits through August 14, 1981. We find and conclude that there is no evidence to support the conclusion that claimant was other than medically stationary on July 6, 1981, as properly found by the August 3, 1981 Determination Order.

ORDER

The Referee's order dated March 7, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which awarded claimant additional compensation for temporary total disability is reversed. The remainder of the Referee's order is affirmed.

MAX A. McKENZIE, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Corey, et al., Attorneys
David Horne, Defense Attorney

WCB 82-04057, 82-02808 & 82-03739
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Knapp's order which set aside its denial of claimant's aggravation claim and which found it responsible for claimant's current condition. Compensability and responsibility are the issues on review.

Claimant is a 32-year-old man who compensably injured his low back on February 6, 1974 while lifting a piece of steel for Wausau's insured. He was diagnosed as having a lumbosacral strain with a possible herniated disc. Dr. Buza performed a myelogram on April 2, 1974. The myelogram was inconclusive because the contrast fluid exuded into the extradural area. Dr. Tsai subsequently evaluated claimant and suspected a herniated disc. During the autumn of 1974, Dr. Buel, claimant's treating physician, opined that

claimant had a herniated disc. However, he felt that the disc had possibly retreated and recommended conservative treatment.

Claimant completed a bachelor's degree in education while enrolled in vocational rehabilitation. In June 1978 a Determination Order awarded him 5% unscheduled disability. The Determination Order was appealed, and ultimately claimant received a 25% award by an Order on Review. Orthopaedic Consultants examined claimant in a "return to work evaluation" in Septmber 1978. They felt there was a slight narrowing of the L5-S1 interspace. They stated that his impairment due to his injury was minimal. They also noted that claimant was abusing pain medication and obtaining it on the street.

On January 27, 1979 claimant was involved in an automobile accident in which he ran his car into a ditch trying to avoid hitting a deer. He complained at that time of cervical and lumbar pain. Dr. Tsai examined claimant and noted:

> "Cerebral concussion with a mild post concussional syndrome; right C6 and L5 radicular irritation all precipitated by the car accident that occurred on January 27, 1979, from history."

In addition to his automobile accident, claimant saw physicians on at least three occasions prior to the claim at issue here. The incidents related to the physicians at those times included one in which he fell over a chair, one in which he was playing with his nephews and one in which he had been playing basketball. A radiologist's report from March 1980 indicates that vertebral bodies, disc spaces and associated elements were intact.

Claimant worked as a mobile home salesman and then in a service station. He was twice convicted of falsifying prescriptions. In 1981 he moved to Umatilla and began working for an employer building log rafts.

On January 22, 1982 claimant took a job working as a ranch hand for Ashbecks, the non-complying employer involved in this case. Claimant alleges that on January 29, 1982 he slipped on ice in the bed of the truck from which he was unloading hay and fell over a bale of hay. He reported the incident to Mrs. Ashbeck that day. Claimant testified that he saw Dr. McCoy on the day of the alleged incident. The first medical report in the record is from Dr. Danner dated January 31, 1982. He repeats the history claimant gave of falling over the hay bale. However, he says that the incident happened the evening before. He then diagnoses acute lumbar strain. On February 7, 1982 claimant was seen in a different hospital emergency room. He related a history of having fallen from a truck two days earlier but not being too bad following the incident. He related that he had fallen again and that was when he began to experience radiating pain in his right buttocks and leg. On that date, the same radiologist who had reported on claimant in 1980 opined that x-rays showed narrowing at L4-5 and L5-S1.

Claimant admitted in his testimony that he told Dr. McCoy a few days after the alleged incident that his wife and child had

been killed in an automobile accident to get even more medication from him. He stated, "I was on a roll."

On February 7, 1982 Dr. Bensmiller related the following history.

> "Pt. fell backwards off a truck & landed on his coccyx. Had low back aching--felt better with rest, worse with walking, bending & lifting. Accident was on 2/1/82. On 2/6/82 he fell down a sand dune at the beach--worse low back pain and radiation down R leg."

On February 16, 1982 Dr. Hill, a neurosurgeon, repeated the history noted in Dr. Bensmiller's report. He admitted claimant for a myelogram and stated:

> "It is my feeling according to the patient's history that this is a continuation of the back injury that he had in 1975, and am requesting that there be a reopening of the claim."

A myelogram was performed which revealed a defect at L4-5. Dr. Hill then operated. The insurer denied the claim, and SAIF, on behalf of the non-complying employer, also denied.

Dr. Buel, who had been claimant's treating physician following the 1974 injury, examined claimant for the insurer. He opined:

> "As I examined Mr. McKenzie today, he is obviously in worse condition then he was when we closed the case in 1979...
>
> "It is my opinion that this could represent an exacerbation of a preexisting condition..."

Dr. Hill concurred with an attorney's statement that, to the extent that claimant's history was unreliable, his determination of the cause of claimant's condition was also unreliable.

The Referee found that claimant had sustained his burden of proving that his condition had worsened since the last arrangement of compensation. We agree with that finding. Dr. Buel's report establishes a worsening.

The Referee noted inconsistencies in claimant's testimony. He also noted that claimant had twice been convicted of falsifying prescriptions. The Referee felt that these factors were not sufficient to establish that claimant was not credible. He then stated:

> "Turning to claimant's alleged January 1982 injury, the different times and dates of the injury and how it happened infer fabrication. . . Regardless, the evidence sufficiently clarified that the incident occurred on January 29, 1982, the day Dr. McCoy first examined claimant and diagnosed

acute strain. . . Any inference of injury fabrication loses its strength when claimant underwent needed surgical correction, even before SAIF denied the claim."

The Referee concluded that claimant had sustained his burden of proving that his worsened condition was causally related to his compensable injury. He assigned responsibility to Wausau because he found that the alleged fall over the hay bale did not independently contribute to claimant's underlying condition.

We disagree with the Referee's conclusion that claimant sustained his burden of proving a causal relation between his compensable injury and his worsened condition in early 1982. Only Dr. Hill and Dr. Buel relate his worsened condition to the compensable injury. Dr. Buel's report is phrased only in terms of possibility. The possibility that his worsened condition is causally related to his compensable injury is insufficient to carry his burden. Dr. Hill candidly admitted that his conclusion was based on the history related by claimant. Thus, his report is only as good as claimant's credibility.

We find that claimant was not a credible witness. His statements to various doctors following the alleged incident are confusing and inconsistent. He conceded at hearing that he had lied to at least one doctor in order to get a change of medication. Because Dr. Hill's conclusion is based at least in part on claimant's history, his conclusion is suspect. Claimant has, therefore, submitted no credible evidence to sustain his burden of proving that his worsened condition in 1982 was causally related to his compensable injury. He has also failed to sustain his burden of proving that any incident occurred while he was working for the Ashbecks which would subject them to liability for his current condition.

ORDER

The Referee's order dated March 25, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which upheld the denial of the non-complying employer and the SAIF Corporation are affirmed. Those portions of the Referee's order which overturned the denial of Wausau are reversed.

IVY E. MILLER, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Bottini & Bottini, Defense Attorneys

WCB 82-04811 & 82-10905
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Barnes.

Mission Insurance Company and the SAIF Corporation request review of Referee Foster's order which found both insurers to be equally responsible for claimant's compensable injury. SAIF was held to be responsible as the processing agent for the non-complying employer, Action Welding. Mission was held responsible as the insurer for AA Action Ambulance. Each insurer contends that the other is fully responsible for claimant's injury.

The facts are not disputed. At the time of claimant's indus-

trial injury on December 18, 1981, Ray and Edith Moore each owned 50% of the common stock of AA Action Ambulance and 50% of the common stock in Action Welding. At the time of claimant's injury, AA Action Ambulance was covered by Mission Insurance Company. Action Welding had been covered by the SAIF Corporation, but had allowed its SAIF coverage to lapse in October 1981. Rob Robinson was the general manager for both companies. The two companies shared a single office with a single telephone, albeit with separate lines for welding and ambulance calls. One bookkeeper worked for both companies until October 31, 1981, then another bookkeeper worked for both companies until the time of hearing. Mr. Moore stated that Action Welding was formed to benefit AA Action Ambulance which needed oxygen, used also in welding, and other medical supplies. All employes performed duties for both companies under the direction of the owners and the manager, giving priority to whatever needed to be done at the time.

In December 1981 claimant was working for both companies. AA Action Ambulance guaranteed claimant $200 per month on a 25¢ per mile basis. Action Welding paid claimant a monthly salary of $700. Claimant was scheduled to work for the ambulance company on Tuesdays and Fridays and for the welding company on Mondays, Wednesdays and Thursdays. Nevertheless, if a welding company delivery needed to be made on a day when claimant was assigned to ambulance driving, claimant would make the welding delivery. On such occasions, claimant's partner would follow claimant in the ambulance or claimant would carry a radio so if an ambulance call came in, claimant would interrupt the welding delivery to perform his ambulance duties. Likewise, if the ambulance company needed a driver on a day claimant was assigned to the welding company, claimant would stop his welding duties and drive an ambulance. Although claimant's job duties were daily intermingled, no attempt was made to adjust claimant's monthly salaries paid by the respective companies.

Prior to claimant's injury, the companies got into financial trouble and were taken over by the bank. Then the companies' bookkeeper quit and Mr. Morimando was hired in October 1981 as the bookkeeper. Mr. Morimando testified that shortly after he was hired, the general manager, Mr. Robinson, instructed him to allow Action Welding's SAIF coverage to lapse. At the same time, Mr. Morimando was instructed to pay all payroll out of the ambulance company account and this was subsequently done, with the exception of a check issued to claimant on December 15, 1981, representing vacation and back pay, which was paid out of the welding account. Mr. Morimando testified that the check was paid out of the welding company account upon the bank's approval because the ambulance company was not generating enough revenue at that time to pay the payroll of both companies. On Friday, December 18, 1981, claimant was assigned as an ambulance driver and was "standing by" for an ambulance call, when he injured his back lifting oxygen supplies for the welding company.

The Referee found that claimant was simultaneously working for the welding company and the ambulance company, that he, therefore, was jointly employed and that both companies were equally responsible for paying his benefits. We disagree.

Claimant undoubtedly performed work for two separate

companies. Whether he worked for two separate employers is another question. We find that claimant worked for one employer, AA Action Ambulance.

Our finding of one employer is supported by the actions of the owner, manager and bookkeeper prior to claimant's injury. The manager instructed the bookkeeper to allow the SAIF coverage of the welding company to lapse and to start paying all payroll out of the ambulance account. Thereafter, payroll was paid out of the welding company account only when the ambulance account had insufficient funds. The owner and manager quit paying for compensation coverage of the welding company and started paying payroll from the ambulance company.

SAIF urges us to rely upon Bos v. SIAC, 211 Or 138 (1957), and Anfilofieff v. SAIF, 52 Or App 127 (1981). Mission urges us to rely on Westfall v. Tilley, 4 Or App 9 (1970). All three of these cases involve one employer who had some tasks in his operation which were covered by the Workers' Compensation Act and some tasks which were exempt from the Act. In Bos and Anfilofieff, the courts found the work the claimants were performing when injured was covered by the Workers' Compensation Act and that performance of otherwise exempt employment was merely incidental to the covered employment and insufficient to take the worker outside the Act. In Westfall the court found the injury compensable by looking at the work claimant was performing at the time of injury, which was covered employment, rather than exempting claimant from the act because he was available for exempt employment at the time of injury.

The present case does not involve the covered/exempt distinction addressed in these cases. Further, these cases give us no guidance in determining whether there is one or two employers or dual liability. Nevertheless, Bos articulates policy that we think is applicable to this case:

> "It is impractical to construe the [workers' compensation] act in such a way that employees and employers dart in and out of coverage with every momentary change in activity. The great majority of decisions, therefore, attempt to classify the overall nature of the claimant's duties, disregarding temporary departures from that class of duties even if the injury occurs during one of the departures." 211 Or at 146-47.

Similarly, in this case where it apparently was intended that claimant be an employe of the ambulance company and workers' compensation coverage was retained for the ambulance company only, "it is impractical to construe the facts to mean that the employer darted in and out of compliance with every change in claimant's activity." We thus find that claimant was employed by AA Action Ambulance as the company through which to pay claimant and to cover claimant for industrial injuries. Therefore, we conclude AA Action Ambulance and its insurer, Mission Insurance Company, are fully responsible for claimant's industrial injury.

ORDER

The Referee's order dated April 15, 1983 is reversed. The costs of claimant's compensable injury of December 18, 1981 will be the full responsibility of AA Action Ambulance, by and through its insurer, Mission Insurance Company. Claimant's attorney is awarded $500 for services performed before the Board on review, to be paid by Mission Insurance Company.

KENNETH W. PATENODE, Deceased
Evohl F. Malagon, Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-10239
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Seifert's order which upheld the SAIF Corporation's denial of benefits for the compensable death of decedent.

We affirm and adopt the Referee's order with the following comment. Claimant is the natural child of the deceased worker. However, the deceased worker voluntarily gave up his parental rights to claimant, and claimant was adopted by another man. The Referee relied on ORS 109.041 which provides that adoption creates a relationship between the adopted child and his natural parents which:

> ". . . shall be the same to all legal intents and purposes after the entry of such decree as if the adopted person had been born in lawful wedlock to his adoptive parents and had not been born to his natural parents..."

We fully agree with the Referee that claimant is not entitled to benefits because of the death of his natural father. We note that, because ORS 656.005(6) specifically provides for benefits to an adopted child from his adoptive parent, claimant's position, if accepted, would create the anomalous result that claimant could conceivably obtain death benefits for the death of both his natural father and his adoptive father. We do not believe this to be the intent of the legislature.

ORDER

The Referee's order dated May 9, 1983 is affirmed.

ROBERT G. PERKINS, Claimant
Roll & Westmoreland, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-02991
December 29, 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: (1) Found permanent neck and chest impairment as a result of claimant's September 1981 compensable injury and thus awarded unscheduled permanent partial disability; (2) awarded additional compensation for temporary

disability; and (3) assessed penalties and attorney fees. Claimant cross-requests review of those portions of the Referee's order which: (1) Upheld the right little finger scheduled disability award granted by the May 27, 1982 Determination Order; and (2) claimant apparently contends that his award for neck disability should be greater than that awarded by the Referee.

We find considerable conflict and confusion in the record. As best as we can tell, the material facts are as follows.

In a compensable motor vehicle accident in September 1981, claimant sustained injuries to his right little finger, right ankle, neck and chest. Although SAIF at times seems to argue there was no neck injury at that time, we find to the contrary based on the September 25, September 29, October 20 and October 27 reports and chart notes of Drs. Lee and Arbeene. Medical attention focused primarily on claimant's finger and ankle injuries.

Claimant's treatment became complicated in about early 1982 when it was discovered that he had angina, coronary artery disease and possibly had an old, previously unknown infarction. SAIF issued a partial denial for these conditions, the Referee upheld that partial denial and claimant does not challenge that finding on review.

In March 1982 SAIF terminated claimant's time loss benefits. The confusion in the record reaches a crescendo regarding the circumstances of that termination. The Referee characterized SAIF's action as an insurer closure pursuant to ORS 656.268(3), but we find no support in the record for that characterization. SAIF subsequently submitted the claim for closure in May 1982, resulting in the May 27, 1982 Determination Order, and claimant seemingly argues that this was a premature closure.

Based on these findings, we conclude as follows.

We agree with the Referee's analysis and assessment of claimant's scheduled finger and ankle injuries.

We disagree with the Referee's finding that claimant sustained permanent neck impairment as a result of his accident. On October 27, 1981 Dr. Lee reported that claimant's neck discomfort was better and that claimant had good range of motion in his neck. On March 9, 1982 Dr. Arbeene, who was aware of claimant's prior neck pain, reported that claimant had no permanent impairment as a result of his injuries. There is no subsequent medical report which even mentions neck problems. Although, as noted above, we find that claimant did sustain a soft tissue neck injury in the September 1981 accident, we find insufficient evidence that that injury resulted in any permanent impairment.

Assessment of claimant's chest impairment borders on the impossible. On the one hand, the medical evidence is unanimous that most of claimant's chest impairment is a result of his noncompensable angina and coronary artery disease. On the other hand, we are satisfied that claimant also has some additional minimal permanent impairment in the form of disabling chest wall pain due to the residuals of rib fractures sustained in the September 1981 accident. Although there is little comfortable basis for separating

the compensable impairment from noncompensable impairment, we conclude that the Referee's award of 64° for 20% chest wall disability is excessive and that claimant would be more properly compensated by an award of 32° for 10% unscheduled disability.

We can find no basis for SAIF's termination of time loss in March 1982 and think that time loss should have continued to be paid until the May 27, 1982 Determination Order was issued. If claimant is contending that the Determination Order was issued prematurely, we disagree because: (1) It is clear -- indeed, not contested -- that claimant's finger and ankle conditions were then stationary; and (2) we find no persuasive evidence that claimant's neck condition and the compensable portion of claimant's chest condition were other than medically stationary at that time. In short, SAIF should be penalized only for a unilateral, pre-Determination Order termination of time loss, and the penalty should run only to the date of the Determination Order.

We agree with the Referee's analysis and assessment of a penalty for nonpayment of medical bills.

ORDER

The Referee's order dated November 16, 1982 is affirmed in part, modified in part and reversed in part.

That portion of the Referee's order which awarded 48° for 15% unscheduled permanent partial neck disability is reversed.

That portion of the Referee's order which awarded 64° for 20% unscheduled permanent partial chest disability is modified and, in lieu of the Referee's award, claimant is awarded 32° for 10% unscheduled permanent partial chest disability; the fee allowed to claimant's attorney out of this increased award should be adjusted accordingly.

That portion of the Referee's order which awarded additional temporary total and/or temporary partial disability from March 9, 1982 to July 1, 1982 is modified and, in lieu of the Referee's award, claimant is awarded compensation for temporary total disability from March 9, 1982 to May 27, 1982, less time worked.

That portion of the Referee's order which imposed a penalty based on the additional temporary disability ordered paid from March 9, 1982 to July 1, 1982 is modified and, in lieu of the penalty assessed by the Referee, the SAIF Corporation shall pay claimant a penalty of 25% of the compensation for temporary total disability from March 9, 1982 to May 27, 1982 payable under the terms of this order.

The remainder of the Referee's order is affirmed.

KAREN M. PETTY, Claimant
Rolf Olson, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 82-02425
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

The employer requests review of Referee Seymour's order which overturned its denial of claimant's aggravation claim. The employer argues that the Referee erred in admitting a report from Dr. Newby which it did not receive until six days prior to the hearing. It requests that we remand the case to the Referee for consideration of the claim without the report in question. It also argues that the Referee erred in overturning its denial.

On the evidentiary issue, we conclude that the Referee erred in admitting Dr. Newby's report. Claimant's attorney was in possession of Dr. Newby's report in June 1982. The employer requested discovery from claimant in July 1982. A Notice of Hearing issued in this matter on September 24, 1982. The employer received Dr. Newby's report on September 30, 1982. The Hearing was held on October 6, 1982. Claimant's attorney offers the explanation that he sent the report as soon as he received the Notice of Hearing and that it was the short time between Notice of Hearing and hearing which caused him to violate OAR 436-83-400(3), the ten day rule. We cannot accept that excuse because claimant's attorney was in possession of Dr. Newby's report months before the hearing and had received a request for production months before the hearing. The employer's attorney had never seen Dr. Newby's report until a few days before the hearing. The employer was clearly prejudiced by receiving Dr. Newby's report at such a late date. See Walter L. Hoskins, 35 Van Natta 885 (1983). We find that the Referee erred in admitting Dr. Newby's report under these circumstances. However, we decline to remand the claim to the Referee and decide the case on de novo review without considering Dr. Newby's report.

On the merits of claimant's aggravation claim we also reverse. Claimant was compensably injured when she strained her low back in February 1981. In April 1981 Dr. Garrett, claimant's then treating doctor, opined that claimant's strain had resolved. The claim was closed as non-disabling on April 13, 1981.

In September 1981 Dr. Sulkosky saw claimant on referral from Dr. Garrett. Dr. Sulkosky opined that the back pain claimant was then complaining of was secondary to sacrilization, a congenital defect. In December 1981 Dr. Sulkosky stated:

> "I do feel that she is going to be more prone to recurrent lumbosacral injuries because of the underlying problems she has with her back. I feel that this is a congenital or developmental problem and not a result of trauma."

In January 1982 the insurer denied reopening of the claim. Dr. Hakala, who also saw claimant on a consulting basis, noted that there were no objective findings to support claimant's complaints. He opined that claimant's back strain from her industrial injury had resolved.

We find claimant has failed to sustain her burden of proving that whatever worsening she has is causally related to her industrial injury.

ORDER

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

DOLLY N. ROBBERDING, Claimant
Bernard Jolles, Claimant's Attorney
Tooze, et al., Defense Attorneys

WCB 80-06487
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Daughtry's Order of Dismissal which dismissed her request for hearing because she did not respond to an Order to Show Cause.

ORS 656.289(3) and ORS 656.295(2) require that statutory notice of the request for Board review be mailed or actual notice received by all parties within thirty days of the mailing date of the Referee's order. Claimant failed to give the opposing parties this required notice. Therefore, we dismiss claimant's request for review. Argonaut Insurance v. King, 6301 App 847 (1983).

ORDER

The claimant's request for review dated March 16, 1982 is dismissed.

SPIROS SARANTIS, Claimant
Bloom, Marandas & Sly, Claimant's Attorneys
Schwabe, et al., Defense Attorney

WCB 81-09183
December 29, 1983
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Shebley's order which increased claimant's permanent disability from the 4° of scheduled permanent partial disability for 100% loss of a fifth toe, awarded by Determination Order dated September 11, 1981, to 27° for a 20% loss of claimant's right foot. The insurer contends that the Referee's award of permanent disability for loss of claimant's right foot is not substantiated by a preponderance of the evidence. We agree and, therefore, reverse the Referee's order.

Claimant sustained a compensable injury on July 31, 1978, when a mop bucket fell and struck his right foot. Claimant suffered a contusion with accompanying swelling but no fracture, dislocation or intrinsic bony abnormality. A diagnosis of cellulitis of the right foot was made by an emergency room physician. The claim was closed by Determination Order dated January 25, 1979, which awarded compensation for temporary total disability and no permanent disability. The claim was reopened in March 1981 in view of continued episodes of drainage from the area of injury, accompanied by swelling. A diagnosis of chronic osteomyelitis of the right fifth toe was made by Dr. Geist, who recommended amputation of the toe.

Claimant was examined by Dr. Nadal at the insurer's request on May 11, 1981. In a report of his findings on that examination, Dr. Nadal concurred with Dr. Geist's recommendation for amputation of the diseased toe, stating: "One would expect little, if any, permanent impairment, assuming that healing takes place in a kindly fashion and with good arterial circulation to the foot I would expect this to be the case." On June 5, 1981 claimant's right fifth toe was amputated through the level of the metatarsophalangeal (MP) joint. On August 18, 1981 Dr. Geist reported to the insurer that claimant had completed treatment and that claim closure was recommended. His office note of that day indicates that claimant continued to complain of pain, and that he experienced a sensation of tightness and pain over the dorsal lateral aspect of his foot and ankle when he attempted to plantar flex the toes. Dr. Geist found normal ankle and hindfoot motion, no evidence of any infection, and that the surgical wound had completely healed. The office note continues:

> "He also complains that he doesn't think he will be able to work because of foot pain. * * * Contrast baths may be of some help, but I think the thing that will help the most is his being stimulated to get back to work. He was advised that he is going to have to expect some degree of pain, but now that he is 2 1/2 months from the time of his surgery, it is time for him to really push activity despite the pain. His pain should eventually go away, if he does not dwell on it. Other than the residual pain and the missing fifth toe, there is no sign of any other permanent impairment. He is now discharged, return prn. Activity is encouraged."

On September 11, 1981, the Determination Order issued awarding claimant additional temporary disability compensation and 4° of scheduled permanent disability for a 100% loss of claimant's fifth toe.

Claimant was examined on September 22, 1981 by Dr. Eckhardt, who claimant had consulted for a second opinion regarding his right foot. Claimant stated that he had attempted to return to work in accordance with Dr. Geist's suggestion, but was only able to work approximately two hours due to pain and swelling. On examination, Dr. Eckhardt found no soft tissue swelling of claimant's ankle or foot and well healed incisional scar. Dr. Eckhardt found a full range of active motion of the right ankle with well balanced musculature and no apparent discomfort. X-rays of the right foot revealed no signs of bone spurs or other bone or joint abnormalities. Dr. Eckhardt's office note concludes:

> ""I cannot explain why the patient continues to have pain and swelling about the right foot preventing him from returning to work. There were no objective findings on examination today to suggest any significant problems. I would recommend that the patient be evaluated by

> a group such as the Orthopaedic Consultants, Inc. in regards to final determination and claim closure."

There is no indication in this record that any such referral for further independent medical examination was made.

At hearing claimant testified that he is presently unable to engage in many of his pre-injury activities, including walking or standing for extended periods of time. He testified that after standing 20 to 30 minutes his right foot usually swells, and depending upon the degree of activity, the swelling extends up his right leg, almost to the knee. He soaks his foot in hot water two or three times each day for 10 to 20 minutes. He uses a water foot massage for relief of the pain and swelling and elevates his right foot frequently. Claimant also testified that cold weather increases the pain. Claimant presently lives in Texas, where he works for his daughter, who owns and operates a restaurant. Claimant's job duties consist mostly of sedentary activities such as answering the telephone and keeping track of inventory.

The Referee considered the fact that prior to claimant's industrial injury he was able to walk and stand with no impediment and engage in recreational activities such as hunting, fishing and dancing, free of pain or difficulty with his right foot or leg; and that, according to claimant's testimony, after his injury, claimant was unable to pursue any of these activities. The Referee stated that although he found no objective medical evidence to substantiate any physiological changes or deterioration of claimant's foot or leg other than that relating to the amputation of his fifth toe, at least one of the doctors who had examined him post-surgery observed swelling in claimant's right foot, as well as the fact that the foot remained painful. In reliance upon claimant's credible testimony that he experiences pain and swelling in his right foot and lower leg, the Referee found that claimant suffers a moderate loss of use and function of his right foot and, therefore, awarded claimant compensation for a 20% loss of the right foot.

Since the Referee issued his order in this case, we have addressed the difficult question of how lay testimony is to be weighed and contrasted with medical evidence in evaluating the permanency and extent of disability. Juena K. McGuire, 35 Van Natta 1053 (1983); James G. Thomas, 35 Van Natta 714, 35 Van Natta 827 (1983). In Thomas we stated:

> "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." 35 Van Natta at 715.

In McGuire we expanded upon the rationale set forth in Thomas, stating that the existence, nature, permanence and extent of physical impairment is primarily a medical question; that the

required quantum of medical opinion depends upon the complexity of the medical issues in a given case; and that the absence of a favorable medical opinion is not necessarily fatal to the position of the party with the burden of proof, but that the absence of such evidence is an important factor to be weighed in the fact-finding process. The absence of medical evidence to support lay evidence on a primarily medical question may lead the fact finder to conclude that the lay evidence is not pursuasive; however, in other than complicated medical situations, it is possible for lay testimony to be found persuasive in the absence of supporting medical documentation. 35 Van Natta at 1055-1056.

There are differences between the facts in Thomas and McGuire, which involved soft tissue injuries in unscheduled areas of the body, and the facts of this case which involve surgical amputation of a toe. The considerations discussed in those cases, however, are pertinent in all cases in which the issue is whether or not the claimant sustains permanent impairment in a particular area of the body as a result of an industrial injury. That is the issue in this case, and the generalizations stated in Thomas and McGuire are applicable. In order to find in claimant's favor, we must be able to find that a preponderance of the persuasive evidence establishes that the complaints to which claimant testified at hearing, and which previously were related to examining physicians, will continue to endure "without fundamental or marked change;" i.e., that they are permanent. Webster's Third New International Dictionary, Unabridged (1968).

Contrary to the Referee's finding, we do not understand either Dr. Geist or Dr. Eckhardt to have found any objective evidence substantiating claimant's complaints of pain or claimant's complaint of swelling in and about his right foot. Indeed, Dr. Eckhardt's examination on September 22, 1981 revealed no soft tissue swelling about the ankle or foot. Dr. Eckhardt did find tenderness to palpation; however, this is a subjective complaint, one which was not verified by any objective findings and one which Dr. Eckhardt was unable to explain on the basis of his findings on examination. When Dr. Geist discharged claimant in August of 1981, he stated that claimant's pain eventually would go away if claimant would not dwell on it and if he would become more active.

Claimant has sustained permanent impairment in the form of the loss of the little toe on his right foot. He maintains that this has resulted in impairment of his foot in the form of pain and swelling. Claimant has presented no medical evidence to verify any impairment other than the loss of the little toe. The medical evidence suggests that the complaints which claimant has related to the physicians will resolve in due course. On this record, we are unable to find claimant's testimony sufficient to substantiate an award for permanent loss of use or function of the foot.

ORDER

The Referee's order dated October 21, 1982 is reversed. The Determination Order dated September 11, 1981, which awarded claimant compensation for 4° of scheduled permanent disability for a 100% loss of a fifth toe is affirmed, except that the Determination Order is corrected to identify claimant's right fifth toe as the affected digit.

KEITH A. SHINE, Claimant
Emmons, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys
Breathouwer, et al., Defense Attorneys

WCB 82-02910 & 82-02911
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Mission Insurance, the insurer for Intercontinental Motor Lines (IML) requests review of Referee Howell's order which assigned responsibility to it for claimant's compensable industrial injury of February 7, 1982. The only issue on review is for which of two employers claimant was working when the compensable injury occurred.

In February 1982 claimant was regularly employed at EBI's insured, Newport Seafood Company (NSC), as a fish and crab buyer. On February 6, 1982 claimant attended the wedding of one of NSC's owners. During the wedding reception, the owner, Steve Manewell, was contacted by a dispatcher from IML. The dispatcher informed Manewell that an IML truck which carried a shipment of fish and seafood which had partially orignated at NSC had overturned near Yachats. Manewell agreed to assist IML in salvaging the cargo. There is no doubt that IML was responsible for the cargo and would have been liable for any failure to deliver the cargo. However, NSC had two good customers in San Diego for whom their portion of the cargo was intended. NSC did not wish to jeopardize the good will of those customers.

Following his agreement with IML, Manewell made an announcement at the wedding reception that a truck had overturned and that anyone who wished to make some money could help unload the overturned truck. Another partner at NSC, Joe Bittler, was also present at the wedding reception. Claimant and several other people, including regular employees of NSC as well as people not employed regularly at NSC, agreed to help unload the truck. These people met at the NSC plant the following morning. Manewell and Bittler were present when claimant and the others met. Claimant was transported to the accident scene by Manewell. The evidence indicates that there was very little actual supervision of the accident scene. However, it appears that both Bittler and the driver of the overturned truck assumed supervisory roles.

Claimant was injured while unloading the overturned truck.

Claimant testified that no one said anything about who would pay him wages before the men unloaded the truck. After the job was completed, claimant said that he had hurt himself. Manewell announced that IML would pay the wages. Claimant testified that before the announcement he thought NSC would be paying his wages. He conceded, however, that he had not punched a time clock as he normally would have done had he been working a shift at NSC.

At hearing, the Referee found that claimant was employed by IML. He based this finding on his conclusion that Manewell and Bittler were not acting as officers of NSC but as individuals who contracted with IML to provide manpower. In essence he concluded that Manewell and Bittler acted as IML's agent in procuring claimant's services. The Referee declined to apply the lent-servant doctrine because, under his analysis, there was no

employer to loan employees to IML. We disagree with the Referee's analysis. We find that there is insufficient evidence to prove that Manewell and Bittler were acting independently and not as officers of NSC. It is true that Manewell and Bittler testified that they were paid as individuals for the work they did on the salvage operation and that they believed they were operating in their individual capacities. However, NSC's business good will was the motivating factor for their involvement. Further, they used NSC facilities as a meeting place and used NSC equipment in the salvage operation. NSC, not Manewell and Bittler, billed IML for all the time and equipment expended in the salvage operation. Accordingly, we find that Manewell and Bittler were acting in their capacity as officers of NSC. Therefore, the lent-servant doctrine should be applied.

Larson summarizes the lent-servant doctrine:

> "When a general employer lends an employee to a special employer, the special employer becomes liable for workmen's compensation only if
>
> "(a)the employee has made a contract of hire, express or implied, with the special employer;
>
> "(b)the work being done is essentially that of the special employer; and
>
> "(c) the special employer has the right to control the details of the work." 1C Larson, Workmen's Compensation Law §48.

The Court of Appeals has approved this formulation of the lent-servant doctrine. Multnomah County v. Hunter, 54 Or App 718 (1981). Larson explains that, under the doctrine, the general employer is presumed to be the claimant's employer absent a showing to the contrary.

> "The only presumption is the continuance of the general employment which is taken for granted as the beginning point of any lent-employee problem. To overcome this presumption, it is not unreasonable to insist upon a clear demonstration that a new temporary employer has been substituted for the old, which demonstration should include a showing that a contract was made between the special employer and the employee, proof that the work being done was essentially that of the special employer, and proof that the special employer assumed the right to control the details of the work; failing this the general employer should remain liable." 1C Larson, supra at §48.10.

We find that NSC has failed to overcome the presumption that

it continued as claimant's employer because it has failed to prove anything which would amount to an employment agreement between claimant and IML. "[T]he basic test for determining an employment relationship for workers' compensation consists of two elements: 1) the existence of a contract for hire; and 2) the employer's right to control..." There was no contract for hire between claimant and IML because claimant's subjective belief was that he was an employee of NSC when he was injured. As Larson states: "An employee, for compensation purposes, cannot have an employer thrust upon him against his will or without his knowledge." Accordingly, we find that claimant was an employee of NSC when he was injured, therefore NSC is responsible for claimant's compensible injury.

ORDER

The Referee's order dated June 21, 1983 is reversed. Mission Insurance Company's denial of March 29, 1982 is reinstated. The claim is remanded to EBI for processing.

CLIFFORD L. STONER, Claimant
David C. Force, Claimant's Attorney
Roberts et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-05554 & 82-07550
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests and claimant cross-requests review of Referee Howell's order which: (1) Found claimant's occupational disease claim compensable; (2) found SAIF to be responsible for the occupational injury as a new claim rather than EBI; and 3) ordered SAIF to pay interim compensation from August 17, 1981 through August 13, 1982 and to pay a penalty for its failure to timely accept, deny or pay interim compensation. SAIF contends that the claim is not compensable, that EBI and not SAIF is responsible if the claim is compensable and that penalties are not appropriate. Claimant contends that SAIF should be ordered to pay interim compensation from June 23, 1981 through August 16, 1981 and that penalties and attorney fees should be imposed with regard to this period of compensation. Claimant also moves to strike the portion of EBI's brief which argues an issue not specifically raised by SAIF or claimant. The Board denies claimant's motion. See Jamie Parkerson, 35 Van Natta 1247 (1983). With regard to the issues of compensability and responsibility, the Board affirms the order of the Referee. Regarding the issue of interim compensation, penalties and attorney fees, however, the Board modifies the Referee's order.

The employer was insured by EBI until April 3, 1980 and by SAIF thereafter. After claimant filed his occupational disease claim with the employer in April 1981, the employer apparently only gave notice of the claim to EBI. On June 23, 1981 EBI denied the claim stating, in part, that the claim would fall under the employer's present insurer. A copy of the denial was mailed to the employer. On August 17, 1981 claimant's attorney wrote to the employer requesting that the employer submit the claim to SAIF. SAIF issued its denial in August 1982 and paid no interim compensation.

The Referee ordered EBI to pay interim compensation through the date of its denial and no one challenges that part of the order. The Referee also ordered SAIF to pay interim compensation starting August 17, 1981, the date of claimant's attorney's letter to the employer, through the date of SAIF's denial. Claimant argues that the employer and not claimant had a statutory duty to notify all potentially liable insurers of the claim filed and that SAIF should be responsible for payment of interim compensation from the date of EBI's denial.

We agree with claimant that the employer had a duty to notify SAIF of the claim and that SAIF is responsible for payment of interim compensation from the date of EBI's denial to the date of SAIF's denial. Therefore, in addition to the interim compensation ordered by the Referee, SAIF is liable for interim compensation from June 24, 1981 through August 16, 1981, less any time worked by claimant. Furthermore, we find the employer's apparent failure to notify SAIF of the claim was unreasonable and order SAIF to pay a penalty of 25% of the interim compensation discussed above, if any is due. SAIF may be entitled to charge the employer for reimbursement of the penalty and attorney fee pursuant to ORS 656.262(3). We affirm the Referee's assessment of a penalty against SAIF.

ORDER

The Referee's order dated February 15, 1983 is affirmed in part and modified in part. SAIF is ordered to pay claimant interim compensation from June 24, 1981 through August 16, 1981, less time worked, a penalty of 25% of the interim compensation due and an attorney fee of $150. The balance of the Referee's order is affirmed. Claimant's attorney is awarded $450 for services before the Board on review.

WILLIAM S. SWENSON, Claimant
Bottini & Bottini, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-06055
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Pferdner's order which awarded claimant 80° for 25% unscheduled permanent disability. Claimant contends he is permanently and totally disabled.

Although we do not find claimant's permanent disability to be total, we find claimant is entitled to a greater award of permanent disability and modify the Referee's order accordingly.

Claimant is a 61-year-old heavy equipment operator who suffered a compensable low back injury in a fall in June 1980. In 1967 claimant had a laminectomy at L5-S1. Also, doctors have noted degenerative disc disease in claimant's lumbar spine. Claimant reported that he had done well since the 1967 surgery and testified that he had no problem performing his job duties prior to the June 1980 injury.

In May 1982, Dr. Vigeland reported that claimant's ongoing low back problem was probably disc herniation and was related in part to the June 1980 injury. Dr. Embick agreed with Dr. Vigeland that

the 1980 injury probably played a role in his present problem. Dr. Kaesche reported that claimant's 1980 industrial injury materially aggravated an asymptomatic, underlying degenerative process. Dr. Cherry ordered a CT scan which showed an abnormality at L5-S1. Further, Dr. Cherry opined that claimant's 1980 injury "did materially worsen his condition and has materially contributed to his present condition." We find the medical evidence as a whole shows that claimant's 1980 injury worsened his underlying degenerative condition. Therefore, we disagree with the Referee's attempt to separate the effects of the degenerative changes from the effects of the 1980 injury. Accordingly, we rate the claimant's disability taking into consideration all of the effects of his 1980 injury.

Our analysis begins with applying the guidelines in OAR 436-65-600 et seq. Claimant's doctors have imposed several restrictions on claimant's activities and have opined that claimant should not return to working as a heavy equipment operator. Based on Drs. Kaesche's and Cherry's assessments of claimant's condition, we assign an impairment factor of +10. Claimant's age of 61 years yields a factor of +10 and his eighth grade education a factor of +10. The vocational preparation required to do claimant's heavy equipment operator job results in a factor of +5 for work experience. Because claimant formerly performed heavy work and is now restricted to light work, we assign +10 for adaptability. We find that only 15% of the labor market is available to claimant and assign a factor of +1 for labor market.

Combining these factors as provided in the rules yields a disability rating of 40%. Comparing that disability rating with other similar cases, we conclude that an award of 40% permanent disability is appropriate in this case.

ORDER

The Referee's order dated January 28, 1983 is affirmed in part and modified in part. That portion awarding claimant 80° for 25% unscheduled permanent disability for his low back is modified so that claimant is awarded 128° for 40% unscheduled permanent disability, an increase of 48° for 15% over that awarded by the Referee and an increase of 128° for 40% over that awarded by Determination Order dated June 10, 1981. Claimant's attorney is allowed 25% of the increase in claimant's permanent disability award as a fee, said fee to be paid out of claimant's disability award and not to exceed $3,000. This fee is in lieu of the fee allowed by the Referee's order. The balance of the Referee's order is affirmed.

SYLVIA TURNBULL, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 82-02855, 82-09564 & 82-09565
December 29, 1983
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Pferdner's order which: (1) Affirmed the Determination Order dated March 15, 1982, which awarded no permanent disability (WCB 82-02855); (2) affirmed St. Mary's Home for Boys' denial of claimant's psychological claim (WCB 82-09565); and (3) affirmed Broadway Motel's denial of claimant's psychological claim (WCB 82-09564). Claimant contends

that she is entitled to an award of permanent disability, that her psychological claims against St. Mary's Home for Boys and Broadway Motel are compensable and that she is entitled to additional temporary disability benefits related to the March 15, 1982 Determination Order.

The Board affirms the Referee's order affirming the March 15, 1982 Determination Order. The Referee made no mention in his order of claimant's claim for additional time loss compensation. Although claimant raised the issue of temporary disability in her request for hearing, at hearing she did not include that issue among the issues to be decided. We decline to address an issue not raised before the Referee.

Regarding claimant's psychological claims, the Board agrees with the Referee's affirmation of St. Mary's Home for Boys' denial. The Board finds the psychological claim made against Broadway Motel, however, to be compensable and reverses the Referee on this issue.

Claimant began working as a maid at the Broadway Motel in June 1981 and worked there for 14 months. Shortly after beginning work at Broadway Motel, claimant saw her treating doctor, Dr. Turner, who recommended psychological evaluation. Claimant saw Dr. Vizzard, psychologist, who reported that claimant was having problems with her work. In June 1982, when Dr. Vizzard moved his practice, claimant began seeing Dr. Christensen, psychologist.

Dr. Christensen reported that claimant confronted many on-the-job stressors including unpredictable hours, excessively heavy work, the manager verbally harassed claimant, claimant was required to work at the desk two or three 24-hour shifts during which the manager came in drunk, demanding money from the cash register and after which claimant would have to work her two-hour maid shift. The manager required claimant to evict tenants, showed no interest when claimant reported that a tenant had attempted to rape her, forced claimant to climb a rickety ladder although she is afraid of heights, tore up rooms after claimant cleaned them and made her clean them again, stole claimant's tips from the rooms and would not provide claimant with necessary supplies. Claimant testified at hearing that these events caused her severe psychological problems, including suicidal thoughts and significant weight loss. Claimant's testimony is supported by the medical and psychological reports. Dr. Christensen reported that the stressors at Broadway Motel were the major contributing cause of the worsening of claimant's underlying depression and her need for intensified psychological treatment.

The Referee found an "incomprehensible variance" between the history recited by Dr. Christensen and claimant's testimony. We do not find claimant's history of being fatigued while doing her maid duties after working a 24-hour shift and her testimony that she averaged less than twelve hours a week to be inconsistent. In fact, we find the history given to Dr. Christensen and claimant's testimony of the events at Broadway Motel to be entirely consistent. Furthermore, we believe the events at Broadway Motel described by claimant to her psychologist and at hearing probably took place, inasmuch as the employer was present and made no attempt to refute claimant's testimony. We find Dr. Christensen's opinion to be persuasive and supported by claimant's uncontradicted account of events, and we find claimant's occupational stress claim against Broadway Motel to be compensable.

ORDER

The Referee's order dated May 11, 1983 is affirmed in part and reversed in part. The portion of the Referee's order affirming Broadway Motel's denial of November 29, 1982 is reversed (WCB 82-09564). Claimant's psychological claim is remanded to Broadway Motel's insurer, the SAIF Corporation, for acceptance. The balance of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services before the Board on review and $800 for services before the Referee, to be paid by the SAIF Corporation.

NANCY E. VANDERPOOL, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-10865
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Seifert's order which: (1) Ordered the SAIF Corporation to pay temporary total disability through November 1, 1982; (2) allowed SAIF to recover an overpayment of temporary disability benefits by deducting claimant's reimbursable mileage expenses from the overpayment; (3) found that claimant was not entitled to an award of permanent disability; and (4) denied claimant's motion to withdraw the issue of extent of permanent disability. Claimant contends she is entitled to temporary disability from November 1, 1982 through January 26, 1983, that SAIF cannot recover the overpayment by deducting reimbursable mileage expenses, and that the Referee erred in denying her motion to withdraw the issue of extent, or in the alternative, that she is entitled to an award of permanent disability.

The Board affirms the Referee on all issues except the recovery of overpayment issue. The Referee allowed SAIF to recover an overpayment by deducting reimbursable mileage expenses from the overpayment, citing OAR 436-54-320. Since the Referee issued his order, however, the Oregon Court of Appeals decided Forney v. Western States Plywood, ___ Or. App. ___ (1983), and Mesa v. Barker Manufacturing Company, ___ Or. App. ___(1983). In Forney, the court held that OAR 436-54-320 is invalid in that it permits the insurer to unilaterally reduce benefits. Forney prohibits an insurer from unilaterally deducting overpayments from current compensation without prior approval from the Referee or Board. Mesa, supra. Therefore, we reverse the Referee's approval of SAIF recovering its overpayment by deducting claimant's reimbursable mileage expenses from the overpayment without prior approval. We affirm, however, the portion of the Referee's order which allows SAIF to recover its overpayment from the temporary total disability benefits awarded by the Referee. Although the Referee relied on the now-invalid administrative rule, we find that the Referee's order constitutes the prior approval required by Forney. SAIF may recover its overpayment from the temporary disability benefits awarded by the Referee as approved by the Referee.

ORDER

The Referee's order dated April 18, 1983 is affirmed in part and reversed in part. The portion of the Referee's order which allows the SAIF Corporation to recover its overpayment by deducting mileage expenses pursuant to the now-invalid OAR 436-54-320 is reversed. SAIF is ordered to pay claimant mileage

expenses for which she has requested reimbursement. The balance of the Referee's order is affirmed. Claimant's attorney is awarded $200 for his services before the Board on review .

KATHY S. WILSON, Claimant
Robert N. Ehmann, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-07351
December 29, 1983
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Mulder's order which affirmed EBI's denial of further benefits and which denied claimant's request for permanent disability. The issues are the propriety of EBI's denial and claimant's entitlement to challenge the insurer's classification of claimant's December 8, 1981 injury as non-disabling.

The Board affirms the order of the Referee with the following comments. The denial issued by EBI was not a denial of compensability of the December 8, 1981 claim, but only of further benefits on the grounds that claimant's continuing hip and leg problems are related to her September 1, 1980 injury insured by Industrial Indemnity. By affirming EBI's denial, claimant will not receive further benefits from EBI. Nothing in this order, however, prevents claimant from obtaining further medical benefits under ORS 656.245 or from asserting future aggravation rights under ORS 656.273 with regard to her September 1980 Industrial Indemnity claim. Furthermore, the parties' discussion of an aggravation claim with regard to the December 1981 incident, presumably against Industrial Indemnity, is inappropriate here inasmuch as the December 1981 claim was accepted by EBI as a new injury.

ORDER

The Referee's order dated April 11, 1983 is affirmed.

LAWRENCE M. SULLIVAN, Claimant
Kenneth D. Peterson, Claimant's Attorney
Kottkamp & O'Rourke, Defense Attorneys

WCB 81-06349
October 26, 1983
Order of Abatement

The Board has received a motion to reconsider our Order on Review dated September 28, 1983.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and the insurer is requested to file a response to the motion for reconsideration within ten days.

IT IS SO ORDERED.

BETTY L. COUNTS, Claimant
Bischoff & Strooband, Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorney s

WCB 82-01199
October 19, 1983
Order of Abatement

The Board has received a motion to reconsider our Order on Review dated September 22, 1983.

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

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation
of Steven Bauman, Claimant.

BAUMAN,
Respondent on review,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Petitioner on review.

(No. 80-04870, CA A24941, SC 29596)

In banc.*

On review from the Court of Appeals.**

Argued and submitted August 3, 1983.

Darrell E. Bewley, Appellate Counsel, Salem, argued the cause and filed the petition and brief for petitioner on review.

Gerald C. Doblie, Portland, argued the cause for respondent on review. With him on the brief was Doblie, Francesconi & Welch, P.C., Portland.

JONES, J.

The Court of Appeals is affirmed and the case is remanded to the Workers' Compensation Board for reconsideration not inconsistent with this opinion.

* Linde, J., did not participate in this decision.

Justice Lent was Chief Justice when case was argued; Justice Peterson was Chief Justice when decision was rendered.

** Judicial review from Workers' Compensation Board. 62 Or App 323, 66 P2d 105 (1983).

JONES, J.

This case arises under the Workers' Compensation Act. We allowed review to determine the permanency of SAIF's original acceptance of a claim for medical benefits. We hold that once an insurer has accepted a claim under ORS 656.262(6), which requires acceptance or denial of a workers' compensation claim within 60 days after the employer has notice or knowledge of the claim, the insurer may not subsequently deny the compensability of the underlying claim.

FACTS

Claimant was a tool and die maker at Omark Industries. In October of 1977, claimant alleged that a bursitis condition was compensable as connected with his employment. On November 16, 1977, his claim was accepted by Omark and its compensation carrier, State Accident Insurance Fund Corporation (SAIF), as a nondisabling "medical only claim" and SAIF thereafter began paying medical benefits to the claimant. In February of 1980, claimant's condition

worsened and his treating physician petitioned SAIF to reopen the claim, stating that claimant was in need of additional medical treatment. SAIF denied this request stating that "unless there is time loss and/or impairment involved, it is not necessary that we reopen the claim to pay for the necessary treatment." In November of 1980, SAIF halted further medical payments concluding independently that the initial bursitis condition was not a compensable injury, as it did not arise out of and in the course of claimant's employment. SAIF reversed its acceptance of the claim and denied the original claim for compensation benefits. Claimant thereafter timely requested a hearing within the 60-day period provided for in ORS 656.262(7).

The referee, apparently relying on our decision in *Frasure v. Agripac,* 290 Or 99, 619 P2d 274 (1980), found that SAIF's denial was timely made and correct. Upon appeal, the Board upheld the referee also concluding that SAIF possessed the authority to reopen and reconsider a previously accepted claim and upon reevaluation of the compensability issue to deny benefits. On the merits the Board found that the medical opinion presented at the hearing supported the conclusion that claimant's condition was not compensable.

We said in *Frasure v. Agripac, supra:*

> "* * * It is better to encourage prompt payment than it is to discourage it by holding that the insurer who makes payment of medical expenses under ORS 656.245 is estopped to contest coverage with respect to an aggravation claim under ORS 656.273. We hold that the payment of medical expenses under ORS 656.245 following the filing of a claim for aggravation does not amount to an acceptance of the aggravation claimed by the employer or the insurer, and does not estop the employer or insurer from contesting the causal connection between the previously determined compensable injury and the claimant's present symptoms." *Id.* at 106, quoting *Jacobson v. SAIF,* 36 Or App 789, 793, 535 P2d 1146 (1978).

Frasure involved an aggravation claim and two distinct and separate employers. The first employer and its insurer accepted the claimant's aggravation claim and awarded time loss only. Between the time of the award and a requested hearing, the claimant's doctors changed their opinion and concluded the claimant's injury was a "new injury" rather than aggravation of an old injury. We held that the first employer was not estopped by his earlier acceptance of the aggravation claim from denying responsibility at the hearing requested by the claimant. In the present case, the Court of Appeals concludes that our holding in *Frasure* does not foreclose the possibility that there can be finality to an employer's or insurer's acceptance of a claim. This is a correct reading of the rule in *Frasure* and this is an appropriate case to clarify any confusion that may exist. In *Frasure,* we said:

> "One of the manifest purposes of Oregon's Workers' Compensation Law is to achieve prompt payment of claims to injured workers. The responsibility for making such payments is imposed on compensation carriers and direct responsibility employers, and such payments are to be made '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 direct responsibility

employer or corporation.' ORS 656.262(2). The first payment must be paid 'no later than the 14th day after the subject employer has notice or knowledge of the claim.' ORS 656.262(4). Written notice of acceptance or denial of the claim must be given to the claimant within 60 days 'after the employer receives notice or knowledge of the claim.' ORS 656.262(5). ORS 656.262(8) provides for a 25 percent penalty for unreasonable delay * * * in acceptance or denial of a claim.

The legislature further provided, in the same statute, that acceptance of a claim or payment of compensation did not prevent the employer or carrier from subsequently denying the claimant's right to compensation. ORS 656.262(7) provides:

> '(7) Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof.' " *Id.* at 105.

We must retreat slightly from what we said in *Frasure*. We are dealing with the statutory scheme found in the relevant parts of ORS 656.262.[1] Former ORS 656.262(7)

(now codified as subsection (8)), relates to the provisions found in ORS 656.262(4), *supra* n 1, which requires the insurer to begin payments within 14 days after notice or knowledge of a claim. In *Frasure*, we indicated that former ORS 656.262(7) allowed an employer to accept a claim and then subsequently to deny the right to compensation. This is not correct. Former

[1] ORS 656.262 provides in relevant part:

"(2) 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.

"* * * * *

"(4) The first instalment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. Thereafter, compensation shall be paid at least once each two weeks, except where the director determines that payment in instalments should be made at some other interval. The director may by rule convert monthly benefit schedules to weekly or other periodic schedules.

"* * * * *

"(6) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or burial expenses. The insurer shall also furnish the employer a copy of the notice of acceptance. The notice of acceptance shall:

(a) Advise the claimant whether the claim is considered disabling or nondisabling.

(b) Inform the claimant of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury of the claimant is nondisabling by requesting a determination thereon pursuant to ORS 656.268.

(c) Inform the claimant of employment reinstatement rights under ORS chapter 659.

(d) Inform the claimant of assistance available to employers for job site modification under ORS 656.622.

"(7) If an insurer or any other duly authorized agent of the employer for such purpose, on record with the Director of the Workers' Compensation Department denies a claim for compensation, written notice of such denial, stating the reason

ORS 656.262(7) merely provides protection to the insurer who begins payments without accepting a claim from having the payments interpreted as acceptance of the claim. What we should have clearly stated was that because an employer complies with the provisions found in subsection (4) and begins making compensation payments no later than the 14th day after notice of the claim, the employer is not subsequently barred from denying the claimant's right to compensation. This is the rule found in former subsection (7). This is so because the threshold payment of benefits within 14 days is not contingent upon a determination of compensability and simple compliance with the statute does not constitute acceptance of a claim by an insurer.

In this case, SAIF specifically accepted a claim as compensable by providing the claimant with an acceptance letter and subsequently paying medical benefits for a three-year period. It was only after claimant attempted to reopen his claim for aggravation that SAIF suddenly reversed its decision and denied compensability for the original claim. SAIF was too late. To allow the employer or the employer's insurer to engage in such vacillating activity would encourage degrees of instability in the workers' compensation system that we do not believe the statute contemplates. ORS 656.262(6) gives the insurer or self-insured employer 60 days after notice of the

claim in which to accept or deny the claim. If, as in this case, the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. The insurer or self-insured employer is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate the issue of compensability. We need not list all of the possible ramifications of such conduct but it is readily evident that problems involving lapsed memories, missing witnesses, missing medical reports, and a host of other difficulties would arise from the delayed litigation of the compensability of a claim. The statutory scheme in ORS 656.262 envisions a speedy resolution of workers' compensation claims including a penalty provision, ORS 656.262(9), for unreasonable delays to pay compensation or unreasonable delays in the acceptance or denial of a claim. Not only can a penalty be imposed for the unreasonable delay of accepting or denying a claim, but we hold that once a claim has been accepted the insurer or self-insured employer may not withdraw such acceptance.

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for the denial, and informing the worker of hearing rights under ORS 656.283, shall be given to the claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the insurer. The worker may request a hearing on the denial at any time within 60 days after the mailing of the notice of denial.

"(8) Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof.

"(9) 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 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

Accordingly, we agree with the Court of Appeals that it was not permissible for SAIF to reconsider and deny the previously accepted claim and that the Board erred in allowing this belated denial. We remand the aggravation claim to the Board for reconsideration not inconsistent with this opinion.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Peter J. Russ, Claimant.

PHIL A. LIVESLEY CO. et al,
Petitioners on Review,

v.

RUSS,
Respondent on Review.

(WCB 80-03289, CA A22795, SC 29140)

On Review from the Court of Appeals.*

Argued and submitted March 7, 1983.

Patric J. Doherty, Portland, argued the cause for Petitioners on Review. With him on the petition and brief were Dennis R. VavRosky and Rankin, McMurry, VavRosky and Doherty, Portland. Also on the brief in the Court of Appeals was Ronald W. Atwood.

Michael J. Hansen, Salem, argued the cause for Respondent on Review. Also on the brief was Thorbeck and Hansen, Salem.

Before Lent, C. J.**, and Peterson***, Campbell, Roberts, Carson and Jones, Justices.

CARSON, J.

The Court of Appeals is affirmed.

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* Judicial Review of the Workers' Compensation Board Order of Review. 60 Or App 292, 653 P2d 274 (1982).

** Chief Justice when case was argued.

*** Chief Justice when decision rendered.

CARSON, J.

This workers' compensation case presents the question of whether an employee is entitled to benefits for injuries sustained in an unexplained on-the-job fall. We conclude that he is, provided he establishes that the fall occurred during the course of his employment and that it was not caused by idiopathic factors.[1]

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[1] We use the term "idiopathic," as it is used by the Court of Appeals and Professor Larson, to mean "peculiar to the individual" and not "arising from an unknown cause." Idiopathic refers to an employee's pre-existing physical weakness or disease which contributes to the accident. 1 A. Larson, Workmen's Compensation Law § 12.00.

The relevant historical facts are uncontested. Claimant was working at his employer's food-processing plant on February 5, 1980, when he sustained his injury. He had just completed a full eight-hour shift sorting onions on a production line. He was walking down a crowded aisle from his work station to the time-clock to punch out, when he unaccountably fell and broke his right hip. He underwent surgery and was ultimately released to return to regular work in September, 1980.

Although the cause remains unknown, the circumstances of claimant's fall are not in dispute. The area where the fall occurred was crowded but it was free from debris or any substance which could account for a slip or trip. Claimant testified that he did not get dizzy, experience vertigo, or lose consciousness prior to the fall. He was unable himself to offer a cause for the fall, however, and admitted that all he could remember of the incident was simply falling. His doctor discounted any pre-existing condition or weakness that could have caused claimant to fall[2] and employer has conceded that the fall was not idiopathic in nature. Employer and its insurer have denied liability, contending that an unexplained fall is noncompensable.[3]

Whenever compensability of an accidental injury is at issue, one question of fact to be resolved is whether the

injury was one "arising out of and in the course of [the claimant's] employment." ORS 656.005(8)(a). The worker has the burden of proving that the injury arose out of and in the course of employment. *Ballou v. Industrial Accident Com.*, 214 Or 123, 328 P2d 137 (1958). Although this statutory definition seems to contemplate a bifurcated test, in *Rogers v. SAIF*, 289 Or 633, 639-644, 616 P2d 485 (1980), we adopted a unitary "work-connection" approach: "is the relationship between the injury and the employment sufficient that the injury should be compensable?" 289 Or at 642. We noted that this unitary test was not intended to "substantially change" existing law:

> "* * * If the injury has sufficient work relationship, then it arises out of and in the course of employment and the statute is satisfied. Existing law regarding proximity, causation, risk, economic benefit, and all other concepts which are useful in determining work relationship remain applicable." 289 Or at 643.

In *Rogers*, we quoted from Professor Larson as follows:

> "In practice, the 'course of employment' and 'arising out of employment' tests are not, and should not be, applied entirely independently; they are both parts of a single test of work-connection, and therefore deficiencies in the strength of one factor are sometimes allowed to be made up by strength in the other. *Id*, § 29.00 at 5-354." 289 Or at 643, n. 3.

Professor Larson further explains the unitary work-connection approach:

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[2] Claimant had experienced episodes of vertigo in the past. However, the referee and the Court of Appeals on *de novo* review determined that this condition was not a factor in claimant's fall on February 5, 1980.

[3] The referee awarded compensation in this case. The Workers' Compensation Board agreed. The Court of Appeals affirmed the Board.

"One is almost tempted to formulate a sort of quantum theory of work-connection that a certain minimum quantum of work-connection must be shown, and if the 'course' quantity is very small, but the 'arising' quantity is large, the quantum will add up to the necessary minimum, as it will also when the 'arising' quantity is very small but the 'course' quantity is relatively large. But if both the 'course' and 'arising' quantities are small, the minimum quantum will not be met." 1A A. Larson, Workmen's Compensation Law § 29.10 at 5-355.[4]

We now turn to the facts of the present case in light of the "course of employment" and "arising out of employment" criteria, which we now recognize as two parts of a single work-connection analysis. We first determine whether the accident occurred "in the course of employment," that is, whether the injury occurred while claimant was at work or engaged in a work-related activity. The time, place and circumstances under which the accident takes place must be considered. *Blair v. State Ind. Acc. Com.*, 133 Or 450, 454, 288 P 204 (1930). The accident here happened during working hours,[5] on the work premises, while claimant was performing a task that was required by employer for its benefit, namely, walking from his work station to the time-clock to punch out. The "course of employment" test is easily met.

We next consider the "arising out of employment" test. An employer, of course, is not liable for any and all injuries to its employees irrespective of their cause, and the fact that an employee is injured on the premises during working hours does not of itself establish a compensable injury. The employee must show a causal link between the occurrence of the injury and a risk connected with his or her employment. *Blair v. State Ind. Acc. Com., supra,* 133 Or at 455. In *Clark v. U.S. Plywood,* 288 Or 255, 260, 605 P2d 265 (1980), for example, we noted that an employee who suffers an appendicitis attack on-the-job is not entitled to workers' compensation benefits; neither is a self-inflicted on-the-job injury compensable, pursuant to ORS 656.156(1).

The question then is whether there is a sufficient causal connection between claimant's unexplained fall and his employment, such that the injury "arose" from the employment. This is truly a case of an unexplained fall because the cause of the accident cannot be directly established. Professor Larson states the problem this way:

"All risks causing injury to a claimant can be brought within three categories: risks distinctly associated with the employment, risks personal to the claimant, and 'neutral'

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[4] Examples of cases with strong "arising" factors but weak "course" factors are where recoveries are allowed off the employment premises, outside business hours, when an employee going to or coming from work is injured by a hazard distinctly traceable to the employment, such as a traffic jam overflowing from the employment premises. Examples of the opposite situation, strong "course" elements and weak "arising" elements, are unexplained fall and other neutral-cause cases. 1A A. Larson, *supra,* § 29.10 at 5-355.

[5] The course of employment is not confined to the actual manipulation of the tools of work nor to the exact hours of work. *Kowcun v. Bybee,* 182 Or 271, 186 P2d 790 (1947). Compensation lies for all activities related to the employment if it carries out the employer's purposes or advances the employer's interest directly or indirectly. *Clark v. U.S. Plywood,* 288 Or 255, 267, 605 P2d 265 (1980).

> risks — i.e., risks having no particular employment or personal character. Harms from the first are universally compensable. Those from the second are universally noncompensable. It is within the third category that most controversy in modern compensation law occurs. The view that the injury should be deemed to arise out of employment if the conditions of employment put claimant in a position to be injured by the neutral risk is gaining increased acceptance." 1 A. Larson, *supra*, § 7.00 at 3-11.[6]

In the present case, the Court of Appeals agreed with the findings of the Workers' Compensation Board that the medical reports and lay testimony persuasively eliminated all idiopathic factors of causation. Under the Court of Appeals' neutral risk analysis, a fall due to idiopathic causes is not compensable; neither is one where it is equally possible that its cause was idiopathic or work-related. However, a truly unexplained fall that occurs on the employer's premises, during working hours, while the employee is performing required duties is compensable if the employee can eliminate idiopathic causes. We agree.

This result is not inconsistent with the cases petitioners cite. In *Mackay v. SAIF*, 60 Or App 536, 654 P2d 1144 (1982), recovery was denied for an unexplained fall at the work place. However, the present case is distinguishable from *Mackay* because here claimant has eliminated any idiopathic causes for his fall. In *Mackay*, the court found that the claimant's evidence showed no more than that it was equally possible that the cause of her fall, her buckling knee, was idiopathic as that it was work-connected. That was not enough to satisfy her burden of proof that the cause of her fall was work-connected and, therefore, her fall was not compensable. *Mackay v. SAIF, supra*, at 539.

So, too, in *Puckett v. Wagner*, 6 Or App 269, 487 P2d 897 (1971), which has been cited as an "unexplained fall" case, there was evidence of idiopathic causation. The claimant in *Puckett* had been sent home early from work because he had

been drinking. While leaving the employer's premises, he fell and was injured. The personal risk of voluntary intoxication removes *Puckett* from the neutral risk category.

Similarly, the claimant in *Raines v. Hines Lbr Co.*, 36 Or App 715, 585 P2d 721 (1978), died from a heart attack for which there were two equally plausible explanations. Decedent's employer presented medical evidence of his pre-existing arteriosclerotic heart condition and hypertension. His widow offered the explanation that he was subjected to on-the-job stress prior to his heart attack. Because the evidence could support both theories equally, the Court of Appeals held that the decedent's widow had not met her burden to prove work-connection.

[6] Some other examples of neutral risks would be an employee, who while working, is hit by a stray bullet, bitten by a mad dog, struck by lightning, or injured by debris from a distant explosion. Another kind of neutral risk is that where the cause itself is unknown. An employee may have died on the job from unexplained causes or been attacked on the job by unknown persons, whose motives may have been personal or related to the employment. 1 A. Larson, *supra*, § 7.30.

Otto v. Moak Chevrolet, 36 Or App 149, 583 P2d 594 (1978) *rev den,* 285 Or 319 (1979), was not an unexplained fall or death case. Nevertheless, petitioner cites it, so we have considered it carefully. The Court of Appeals in *Otto,* held that a claimant who was injured when she pulled up her underwear and slacks after using the toilet facilities on her employer's premises during working hours, was not entitled to compensation because the injury could have occurred at some other place. The majority in *Otto* found an insufficient causal link between the risk of the claimant's employment and her injury. *Otto* was decided before *Rogers v. SAIF, supra,* where this court recognized the full implications of a unitary work-connection analysis. In *Otto,* the "course of employment" factors were conceded; the only issue that the Court of Appeals considered was the "arising out of" element. We now recognize that while risk and causation are important factors in a work-connection analysis, they are but two of many factors, and even when risk and causation are weak, compensation is not automatically foreclosed. We note Professor Larson's warning on this subject:

> "* * * it should never be forgotten that the basic concept of compensation coverage is unitary, not dual. * * * [A]n uncompromising insistence on independent application of the two portions of the test can, in certain cases, exclude clearly work-connected injuries." 1 A. Larson, *supra,* § 6.10 at 3-2.

Oregon caselaw has rejected the largely obsolete "peculiar-risk" and "increased-risk" considerations which the majority in *Otto* quoted with approval from an Arizona case.

In analyzing the risk factor we now determine whether the injury had its origin in a risk connected with the employment or rationally and naturally incidental thereto. *Stuhr v. State Ind. Acc. Com'n,* 186 Or 629, 636-37, 208 P2d 450 (1949). In *Jordan v. Western Electric,* 1 Or App 441, 443, 463 P2d 598 (1970), the Court of Appeals phrased the issue as whether the activity was an "ordinary risk" of the employment, citing *Stuhr v. State Ind. Acc. Com'n, supra.* In *Otto,* there was no finding that the claimant presented affirmative evidence to exclude idiopathic factors as the cause of her injury. In the present case, where idiopathic causes for an unexplained fall have been eliminated, the inference arises that the fall was traceable to some ordinary risk, albeit unidentified, to which the employment premises exposed the employee. *Larsen v. State Ind. Acc. Com.,* 135 Or 137, 140, 295 P 195 (1931).

Petitioners contend that this result in unexplained fall cases relieves claimants of their burden of proving work-connection. We do not agree. The facts found by the referee and the Court of Appeals permit the reasonable inference that the fall was caused by the employment environment. Claimant has met his burden of eliminating idiopathic causes. There is no finding that any force or condition independent of the employment caused the fall. Claimant was engaged in the duties of his employment, on employer's premises, and exposed to the risks inherent in his work environment. In such a situation, where the "course of employment" test is so fully met, where the cause-in-fact cannot be directly established, and where claimant has met his burden of eliminating idiopathic causes, we construe the Workers' Compensation Law

to allow the inference that the unexplained fall "arose out of" claimant's employment.

Because the "course of employment" elements are strong, because personal risks are eliminated, and because the "arising" elements are incapable of direct determination, we hold that the administrative agency and the Court of Appeals could find that claimant has carried his burden of proof and that the unitary work-connection test is sufficiently satisfied to allow compensation for this unexplained fall.

The Court of Appeals is affirmed.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Catherine Bailey, Claimant.

BAILEY,
Petitioner on review,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent on review.

(No. 77-7554, CA A24892, SC 29294)

In Banc*

On review from the Court of Appeals.**

Argued and submitted June 8, 1983.

Kenneth D. Peterson, Jr., Hermiston, argued the cause and filed the petition and brief for petitioner on review.

Darrell E. Bewley, Appellate Counsel, SAIF Corporation, Salem, argued the cause for respondent on review. With him on the brief was Donna Parton, Assistant Appellate Counsel, Salem.

JONES, J.

The Court of Appeals is reversed and this case is remanded to the Workers' Compensation Board for further proceedings not inconsistent with this opinion.

Peterson, C. J., filed a concurring opinion.

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* Justice Lent was Chief Justice when case argued; Justice Peterson was Chief Justice when decision rendered.

** Judicial review from Workers' Compensation Board. 61 Or App 225, 656 P2d 964 (1982).

JONES, J.

This is an appeal from a denial of a claim for workers' compensation benefits for an alleged occupational disease. The claimant challenges the refusal of the Workers' Compensation Board (Board) to remand her case to the referee for the taking of additional evidence. The Court of Appeals affirmed the Board's ruling.

Claimant was employed at Bramco, Inc., a fiberglass boat manufacturing company, between September, 1974, and April, 1977. In 1976, she was required to perform work using varnish which contained acetone. Initially, this work was done outside, but was subsequently undertaken indoors. The ventilation was allegedly poor and some of the other employes were provided with respirators. Claimant saw a doctor in January of 1977, complaining of fever, cough, and throat and chest pain. On September 2, 1977, claimant filed a report of an occupational disease claiming her work environment as the cause of her respiratory condition.[1] On April 14, 1981, a hearing was held to determine the compensability of this claim.[2] The issue at the hearing was the causation of claimant's respiratory condition. Claimant had been represented by a prominent workers' compensation attorney who withdrew from the case. Claimant, accompanied by her husband, represented herself at the hearing. The medical reports indicated that she was suffering from sarcoidosis, a disease not related to her employment or industrial exposure. The medical report most favorable to claimant stated only that her condition was most likely due to breathing "something" over a course of months or years.

The referee issued an opinion and order on May 11, 1981, denying compensability, and claimant appealed the order to the Board. Subsequently, but prior to the Board's issuance of an order, claimant retained an attorney and filed a

motion based on ORS 656.295(5) to remand the case for the taking of further evidence, alleging that the case had been "incompletely or otherwise insufficiently developed" before the referee. The Board denied the motion because the evidence proffered by claimant to substantiate her claim of incompleteness had been obtainable at the time of the hearing. Thereafter, the Board issued a final order affirming the order of the referee.

The Court of Appeals affirmed the action of the Board without opinion. Claimant petitioned this court for review of both the decision of the Court of Appeals and the final order of the Board.

ORS 656.295(5) provides:

> "The review by the board shall be based upon the record submitted to it under subsection (3) of this section and such oral or written argument as it may receive. However, if the board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee, it may remand the case to the referee for further evidence taking, correction or other necessary action."

ORS 656.295(5) imposes a two-step process on the Board when a claimant requests review and remand of an order of the referee for the taking of additional evidence. First,

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[1] Throughout the record the parties refer to the claimant's "respiratory condition." ORS 656.802(1)(a) defines an "occupational disease" (for persons other than fire fighters) as "[a]ny disease or infection * * *." The accurate use of statutory terms by the parties would facilitate judicial review.

[2] ORS 656.804 provides:

> "An occupational disease, as defined in ORS 656.802, is considered an injury for employes of employers who have come under ORS 656.001 to 656.794, except as otherwise provided in ORS 656.802 to 656.824."

the Board reviews the record, as defined, and determines whether the case has been "improperly, incompletely or otherwise insufficiently developed." Second, if this question is resolved in the affirmative, the Board exercises its discretion to determine whether to remand the case.

The Board's order on review stated:

> "The Board standards governing remands are stated in its administrative rules as interpreted in *Robert Barnett,* 31 Van Natta 172 (1981). Claimant has previously conceded that her motion for remand does not satisfy the *Barnett* standards and the Board has previously denied remand by order dated April 30, 1982.
>
> "Claimant's reply brief advises that an appeal to the Court of Appeals is certain regardless of the Board's ruling on review. If that forecast proves to be true and if the Court of Appeals concludes that motions to remand should be governed by some standard other than that articulated in the Board's rules as interpreted in *Barnett,* it would avoid future needless appeals if the Court of Appeals would clearly define what it regards the test for remand requests to be."

The Board in *Robert Barnett,* 31 Van Natta 172 (1981), was construing a motion by the EBI Company which it regarded as being in the nature of a motion to remand to the referee on the ground of newly discovered evidence. The Board stated, after noting that ORS 656.295(5) authorized it discretion to remand to a referee "for further evidence taking," that the Board's discretion was limited by its own rules, citing OAR 436-83-700(5), which states:

> "If Board review is sought on newly-discovered evidence, the request should conform to Rule 83-480(2)."

This latter procedural rule was adopted for referees and it provides:

> "WHEN REFEREE MAY REQUIRE ADDITIONAL EVIDENCE
>
> "The referee may reopen the record and reconsider his decision before a notice of appeal is filed or, if none is filed, before the appeal period expires. Reconsideration may be upon the referee's own motion or upon a motion by a party showing error, omission, misconstruction of an applicable statute or the discovery of new material evidence.
>
> "(2) A motion to reconsider shall be served on the opposite parties by the movant and, if based on newly discovered evidence, shall state:
>
> "(a) The nature of the new evidence; and
>
> "(b) An explanation why the evidence could not reasonably have been discovered and produced at the hearing." OAR 436-83-480(2).

In *Barnett,* the Board then adopted OAR 436-83-480(2) as its own interpretation of its own rule governing remands,[3] which was originally intended for actions by the

[3] ORS 656.295(5) mandates that the Board's review shall be on the transcription of the oral proceedings and exhibits at the hearing before the referee and such oral and written argument as the Board receives. The Board has no authority whatsoever to consider newly discovered evidence. We agree with the straightforward look at the text of the statute that the Court of Appeals noted in *Muffett v. SAIF,* 58 Or App 684, 650 P2d 139 (1982), where in footnote 1, *id.* at 686, after quoting ORS 656.295(5), the

referee. To complicate matters, the Board in *Barnett* then said:

> "* * * To merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing. * * *" *Barnett* at 173.

The purpose of this statement apparently was to provide criteria for the Board's review to remand as well as standards for the referee's consideration to reopen a case.

It must be remembered that we are considering the actions of an administrative board designed to be flexible in its search for accurate facts and just conclusions. The formal rules of evidence designed for trials are relaxed. Decisions on compensability may be reopened to develop completely the record with much greater ease than judgments in civil cases where one of the parties wishes to set aside, for example, a judgment for newly discovered evidence.[4] In a workers' com-

pensation case the Board may in effect reopen the case and remand it to the referee "for further evidence taking, correction or other necessary action" if the Board determines "that a case has been improperly, incompletely or otherwise developed or heard by the referee." ORS 656.295(5). Nothing was said by the legislature about newly discovered evidence, nor about evidence that was available, but not produced, nor about evidence that could have been produced with due diligence.

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court said:

> "The Board had no power to consider any evidence not already included in the record. Its only statutory power was to remand the case to the referee for further evidence taking. *Gallea v. Willamette Industries*, 56 Or App 763, 643 P2d 390 (1982); *Brown v. SAIF*, 51 Or App 389, 625 P2d 1351 (1981); *Penfold v. SAIF*, 49 Or App 1015, 621 P2d 646 (1980). * * *"

The Board expressed some doubt as to whether it has authority to decide a case based upon the newly discovered evidence when it said in *Robert Barnett*, 31 Van Natta 172 (1981):

> "There is some doubt whether, absent stipulation of the parties, this Board can consider evidence that was not introduced before a Referee. See *Brown v. SAIF*, 51 Or App 389 (1981). * * *" *Id.* at 172.

It is clear from our discussion above that the Board has no such authority.

[4] ORCP 64 provides in pertinent part:

> "B. A former judgment may be set aside and a new trial granted in an action where there has been a trial by jury on the motion of the party aggrieved for any of the following causes materially affecting the substantial rights of such party:
>
> "B.(1) Irregularity in the proceedings of the court, jury or adverse party, or any order of the court, or abuse of discretion, by which such party was prevented from having fair trial.
>
> "B.(2) Misconduct of the jury or prevailing party.
>
> "B.(3) Accident or surprise which ordinary prudence could not have guarded against.
>
> "B.(4) Newly discovered evidence, material for the party making the application, which such party could not with reasonable diligence have discovered and produced at the trial.
>
> "B.(5) Insufficiency of the evidence to justify the verdict or other decision, or that it is against law.
>
> "B.(6) Error in law occurring at the trial and objected to or excepted to by the party making the application."

The Board, in applying its ruling in *Barnett* to this case, has scrambled the legal eggs. *Barnett* dealt with "newly discovered evidence"; this case involves evidence that was not strictly in existence, but which admittedly could have been developed with due diligence. The evidence the claimant wishes to have considered by the referee is not "newly discovered evidence" as defined by ORCP 64 B.(4): "material * * * which such party could not with reasonable diligence have discovered and produced at the trial." Further, the claimant admits in her brief that the evidence she wishes to have considered was "obtainable with due diligence," thus not satisfying the standard in *Barnett*. The evidence sought to be produced did not *exist* at the time of the hearing—the second lawyer *developed* it. SAIF acknowledges in its brief that the new reports were not "newly discovered evidence," but newly *created* evidence. These reports, dated after the hearing, were:

1. A report from Dr. Buist, M.D., dated August 3, 1981, which states the claimant's work exposure was a material contributing cause of the worker's respiratory condition.

2. A report from Dr. Olson, M.D., who wishes to study the problem further.

3. A report from Professor Peter Breysse, University of Washington Department of Environmental Health, stating, "there is no doubt in my mind that her employment in the boat plant was responsible for her present respiratory condition."

The problem with applying the newly discovered evidence *Barnett* standards to this case is obvious. This case deals with a potentially incompletely developed record, not with newly discovered evidence. What the Board did in *Barnett* was this:

1. The Board first recognized that it has the power to remand "if the board determines that a case has been

improperly, incompletely or otherwise insufficiently developed or heard by the referee." ORS 656.295(5).

2. Then the Board stated that one reason why a case might be remanded is on the ground of newly discovered evidence.

3. The Board noted the corollary statute, ORS 656.298(6), permits the Court of Appeals to "hear additional evidence concerning disability that was not obtainable at the time of the hearing."

4. The Board further noted that the Court of Appeals, in a series of cases, had construed ORS 656.298(6) to require that before the Court of Appeals would apply that statute, there must be a showing that such evidence was unavailable at the hearing and could not have been obtained by reasonable effort. *Logue v. SAIF*, 43 Or App 991, 607 P2d 750 (1979); *Petersen v. Travelers Insurance*, 21 Or App 637, 536 P2d 448 (1975); *Maumary v. Mayfair Markets*, 14 Or App 180, 512 P2d 1370 (1973).

5. Finally, the Board adopted, as its own doctrine, a similar rule: "To merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing." *Barnett* at 173. In reaching this conclusion, the Board noted its own rule relative to reopening a

hearing before the referee, OAR 436-83-480(2).

The Workers' Compensation Board has chosen to limit remands on the basis of "newly discovered evidence" to cases where there is a showing that the evidence "could not reasonably have been discovered and produced at the hearing" and, further, "to merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing." We agree that the rule is permissible for remands for "newly discovered evidence." However, the Board has not articulated rules[5] for myriad other situations in

which a case may be "improperly, incompletely or otherwise insufficiently developed or heard" under ORS 656.295(5).

We, therefore, reverse and remand this case to the Board to make a decision under ORS 656.295(5) as to whether the case should be remanded to the referee because the "case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee." In making that decision, the Board should not apply its inapplicable rule, OAR 436-83-700(5).

Reversed and remanded.

[5] ORS 656.726(5) states:

"The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. Such rules may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings."

PETERSON, C. J., concurring

I agree with the result, but upon a different analysis. In denying the claimant's motion the Board relied upon two rules, OAR 436-83-480 and OAR 436-83-700(5), which have no application to Board consideration of motions to remand for further evidence taking, correction, or other necessary action. For this reason, the case should be remanded to the Board.[1]

I disagree with the newly-discovered evidence/newly-created evidence dichotomy discussed on pages 5-8 of the majority opinion. I believe that "newly-created evidence" is a species of newly-discovered evidence which, by definition, could have been discovered and produced at the hearing before the referee. Therefore, a separate rule need not be promulgated to cover "newly-created evidence."

[1] The Board can promulgate a rule that in considering motions to remand under ORS 656.295(5) the party would have to make the type of showing required under present OAR 436-83-480(2).

IN THE SUPREME COURT OF THE STATE OF OREGON

WALLACE,
Respondent on Review,
v.
GREEN THUMB, INC.,
Petitioner on Review.

(WCB No. 81-02577; CA A24243; SC 29443)

In Banc

On review from the Court of Appeals.*

Argued and submitted June 8, 1983.

Emil R. Berg, Portland, argued the cause for petitioner on review. With him on the briefs was Wolf, Griffith, Bittner, Abbott & Roberts, Portland.

Charles S. Tauman, Portland, argued the cause for respondent on review. With him on the briefs was Willner, Bennett, Bobbitt & Hartman, Portland.

LENT, J.

Affirmed.

* On judicial review from order of Workers' Compensation Board dated March 23, 1982. 61 Or App 695, 658 P2d 560 (1983).

LENT, J.

The issue is whether an injury sustained on the employer's premises during personal comfort activities by a resident employee continuously on call[1] is compensable. We hold that it is and affirm the Court of Appeals. The employer's denial of the claim was affirmed by the referee and the Workers' Compensation Board. Claimant requested judicial review, and the Court of Appeals reversed and remanded with instructions to accept the claim. *Wallace v. Green Thumb, Inc.*, 61 Or App 695, 658 P2d 560 (1983).

Claimant was the caretaker of a rural fire station used by a volunteer fire department. Among his duties was responding to every fire alarm by preparing the station and

[1] We define, for purposes of this opinion, the term "resident employee" to mean any employee who is required due to the nature of the employment to reside on employer's premises, and the term "continuously on call" to mean a requirement that the employee be available for duty twenty-four hours a day.

The record is not completely clear as to the relationship between the fire department and Green Thumb, Inc. The claim was originally denied by "GAB Business Services, Inc.," which appears to be some kind of service agency for the Workers' Compensation insurer for Green Thumb, Inc. In its brief on review by the Workers' Compensation Board, the employer/insurer stated that the fire and injury "occurred in a mobile home owned by the claimant and parked on the employer's premises. * * * At the time of his initial employment, the claimant's mobile home was moved onto property immediately adjacent to the Mosier Fire Station which was owned by the employer."

fire truck for the arrival of the volunteer firemen. Claimant was on call 24 hours a day and was required by the employer to live on the fire station premises. He lived in his own mobile home, which had been moved onto the premises and connected to utilities by the employer. He was injured while preparing a meal when a fire started in the butane stove of this mobile home.

ORS 656.005(8)(a) defines a "compensable injury" as an accidental injury "arising out of and in the course of employment * * *." When interpreting the language "arising out of and in the course of employment," this court has "repeatedly cautioned that the reading of other decisions is normally of little assistance when this issue is presented and that each case must be decided on its own particular facts." *See, e.g., Ramseth v. Maycock,* 209 Or 66, 70-71, 304 P2d 415 (1956). Two of our recent decisions, however, are instructive

on the test to be used in determining whether claimant's injury herein arose out of and in the course of employment.

In *Rogers v. SAIF,* 289 Or 633, 616 P2d 485 (1980), we adopted a unitary "work-connection" approach to supplant the former two-step analysis, which considered "arising out of" and "in the course of" as two separate tests. In doing so, we stated that:

> "* * * the ultimate inquiry is the same: is the relationship between the injury and the employment sufficient that the injury should be compensable?"

289 Or at 642. We also noted the intended effect of the unitary test, specifying that it was

> "* * * not our intention to substantially change fundamental Workers' Compensation law. If the injury has sufficient work relationship, then it arises out of and in the course of employment and the statute is satisfied. Existing law regarding proximity, causation, risk, economic benefit, and all other concepts which are useful in determining work relationship remain applicable. * * *"

289 Or at 643.

In *Clark v. U.S. Plywood,* 288 Or 255, 605 P2d 265 (1980), we stated:

> "We believe that the compensability of on premises injuries sustained while engaged in activities for the personal comfort of the employee can best be determined by a test which asks: Was the conduct expressly or impliedly allowed by the employer?"

288 Or at 266. We expanded on this, saying that:

> "* * * conduct which an employer expressly authorizes and which leads to the injury of an employee should be compensated whether it occurs in a directly related work activity or in conduct incidental to the employment. 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."

288 Or at 267.

Rogers and *Clark*, read together, formulated a unitary work-connection test, which, in instances of injuries occurring

on premises and during personal comfort activities, focuses on whether the employer has allowed the activity and whether the conduct occurs in a directly related work activity or in conduct incidental to the employment.

Compensation awards should not result, however, from the "mere fact" that the employment placed the employee at the site of the injury; a disfavored outcome in Oregon. *See Blair v. State Ind. Acc. Comm'n.*, 133 Or 450, 455, 288 P 204 (1930) ("For a personal injury to arise out of and in the course of the employment, there must be some connection between the injury and the employment other than the mere fact that the employment brought the injured party to the place of injury"); *Stuhr v. State Ind. Acc. Comm'n.*, 186 Or 629, 634, 208 P2d 450 (1949) ("The mere fact that the employment brought the injured person to the place of the accident is not sufficient" to establish a work connection).

A recent Court of Appeals decision has been relied upon by the employer to assert the noncompensability of the injury to the claimant in the instant case. However, we view *Otto v. Moak Chevrolet,* 36 Or App 149, 583 P2d 594 (1978), *rev den* 285 Or 319 (1979), as following the "mere fact" principle enunciated in *Blair* and *Stuhr*. The holding in *Otto* was:

> "The mere fact that the injury occurred on her employer's premises during working hours does not entitle claimant to benefits absent some connection between her injury and her work."

36 Or App at 154. No connection between claimant's injury and a risk of her employment was shown in *Otto*. It was not alleged that she was injured by an instrumentality connected to employment, which is the situation in the instant case.[2] *Otto* is thus inapposite.[3]

Once it is established, however, that the injury-causing activity engaged in is connected to the "on-duty" work of the resident employee, then the employee's status as a resident employee continuously on call must be considered. It is this factor which typically requires the activity to be engaged in on the premises and which typically leaves no off-premises alternatives available to the employee for accomplishing the personal comfort activity. The presence of this requirement of the employment is an integral part of compen-

[2] If the claimant in *Otto* had been injured due to a broken toilet seat, for example, she would be in an analytically similar position as claimant herein so far as determination of this particular issue is concerned, and her injury would have been compensable. This does not imply that injuries are compensable only if caused by an instrumentality of the employment; such is not the case so long as sufficient work connection is demonstrated under the rule of *Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980).

[3] For the reasons stated in our opinion in *Phil A. Livesley Co. v. Russ*, 296 Or 25, ____ P2d ____ (1983) we do not regard that case as being a "mere fact" case in the sense of the decisions to which reference has just been made in the text of this opinion.

sability for work-connected injuries sustained by resident employees continuously on call.[4]

The preparation and consumption of meals are requisite for the effective performance of the "on-duty" tasks of virtually any resident employee continuously on call. The injury incurred by claimant while preparing a meal was thus work connected. To perform adequately the "on-duty" tasks as caretaker of the fire station, claimant had to eat, and to eat he had to prepare meals. His status as a resident employee continuously on call necessitated that he be on the premises during meal preparation, and because the employer had provided no means by which claimant could prepare hot meals other than cooking in his mobile home, his injuries arising from that activity are compensable. His injury arose directly from an unexpected fire occurring in an instrumentality he was required to use in activities not only allowed, but expected, by the employer.

The decision of the Court of Appeals is affirmed.

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[4] This analysis does not effect a return to the two-step conjunctive approach to work connection. *Rogers* states that "the two tests are ultimately one test; 'in the course of' is merely one aspect of 'arising out of.'" 289 Or at 640. Our analysis in the instant case identifies two aspects of the "arising out of" or work-connection test: whether the activity is necessary for effective performance of "on-duty" tasks and whether it was required to be engaged in on the premises. The latter could be considered the "in the course of" aspect of the test.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Terry L. Bond, Claimant.
STATE ACCIDENT INSURANCE FUND
CORPORATION,
Petitioner,

v.

BOND,
Respondent.

(81-01288 and 81-04848; CA A27713)

On respondent's petition for attorney fee filed June 29, 1983.

Paul J. Lipscomb, P.C., Salem, appeared for the petition.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, appeared contra.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

PER CURIAM

$290 attorney fee allowed.

PER CURIAM

After insurer appealed the decision of the Workers' Compensation Board in this case, insurer failed timely to file a brief. Thereafter, on insurer's motion, we dismissed the appeal. Claimant seeks award of an attorney fee for his attorney's services before the appeal was dismissed.

Insurer contends that attorney fees are not authorized because in an insurer-initiated appeal claimant is entitled to fees only when the fact-finder finds that the compensation should not be disallowed or reduced. ORS 656.382(2). Insurer argues that because the appeal was dismissed, this court made no finding to that effect.

Generally, the Workers' Compensation Act should be interpreted in a light most favorable to the worker. *Coombs v. SAIF*, 39 Or App 293, 300, 592 P2d 242 (1979). One of the objectives of the Workers' Compensation Act is:

> "To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable." ORS 656.012(2)(b).

In determining legislative intent, a literal reading of a statute should be avoided when to do so would do violence to an obvious legislative purpose. *See Coombs v. SAIF, supra.*

In interpreting ORS 656.382(2), we look to the history and purpose of the statute, *Teel v. Weyerhaeuser Co.*, 294 Or

588, 591, 660 P2d 155 (1983), *i.e.*, to discourage harassing or wearing down a claimant through overzealous use of the appeals process. *See Bracke v. Baza'r*, 294 Or 483, 658 Pd 1158 (1983). As claimant correctly observes, an insurer could appeal, file a brief and argue the case, forcing the claimant to defend an award, and then have its appeal dismissed before we had an opportunity to "find" that compensation should not be reduced or disallowed.

It is implicit in our granting of a motion to dismiss an insurer-initiated appeal that claimant's compensation should not be reduced or disallowed. We hold that, in enacting ORS 656.382(2), the legislature intended that a claimant receive a

reasonable attorney's fee paid by the employer or insurer when claimant prevails, whether on the merits or because the appeal is dismissed, because the result is the same. Our holding comports with the legislative purpose stated in ORS 656.012(2)(b).

$290 attorney fee allowed.

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602 September 21, 1983 No. 441

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lawrence McLees, Claimant.

AMERICAN BUILDING MAINTENANCE,
Petitioner,

v.

McLEES,
Respondent.

(WCB No. 81-02113; CA A25521)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted March 7, 1983; resubmitted in banc August 3, 1983.

Ridgway K. Foley, Jr., Portland, argued the cause for petitioner. With him on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Peter McSwain, Eugene, argued the cause for respondent. On the brief was David C. Force, Eugene.

WARDEN, J.

Affirmed.

Rossman, J., dissenting.

WARDEN, J.

In this workers' compensation case, we are asked to decide whether Oregon law requires a referee to consider a previous Veterans' Administration (VA) disability award

when determining the amount of a later Oregon workers' compensation award for injury to the same portion of the body. Both the referee and the Board concluded that claimant's VA compensation should not be considered in calculating his disability award.

Claimant first injured his knee while playing basketball in the United States Marine Corps. He was discharged from the service with a 10 percent disability and subsequently underwent surgeries in 1974 and 1975. In November, 1977, as a result of its continuing yearly evaluations, the VA increased his disability award to a total of 20 percent. He reinjured his knee on April 6, 1977, while employed by petitioner. The Evaluation Division awarded 15 degrees for 10 percent loss of his right leg.

The findings of the Evaluation Division were reversed by the referee, who awarded 45 percent loss of the right leg equal to 67.5 degrees. The referee also held that claimant's VA compensation should not be considered in calculating his workers' compensation award. The Board affirmed the referee, holding that the term "compensation" found in ORS 656.222 is limited by ORS 656.005(9)[1] to benefits provided pursuant to Oregon Workers' Compensation Law.

This case presents a narrow question of statutory construction. 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 accident shall be made with regard to the combined effect of his injuries and his past receipt of money for such disabilities."

The sole issue in this appeal is whether "compensation" as it is used in this statute includes benefits received from the VA.

In *Nesselrodt v. Compensation Department,* 248 Or 452, 435 P2d 315 (1967), the court applied ORS 656.222 to reduce an award of permanent partial disability of 100 percent loss of function of an arm by the percentage of permanent partial disability the claimant had been awarded previously for an earlier injury to the same arm. Both injuries were covered by Oregon's workers' compensation law. In *Nesselrodt,* the Supreme Court recognized that it had held in *Green v. State Ind. Acc. Com.,* 197 Or 160, 251 P2d 437, 252 P2 545 (1953), that ORS 656.222 did not apply to unscheduled permanent partial disabilities.

In *Harris v. SAIF,* 55 Or App 158, 637 P2d 1292 (1981), this court, without reference to *Nesselrodt* or *Green,* purported to apply ORS 656.222 to successive unscheduled injuries, the earlier of which was compensated under California workers' compensation law.[2] *Harris* is doubtful authority in view of the Supreme Court's holding in *Green* that ORS 656.222 does not apply to successive unscheduled injuries, even when both are covered by Oregon workers' compensation statutes.

[1] ORS 656.005(9) provides:

" 'Compensation' includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by a direct responsibility employer or the State Accident Insurance Fund Corporation pursuant to this chapter."

We are left with the conclusion that ORS 656.222 applies only to successive awards for disability for injuries to the same scheduled member – those enumerated in ORS 656.214(2) through (4) – when both awards are made pursuant to ORS ch 656, the Oregon Workers' Compensation law. Our reading of ORS 656.005(9) confirms that conclusion. Accordingly, we hold that "compensation" as that term is used in ORS 656.222, does not include disability benefits received from the VA.

Affirmed.

ROSSMAN, J., dissenting.

If we were deciding this case in a vacuum, I might well be able to agree with the majority's conclusion that ORS 656.222 does not provide for consideration of VA compensation in calculating a workers' compensation award. However,

we are bound by our earlier decision in *Harris v. SAIF,* 55 Or App 158, 637 P2d 1292 (1981). The majority does not attempt to distinguish *Harris* but merely states that it "is doubtful authority in view of the Supreme Court's holding in *Green [v. State Ind. Acc. Comm.,* 197 Or 160, 251 P2d 437, 252 P2d 545 (1953)]." *Green* was decided in 1953, 24 years before this court's decision in *Harris.* The majority appears to assume that Chief Judge Joseph wrote *Harris* without giving due consideration to the established law. I cannot agree with their assumption, and I do not believe *Harris* is distinguishable from this case. There is no legislative, judicial or logical reason for distinguishing between federal awards for injuries and state awards for injuries. Accordingly, in this case, I would hold that a prior veteran's disability award should be given due consideration under ORS 656.222, when a claimant later seeks a workers' compensation award for injury to the same portion of the body.

Therefore, I must respectfully dissent.

Joseph, Chief Judge, and Buttler and Warren, Judges, join in this dissent.

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[2] In *Harris* we said: "ORS 656.222 requires that the combined effect of claimant's prior injuries and his past award for *any* previous disability also be considered." 55 Or App at 161 (Emphasis supplied; footnote omitted.) It is not clear how we considered the claimant's California award; the record did not reveal what percentage of disability the California award represented, and we actually increased the award from the 40 percent ordered by the Board to 60 percent, as found by the referee.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Clarice Banks, Claimant.

UNITED PACIFIC RELIANCE
INSURANCE COMPANY,
Petitioner,

v.

BANKS et al,
Respondents.

(79-08983 & 79-09538; CA A25014)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 13, 1983.

Jerald P. Keene, Portland, argued the cause for petitioner. With him on the brief was Wolf, Griffith, Bittner, Abbott & Roberts, Portland.

Noreen K. Saltveit, Portland, argued the cause for respondent Clarice J. Banks. With her on the brief was Law Offices of Noreen K. Saltveit and Associates, Portland.

Mildred J. Carmack, Portland, argued the cause for respondent Argonaut Insurance Company. With her on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

The question in this workers' compensation case is which of two successive carriers is responsible. Claimant, a sandwich maker for Papa John's Sandwich Company, began to experience symptoms of her shoulder condition January 8, 1979, while United Pacific Reliance (U.P.) was the carrier. However, claimant did not seek medical attention or miss work until May, 1979, when Argonaut Insurance Company (Argonaut) was the carrier. Argonaut contends that claimant's condition is an injury for which U.P. is responsible; U.P. contends that it is a disease for which Argonaut is responsible, or alternatively that, if it is an injury, Argonaut is nevertheless responsible because claimant's employment while Argonaut was the carrier contributed independently to her injury.

The referee found that Argonaut was the responsible carrier. He concluded that, whether claimant suffered from an injury or an occupational disease, her employment while Argonaut was the carrier had contributed to her condition, also noting that she was not disabled until after Argonaut became the carrier. The Workers' Compensation Board reversed, finding that claimant suffered an injury while U.P.

was the carrier and that her employment while Argonaut was the carrier did not alter U.P.'s liability. On *de novo* review, ORS 656.298(6), we conclude that claimant suffered an injury and that U.P., the carrier at the time of the injury, is responsible.

Claimant's trouble began on the day she returned to the production line after a period of three or four weeks replacing a vacationing worker at a desk job. That day was one of the particularly strenuous days, known as "triangle days," when "triangle sandwiches" were produced. As the referee described claimant's work:

> "* * * Claimant's job was standing at the counter approximately waist high with stacks of bread on breadboards to her left, mustard and mayonnaise in large bowls to her right, meat, cheese and other ingredients in front of her. She would pick two pieces of bread at a time, lay them down in rows in front of her with the left hand, apply mayonnaise or mustard and then fill the sandwiches with meat and cheese as necessary. This was a fast twisting side-to-side motion with her arms and hands working very quickly. Occasionally claimant had to stoop or bend to fetch a new breadboard full of bread

> from underneath her counter and put it on top of her counter to her left. Occasionally she would have to stoop to her right to fill the mustard and mayonnaise bowls from vats."

The work was very fast and involved particularly awkward movements. The boards she was required to lift were heavy. Claimant testified that she felt a sudden sharp pain in her left shoulder, which she described as feeling like

> "* * * somebody was turning on something, off and on, like a switch or something, a shock or something like that * * *."

She believed she had been bending at the time and at that moment thought she must have "moved wrong," although she could remember no single specific movement to which she attributed the onset of the pain. At an earlier hearing[1] she had testified:

> "* * * I was just hurrying and involved in doing my work, and I lifted. All of a sudden I got this pain in my shoulder, and I said must have moved wrong or something. I said to Becky, 'I must have moved wrong or something.' She said, 'Oh, is it really bothering you?' I said 'Yes, it is really bothering me, but I guess it will go away.' * * *"

At that hearing, in response to her attorney's question as to whether there was one specific incident when she felt pain in her arm, she responded, "Yes, when I went to go like this (indicating) to make my normal way to make my sandwiches." Before that incident, claimant had not had any problems with her shoulder.

Claimant continued to experience pain in her left shoulder area after the January 8 incident, but did not immediately seek medical attention or miss work. She did,

[1] On December 7, 1979, a hearing was conducted to determine whether Argonaut had wrongfully terminated the claim in October, 1979.

however, frequently perform lighter work or ask her co-worker to help with the tasks that caused her pain. Supervisory personnel and a co-worker recalled her complaints. She testified that at first her shoulder only bothered her on "triangle days," but eventually it bothered her on other days as well. At the end of April or beginning of May she went to the emergency room at Holladay Park Hospital, where she was

told she had a "charley horse."[2] On May 7, 1979, claimant first saw her initial treating physician, Dr. Berselli, an orthopedic surgeon, who prescribed medication and physical therapy and advised her to stop working. His initial diagnosis was "chronic mild fascitis of the rhomboid muscle group." She was referred to Dr. Langston in September, 1979. He diagnosed "musculoligamentous strain of the left supraspinatus and overlying trapezius area, by history," and could not find "objective evidence of disability." An artherogram by a radiologist revealed no underlying rotator cuff tear. In November, 1979, Dr. Berselli stated that he could find no specific organic reason for claimant's pain. That December she consulted Dr. Thompson, an orthopedic surgeon. He thought she might have a herniated cervical disc and referred her to Dr. Berkeley, who performed a myelogram in February, 1980. He found a "discrete C5-C6 lesion causing bilateral nerve root amputation," confirming his diagnosis of "traumatic cervical spondylopathy at C5-6." He recommended surgery. Dr. Berkeley concluded that claimant's condition was the direct result of her January 8, 1979, injury, an opinion in which Dr. Berselli concurred.

The first inquiry is whether claimant's condition resulted from an industrial injury or an occupational disease. In *O'Neal v. Sisters of Providence*, 22 Or App 9, 537 P2d 580 (1975), we approved the following language to define the distinction:

> " '* * * 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. * * *' (Quoting from 1A Larson Workmen's Compensation Law § 41.31 (1973))." 22 Or App at 16.

> " '* * * An occupational disease is stealthy and steals upon its victim when he is unaware of its presence and approach. Accordingly, he can not later tell the day, month or possibly even the year when the insidious disease made its intrusion into his body. * * * Upon the other hand, the victim of an industrial accident virtually always can tell the day and even

> the hour when the purported injury befell him. He does not attribute his present condition to something that crept in upon him unobserved but to an accident which he and possibly [many] [sic] others observed. * * *' *White v. State Ind. Acc. Com.*, 227 Or 306, 322, 362 P2d 302 (1961)." 22 Or App at 14.

[2] An illegible report from Holladay Park Hospital in the record appears to be dated May 1, 1979.

Applying these distinctions in this case, we find the description of the onset of claimant's condition to be more consistent with an injury. It was sudden and occurred on claimant's first day back on the line on a particularly strenuous day. Although she said that she could not connect the pain with a particular movement, she also stated that she thought she was bending when she felt the pain and at the previous hearing even indicated the motion she had made.[3] She had had no previous shoulder problem. Although it is not unexpected that the kind of work claimant performed could result in such a shoulder condition, *see O'Neal v. Sisters of Providence, supra,* it is less to be expected that a *disease* condition caused by claimant's sandwich making work would manifest itself after a period of sedentary office work.

The determination that claimant's condition originally resulted from an injury is not dispositive. We must also consider the effect on her condition of her continued work. Because it is the result of an injury, claimant's disability is governed by the "last injury rule" enunciated in *Smith v. Ed's Pancake House,* 27 Or App 361, 556 P2d 158 (1976), and clarified in *Boise Cascade Corp. v. Starbuck,* 61 Or App 631, 659 P2d 424, *rev allowed* 294 Or 792 (1983). In cases involving successive injuries and successive insurance carriers, we stated in *Smith* that the rule set forth in 4 Larson, Workmen's Compensation Law 17-72—17-78, § 95.12 (1976),[4] applies:

> " *'If the second injury takes the form merely of a recurrence of the first, and if the second incident does not contribute even slightly to the causation of the disabling condition,*

> *the insurer on the risk at the time of the original injury remains liable for the second.* In this class would fall most of the cases discussed in the section on range of consequences in which a second injury occurred as the direct result of the first, as when claimant falls because of crutches which his first injury requires him to use. *This group also includes the kind of case in which a man has suffered a back strain, followed by a period of work with continuing symptoms indicating that the original condition persists, and culminating in a second period of disability precipitated by some lift or exertion.*
>
> " 'On the other hand, if 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. This is consistent with the general principle of the compensability of the aggravation of a pre-existing condition.' " 27 Or App at 365. (Emphasis supplied.)

Thus, "if the original disability was the result of an injury, liability is not imposed on the last employer unless a new incident contributed independently to the injury." *Fireman's*

[3] In support of its argument that claimant's disability did not result from an injury, U.P. points to portions of the record in which claimant described the onset of her pain as "gradual." We agree with the Board's conclusion that

> "* * * the references in the record to the gradual *onset* of pain are best interpreted to mean claimant's symptoms gradually increased in degree between January 8, 1979 and May 8, 1979, when claimant was advised by her physician to cease her work activity." (Emphasis the Board's.)

[4] The same language appears in the 1983 edition.

Fund Ins. Co. v. Ore. Ptld Cement Co., 63 Or App 63, 66, 663 P2d 416 (1983).

We conclude, after reviewing the evidence, that while Argonaut was the carrier claimant suffered no subsequent injury contributing to the causation of her disability. Dr. Berkeley wrote to Argonaut's counsel that claimant's condition was the direct result of the January, 1979, injury. However, it is not clear to what question he was responding and whether he was ruling out subsequent contributing causation. The primary medical evidence is from Dr. Berselli, claimant's original treating physician, which, taken as a whole, indicates that claimant's subsequent work did not contribute to her injury.[5] At most, Dr. Berselli's testimony indicates the

possibility that claimant felt pain from her original injury when she engaged in continued activity at work. With the possible exception of the visit to the hospital emergency room, there is no evidence of an identifiable subsequent incident. The evidence describes a situation similar to the example of the person with back strain described by Larson and quoted in *Smith v. Ed's Pancake House, supra. Compare Buchanan v. Owen Chevrolet,* 44 Or App 31, 604 P2d 1277 (1980), *with Clayton's Automotive v. Stayton Auto Supply,* 54 Or App 980, 636 P2d 1020 (1981), *rev den* 292 Or 581 (1982). Claimant experienced continuing symptoms at work and increasing pain, but no new incident contributed to the causation of her injury. Thus Argonaut is not responsible for her claim by virtue of a subsequent injury.

U.P. argues that, because claimant did not miss work or seek medical treatment while U.P. was the carrier, it should not be responsible. The referee stated that "compensation payments are not for the injury. They are for disablement." We agree with the Board that the insurer covering the risk at the time of the injury bears responsibility for that injury, even if resulting disability develops later. That is the arrangement contemplated by the compensation statutes. *See, e.g.,* ORS 656.005(19), ORS 656.202(2).[6]

Affirmed.

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[5] In April, 1980, he wrote U.P. that "it is medically probable that the claimant's continual work activity did indeed contribute to her need for medical care and treatment." In June, 1980, he wrote Argonaut's counsel that he concurred with Dr. Berkeley's evaluation. The same month, Dr. Berselli was deposed. In answer to a question whether claimant's work would have caused an aggravation of her underlying condition, Dr. Berselli replied:

> "* * * I just can't say if it made her underlying condition worse or not. It undoubtedly caused her more pain, but whether or not it worsened the underlying pathologic changes going on, I just don't know."

[6] ORS 656.005(19) provides:

> " 'Party' means a claimant for compensation, the employer of the injured worker *at the time of injury* and the insurer, if any, of such employer." (Emphasis supplied.)

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.*" (Emphasis supplied.)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wayne Patterson, Claimant.

PATTERSON,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(81-09179; CA A26423)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 25, 1983.

Janet A. Metcalf, Portland, argued the cause for petitioner. With her on the brief were English & Metcalf, Brian L. Welch, and Welch, Bruun & Green, Portland.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

RICHARDSON, P. J.

Reversed; referee's order reinstated.

RICHARDSON, P. J.

In this workers' compensation case, the State Accident Insurance Fund (SAIF) denied claimant's claim for compensation. The referee overturned that denial, and the Worker's Compensation Board reversed the referee's decision. Claimant appeals, and we reverse.

Neither party disputes the referee's factual findings. Therefore, we summarize the facts from those findings. Claimant worked as a security guard at the University of Oregon Health Sciences Center. He was called to the psychiatric crisis center to assist the medical staff in releasing a patient who did not wish to leave the unit. The medical staff wanted the patient taken "off the hill," meaning that the patient was to be taken to the edge of the employer's premises and released. While claimant and another security guard, Debbie Turner, were escorting the patient out of the crisis unit, he became unruly. Turner, assisted by three medical aides, restrained and handcuffed the patient. Claimant was not involved in that struggle, although his handcuffs were used on the patient.[1]

[1] Claimant testified that he was involved in this initial scuffle on the hospital premises. The referee, however, found that Security Guard Turner was the more credible witness. Turner contradicted claimant's story and testified that the only time claimant was involved in an altercation with the patient was in downtown Portland. We defer to the referee's specific credibility finding. *See Hannan v. Good Samaritan Hosp.*, 4 Or App 178, 471 P2d 831, 476 P2d 931 (1970), *rev den* (1971).

Claimant and Turner then placed the patient in the employer's patrol car and drove to downtown Portland to release him. The employer had a policy against transporting unwanted persons beyond the limits of the employer's property. Claimant previously had been expressly informed of this policy.

When the three arrived in downtown Portland, the patient was removed from the patrol car to be released. At that point, he became verbally abusive and began to walk away, still wearing claimant's handcuffs. Turner stopped the patient by grabbing the chain linking the handcuffs and led him back to the patrol car. Claimant then forcibly and repeatedly kicked the patient forcing him into the back seat of the car. Later that day, claimant left work complaining of back pain. Two weeks later, he applied for workers' compensation benefits, alleging

that he had sustained an injury to his lower back while physically restraining the patient.

SAIF does not dispute the fact that claimant suffered an injury or that the injury was sustained in an altercation with the patient. SAIF argues instead that the injury did not arise out of or in the course of claimant's employment and thus is not compensable.[2] At oral argument, counsel for SAIF conceded that had claimant assaulted the patient on the employer's premises, the resulting injury would be compensable. We therefore do not consider the question of the reasonableness of claimant's conduct to determine whether he was an "active participant" in an assault that was "not connected to the job assignment and that amounted to a deviation from customary duties," ORS 656.005(8)(a), and is thereby precluded from benefits. The sole issue for our consideration is whether claimant is precluded from receiving compensation for his back injury because of his deliberate disobedience of the employer's rule.

In *Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980), the court analyzed the "arising out of" and "in the course of" provisions of ORS 656.005(8)(a). It reasoned that although the "arising out of" aspect traditionally had been analyzed separately from the "in the course of" aspect, the ultimate inquiry is simply whether an injury is work-related. That issue, the court explained, could be resolved with a single inquiry: whether the relationship between the injury and the employment was such that the injury should be compensable. 289 Or at 642. Any questions of sufficiency should be resolved in the light of the policy of the Workers' Compensation Act:

" 'The statutory phrase "arising out of and in the course of

[2] ORS 656.005(8)(a) provides:

"A 'compensable injury' is 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; an injury is accidental if the result is an accident, whether or not due to accidental means. However, 'compensable injury' does not include injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties."

employment" must be applied in each case so as to best effectuate the socio-economic purpose of the Worker's Compensation

> Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer. 1 Larson, Workmen's Compensation Law § 2.20. Various concepts have arisen from attempts to rationalize that purpose, e.g., the going and coming rule, special errands, lunch hour cases, dual purpose trips, impedimenta of employment, horseplay, etc. Each is helpful for conceptualization and indexing, but there is no formula for decision. *Etchison v. SAIF,* 8 Or App 395, 398, 494 P2d 455 (1972). Rather, in each case, every pertinent factor must be considered as a part of the whole. It is the basic purpose of the Act which gives weight to particular facts and direction to the analysis of whether an injury arises out of and in the course of employment.' * * *" 289 Or at 643, quoting with approval *Allen v. SAIF,* 29 Or App 631, 564 P2d 1086, *rev den* 280 Or 1 (1977).

Bearing in mind that the purpose of the Workers' Compensation Act is financial protection for an injured worker without regard to fault, we conclude that claimant's injury is sufficiently work-related to be compensable. He was injured while he was executing the assigned task of removing an unruly patient from the employer's premises. His disregard of the employer's rules was deliberate but did not involve a prohibited overstepping of the boundaries defining his ultimate job responsibilities. Rather, his misconduct involved a violation of the employer's rules governing the *method* of accomplishing his ultimate work, and therefore he remained within the scope of his employment. *See* 1A Larson, Workmen's Compensation Law 6-7, § 31.00 (1979).

Because SAIF concedes that the dispositive misconduct here is the prohibited act of leaving the premises (as opposed to assaulting the patient), claimant's misconduct is nothing more than disobedience to specific instructions limiting the sphere of the execution of his employment responsibilities. Because we find that misconduct to be a mere violation of the designated method of execution of his ultimate job duty, the resulting injury is sufficiently work-related to be compensable. *Cf. Mtr. of Feldman v. A.B.C. Vending,* 16 AD 2d 189, 226 NYS 2d 892 (1962); *aff'd* 12 NY2d 223, 238 NYS 2d 667, 188 NE2d 905 (1963) (deceased violated rule restricting him to employer's premises to investigate a nearby fire, compensation allowed); *Green v. DeFuria,* 19 NJ 290, 116 A2d 19

(1955) (injury sustained by gas station attendant who left station to silence horn of a car across the street in contravention of employer's rule is compensable); 1A Larson Workmen's Compensation Law, 6-22–6-26, § 31.23 (1979).

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Eugene Muehlhauser, Claimant.
STATE ACCIDENT INSURANCE FUND
CORPORATION,
Petitioner,
v.
MUEHLHAUSER,
Respondent.
(83-0027M; CA A28596)

On respondent's petition for attorney fee filed July 27, 1983.

Willard E. Merkel, Portland, appeared for the petition.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, appeared contra.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

PER CURIAM

$375 attorney fee allowed.

PER CURIAM

After SAIF appealed the decision of the Workers' Compensation Board here, claimant moved to dismiss on the ground that we lacked jurisdiction because the order appealed from was not final. We agreed and dismissed SAIF's appeal. Claimant now seeks an award of attorney fees for his attorney's services before the appeal was dismissed. SAIF objects.

Claimant's compensation was not reduced or disallowed as a result of SAIF's appeal. Claimant is therefore entitled to receive a reasonable attorney's fee. ORS 656.012(2)(b); *see SAIF v. Bond,* 64 Or App 505, ___ P2d ___ (1983).

$375 attorney fee allowed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Pauline Cutter, Claimant.

MONTGOMERY WARD,
Petitioner,

v.

CUTTER,
Respondent.

(81-05803; CA A27134)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 20, 1983.

Allan M. Muir, Portland, argued the cause for petitioner. With him on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

J. Michael Alexander, Salem, argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

Employer appeals from an order on review of the Workers' Compensation Board affirming the referee's decision that claimant's injury was compensable. We affirm.

The facts are not disputed. Claimant is an employe of a store located in a shopping mall. She injured her left ankle on May 26, 1981, while she was returning to work after doing a personal errand at the bank during her lunch break. She had parked her car in the portion of the mall parking lot where she had been instructed to park, an area which had been designated by the mall operator as one in which this store's employes were to park. While walking in a direct line from her car to the store, claimant stepped in a hole in the parking lot, causing the injury about which she complains. Her injury occurred only a few feet from an area through which claimant was required to pass daily during the course of her regular employment in walking between employer's main store and its automobile department in a separate, but adjacent, building. Although the mall owners provided regular maintenance and supervision of the parking lot, employer paid a common area fee for those services and could require the owners to make repairs.

Employer contends that claimant's accident did not

"arise out of and in the course of employment," as required by ORS 656.005(8)(a), and is, therefore, not compensable. Although that language consistently has been given a broad and liberal construction in order to effectuate the legislative intention, *Stuhr v. State Ind. Acc. Comm.*, 186 Or 629, 208 P2d 450 (1949), injuries received while a claimant is going to or coming from work are not compensable, as a general rule. *Adamson v. The Dalles Cherry Growers, Inc.*, 54 Or App 52, 56, 633 P2d 1316 (1981). An exception to that rule is that an injury may be compensable, even if it occurs while the claimant is going to or coming from work, if it occurs on the premises of the employer.[1] No Oregon appellate court has

been called upon to decide whether a parking lot, which is a part of of a shopping mall, constitutes a part of the premises of the employer-tenant of the shopping mall such that an injury sustained there by an employe of the tenant is compensable under the Act. Although we need not answer that question fully here, we hold that the portion of the parking lot where claimant was injured was a part of the employer's premises and that claimant is entitled to compensation.

Oregon cases have uniformly held that injuries that occur in parking lots that are owned or maintained by the employer arise out of and in the course of employment and are compensable. If the injury occurs in a parking lot or other off-premises area over which the employer has no control, it is generally not compensable. *Montgomery v. State Ind. Acc. Comm.*, 224 Or 380, 356 P2d 524 (1960); *Kowcun v. Bybee*, 182 Or 271, 186 P2d 790 (1947); *Adamson v. The Dalles Cherry Growers, Inc., supra; Rohrs v. SAIF*, 27 Or App 505, 556 P2d 714 (1976); *Willis v. SAIF*, 3 Or App 565, 475 P2d 986 (1970).

Although courts in other jurisdictions are divided, but a majority of those that have considered the question have held that an injury that occurs in a shopping center parking lot while an employe of a tenant is going to or coming from work is compensable.[2] However, we need not go so far here, because, although claimant fell while returning to work from her lunch hour, she fell in an area through which she was required by her work to travel repeatedly on a daily basis. Further, she was injured in a portion of the parking lot where she was required to park and in which employer had the right to have its employes park. Employer could have required the shopping mall to repair the hole.

[1] In *Otto v. Moak Chevrolet*, 36 Or App 149, 583 P2d 594 (1978), *rev den* 285 Or 319 (1979), we held that there was an exception to the "on the premises" doctrine if the injury occurs while the claimant is on a personal comfort mission on the premises and there are no work-related conditions that contribute to the injury. However, we stated in *Wallace v. Green Thumb, Inc.*, 61 Or App 695, 658 P2d 560, *rev allowed* 294 Or 792 (1983), that *Otto* is no longer viable, given *Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980), and *Clark v. U.S. Plywood, infra.*

[2] The following jurisdictions hold such injuries to be compensable: *Barfield v. Grant Food, Inc.*, 16 Md App 726 299 A2d 523, (1973); *Merrill v. J. C. Penney*, 256 NW2d 518 (Minn 1977); *People v. LaRosa*, 267 NYS2d 235, 25 AD2d 597 (1966); *Frishkorn v. Flowers*, 26 Ohio App 2d 165, 270 NE2d 366 (1971); *Hall v. Goodman Company*, 456 A2d 1029 (Pa Sup Ct 1983). The jurisdictions holding that such injuries are not compensable are: *Barham v. Food World*, 300 NC 329, 266 SE2d 676 (1980); *White v. Milk Producers, Inc.*, 496 P2d 1172 (Okla 1972); *Pacific Employers Ins. Co. v. Booker*, 553 SW2d 586 (Tenn 1977).

Under these facts, it is clear that the portion of the parking lot where claimant was injured was sufficiently within employer's control to be treated as part of its premises for the

purpose of the Workers' Compensation Law. Because claimant was injured on employer's premises, it matters not that her injury occurred while she was returning from an activity permitted her by employer during her lunch break. *See Clark v. U.S. Plywood,* 288 Or 255, 605 P2d 265 (1980).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of George F. Weiland, Claimant.

WEILAND,
Petitioner,
v.
SAIF CORPORATION,
Respondent.

(WCB No. 79-06914, 79-03871; CA A25284)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 23, 1982.

Peter W. McSwain, Eugene, argued the cause for petitioner. On the brief was David C. Force, Eugene.

Donna M. Parton, Associate Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause for respondent. With her on the brief was Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed; referee's order reinstated.

WARREN, J.

Claimant appeals an order of the Workers' Compensation Board that reversed the referee and held that claimant's occupational disease was not caused by his employment at Lane County. He further appeals the Board's affirmance of the referee's holding that he had not timely filed his claim against Linn County. We hold that the Board erred in the first holding and reverse.[1]

[1] Because of our disposition of this case, we do not need to reach the issue of the timeliness of the claim against Linn County.

Claimant seeks compensation for transient visual loss and migraine headaches, which he claims are an occupational disease caused by anxiety and stress in his employment. He became employed as a law enforcement officer in 1961. Within a year of that date, he suffered his first migraine headache. After he had undergone a series of tests, his condition was diagnosed as being related to tension. The headaches subsided, and he continued his employment. In 1969, while employed as a deputy sheriff in Linn County, he was accused of the misdemeanor of false swearing resulting from testimony he had given about the performance of his duties in a criminal case. He resigned under pressure. Thereafter, he was acquitted of the charges in a jury trial. After leaving Linn County, claimant left law enforcement for approximately two years, during which time he went to school and worked in a mill. During this period, he had no problem with headaches. In 1972, he became employed as a deputy sheriff with Lane County. In approximately 1974 or 1975, he began to have transient visual loss, beginning with small black dots on the right visual field of both eyes lasting 20 to 25 minutes. These periods of transient visual loss were followed by periods of "throbbing, pounding left posterior headache" which left when he was able to sleep them off. He would be lethargic for a day or so after these headaches. His condition gradually worsened until the transient visual loss involved total blindness and occurred on a more frequent basis. Eventually, his employer became aware of the blindness, and claimant was retired as being unfit for duty.

The issue is whether claimant's condition is causally related to his employment at Linn County, his employment at

Lane County or to stress factors which occurred off the job.[2] The only evidence of stress at Linn County is the accusation of false swearing that resulted in his resignation. He testified that his employment at Lane County was very difficult, because his captain "* * * would work my men against, try to work my men against me * * *." He also testified that during his off hours he was subjected to frequent calls from police officers requiring his supervision. Finally, he testified that, whenever he was called to testify in a criminal case as a result of his police work, "I was scared, constantly scared. I would get into testimony and my voice would break off and start squeaking. It was a terrible feeling to sit there in a courtroom * * *." He testified that, prior to being a police officer for Lane County, he did not have headaches on a regular basis and had never suffered from loss of vision or serious depression.

The medical evidence on causation is inconsistent. Dr. Myers stated in 1977 that the only precipitating factor noted by claimant for the headaches was his employment. In February, 1978, Dr. Yatsu stated that he agreed with Dr. Myers completely

"* * * that this patient's visual loss is the aura antecedent

[2] There was no evidence that claimant was subjected to off-the-job stress similar to the kind he encountered at work.

to a classic migraine headache and the symptom complex is job-related in that it is induced by stress while working in the sheriff's department.

"* * * * *

"The job realities for [claimant] are very difficult, but the presence of clearly stress and job related migraine headaches with associated visual loss plus the likelihood that effective therapy which would not impair his function are not likely, another line of employment would appear to be indicated."

Sometime in 1978, claimant began to undergo regular psychiatric treatment by Dr. Carter, who he saw approximately 80 to 90 times over a period of two years. The doctor's final medical conclusion after this treatment was:

"It is my opinion, with reasonable medical probability, that [claimant's] illness reflects post traumatic stress disorder, chronic, moderate to severe, having been initiated by the stress experienced by [claimant] relative to his court hearing

and surrounding events in Linn County in 1968 with worsening of the underlying condition by exposure to events that symbolized or resembled these traumatic events in the pursuit of his routine duties as a Lane County Sheriff's Officer. * * *"

Dr. Holland, who saw claimant twice, and Dr. Colbach, who saw him once, both at SAIF's request, concluded that there was no causal relationship between the employment and the loss of vision and depression.

When the medical evidence is divided, we have tended to give greater weight to the conclusions of a claimant's treating physician, absent persuasive reasons not to do so. *Abbott v. SAIF,* 45 Or App 657, 609 P2d 396 (1980); *Hamlin v. Roseburg Lumber,* 30 Or App 615, 567 P2d 612 (1977). In this case, claimant's treating physician had the opportunity to see him 80 to 90 times over a period of two years. He had a much better opportunity to evaluate claimant's condition than either of SAIF's doctors, who examined him on a very limited basis. We accept the opinion of the treating physician, Dr. Carter, and hold that the employment at Lane County worsened his underlying condition and constituted the last injurious exposure for his occupational disease. The fact that a claimant may have been "highly susceptible" to having an occupational disease as a result of stress does not render it noncompensable. *SAIF v. Gygi,* 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982). Further, it is not relevant whether a claimant's work complaints were well founded or whether they would have had an effect on a normal person. The only issue is whether they were a major contributing cause of the claimant's occupational disease. *McGarrah v. SAIF,* 59 Or App 448, 651 P2d 153 (1982), *rev allowed* 294 Or 491, 660 P2d 681 (1983). Under the last injurious exposure rule, Lane County is responsible for claimant's condition.

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Max Madden, Claimant.

MADDEN,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(WCB No. 80-03372; CA A25475)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 25, 1983.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

Darrell E. Bewley, Appellate Counsel, SAIF Corporation, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed and remanded for determination of penalties and attorney fees.

WARREN, J.

Claimant appeals an order of the Workers' Compensation Board, that denied him penalties and attorney fees for SAIF's delay in paying bills for medical services. We reverse.

Claimant sustained a compensable injury to his back on June 15, 1979. After a period of conservative treatment, Dr. Smith performed a myelogram and determined that he would benefit from surgery. Dr. Miller later examined him, performed a second myelogram and also recommended surgery. On November 20, 1980, Dr. Smith reported to SAIF that claimant would benefit from surgery. On November 21, 1980, SAIF notified claimant that he was to see Orthopaedic Consultants on December 1, 1980. On November 26, 1980, Dr. Smith notified SAIF that Dr. Miller had agreed with his diagnosis and that surgery would be performed on December 1, 1980. Claimant chose to undergo the surgery rather than wait until after Orthopaedic Consultants' examination. The surgery was a success.

On February 9, 1981, SAIF reported to the medical director that Dr. Smith had apparently violated the medical rules concerning SAIF's right to an independent medical evaluation. On May 11, 1981, SAIF notified St. Vincent's Hospital that it would not pay the bill, because "treatment was for a condition not accepted by SAIF." In addition to the bills of Dr. Smith and the hospital, SAIF refused to pay physical therapy bills, radiology bills and all other bills gener-

ated from November, 1980, on. Claimant requested a hearing. At the hearing, SAIF stated that it had not "denied the compensability of the medical treatment"; it defended the nonpayment of the medical bills only by arguing that Dr. Smith had prevented it from obtaining an independent evaluation. The referee ruled that, pending resolution of SAIF's complaint before the medical director, SAIF was responsible to pay all of the vendors other than Dr. Smith. The referee awarded a 20 percent penalty against SAIF for its unreasonable refusal to pay the medical bills. The Board reversed the referee and held that SAIF was required to pay for all of the medical services provided, including those of Dr. Smith, but refused to award penalties or attorney fees. Claimant has appealed to this court, claiming that penalties and attorney fees should have been awarded.

Three administrative rules which were in effect both at the time of the injury and at the time of SAIF's refusal to pay the medical benefits govern this case. OAR 436-69-130[1] required that an attending surgeon notify the insurer at least five days before the date of proposed surgery and give the insurer the right to require the surgeon recommending surgery to obtain an independent consultation.[2] OAR 436-69-210[3] provided that no medical examination requested by an insurer should delay or interrupt proper treatment of a claimant. OAR 436-69-510 provided for penalties that could be assessed if a complaint was filed with the director for violation of these provisions:

> "If the medical director finds any violation of these rules involving reporting requirements, the medical director may recommend to the director, and the director may impose, one or more of the following sanctions:
>
> "(a) reprimand by the director;
>
> "(b) nonpayment or recovery of fees in part, or whole, for services rendered;

[1] OAR 436-69-130 provided:

"(1) Determination for the need to perform elective surgery for occupational injury or illness is the responsibility of the attending surgeon, who shall notify the insurer at least five (5) working days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, and an estimate of surgical date.

"(2) When elective major orthopedic or neurologic surgery is recommended, the insurer may require the surgeon recommending surgery to obtain an independent consultation. The consultant shall submit a written report prior to the surgery. If a conflicting opinion of the condition exists that questions the need for surgery, the worker shall be referred to a second independent qualified consultant who is mutually agreeable to the attending physician and the insurer."

[2] OAR 436-69-130 was amended in 1982 after all of the relevant dates in this case to provide that the insurer has the right to choose the physician to perform the independent consultation.

[3] OAR 436-69-210 provides:

"(1) The Board, the Director, or insurer have the right to obtain medical examinations of the worker by physicians of their choice. The worker shall be notified of the purpose of the examination. Such examinations shall be at places, times, and intervals reasonably convenient to the worker, and shall not delay or interrupt proper treatment of the worker.

"(2) The person requesting the examination should consult with the attending physician and eendeavor to choose a mutually agreeable examiner. However, the selection of the examiner finally rests with the Board, the Department or insurer.

"(3) The person requesting the examination shall send a copy of the report to the treating physician."

"(c) referral to the appropriate medical licensing board; and/or

"(d) civil penalty not to exceed $1,000, for each occurrence * * *."

The administrative rules established a procedure which required that medical services be paid pending the complaint until such time as the medical director should rule that sanctions should be imposed. That procedure was consistent with the version of ORS 656.313[4] then in effect, which required that medical bills be paid pending an appeal. Nothing in the statutes or in the administrative rules justifies a unilateral decision by an insurer to refuse to pay medical bills. Further, other than the convoluted reasoning presented by SAIF, there is certainly no justification based on a grievance against Dr. Smith for SAIF's refusal to pay medical bills to the hospital and to all other medical providers. That is compounded by the fact that SAIF did not even accurately represent to the vendors the reason for its refusal, but specifically stated to the hospital that it had denied compensability of the claim, which, according to SAIF's attorney at the hearing, had never been the case.

The Board was clearly correct in holding that SAIF erred in refusing to pay the medical bills and in ordering SAIF to pay them. However, under all of the evidence, including the unambiguous nature of the statutes and administrative rules in effect at that time and the misrepresentation of SAIF to the hospital, SAIF was unreasonable in its refusal to pay the medical bills. Claimant is entitled to penalties and attorney fees under ORS 656.262(9).[5]

Reversed and remanded for determination of penalties and attorney fees.

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[4] ORS 656.313 provided:

"(1) Filing by an employer or the State Accident Insurance Fund of a request for review or court appeal shall not stay payment of compensation to a claimant.

"(2) If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal."

On October 3, 1979, changes in the law became effective (Or Laws 1979, ch 673, § 4) which provide that "compensation" does not include medical services required to be paid pending appeal. This court has held that that change does not apply retroactively to claimants who were injured prior to the effective date of the statute. *SAIF v. Matthews*, 55 Or App 608, 639 P2d 668, *rev den* 292 Or 825 (1982).

[5] ORS 656.262(9) provides:

"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 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of George N. Wilkins, Claimant.

WILKINS,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Respondent.

(WCB No. 79-02117; CA A25408)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 29, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Brian L. Pocock, Eugene, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed and remanded for determination of extent of disability.

WARREN, J.

Claimant appeals an order of the Workers' Compensation Board that affirmed the referee and upheld a denial issued more than five years after the alleged accident had occurred. We reverse.

On November 13, 1975, claimant allegedly fell to the ground from the top of a loaded veneer truck and sustained injuries to his hips. The claim was accepted by SAIF, and compensation was paid for time loss and medical benefits for total hip replacement surgery on both the left and right hips and a third surgery to remove trochanteric wires in the right hip. The claim was closed by a determination order on February 23, 1979, with an award of 80 percent permanent partial disability. Both parties requested a hearing on the extent of disability. At the time of the first hearing in August, 1979, employer's attorney stated: "The sole issue involved is extent of disability." That remained the sole issue through four continuances of hearing until the denial was issued on May 6, 1981,[1] over five years after the alleged accident, over

[1] Three of the continuances were the result of inadequate time being alloted for the testimony. The fourth, on September 2, 1980, was the result of SAIF's attorney having left SAIF and joined a law firm. Thereafter, a partner of that firm left and joined the firm that represented claimant. The parties determined that action created a conflict, and claimant's attorney was removed from the case. The next hearing was not held until May 6, 1981, two days after the denial was issued.

two years after the determination order and only two days before the fifth scheduled hearing on the determination order.

Kevin Murphy, the general manager of Murphy Company, testified that he had made the decision to deny the claim. He said that the denial was not issued earlier because the company did not have sufficient proof that an incident had not occurred and that the employer did not have a "legal vehicle" to deny it. When he was asked what the evidence was of which he had no knowledge before January 1, 1981, that influenced his decision to deny the claim in May, 1981, he initially stated that he could not identify any evidence that had so influenced his decision. Later, he stated that his decision to deny the claim was based on 1971-73 hospital reports from Sacred Heart, Dr. Ulman's reports and testimony he had heard in previous hearings. He testified that he knew claimant had been treated at Sacred Heart Hospital in

1971-1973 and that he knew that Dr. Ulman had been treating claimant and issuing reports since 1975. It is evident that, with reasonable diligence, those reports could have been obtained by the employer at any time during its investigation of the claim. We therefore construe the issue in this case to be whether an employer has an absolute right to issue a denial at any time before final determination of a claim, without regard to when the evidence on which the denial is based was known or discoverable.

Only two Oregon cases have any direct relevance to this issue. In *Frasure v. Agripac,* 290 Or 99, 619 P2d 274 (1980), the claimant had sustained an initial injury at Permaneer and had had surgery, and the claim was closed. The claimant worked for two days at a second company, Agripac, and again became disabled. All the physicians stated at that point that the work at Agripac had only aggravated the earlier back injury. The claim against Permaneer was closed with an award for time loss only, and the claimant requested a hearing. Before the hearing, the claimant's doctors changed their opinion and unanimously said that a new injury had occurred at Agripac. The claimant filed a claim for new injury against Agripac, which was denied as not having been timely filed. Permaneer issued a denial. The claimant requested a hearing, and the referee concluded that a new injury had occurred and that a claim for the new injury was not barred because Agripac had actual knowledge. The Board affirmed. We reversed, holding that Agripac had not received notice, so the new injury claim was barred but that Permaneer was estopped from denying the aggravation claim. The Supreme Court reversed our decision and held that Permaneer was not estopped to deny the aggravation claim. It held that an employer is not required to deny a claim within 60 days or be barred from a subsequent denial. The court noted:

> "* * * [T]he statutes assure employers and carriers that they will not be prejudiced by prompt payments of claims when they receive new information which reveals their nonliability for a claim." 290 Or at 107.

In *Bauman v. SAIF,* 62 Or App 323, 661 P2d 105, *rev allowed* 295 Or 259 (1983), the claimant submitted a claim for injury in October, 1977. SAIF accepted the claim and paid

benefits through 1980. In February, 1980, after the claim had been closed, the doctor notified SAIF that the claimant was in

need of further treatment and requested that the claim be reopened. In April, 1980, surgery was performed and in May, 1980, SAIF denied the aggravation claim stating that there was insufficient evidence that it was related. On November 26, 1980, SAIF denied the original claim, stating that it now believed that no compensable accident had ever occurred. The Court of Appeals held that the denial of the original accident was invalid, because it was issued after a final determination of compensation.

The facts of the present case fall into the grey area between *Frasure* and *Bauman:* a denial issued a substantial time after the accident but before final determination in the case. SAIF argues that, under *Frasure,* there are no limitations on the employer's ability to deny at any time before the final determination of a claim. That would establish a very broad rule that would lead to unconscionable results in some cases. Because of the medical instability of some claimants, a claim can remain open for substantial periods of time and still not be ripe for a final determination. An example is the recent case of *Kociemba v. SAIF,* 63 Or App 557, ___ P2d ___ (1983), which involved an accident that occurred in 1965. In that opinion, we referred the case back to the Board for further processing, holding that after 18 years the claimant was still not medically stationary and that no determination could be made on the extent of his disability. Under SAIF's theory of this case, Kociemba's claim could be denied after 18 years and a contention be made that the accident never occurred. There is no reason in law or justice why a claimant should remain vulnerable to a denial of the entire claim for such an extended period of time merely because procedural complications of the workers' compensation law or the nature of the injury prevent a more prompt final arrangement of compensation. The justification for such a rule cannot be found in the cases relied on by SAIF.

In *Frasure,* the Supreme Court upheld the late denial because it was based on new facts, *i.e.,* consistent medical reports by all doctors that were different from the consistent medical reports issued at the time the claim was accepted. In *Bauman,* we stated that *Frasure* merely holds

> "* * * 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." 62 Or App at 328. (Emphasis supplied.)

A holding that an employer is not automatically foreclosed cannot be construed to be a holding that an employer can never be foreclosed before a final determination under any factual situation. The factual situations under which late denials may be issued are myriad and cannot possibly be covered by any fixed rule establishing when a denial could or could not be issued before final determination

of the claim. We hold, rather, that the decision must be made on a case-by-case basis, evaluating the reasonableness of the employer's late denial. In making that determination, the trier of fact must take into consideration many factors, some of which are the length of time between the alleged accident and the denial of the claim, the complexity of the causation issue and the difficulty of obtaining evidence as to whether causation exists, new evidence available at the time of the denial which was not reasonably available to the employer at an earlier date, the reason for the delay in the claim reaching finality and prejudice to the claimant by the delay.[2]

These facts are relevant in this case:

(1) The causation issue was a relatively simple one, based solely on the employer's contention that the accident never occurred. All evidence relevant to this issue could have been ascertained by the employer within a relatively short time after the accident.

(2) The determination order was issued over two years before the denial. The only reason the claim was still open at the time of the denial was that the hearing had been continued four times from August 29, 1979, until June 11, 1981, when the final hearing was held.

(3) The period of time from the initial accident to the date of the denial was five and one-half years.

(4) The denial was not based on any evidence that could not have been obtained by the employer a significant period of time before the denial.

Employer's basis for the denial is that the accident never occurred. That was supported by evidence of witnesses who saw nothing and by employer's argument that claimant's description of the accident was inherently incredible. Employer had the ability immediately after the accident to interview potential witnesses and to inform claimant that it did not believe his description of the accident. After five years, claimant's memory and that of any witnesses was undoubtedly dimmed. Claimant's ability to describe the accident in a consistent, believable manner is lessened, and his ability to locate potential witnesses is diminished. He was therefore prejudiced by the late denial.

We hold that employer acted unreasonably in delaying five years before issuing a denial. Employer was barred from denying the claim on that date.

Claimant also assigns as error the referee's failure to make findings concerning SAIF's failure to process claimant's aggravation claim. A July 20, 1979, report of Dr. Bert established that claimant had slipped at work and was now totally disabled. Under ORS 656.273(3), that report could be an aggravation claim. As in *Vandehey v. Pumilite Glass & Building Co.*, 35 Or App 187, 580 P2d 1068 (1978), the question is whether the letter was a claim. We hold that it was not. The extent of plaintiff's disability was still unresolved, and a hearing on that issue had been requested. The letter was relevant evidence in a pending claim; it was not a new claim. Claimant is not entitled to penalties and attorney fees for

[2] Prejudice may be inferred from the mere passage of time in some cases. *Vandre v. Weyerhaeuser Co.*, 42 Or App 705, 709, 601 P2d 1265 (1979).

unreasonable delay in processing a claim. ORS 656.382; ORS 656.262(9); *Vandehey v. Pumilite Glass & Building Co., supra.*

Finally, claimant requests that this court find him to be permanently and totally disabled. Although evidence was fully presented to the referee on the extent of disability, his affirmance of the denial prevented him from reaching the issue of extent. We therefore remand to the Board for determination on this record of the extent of disability.

Reversed and remanded for a determination of the extent of disability.

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88 October 12, 1983 No. 505

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Karen L. Fink, Claimant.

FINK,
Petitioner,
v.
METROPOLITAN PUBLIC DEFENDER,
Respondent.

(80-10425; CA A26671)

Judicial review from Workers' Compensation Board.

Argued and submitted May 9, 1983.

Elden M. Rosenthal, Portland, argued the cause and filed the brief for petitioner. With him on the brief was Rosenthal & Green, P.C., Portland.

David O. Horne, Beaverton, argued the cause and filed the brief for respondent.

Before Gillette, Presiding Judge, and Warden and Young, Judges.

WARDEN, J.

Affirmed.

WARDEN, J.

Claimant appeals from an order of the Worker's Compensation Board which affirmed the hearing referee's decision that former OAR 436-54-225 establishes a proper formula for computing temporary partial disability and that claimant's condition is not a compensable occupational disease. We review *de novo,* ORS 656.298(6), and affirm.

Claimant, age 35 at the time of the hearing, is an attorney. She graduated from law school and was admitted to the Oregon Bar in 1977. She was self-employed until May, 1978, when she became employed with the Metropolitan Public Defender's Office (MPD) in Portland. At MPD she initially handled a case load of 70 to 80 misdemeanor clients.

In January, 1979, she was transferred to the felony division, and her workload and responsibilities increased substantially. According to claimant, her weekday work hours typically were from 8:00 a.m. to 11:00 p.m., and she regularly worked weekends as well.

Early in 1979, claimant began to experience fatigue and complained of pain in her shoulders, arms and hips. In August, 1979, she voluntarily left MPD. She testified that she left because her health was deteriorating, she was exhausted and she could not handle the stress level of that office. In mid-October, she began working for a law firm in private practice on a half-time basis and remained so employed at the time of the hearing.

Claimant did not seek medical attention until March 27, 1980, when she was examined by Dr. Rosenbaum. Claimant reported continuing symptoms of fatigue and joint pain. Dr. Rosenbaum conducted a physical examination and laboratory tests. He made an essentially negative diagnosis but suggested the possibility of rheumatoid arthritis. On August 20, 1980, claimant was examined by Dr. Robert Bennett, who diagnosed fibrositis.

Claimant filed a claim with MPD for compensation for fibrositis on September 19, 1980. The claim was denied on May 4, 1981. She requested a hearing. The referee held that she was entitled to temporary total disability benefits from August 3, 1979, when she left her job because of her fibrositis, until October 1, 1979, when she started working half-time in

private practice. He awarded her temporary partial disability benefits for October, November and December, 1979, but found that she was not entitled to any temporary partial disability benefits after January 1, 1980. The referee also concluded that claimant had failed to establish that she had a compensable occupational disease.[1] She appealed to the Board, which affirmed the referee's order. This appeal followed.

Claimant appeals the Board's ruling that her occupational disease claim was not compensable. She argues that she satisfied her burden to prove that her job stresses exacerbated her symptoms and caused a worsening of her fibrositis. On *de novo* review, we find the evidence insufficient to establish compensability of this claim.[2]

In order to prevail on an occupational disease claim, a

[1] MPD has not contested the ward of temporary total disability or temporary parial disability benefits. A claimant is not obligated to repay compensation paid ending review by the board or appeal to this court, even if the board or court determines that compensation should not have been allowed. ORS 656.31(2).

[2] The referee denied claimant's occupational disease claim on the basis of *James v. SAIF*, 290 Or 343, 624 P2d 565 (1981), because her fibrositis was not caused solely by circumstances of the work environment. The Board subsequently assessed the claim under the standard established in *SAIF v. Gygi*, 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982), which this court decided between the hearing and the Board's review. The Board found that claimant failed to meet the *Gygi* standard, *i.e.*, she failed to prove that her work was the major contributing cause of her disability. Because we find that claimant failed to show a worsening of the underlying pathology of her disease, we do not decide whether the evidence is sufficient to prove that her job conditions were a major contributing cause of her disability.

claimant must prove each of the elements articulated in *Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979). *Weller* requires that a claimant prove by a preponderance of evidence that "(1) his work activity and conditions (2) caused a worsening of his underlying disease (3) resulting in an increase in his pain (4) to the extent that it produces disability or requires medical services." 288 Or at 35. Claimant has failed to meet that burden of proof.

The doctors who examined her essentially agree that the symptoms she reported can be consistent with a diagnosis of fibrositis and that a person who has symptoms of fibrositis and works in a stressful job situation could become more symptomatic. Dr. Bennett, who initially diagnosed fibrositis, testified that the stress of claimant's MPD job probably

exacerbated her symptoms and that that exacerbation probably left her with the residual level of symptoms she was experiencing at the time she filed her claim. However, the record is devoid of any evidence to indicate a worsening of claimant's underlying disease, as distinguished from symptoms alone.

Claimant's examining doctors, both specialists in rheumatology, indicated that the underlying pathology of fibrositis has not been determined. From this record, we cannot say that fibrositis exists, nor does the evidence in the record establish that the symptoms of fibrositis *are* the disease. Therefore, from this record, it would be purely speculative to infer that claimant's employment caused a worsening of her underlying disease.[3] We conclude that she has failed to establish a compensable ocupational disease.

Claimant also contends that she is entitled to temporary partial benefits after January 1, 1980. Because we conclude that she has failed to establish a compensable occupational disease, we do not address that contention.

Affirmed.

[3] We note that the referee concluded that the evidence that claimant's symptoms remained at a higher level at the time of the hearing than before she became symptomatic on the job more than two years earlier tends to support the conclusion that her work activities and conditions contributed to a worsening of her underlying disease. We are not bound by that conclusion, and we do not find that analysis persuasive.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of William R. Carr, Claimant.

CARR,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(WCB No. 80-00053; CA A23840)

In Banc*

Judicial Review from Workers' Compensation Board.

Argued and submitted September 22, 1982; resubmitted in banc September 9, 1983.

Steven C. Yates, Eugene, argued the cause and filed the brief for petitioner.

Darrell E. Bewley, Appellate Counsel, SAIF Corporation, Salem, argued the cause and filed the brief for respondent.

WARREN, J.

Reversed and remanded for entry of an order awarding claimant temporary total disability benefits at the rate determined by the referee from June 5, 1980, until July 25, 1980.

Richardson, J., concurring.

Joseph, C. J., dissenting.

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* Buttler, J., did not participate in this decision.

WARREN, J.

Claimant seeks review of an order of the Workers' Compensation Board, affirming the suspension of his temporary total disability benefits under ORS 656.325 and the administrative rules adopted thereunder, because claimant failed to attend a medical examination scheduled for him by SAIF. Claimant contends that the suspension was unlawful, because he had notified SAIF of a valid reason why he would not be able to attend the scheduled examination. He also contends that the procedures employed by the Workers' Compensation Department (Department) under ORS 656.325 and OAR 436-54-281 and 436-54-283, which allowed it to suspend his benefits without providing him with notice and an opportunity for a hearing before the suspension, violated his right to due process of law under the United States and Oregon Constitutions. We reverse.

In December, 1979, claimant sustained injuries to his spine in the course and scope of his employment. The claim was accepted, and SAIF began paying him temporary total disability compensation on December 17, 1979. Claimant, a Eugene resident, became a patient of a Eugene orthopedic

surgeon, who eventually requested that SAIF refer him to another physician because he had missed several appointments. SAIF scheduled an appointment with another Eugene physician, who reviewed the medical records and informed SAIF that he did not want to treat claimant.

On May 16, 1980, SAIF sent claimant a notice of appointment for the examination at issue. The notice informed him that he was scheduled for an examination by Orthopaedic Consultants in Portland on June 5, 1980, and that his failure to keep the appointment without notifying SAIF before the appointment of a valid reason why he could not attend would result in suspension of compensation under ORS 656.325 and OAR 436-54. The purpose of the examination was to determine the type of treatment claimant required, whether he was medically stationary and when he could return to work.

By letter dated May 19, 1980, claimant's attorney informed SAIF that claimant's wife was due to have a baby on June 5 and requested that the appointment be rescheduled for some time after July 1, 1980. SAIF told claimant's attorney by

phone on June 2, 1980, and by letter dated June 5, 1980, that it insisted that claimant keep the appointment.

On June 4, 1980, claimant's attorney called SAIF and reported that claimant's wife was enroute to the hospital to give birth. SAIF responded that, if the baby was born at a reasonable hour on June 4, claimant must keep the appointment. SAIF's claims representative attempted to verify that claimant's wife had been admitted to a hospital. Although the claims representative did not know the wife's name or her obstetrician's name, she called all of the hospitals in the Eugene area that she believed had obstetrical departments on June 4 and 5, 1980, and was told that no Mrs. Carr had been admitted. On June 5, 1980, she verified that claimant did not keep his appointment. On June 6, 1980, the claims representative called claimant's attorney, who said that he had been unable to contact claimant to determine what hospital his wife had entered and whether she had given birth. The claims representative told the attorney that SAIF intended to petition the Department for suspension of compensation. Later that day, the claims representative tried unsuccessfully to contact claimant.

On June 6, 1980, SAIF petitioned the Department's Compliance Division for suspension of benefits in a letter that stated most of the facts discussed above. On June 18, 1980, SAIF's claims supervisor called the attorney to inquire whether claimant's wife had given birth. He said that she had not. An assistant claims supervisor of the Division processed the petition. Her inquiry consisted of a call to Orthopaedic Consultants to verify that claimant failed to keep his appointment and a call to SAIF on June 24, 1980, to verify that claimant's wife had not yet given birth.

On the basis of those two calls and the information contained in the petition, the Division decided to suspend compensation. The assistant claims supervisor informed

claimant of the decision by a letter dated June 24, 1980, which stated, in part:

> "On June 4, 1980 your attorney advised State Accident Insurance Fund that your wife was on the way to the hospital to await delivery of her baby.
>
> "State Accident Insurance Fund advises that upon making a check with all of the hospitals in your area there is no record

> for the admittance of your wife to any of the local hospitals. They also advise that your wife has not yet delivered the baby.
>
> "Therefore I find *no valid reason available to me* to indicate you could not attend the June 5, 1980 examination with Orthopaedic Consultants.
>
> "The Department, pursuant [to] ORS 656.325 and OAR 436.54, *[sic]* has no alternative but to give State Accident Insurance Fund authorization to suspend your compensation as of June 5, 1980. The suspension may continue until such time as you have notified them of your agreement to be examined, and in fact, submit to an examination by [a] physician designated by them. * * *" (Emphasis supplied.)

On June 27, 1980, claimant requested a hearing on the suspension. On September 5, 1980, a hearing began concerning three issues relevant to claimant's compensation, including whether the suspension was reasonable. On February 20, 1981, another hearing was held, and by May 8, 1981, the parties filed written arguments on the three issues. On May 22, 1981, the referee issued his opinion and order. He affirmed the Division's decision to suspend compensation and refused to consider claimant's constitutional challenge.[1] The Board affirmed the referee, and claimant filed this appeal.

The first question is whether the Division's decision to suspend compensation under ORS 656.325 and OAR 436-54-281 and 436-54-283 was arbitrary or unreasonable. It is clear from the record that SAIF and the Division followed the applicable statutory and regulatory procedures. We do not address the reasonableness of those procedures. The narrow focus of our inquiry is whether, on the basis of the facts the Division had before it through those procedures, the *substance* of its decision that claimant had no valid reason for missing his appointment was arbitrary or unreasonable. We have reviewed the record and conclude that the Division's decision was not arbitrary or unreasonable.

The other and quite different issue is whether the *procedure* used by the Division under ORS 656.325 and OAR

436-54-281 and 436-54-283, which allowed it to suspend claimant's benefits without providing him with notice and an opportunity to be heard *before* the suspension, deprived him of his right to procedural due process under the Fourteenth Amendment and the "due course of law" provision of Article I,

[1] The referee also decided that claimant was entitled to benefits for temporary total disability payments at a rate higher than that previously determined and that the extent of his permanent partial disability was correctly determined. These portions of the decision are not before us.

section 10, of the Oregon Constitution. The procedural due process protection of the "due course of law" provision is essentially the same as that of the Fourteenth Amendment. *Tupper v. Fairview Hospital*, 276 Or 657, 664 n 2, 556 P2d 1340 (1977).[2] This issue, therefore, involves three questions: whether claimant had a constitutionally significant interest in his temporary total disability benefits, whether the deprivation of the interest involved government action and whether the procedures employed by the Division were constitutionally adequate.

ORS 656.325(1) provides, in relevant part:

> "Any worker entitled to receive compensation under ORS 656.001 to 656.794 is required, if requested by the director, the insurer or self-insured employer, to submit to a medical examination at a time and from time to time at a place reasonably convenient for the worker and as may be provided by the rules of the director. * * * If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period."

OAR 436-54-283(2) requires that SAIF notify a worker ten days before the examination of its purpose, date, time and place and that the notice include the following paragraph in bold-face type:

> "ATTENDANCE OF THIS EXAMINATION IS MANDATORY. YOU ARE RESPONSIBLE FOR NOTIFYING US PRIOR TO THE DATE OR TIME OF THE EXAMINATION OF ANY VALID REASON WHY YOU CANNOT ATTEND AS SCHEDULED. FAILURE TO ATTEND THIS EXAMINATION, OBSTRUCTION OF SAME, OR AN INVALID REASON FOR NOT ATTENDING SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS PURSUANT TO ORS 656.325 AND OAR 436-54."

OAR 436-54-281 gives the Division the authority to issue orders of consent to suspend compensation if a worker fails to attend the examination. OAR 436-54-283(5) describes the required contents of SAIF's application to the Division for suspension of compensation:

> "The insurer or self-insured employer requesting consent to suspension of compensation because of a worker's failure or refusal to submit to a medical examination, or obstruction of same, shall apply to the Compliance Division. The application in letter form shall contain the following information:

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[2] In response to the position in the concurring opinion in *Tupper v. Fairview Hospital*, 276 Or 657, 556 P2d 1340 (1977), that Article I, section 10, of the Oregon Constitution, should be interpreted to require more extensive procedural protections than the Fourteenth Amendment, the majority stated:

> "* * * [T]he procedural effect of state 'due course of law' constitutional provisions is essentially the same as the procedural effect of the due process clause of the fourteenth amendment to the federal constitution. Therefore, in the absence of some compelling public interest in giving Art 1, § 10, of our constitution a broader interpretation in this situation than that given to the due process clause of the fourteenth amendment by the federal courts, we decline to adopt such a construction. * * *" 276 Or at 664 n 2.

"(a) consent for suspension of compensation is requested pursuant to ORS 656.325 and OAR 436-54;

"(b) what the worker was requested to submit to;

"(c) whether the attending physician was consulted to choose a mutually agreeable examining physician;

"(d) that the worker failed or refused to be examined and did not advise of any valid reason why the examination could not be attended as scheduled; (If a reason was provided but is considered invalid, explain.)

"(e) the date that verification of failure to attend was obtained from the examining physician, facility or their staff; (Any delay in obtaining verification or in requesting consent for suspension of compensation may result in authorization being denied or the date of authorization be modified by the date of actual verification or the date the request is received by the Compliance Division.)

"(f) the date, time and place of any rescheduled examination; and

"(g) any pertinent information that supports the request for suspension of compensation."

Under the statutory system and the rules, a claimant's compensation is suspended for the period between the

date of the scheduled examination that he does not attend and any rescheduled examination that does take place. If the suspension is valid, benefits for that period are forfeited and are not recoverable retroactively.

The first issue is whether claimant had a constitutionally significant interest in his temporary total disability benefits. "The requirements of procedural due process apply only to the deprivation of interests encompassed by the Fourteenth Amendment's protection of liberty and property." *Board of Regents v. Roth,* 408 US 564, 569, 92 S Ct 2701, 33 L Ed 2d 548 (1972). Interests encompassed by the Fourteenth Amendment's protection of property include interests in tangible property, *e.g; Fuentes v. Shevin,* 407 US 67, 92 S Ct 1983, 32 L Ed 2d 556 (1972), and certain interests in benefits, *Slochower v. Board of Education,* 350 US 551, 76 S Ct 637, 100 L Ed 692 (1956) (tenured professor's interest in continued public employment).

In *Roth,* the Court analyzed the nature of these interests in benefits that are protected by the Fourteenth Amendment:

"* * * To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must, instead, have a legitimate claim of entitlement to it. * * *

"Property interests, of course, are not created by the Constitution. Rather, they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law—rules or understandings that secure certain benefits and that support claims of entitlement to those benefits. * * *" 408 US at 577.

Using this analysis, the Court has held that the requirements of procedural due process apply to the termination of Social Security disability benefits, *Mathews v. Eldridge,* 424 US 319,

96 S Ct 893, 47 L Ed 2d 18 (1976), and welfare benefits, *Goldberg v. Kelly,* 397 US 254, 90 S Ct 1011, 25 L Ed 2d 287 (1970), because the recipients' claims of entitlement to the benefits were grounded in the statutes defining eligiblity for them.

The nature of claimant's interest in workers' compensation benefits here differs in one respect from the recipients' interests in *Mathews* and *Goldberg,* where the benefits

were paid directly by the government. Claimant's entitlement to workers' compensation benefits derives from the requirement of state law directing that employers provide specific benefits for injured workers. ORS 656.017. Eligibility for such benefits is defined by state law. There is no dispute that claimant incurred a "disabling compensable injury" under ORS 656.005(8) and was entitled to "temporary total disability" benefits under ORS 656.210. He was entitled to receive those benefits until it was determined that his disability was permanent, ORS 656.268, or no longer total, or that his benefits could be suspended under ORS 656.325. Therefore, even though the benefits are paid by the employer, SAIF or another insurer rather than the state, claimant's right to continuing benefits, derived from state law, is a property interest encompassed by the Fourteenth Amendment.

A person's constitutionally significant property interest is protected by the Fourteenth Amendment against governmental rather than private infringement. *Flagg Brothers, Inc. v. Brooks,* 436 US 149, 156, 98 S Ct 1729, 56 L Ed 2d 185 (1978). The procedural protections of the Fourteenth Amendment apply if the government is overtly involved in a private deprivation of protected property rights. 436 US at 157. *See also Fuentes v. Shevin, supra.* Under ORS 656.325 and OAR 436-54-281 and 436-54-283, the Workers' Compensation Department, a state agency, investigates an insurer's request for suspension of benefits, decides whether suspension is appropriate, and informs the claimants of its decision. The deprivation here is clearly governmental. Because claimant's interest in his benefits are encompassed by the Fourteenth Amendment, the state, through the Division, could not lawfully deprive him of them without due process of law.

Having decided that due process applies, the question remains what process is due. Except in unusual circumstances,[3] due process requires, at a minimum, that a

governmental deprivation of a property interest be preceded by some form of notice of the contemplated action and some opportunity to be heard informally if the action is contested. *Mathews v. Eldridge, supra; Goss v. Lopez,* 419 US 565, 95 S Ct

[3] In *Memphis Light Gas & Water Div. v. Craft,* 436 US 1, 19, 98 S Ct 1554, 56 L Ed 2d 30 (1978), the Court said:

> "Ordinarily, due process of law requires an opportunity for 'some kind of hearing' prior to the deprivation of a significant property interest. * * * On occasion, this Court has recognized that where the potential length or severity of the deprivation does not indicate a likelihood of serious loss and where the procedures underlying the decision to act are sufficiently reliable to minimize the risk of erroneous determination, government may act without providing additional 'advance procedural safeguards,' * * *"

729, 42 L Ed 2d 725 (1975); *Goldberg v. Kelly, supra; Tupper v. Fairview Hospital, supra; Hammer v. OSP,* 276 Or 651, 556 Pd 1348 (1976). The form of the notice and an opportunity to be heard which is required varies from case to case, depending on the circumstances and interests involved.

> "* * * [I]dentification of the specific dictates of due process generally requires consideration of three distinct factors: first, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail. * * *" *Mathews v. Eldridge, supra,* 424 US at 335; *see also Tupper v. Fairview Hospital, supra,* 276 Or at 662.

The factors to be weighed here are similar to those weighed in *Mathews,* which involved the termination of disability benefits under the Social Security Act. In 1968, Eldridge began receiving disability benefits, because he could not engage in substantial gainful activity as a result of physical and mental impairment. In 1972, he responded to a detailed questionnaire from the agency administering the Act regarding his condition at that time. On the basis of the questionnaire and reports from Eldridge's physician and a psychiatric consultant, the agency made a tentative determination that his disability had ceased. Pursuant to administrative rules, the agency sent Eldridge a letter informing him of the proposed termination of benefits, providing a summary of the evidence on which the proposed termination was based and informing him of his rights to review the medical reports and his file and to respond in writing and submit additional evidence. After Eldridge refused to submit additional evidence, the agency made a final determination to terminate benefits. Eldridge brought an action, arguing that due process required a trial-type hearing prior to termination of his benefits. The Court balanced the three factors quoted above and held "that an evidentiary hearing is not required prior to the termination of disability benefits and that the present

administrative procedures fully comport with due process." 424 US at 349.

As to the first factor, the Court reasoned that, because the Act provided that a recipient whose benefits were terminated was entitled to full retroactive relief if he ultimately prevailed, his sole interest was in the uninterrupted receipt of his benefits pending final administrative decision on his claim. The Court found that interest to be significant, because a disabled recipient would be unable to ameliorate the interim loss through temporary employment and the delay between termination of benefits and final decision after a post-termination evidentiary hearing exceeded one year. 424 US at 340.

In the case at bar, claimant's interest in the uninterrupted receipt of temporary total disability benefits is the same as that of the recipient in *Mathews,* except in one respect. In *Mathews,* recipients could potentially be without benefits until after final administrative review over one year

after termination; here, suspension of benefits lasts only until claimant attends a rescheduled examination. ORS 656.325(1). Although the evidence shows that it was unusually difficult for SAIF to schedule appointments for this claimant, it rescheduled him for an examination only six weeks after the effective date of his suspension. Therefore, although the interest of claimant in temporary total disability benefits is significant, it is generally less than the interest of a recipient in *Mathews*.

Claimant's interest in continued benefits is analogous to that of the utility customers in *Memphis Light, Gas & Water Div. v. Craft*, 436 US 1, 98 S Ct 1554, 56 L Ed 2d 30 (1978), whose utility services were terminated due to nonpayment of a disputed billing charge. The ratepayers were notified before termination that failure to pay the bill by a certain date would result in termination of services. They were not notified of any available pretermination administrative procedure for contesting the proposed termination. In holding that the utility's actions in terminating service deprived the ratepayers of a property interest without due process, the United States Supreme Court said:

> "Utility service is a necessity of modern life; indeed, the discontinuance of water or heating for even short periods of time may threaten health and safety. * * *" 436 US at 18.

Here, temporary total disability benefits are designed to provide a substitute for income lost due to a worker's temporary inability to otherwise provide for himself. Deprivation of compensation, even for a relatively brief period of time, and the resulting possible loss of ability to acquire essential goods and services, may threaten the health and safety of the worker and his dependents.

Concerning the second factor, the Court in *Mathews* concluded that the risk of an erroneous determination to terminate benefits under the agency's pretermination procedures was not great. The Court emphasized several bases for that conclusion. First, the determination was based on medical reports written by experts, and generally questions of veracity and credibility were not present. Second, because the notice of the proposed termination contained a summary of the relevant evidence and the recipient had the right to review his file, he could mold his arguments to the precise issues that the decisionmaker regarded as crucial. Third, the recipient's opportunity to present additional evidence and arguments before termination allowed him to challenge both the accuracy of the information in his file and the correctness of the agency's tentative conclusion. 424 US at 344.

Like the recipients in *Mathews*, claimants are entitled to a post-suspension evidentiary hearing. ORS 656.325(6).[4] Unlike the extensive pretermination procedures in *Mathews* that minimized the risk of an erroneous decision to terminate benefits, however, virtually no presuspension procedural safeguards applied to the suspension of benefits here. The only provision for presuspension notice to claimants

under ORS 656.325 and OAR 436-54-283 is the paragraph in the notice of appointment informing a claimant that failure to

attend the examination for an invalid reason will result in the suspension of benefits. OAR 436-54-283(2). No statute or rule requires the insurer to inform claimants that it considers their reasons to be invalid or requires the Division to inform claimants that the insurer has petitioned to suspend benefits.

Here, SAIF informed claimant on June 6, 1980, that his reason for failing to attend his June 5, 1980, appointment was invalid and that it would petition the Division for suspension of his benefits. However, claimant was never notified by SAIF or the Division that SAIF had, in fact, petitioned for suspension or that the Division was considering suspension. Further, claimant could reasonably have inferred from SAIF's June 18, 1980, call to his attorney, inquiring about his wife's condition, that SAIF had not petitioned for suspension. Thus, the notice claimant received did not achieve the goal of adequate notice to inform one whose interests may be affected that the suspension was pending so he could choose whether to contest it before suspension. *Goss v. Lopez, supra,* 419 US at 579; *Tupper v. Fairview Hospital, supra,* 276 Or at 664-65; *Hammer v. OSP, supra,* 276 Or at 654-55.

SAIF argues that ORS 656.325(6) and 656.283, which give claimants the right to a hearing on any question involving the reasonableness of the scheduled time for an examination, minimize the risk of an erroneous suspension. We disagree for two reasons. First, because there is no provision that a claimant receive notice that the insurer has petitioned for suspension, he would have to request a hearing and spend time and money preparing his case before he knows whether his benefits are in jeopardy. Second, no statutes or rules require that a claimant be given an opportunity to be heard informally *before* benefits are suspended.

Under the existing presuspension procedures, there is a significant risk of an erroneous decision to suspend benefits. The determination whether a reason for failing to attend an examination is valid will often turn on information solely in the possession of a claimant and the claimant's veracity and credibility. However, the applicable statutes and rules do not require the Division to contact claimants prior to suspension. The Division's assistant claims supervisor testified that a suspension decision is usually made on the basis of the

petition and contacts with the insurer and that she processed approximately 1500 petitions between 1977 and 1980 but contacted claimants in only two or three of those.

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[4] ORS 656.325(6) provides:

"Any party may request a hearing on any dispute under this section pursuant to ORS 656.283."

ORS 656.283 provides, in part:

"(1) Subject to ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim. * * *

"* * * * *

"(2) A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, requesting the hearing, stating that a hearing is desired, and mailed to the board.

"(3) The board shall refer the request for hearing to a referee for determination as expeditiously as possible."

The facts of this case illustrate the risk of an erroneous decision to suspend benefits under the existing presuspension procedures. The issue was whether claimant had a valid excuse for missing his June 5, 1980, appointment. Claimant's attorney notified SAIF on June 4 that claimant's wife was enroute to the hospital to give birth. SAIF's claims representative concluded that this reason was invalid, because she could not verify that claimant's wife had been admitted to a hospital. She admitted, however, that she called only the hospitals in the Eugene area that *she believed* had obstetrical departments and that she did not know the names of claimant's wife or her obstetrician.

The Division's assistant claims supervisor testified that claimant's reason would have been valid if his wife had been in false labor or her obstetrician had told claimant to stay with her at home. Nevertheless, without contacting claimant, she concluded on the basis of SAIF's petition that the reason was invalid. Under these circumstances, the potential for an erroneous suspension were significant. It is possible that SAIF could not verify that claimant's wife was admitted to a hospital because she went to a hospital outside of the Eugene area, because she went to a hospital without an obstetrical department due to an emergency, because she went to a hospital in the Eugene area with an obstetrical department that the claims representative was unaware of, because her last name was different from that of her husband, because she went to her obstetrician's office rather than a hospital or a myriad other reasons.

Regarding the third factor, the Court in *Mathews* concluded that the government's interest was substantial because of the increased administrative burden and expense of providing pretermination trial-type hearings and the expense of benefits to ineligible recipients. 424 US at 347. Although the expense of paying benefits to ineligible claimants is like that in *Mathews,*[5] the Division's burden of providing some

sort of presuspension notice and an opportunity to be heard would be minimal. By simply sending a claimant a copy of the insurer's application for suspension, the Division would give him adequate notice that the insurer had petitioned for and the Division was considering suspension, notice of the charges against him and notice of evidence on which the insurer relies. The Division could then give a claimant an opportunity to respond informally, orally or in writing. The risk of erroneous suspension would be significantly reduced if claimants were provided these minimal presuspension procedural safeguards, because they could inform the Division of facts solely in their possession that may be essential to a fully informed decision.

On the basis of *Mathews v. Eldridge, supra,* and our balancing of the three factors, we conclude that, in addition to the right to a post-suspension evidentiary hearing, claimant was entitled to the following presuspension procedural safe-

[5] In *Mathews v. Eldridge,* 424 US 319, 96 S Ct 893, 47 L Ed 2d 18 (1976), the Act provided that, if a beneficiary received payments to which he was not entitled, the agency could recoup these payments by reducing other benefits to which the beneficiary was entitled. 424 US at 339 n 22. Under OAR 436-54-320, the insurer can recoup overpayments in a similar manner.

guards: (1) notice that SAIF had petitioned for and the Division was considering suspension of his benefits; (2) notice of the basis on which SAIF contended that benefits should be suspended and of the evidence SAIF relied on; and (3) an opportunity informally to respond to SAIF's contentions either orally or in writing. *See Tupper v. Fairview Hospital, supra,* 276 Or at 665.[6]

Because none of these procedural safeguards were provided, we hold that the procedures employed under ORS 656.325 and OAR 436-54-281 and 436-54-283 to suspend claimant's benefits did not comply with the procedural due process guarantees of the Fourteenth Amendment and Article I, section 10, of the Oregon Constitution. Because his suspension was invalid, claimant was entitled to receive temporary total disability benefits until he was suspended pursuant to procedures that complied with due process or he was no longer medically eligible, whichever came first. The uncontroverted medical evidence shows that on July 25, 1980, claimant became medically stationary and was released for work with limitations due to a permanent impairment. Therefore, he was entitled to temporary total disability benefits until that date.

Reversed and remanded for entry of an order awarding claimant temporary total disability benefits at the rate determined by the referee from June 5, 1980, until July 25, 1980.

[6] We do not purport to tell the state how it must act in deciding whether to suspend benefits under ORS 656.325. We merely outline the minimum requirements of due process and leave it to the agency to adopt rules mandating the specific procedures it will follow to guarantee that claimants' constitutional rights will not be violated.

RICHARDSON, J., concurring.

I agree with the holding and with most of the reasoning in the lead opinion. My first reason for writing separately is to expand upon the opinion's analysis of the relationship between this case, involving benefits payable by private employers and insurers,[1] and *Mathews v. Eldridge,* 424 US 319, 96 S Ct 893, 47 L Ed 2d 18 (1976), *Goldberg v. Kelly,* 397 US 254, 90 S Ct 1011, 25 L Ed 2d 287 (1970), and other cases involving "benefits * * * paid directly by the government." ___ Or App at ___. (Slip opinion at 9.) I do not understand those cases to be the principal authority supporting our holding that due process protections attach to claimant's interest in continued payment of his benefits. In my view, claimant's due process rights arise because the procedure for terminating his privately-paid benefits is affected with state action, and cases such as *Flagg Brothers, Inc. v. Brooks,* 436 US 149, 98 S Ct 1729, 56 L Ed 2d 185 (1978), and *Fuentes v. Shevin,* 407 US 67, 92 S Ct 1983, 32 L Ed 2d 556 (1972), are the authority for our decision.

[1] Although SAIF is the insurer involved in this case, I understand the majority's holding to apply to *all* employers and insurers subject to the Workers' Compensation Law. The vast majority are not governmental bodies. My use of terms such as "private" in this opinion should be understood as generic language referring to the typical employer or insurer, and should surely not be understood as a specific comment on SAIF's status.

I do not think the lead opinion says otherwise. However, some confusion arises from its reliance on *Mathews, Goldberg* and similar cases in its discussion of whether claimant has a constitutionally significant interest in the continuity of his benefits. Here, as in *Goldberg* and *Kelly,* the *source* of the interest is governmental, *i.e.,* a statutory or regulatory requirement. But unlike *Goldberg* and *Mathews,* where a government was the obligor as well as the source of the mandate, the requirement here falls upon private employers and insurers. The relationship between insurers and claimants is no less "private" because it is statutorily-defined than it would be if it were contractual. In other words,

Goldberg and *Mathews* may further the analysis of whether claimant has a constitutionally protectible interest, but they cease to be relevant after that question is answered. Thereafter, claimant's interest is the equivalent of a private contract right or of an interest in tangible property. The question becomes whether the governmental involvement in terminating the interest is sufficient to constitute state action, and not whether the interest being terminated is in a governmental benefit. I agree with the answer in the lead opinion and, consistent with the foregoing, I also think that that opinion answers the right question.

My second reason for writing separately is that I question the need and the appropriateness of the specificity of the lead opinion's answer to the question "what process is due." The opinion's detailed discussion of required procedures may invade the board's authority to adopt its own procedures. *See McPherson v. Employment Division,* 285 Or 541, 591 P2d 1381 (1979). In any event, the detailed treatment is extraneous, because nothing is to take place on remand which involves the application of due process pre-termination requirements.[2]

Warden, J., joins in this concurring opinion.

JOSEPH, C. J., dissenting.

Although Judge Richardson's concurring opinion expresses some of my doubts about the majority's view, I cannot join in the concurrence, for I would hold that the petitioner had all the process that was due. I therefore dissent.

Stripped down to its necessary fundamentals, the majority's opinion rests on *Memphis Light, Gas & Water Div. v. Craft,* 436 US 1, 98 S Ct 1554, 56 L Ed 2d 30 (1978), which the majority finds is analagous and compelling. Although it is my view that that case comes perilously close to an absurd extension of *Board of Regents v. Roth,* 408 US 564, 92 S Ct 2701, 33 L Ed 2d 548 (1972), I need not dispute its validity, because it is distinguishable on the facts. The majority points out:

[2]The lead opinion's footnote 6, ____ Or App at ____ (slip opinion at 23, n 6), does not satisfy my concern, although it does make it apparent that the majority does not share that concern.

"* * * The ratepayers were notified before termination that failure to pay the bill by a certain date would result in termination of services. They were not notified of any available pretermination administrative procedure for contesting the proposed termination." (Slip opinion at 13.)

In the case before us claimant's claim had been accepted, and he was receiving temporary total disability compensation. He was given express notice that his failure to keep a medical appointment without notice to the insurer of a valid reason why he could not would result in suspension of compensation. The record is perfectly clear that from that point on claimant avoided any contact with SAIF about the problem; to be sure, the record discloses that he avoided contact with his own attorney. Keeping in mind that, to avoid suspension, all claimant needed to do was either to keep an appointment of which he had notice or to notify the insurer of a substantial reason why he could not, we should recognize that we are not dealing here with governmental action that is unreasonable or arbitrary. We should also recognize, then, that there is no substantial due process problem.[1]

Therefore, I dissent.

Gillette, Van Hoomissen and Young, JJ, join in this dissent.

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[1]ORS 656.325 provides, with respect to required medical examinations:

"* * * If the worker refuses to submit to any such examination, or obstruct the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period."

Under this provision, suspended benefits are apparently permanently lost, even if the worker subsequently submits to and satisfies a medical examination. (Presumably, if the worker prevails after a hearing on a medical examination dispute under ORS 656.325(6) and ORS 656.283, the suspended benefits would have to be paid.) If the facts here actually presented the threat of an unfair, arbitrary or unreasonable loss of benefits, the majority's analysis might be well taken.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
James R. Allison, Sr., Claimant.

ALLISON,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Respondent.

(81-05265; A25972)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 25, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. On the brief were William H. Schultz, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

VAN HOOMISSEN, J.

Affirmed.

NEWMAN, J., dissenting.

VAN HOOMISSEN, J.

The question in this workers' compensation case is the extent of claimant's disability. The referee awarded permanent total disability. On review, the Workers' Compensation Board concluded that claimant had sustained 60 percent unscheduled right shoulder disability. We review *de novo* and affirm.

Claimant sustained a compensable injury to his right shoulder when he fell on a pile of lumber. He underwent two surgeries. His treating physician concluded that his right shoulder and arm pain were caused by cervical osteoarthritis and disc disease, resulting in significant disability of the shoulder. He did not feel that claimant could return to carpentry, his occupation for 30 years.

Claimant complains of severe pain and physical limitations. The referee and the Board both found that his complaints substantially exceeded any complaints made by him to his treating physician and both disregarded his testimony on that point. We give great weight to the referee's findings of credibility. *Hannan v. Good Samaritan Hosp.*, 4 Or App 178, 471 P2d 831, 476 P2d 931 (1970), *rev den* (1971). Accordingly, we evaluate claimant's disability based on the

medical and vocational reports without regard to his testimony about his pain and limitations.

Claimant's disability is isolated in his right shoulder and arm. While severe, it does not affect his ability to use the rest of his body. The Board found that the objective medical findings alone did not warrant a finding of permanent total disability. We agree.

There are two types of permanent total disability: one arising entirely from medical or physical incapacity, and the other arising from conditions of less than total medical or physical incapacity plus additional conditions such as age, education aptitude, adaptability to nonphysical labor, and mental and emotional condition, which together result in permanent total disability. *Wilson v. Weyerhaeuser,* 30 Or App 403, 567 P2d 567 (1977). Unless a claimant shows that he comes within the first type of total disability, making it futile to attempt to find work, he must make reasonable efforts to

obtain employment before an award of permanent total disability will be granted. ORS 656.206(3);[1] *see Home Ins. Co. v. Hall,* 60 Or App 750, 654 P2d 167 (1982), *rev den* 294 Or 536 (1983); *Butcher v. SAIF,* 45 Or App 313, 608 P2d 575 (1980).

We agree with the Board's conclusion that claimant has not made reasonable efforts to find suitable work. The record reflects that, while he appeared to cooperate in placement efforts, he did not follow through on his vocational counselor's suggestions. He placed unreasonable wage requirements on the jobs he would accept, and he rejected employment opportunities that he could perform as being beyond his physical or medical capabilities. As a result of his non-cooperation, his file with Vocational Planning Consultants was closed. He was also interviewed at the Callahan Center, which reported that it was "unable to determine his physical tolerance for more specific job possibilities because [he] refused to stay at the Center and complete an evaluation." His trips to the employment office and his CETA inquiries appear, in light of his history with employment consultants, to be little more than perfunctory attempts to satisfy the statutory requirement that he seek work.

Affirmed.

[1] ORS 656.206(3) provides:

"The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

NEWMAN, J., dissenting.

The majority affirms the order of the Workers' Compensation Board. I respectfully dissent and would reinstate the referee's order that found claimant permanently and totally disabled.

Claimant is a 62-year-old man. He was 58 at the time of the accident. While employed as a construction carpenter in March, 1979, he suffered an injury to his right shoulder. After conservative treatment, he underwent surgery to remove an inch from the right distal clavicle. A further examination

showed a rotator cuff tear. The claim was first closed in May, 1980, with an award of 35 percent scheduled loss of the right arm. The claim was reopened, and surgery was performed

again. Claimant was then determined to be medically stationary, and the claim was again closed with an additional award of 35 percent for unscheduled right shoulder disability.

The referee, however, found:

> "Based upon the medical evidence, without regard to claimant's testimony, the objective medical findings of Dr. Sulkosky support a finding of severe unscheduled right shoulder impairment. Although there might be a field of endeavor in which claimant could find gainful and suitable employment were it not for the recession, numerous areas of endeavor are precluded because the market for one-armed workers is limited in the best of times. In view of the prevalent economic climate the referee is unable to perceive any possibility of claimant obtaining suitable, gainful employment in the foreseeable future and it is the opinion of the referee claimant is permanently and totally disabled."

The Board found that the referee erred in basing an award for a worker's loss of wage earning capacity "on the economic stability or instability of the market place" and reduced the award to 60 percent.

Of course, claimant must demonstrate his inability to sell his services on a regular basis in a "hypothetically normal labor market." *Wilson v. Weyerhaeuser,* 30 Or App 403, 408, 567 P2d 567 (1977). I agree with claimant's position, however, that the error on the referee's part was "harmless," because, regardless of the referee's reference to the recession, claimant is incapable of regularly performing work at a gainful and suitable occupation and is permanently and totally disabled because of his physical condition combined with his limited personal resources. *See Wilson v. Weyerhaeuser, supra; Looper v. SAIF,* 56 Or App 437, 642 P2d 325 (1982); *Morris v. Denny's,* 50 Or App 533, 623 P2d 1118 (1981); *Butcher v. SAIF,* 45 Or App 313, 608 P2d 575 (1980).

Although the referee and the Board found that claimant's testimony about his limitations conflicted with the reports of his treating physician, there is no dispute that claimant suffered a severe injury to his right shoulder. There is no dispute that, because of pain, he cannot sleep with regularity and cannot lie on his right side. There is no dispute but that his grip strength in his right hand is seriously diminished. There is also no dispute but that he is on chronic

pain medication, that his wife helps him dress, takes off his boots, combs his hair and cuts his food, that he no longer can hunt, fish or work in the yard and that he does not help with any cooking, cleaning or housework.

Dr. Surosky, the treating physician, reported that claimant is "subjectively completely disabled with regards [sic] to his right arm." It was his opinion that claimant cannot return to construction carpentry. The Callahan Center also

concluded that claimant suffers from considerable functional overlay and an overprotective attitude.

I conclude on this record that claimant's physical disability and his non-medical limitations prevent him from obtaining suitable and gainful employment. He is 62 years old and has a sixth or seventh grade education. He has worked for 30 years only as a carpenter, has no supervisory or management experience, has marginal reading ability, suffers from poor vision and is unable to write due to restricted right arm and elbow movement. He has cooperated with vocational rehabilitation efforts but has not found suitable and gainful employment. Because of his limited educational background, his adaptability to non-physical labor is low.

The majority opinion asserts that the referee "disregarded" claimant's testimony with respect to his pain and physical limits. The majority then states that "we give great weight to the referee's findings of credibility * * *. Accordingly, we evaluate claimant's disability based on the medical reports without regard to his testimony." The referee's opinion does not support the majority's extreme response. He clearly accepted as credible much of claimant's testimony, much of which is not disputed. The referee stated that, without regard to claimant's testimony, the objective medical evidence showed a severe right shoulder impairment. He did *not* evaluate the disability "without regard" to claimant's testimony, and neither should this court. Claimant is a person whose tolerance for pain appears from the record to be lower than some. We should not, because of his subjective, as well as objective, response to a severe injury, sustain the board's reversal of the referee's finding of permanent and total disability.

The majority finds, as did the Board, that claimant has not made reasonable efforts to obtain employment. The

referee did not so find. Claimant has continued to seek employment through vocational rehabilitation programs as well as on his own. The Vocational Rehabilitation Division suggested that claimant investigate hotel/motel management. He applied to several motels without success. Finally he was encouraged by a chain that would train him, but the description of the job duties demonstrated that the job was beyond his physical capacity because it required heavy lifting. He also has continued to make himself available for a position as a security guard, although it is questionable that he can perform duties that require reading and writing. He has pursued employment possibilities available to him but has been unable to find gainful employment. Under the circumstances, he has made reasonable efforts to locate work and has carried his burden of proving that, due to physical disability and limited personal resources, he is permanently incapacitated from regularly performing work at a suitable and gainful occupation in a hypothetically normal labor market. *Wilson v. Weyerhaeuser, supra; Looper v. SAIF, supra; Morris v. Denny's, supra; Butcher v. SAIF, supra;* ORS 656.206(3).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Della A. Laymon, Claimant.

LAYMON,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(80-10479; A26297)

In Banc*

Judicial Review from Workers' Compensation Board.

Argued and submitted May 25, 1983; resubmitted in banc September 9, 1983.

Janet A. Metcalf, Portland, argued the cause for petitioner. With her on the brief were English & Metcalf, Larry K. Bruun and Welch, Bruun & Green, Portland.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for respondent.

VAN HOOMISSEN, J.

Affirmed.

NEWMAN, J., dissenting.

* Butler, J., did not participate in this decision.

VAN HOOMISSEN, J.

Claimant appeals from an order of the Workers' Compensation Board that reduced the referee's award of permanent total disability. We review *de novo.*

Claimant concedes that physical incapacity alone has not rendered her permanently and totally disabled. She is therefore required to show a reasonable effort to obtain employment before she is qualified for permanent total disability, ORS 656.206(3),[1] unless she can show that she is completely incapacitated and that it would be futile for her to attempt to become employed. *See Morris v. Denny's,* 50 Or App 533, 623 P2d 1118 (1981); *Butcher v. SAIF,* 45 Or App 313, 608 P2d 575 (1980). She contends that she is excused from the requirements of ORS 656.206(3).

The referee stated:

[1] ORS 656.206(3) provides:

"The worker has the burden of proving permanent worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

"Considering the medical and nonmedical factors, I conclude that there is no realistic likelihood based upon existing occupational abilities that claimant will be able to sell her services to any employer and therefore find she is permanently and totally disabled."

On review, the Board adopted the referee's findings of fact. It concluded, however:

"Although we agree with the Referee that claimant suffers from some serious social/vocational obstacles to employability, we do not believe that they are serious enough, when combined with her fairly moderate impairment (moderate enough that no physician believes that surgery is warranted) that permanent total disability is warranted. All of claimant's treatment for her injury has been conservative, and all of claimant's physicians agree that claimant is physically capable of doing some form of work. Claimant has been successfully retrained for an occupation suitable to her physical restrictions, but she has made minimal efforts to find work. We do not find the record to indicate that claimant is excused from the ORS 656.206(3) seek-work requirement by *Butcher v. SAIF,* 45 Or App 313 (1980)."

Accordingly, after considering the referee's findings and all other relevant evidence, the Board reduced claimant's award to 70 percent permanent partial disability.

We agree with the Board that the record does not support the referee's finding that it would be futile for claimant to seek employment. All of the treatment for her injury has been conservative. All of her doctors agree that she is physically capable of doing some form of work. She was enrolled in a vocational rehabilitation program where she progressed satisfactorily and completed the course with high marks for speed and dexterity. The Field Services Division regarded her as rehabilitatable and able to make at least a part-time income. She is neither illiterate nor inarticulate. She is an avid reader. She would not be precluded from light work requiring simple written instructions or verbal communications. Her limited formal education is but one indicator of her ability. We have denied permanent total disability to claimants with limited formal education when that deficiency had little or no impact on other indicators of ability. *See Owen v. SAIF,* 33 Or App 385, 576 P2d 821 (1978); *Williams v. SAIF,* 20 Or App 208, 530 P2d 1255 (1975).

In a factually similar case, *Home Ins. Co. v. Hall,* 60 Or App 750, 654 P2d 1167 (1982), *rev den* 294 Or 536 (1983), the claimant was a 57-year-old woman with a tenth-grade education and no special job skills. She contended that her physical condition plus other non-medical factors rendered her permanently and totally disabled. We held that she had failed to prove that she was excused from the requirements of ORS 656.206(3). Likewise, the totality of the evidence here does not persuade us that claimant is excused from the requirements of ORS 656.206(3).

Affirmed.

NEWMAN, J., dissenting.

I dissent and would reinstate the referee's award. After considering claimant's physical restrictions in conjunction with nonmedical factors, such as her age, limited education, limited employment experience and limited transferable skills, the referee concluded that

> "* * * there is no realistic likelihood based upon existing occupational abilities that claimant will be able to sell her services to any employer and therefore find she is permanently and totally disabled."

Claimant, 52 years old, slipped and fell while working as a cook, breaking her sacrum and right middle finger in July, 1978. The fractures healed with bed rest, but claimant developed headache and pain on the left side of her body and in her left shoulder and cervical area. She has seen numerous physicians and undergone extensive testing and evaluation. In July, 1979, at the insurer's request, she was seen by Dr. Pasquesi. At that time, she was receiving physical therapy three times a week and chiropractic treatments twice a week and was wearing a low back brace. Dr. Pasquesi noted that x-rays submitted for the examination revealed extensive degenerative changes in both the lower lumbar area and the cervical spine area. He also stated that claimant had chronic moderate to severe pain.

In August, 1979, claimant entered a vocational rehabilitation program. Because she was physically unable to return to her usual occupation as a cook, she received training as an electronic component assembler. Her treating orthopedist, Dr. Neufeld, reported that, although she was experiencing pain, she was progressing in the program and wished to continue it. During the training, claimant was allowed to sit or stand as necessary to alleviate the pain; however, she was still unable to attend classes on a full-time schedule because of her physical condition.

Myelography was performed in January, 1980, which revealed small defects at the cervical and lumbar levels, but surgery was not recommended. In February, 1980, claimant's treating chiropractor reported that the sitting required in her training classes "is a continuous aggravation which I believe is very damaging to her recovery rate."

In July, 1980, claimant was again seen by Dr. Pasquesi. He reported:

> "Healed fracture of the sacrum with marked preexisting degenerative disease in the lumbar spine area with some radiculitis extending down the left leg without motor or sensory objective changes. Pre-existing degenerative changes in the cervical spine area with radiculitis down the left arm. The patient also has apparent peritendinitis in the region of the left shoulder with restricted motion and continued discomfort."

He stated that claimant should be able to function in some type of employment not requiring that she sit continually for

an eight-hour period and that she has limited motion in her left arm and probably could not effectively use the arm above waist level. In July, 1980, her treating chiropractor described claimant's lumbar pain as "excruciating, with [her] neck difficulties almost as bad."

In August, 1980, the Vocational Rehabilitation Division closed her file because of "handicap too severe or unfavorable medical prognosis." Claimant continued to seek medical assistance for pain. In April, 1981, Dr. Neufeld reported that her medical condition was essentially stable and that "[s]he will be restricted to very sedentary-type of work where she is doing only fine manipulations with her hands. Associated with this type of work would be the need for her to be able to get up and move around as needed." In May, 1981, Dr. Franks, claimant's treating neurosurgeon, stated that she had "a significant limitation of range of motion from a partial frozen shoulder, plus * * * continuing symptoms of tingling and discomfort going into the left thumb in the C6 nerve distribution which fits the myelographic defect, and also the EMG abnormality * * *." In October, 1981, claimant underwent a vocational evaluation. The vocational evaluator reported that she has extremely limited transferable skills to be utilized to locate employment in a competitive labor market and that she is vocationally handicapped with an extremely poor prognosis in locating any future employment within her skills and physical restrictions.

In December, 1981, Dr. Franks reported:

> "She finds that she cannot walk for more than thirty minutes without having to stop or sit or preferably lie down because the pain gets so severe. When in the kitchen at home, she tries to stand and if over a few minutes, this will also increase the disabling pain in her low back."
>
> "* * * * *
>
> "From a functional point of view [claimant], is unable to work in any activity involving bending, stopping, standing, walking [or], maintenance of a fixed posture. Thus, she needs work that will meet the fact that she is very restricted in her

> work activities. She will have pain whether or not she works; but, any activity involving the above functions will increase her degree of distress. She will always need a job in which she is able to change positions at will, to get up and move around, lie down when one fixed position or activity causes an increase of her pain. [Claimant] considers herself totally disabled, and at the age of fifty, not too many people would want to hire her with the significant restrictions placed upon her."

Although Dr. Franks did not feel that claimant was "totally disabled," he stated that "because of her chronic pain in the neck and low back which is exacerbated by activity, that her limitations will be rather prohibitive in her getting any type of reasonable employment."

The record suggests that one of the reasons why claimant has not had surgery is that her condition would not be improved by surgery. Dr. Neufield had noted that he did not feel that surgery would help her low back pain and that an operation would "only be possibly of some help in the neck area."

As detailed above, claimant has suffered continuous and severe pain in her low back, left leg, neck, left shoulder and left arm as a result of her injury. She is restricted in her ability to bend, stoop, walk, reach, stand, sit and maintain any fixed position. She has difficulty sitting for any length of time and is required to change positions frequently. She experiences increased symptoms when standing, walking, bending or engaging in any physical activity. She has a fifth-grade education. For the past 35 years she has been a fry cook. She has no other employment experience. She is incapable of returning to work as a cook and was enrolled in a vocational training program. Because of continual pain and inability to stand or sit for any length of time, she was only able to attend her training program for 2-1/2 hours per day. She completed her training as an electronics component assembler, but her rehabilitation counselor concluded that "her health has so deteriorated and she is in such pain that she is physically capable of doing only homebound employment. This would never provide enough income for a living wage." Home employment was never secured for claimant.

Ultimately, claimant's vocational rehabilitation file was closed, because the Vocational Rehabilitation Division

determined that her handicap was "too severe" to obtain employment.

It appears that in light of claimant's physical limitations, age, limited education and limited employment experience, further efforts to sell her services to an employer would be futile. *Looper v. SAIF,* 56 Or App 437, 642 P2d 325 (1982); *Morris v. Denny's,* 50 Or App 533, 623 P2d 1118 (1981); *Butcher v. SAIF,* 45 Or App 313, 608 P2d 575 (1980). The referee's award of permanent total disability was correct.

Richardson, J., joins in this dissenting opinion.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard D. Harris, Claimant.

HARRIS,
Petitioner,

v.

ALBERTSON'S INC., et al,
Respondents.

(78-07592; CA A26123)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 11, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

LaVonne Reimer, Portland, argued the cause for respondents. With her on the brief was Lindsay, Hart, Neil & Weigler, Portland.

Before Gillette, Presiding Judge, and Warden and Young, Judges.

GILLETTE, P. J.

Reversed and remanded.

GILLETTE, P. J.

Claimant appeals from an order of the Workers' Compensation Board (Board) affirming a referee's determination that claimant's lower back condition is not compensable. We reverse.

On December 26, 1977, claimant, a 48 year old frozen food key man and occasional grocery checker at Albertson's, was injured in an off-the-job rear-end automobile accident. Following the accident, claimant was treated for pain in his entire spine, with most of the pain concentrated in his neck and shoulder area. He also experienced some lower back discomfort and was prescribed a back brace, which he wore for a time. He returned to work on April 2, 1978, gradually assuming his regular duties, but he experienced occasional lower back pain when he was required to stand in one spot for a long while.

On June 23, 1978, claimant, while working as a grocery checker, turned to put a bag of groceries into a customer's cart, felt something in his lower back "snap" and experienced an immediate onset of severe pain. He was relieved of his duties and taken to the hospital, where he was diagnosed as having an acute muscle strain. He was later diagnosed by an orthopedic surgeon as suffering from chronic cervical and lumbar strain.

On August 24, 1978, Albertson's carrier denied claimant's claim on the ground that his complaints were not the result of a specific incident at work, but a natural progression of his injuries suffered in the automobile accident. The referee, affirming the denial, concluded that, under *Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979), claimant's back claim failed "to meet the requirement that more than mere symptoms of a pre-existing condition need be increased for the result to be compensable." The Board affirmed and adopted the referee's order.

The initial issue is whether the claimant suffered an on-the-job injury which was a material contributing cause of his disability. An injurious event is one that is sudden, unexpected and occurs during a discrete period of time. *Valtinson v. SAIF,* 56 Or App 184, 641 P2d 598 (1982). The evidence establishes that, although claimant did have some

residual back pain, it was the lifting of the bag of groceries that caused him to experience a snapping in his back, followed by an immediate onset of pain unlike any he had experienced previously. The incident meets the injurious event criteria, and we find as a matter of fact that claimant suffered an on-the-job injury.

The medical evidence, on which respondent relies, is not to the contrary. Dr. Mathiesen, who initially treated claimant for his automobile accident injuries, stated:

> "It is my medical opinion that the patient's pain which he noted on June 23, 1978, while checking groceries at Albertson's is a direct aggravation of his pre-existing back sprain injuries of the automobile accident on December 26, 1977."

Dr. Neufeld, an orthopedic surgeon, stated that:

> "* * * I would feel that the back difficulty probably would have to be related to his original injury, and perhaps there was some aggravation of the original injury that occurred while he was at work. I cannot say for sure, but it is doubtful that he would have had the problem at work if there had not been the original injury."

Although these statements are not models of certainity, we find from the medical history, viewed in conjunction with these medical opinions, that the "back difficulty" referred to by Dr. Neufeld was the result of a discrete injury. Claimant's pre-existing susceptibility to this type of difficulty does not defeat his claim.

Having found that claimant suffered an on-the-job injury, the only question remaining is whether claimant has met the requisite burden of proof. The referee incorrectly applied the standard of proof set out in *Weller v. Union Carbide, supra,* in finding this claim noncompensable. When a disability is the result of an accidental injury, rather than an occupational disease, *Weller* does not apply. *Jameson v. SAIF,* 63 Or App 553, 665 P2d 379 (1983). In injury cases, the correct standard of proof is that a claimant must establish by a prepondence of the evidence that the industrial injury was a material contributing cause of the existing disability. *Hutchinson v. Weyerhaeuser,* 288 Or 51, 602 P2d 1289 (1979); *Briggs v. SAIF,* 36 Or App 709, 585 P2d 719 (1978). In this

case, although no doctor used the language "material contributing cause," the evidence as a whole supports compensability. Before the lifting injury, claimant had returned to work full time, assuming his regular duties. After the injury, claimant was in such severe pain that he could not return to work. The new injury which produced this pain materially contributed to his disabling condition. Claimant has met his burden of proof; his claim is compensable.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Edward L. Culwell, Claimant.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Appellant,

v.

CULWELL,
Respondent.

(16-82-07073; CA A26820)

Appeal from Circuit Court, Lane County.

Edwin E. Allen, Judge.

Argued and submitted September 26, 1983.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause for appellant. With him on the brief was Donna M. Parton, Associate Appellate Counsel, Salem.

Evohl F. Malagon, Eugene, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Order vacated.

BUTTLER, P. J.

Petitioner appeals a decision of the Circuit Court of Lane County in a proceeding submitted pursuant to ORS 656.388(2)[1] to settle a dispute between claimant's counsel and the Workers' Compensation Board over an award of attorney fees. The court set aside the Board's award of attorney fees and allowed claimant's attorney a fee of $2,000 to be paid by SAIF in addition to compensation. SAIF appeals that decision, and we vacate it for lack of jurisdiction.

The Board's order on review was issued on May 28, 1982. Claimant's counsel did not file the proceeding in the circuit court until August 17, 1982. SAIF argues that, because the proceeding was not filed within 30 days as required by ORS 656.295(8), the circuit court had no jurisdiction. ORS 656.295(8) provides:

[1] ORS 656.388(2) provides:

"If an attorney and the referee or board cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge of the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

"An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298. The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.298."

Claimant responds that ORS 656.295(8), by its terms, applies only to appeals to the Court of Appeals and that the statute authorizing circuit court review of attorney fees requires only that the matter be submitted "forthwith."

If claimant's argument were accepted, a dispute over attorney fees could be submitted to the circuit court pursuant to ORS 656.388(2) *any* time after the order on review, so long as the circuit court were to determine that it was submitted "forthwith." Here, the court held that claimant sought circuit court review "forthwith," even though he submitted it nearly three months after the order on review was filed. A circuit court could just as well decide that a petition filed within 30 days was not filed "forthwith," given that forthwith means

immediately, or that a petition filed a year after the order on review was filed "forthwith."

Under claimant's theory, there would be no certainty as to when the right to seek review on the limited issue of attorney fees actually expires. Judicial review of a Board order awarding attorney fees in workers' compensation cases would, therefore, be governed by a rule substantially different from that which governs every other agency or court order in the state. All other systems of which we are aware have definite time limits within which appeals must be filed. We see no reason for a different rule in this case. Statutes must be construed together, giving effect to the manifest legislative intent. *Gevurtz v. Myers,* 10 Or App 491, 493, 500 P2d 730 (1972). Further, a statute should be construed, if possible, to avoid an absurd or unreasonable result. *Rogue Valley Memorial Hosp. v. Jackson Cty.,* 52 Or App 357, 365, 629 P2d 377, *rev den* 291 Or 368 (1981). The interpretation adopted by the circuit court that, because no specific appeal time is provided, the court is free to decide in each case whether the matter was submitted "forthwith" would lead to an absurd result and one that the legislature could not have intended. A much more reasonable interpretation is achieved by reading ORS 656.295(8) in conjunction with ORS 656.388(2) and holding that the 30-day time limit applies to all appeals of any kind from an order of the Board.

We hold, therefore, that disputes over attorney fees awarded by the Board must be filed in the circuit court pursuant to ORS 656.388(2) forthwith, but in no event later than 30 days after the date of the Board's order on review. Because claimant failed to file within that period of time, the circuit court had no jurisdiction to resolve the dispute.[2]

Order vacated.

[2] Given our disposition of this case, we need not reach SAIF's other assignment of error that the circuit court awarded fees which are not authorized under any statute.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Jack Reef, Claimant.

REEF,
Petitioner,

v.

WILLAMETTE INDUSTRIES,
Respondent.

(81-02391; CA A24943)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted February 18, 1983; resubmitted in banc June 8, 1983.

Gerald C. Doblie, Portland, argued the cause for petitioner. With him on the brief was Doblie Francesconi & Welch, PC, Portland.

Emil R. Berg, Portland, argued the cause for respondent. With him on the brief was Wolf, Griffith, Bittner, Abbott & Roberts, Portland.

GILLETTE, J.

Reversed.

Richardson, J., concurring.

GILLETTE, J.

Claimant appeals an order of the Workers' Compensation Board suspending temporary total disability benefits pursuant to ORS 656.325 because of his failure to submit to certain medical treatment. We reverse.

Under ORS 656.325(2)[1] and the relevant regulations, temporary total disability compensation may be suspended for any period of time during which a worker refuses to submit to treatment "reasonably essential to promote recovery." The procedure for obtaining a suspension is prescribed in OAR 436-54-286. The first step is for the employer or insurer to write to the worker, providing certain information and requesting that the worker submit to treatment by a specific date. After verifying that the claimant did not submit to the treatment, the insurer or employer may apply to the Workers'

[1] ORS 656.325(2) provides:

"For any period of time during which any worker commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a program at a physicial rehabilitation center, the right of the worker to compensation shall be suspended with the consent of the director and no payment shall be made for such period. The period during which such worker would otherwise be entitled to compensation may be reduced with the consent of the director to such an extent as the disability has been increased by such refusal."

Compensation Department Compliance Division for consent to suspend compensation. If the worker makes no effort to have compensation reinstated within 60 days after the Compliance Division authorizes suspension, the insurer or employer may request closure.

At issue in this case is a Compliance Division suspension order. Claimant sustained a compensable back injury in December, 1979. His physician prescribed conservative treatment, including muscle relaxants, heat, massage and hospitalization for traction. He referred claimant to Dr. Melgard, who first saw him in June, 1980, and who requested and received authorization for a myelogram, which claimant was reluctant to undergo. That September claimant saw Dr. Becker, who recommended additional conservative treatment before a myelogram. Claimant's symptoms continued and, in December, Dr. Becker recommended a myelogram and surgery, if Dr. Melgard still agreed. In January, 1981, he wrote employer that

the claim should be closed if claimant did not undergo the myelogram and surgery. Dr. Becker stated that claimant had apparently failed to keep a follow-up appointment with Dr. Melgard. In February, 1981, employer wrote claimant, stating its intention to request a suspension of benefits if he did not report to his doctor for a myelogram and possible surgery within two weeks. Claimant did not respond. On March 10, the Compliance Division suspended his benefits as of February 25. He was subsequently examined by a clinical psychologist, who reported to claimant's attorney that he would be a poor risk for surgery because of his extreme fear of any surgical procedure.

After a hearing, the referee upheld the Compliance Division, and the suspension order was affirmed by the Workers' Compensation Board.

Claimant makes two basic arguments for the invalidity of the suspension order: first, it was not issued in compliance with ORS 656.325 and applicable regulations, and, second, that his refusal to undergo the treatment was reasonable and that his reasonable refusal should be taken into account in determining whether the myelogram is "reasonably essential to promote recovery" under ORS 656.325(2). We consider these contentions in order.

As specified in OAR 436-54-286, part of the procedure the employer must follow before a suspension order can issue is:

> "(1) The insurer or self-insured employer shall upon knowledge of a worker refusing to submit to such medical or surgical treatment as is reasonably essential to promote recovery, request in writing to the worker that such treatment be obtained. The letter to the worker shall explain:
>
> "(a) the need for the recommended medical or surgical treatment;
>
> "(b) that such treatment is considered essential by the attending physician to promote the workers' recovery;
>
> "(c) that consent for such treatment be given to the

attending physician by a specified date in the reasonable future; and

"(d) in prominent or bold-face type the paragraph:

" 'THE DECISION WHETHER TO RECEIVE MEDICAL OR SURGICAL TREATMENT CONSIDERED ESSENTIAL BY THE ATTENDING PHYSICIAN TO PROMOTE RECOVERY IS A DECISION OF THE INJURED WORKER. FAILURE, HOWEVER, TO GIVE CONSENT BY THE DATE INDICATED OR FAILURE TO ACTUALLY RECEIVE SUCH TREATMENT SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS AND POSSIBLE REDUCTION OF ANY PERMANENT DISABILITY AWARDED PURSUANT TO ORS 656.325 AND OAR 436-54.'

"* * * * *

"(3) The insurer or self-insured employer shall provide documentation to adequately demonstrate that the medical or surgical treatment is reasonably essential to promotion of the worker's recovery and that the need for such medical or surgical treatment has been fully explained to the worker by the attending physician. Documentation should consist of doctor's reports, copies of correspondence, reports of consultation on the medical or surgical treatment recommended or any other written evidence which demonstrates the recommended treatment is reasonably essential."

Although the question is a close one, we agree with employer and the Board that the evidence does demonstrate that the recommended treatment was "reasonably essential to promote recovery."

Employer depends principally on the opinions of Drs. Melgard and Becker to support the suspension order. In June, 1980, Dr. Melgard, after a conservative treatment program, thought claimant probably had a spinal stenosis and requested authorization for a myelogram.[2] A month later he and

claimant discussed the possibility of a myelogram to determine whether or not he did have a spinal stenosis. The doctor's records contain the following entry:

"This patient and I had a long talk today. He understands the ramifications of possible surgery and myelography. I have told him that I can't guarantee him anything, but maybe if he wants to go ahead with the myelogram, we will see if he does have a spinal stenosis. The carrier has authorized it, but I

[2] Dr. Melgard's report to claimant's regular physician concluded:

"IMPRESSION: This patient has a subluxation at L4-5, and probably a spinal stenosis. Some of this may be related to his old horse injury that he has probably aggravated, with his injury of December 7, 1979. It is possible he may have subluxed it to some extent with his recent injury, but he doesn't have a lot of room for the lower lumbar nerve roots. He has not really done anything, and I suspect as he gets to be more active he is going to have more and more trouble. He is not anxious to have a myelogram or anything else at the present time. I am going to send him home and be as active as he can, and see him in thirty days. In the mean time I am going to write to Willamette Industries in which a copy of this letter is being sent requesting authorization for myelogram.

"I think that the patient has a spinal stenosis. I think it is related to his present injury of December 1979. I think he may very well come to decompression."

don't really think he will go ahead with it. We will arrange this as soon as he lets us know. I have told him that the insurance carrier will not let his claim stay open indefinitely."

There are no further reports in the record from Dr. Melgard. Dr. Becker, who at first suggested further conservative treatment, wrote to employer in December, 1980:

"* * * It was felt that with continuing radicular complaints down as far as the left foot, despite the patient's sincere efforts to control his symptoms conservatively, if Dr. Melgard still agrees, lumbar myelogram and surgery would be the next move."

Finally, on January 22, 1981, he wrote:

"If Mr. Reef chooses not to consider myelogram or surgery, then I feel that all has been done that can be done for Mr. Reef from an orthopedic standpoint, and I would suggest that his claim be declared medically stationary and his claim closed accordingly."

There is nothing further in the record regarding the recommendation of myelography and surgery. However, we think what there is suffices. As we see it, the doctors' recommendations of a myelogram can only be reasonably construed to mean that they believe that it is reasonably necessary for claimant to have the myelogram (and, if the myelogram indicates what they believe it will indicate, the subsequent surgery) in order to get better.[3] We hold that the evidence

establishes that the myelogram is "reasonably essential to promote recovery."[4]

Our conclusion that the myelogram was "reasonably essential to promote recovery" brings us to the second question posed by this case: May a claimant who is receiving

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[3] We consider this a fair, commonsense reading of the recommendations. By contrast, the specially concurring opinion's construcion of the recommendations is unrealistic and hypertechnical. We suspect that it would come as a great surprise to Drs. Melgard and Becker to learn that, in the view of some, the myelogram each recommended was not "reasonably essential to promote recovery" because they did not use those magic words in making their recommendations.

[4] The Board, in affirming the suspension order, said:

"* * * The suspension order terminated claimant's right to temporary total disability effective February 25, 1981. Had a Determination Order instead been issued, from the available information it appears that claimant's right to temporary total disability would have ended on January 22, 1981. Any error committed by following the suspension order route rather than the Determination Order route was harmless."

Employer argues that, if we agree with either of claimant's contentions, we can uphold the suspension on the basis of harmless error. The difficulty with that position is that it sought suspension of temporary total disability benefits and did not request a determination order. Had a determination order been requested, the issues incident to such a request could have been litigated. It is not at all certain on this record whether a determination order would have issued, what the extent of disability would have been or what the date for termination of temporary total disability benefits would be. Employer, having selected the procedure for suspension of benefits, is not in a position to contend that had a determination order been sought claimant would not have been better off. The validity of the suspension order is the only issue before us, and the possible consequences of a determination request were not litigated below.

temporary total disability payments reasonably refuse[5] to accept such treatment and still be entitled to receive temporary benefits?

In urging a negative answer to this question, employer argues, in essence, that a claimant must either undergo "reasonbly essential" treatment or, if he refuses,

or his case is closed by a determination order. The reason for refusing, employer argues, is irrelevant.

On the other hand, claimant argues that, under ORS 656.325(2), a reasonable refusal to submit to treatment is no bar to receiving time loss benefits, citing *Waldroup v. J. C. Penney Company,* 30 Or App 443, 448, 567 P2d 576 (1977), and *Clemons v. Roseburg Lumber Company,* 34 Or App 135, 578 P2d 429 (1980). Neither case is dispositive. Our statement in *Waldroup* to the effect that a refusal like that in this case is "simply a factor to be considered in determining what treatment is 'reasonably essential' " was *dictum;* the case was resolved on other grounds. *Clemons* is a case of extent of permanent disability in which, exercising our authority as fact finder, we found a claimant's refusal to undergo a transaxillary rib resection to be reasonable under all the facts of that case.

That the foregoing cases are not strictly in point does not mean, however, that they are not helpful. The mere fact that a particular medical procedure may help cannot be viewed *in vacuo.* What side effects will or may arise? What is the likelihood of improvement? Concerning this kind of case, we adopt the following statement from *Clemons:*

> "The test * * * is whether the refusal is reasonable. 1 Larson, Workmen's Compensation Law, § 13.22 at 3-398 (1978). Reasonableness is a question of fact. *See, Grant v. State Industrial Acc. Comm.,* 102 Or 26, 46, 201 P 438 (1921). The relevant inquiry is whether, if compensation were not an issue, an ordinarily prudent and reasonable person would submit to the recommended treatment. Such a determination must be based upon all relevant factors, including the worker's present physical and psychological condition, the degree of pain accompanying and following his treatment, the risks posed by the treatment and the likelihood that it would significantly reduce the worker's disability. *Grant v. State*

[5] The *reasonableness* of the refusal—as distinguished from its *legal effect*—would normally be a separate factual issue, but is not presented in this case. At the hearing before the referee, the following colloquy occurred:

> "MR. DOBLIE [claimant's attorney]: Yes. I think you asked if we'd be putting on evidence and, based upon my understanding that counsel has stipulated that for the purpose of your decision the evidence would support that Mr. Reef's refusal to have a myelogram and laminectomy was reasonable and that term is used in the cases, then there's no — we would have no further evidence to present.
>
> "REFEREE: Do you wish to so stipulate, Mr. Goodman? [Defendant's attorney] I think you already did, but I'm not sure if we were on or off the record, because we've been on and off so much.
>
> "MR. GOODMAN: I would stipulate that the reasonableness of Mr. Reef's decision is irrelevant to this particular administrative rule and that the evidence in the record that I have right now does not, in any way, indicate it was an unreasonable reason."

The factual question being resolved, the legal issue remains.

Industrial Acc. Comm., 102 Or at 45; *see* 1 Larson, Workmen's Compensation Law, *supra*." 34 Or App at 139.

To hold that ORS 656.325(2) requires that a claimant submit to any otherwise appropriate medical procedure in spite of having reasonable grounds for refusing to do so would turn a salutary statutory principle into a draconian one. We decline to do so. We hold that, under ORS 656.325(2), a claimant may not be denied benefits if he reasonably refuses

treatment that is "reasonably essential to promote recovery." *See Grant v. State Industrial Acc. Com., supra.*

Because claimant's refusal was reasonable, the Board's decision affirming termination of claimant's benefits under ORS 656.325(2) was in error.

Reversed.

RICHARDSON, J., concurring.

I concur in the decision to reverse the Workers' Compensation Board's order, but for a different reason. The lead opinion says:

> "While the question is a close one, we agree with employer and the Board that the evidence does demonstrate that the recommended treatment was 'reasonably essential to promote recovery.' " ___ Or App at ___ (slip opinion at 4).

The opinion suggests that this concurring opinion views the medical evidence in an unrealistic and hypertechnical manner, because the doctors did not use the "magic words" "reasonably essential to promote recovery." I do not suggest the ghoulish possibility that the doctors suggested diagnostic surgery because they had nothing else to do. I do suggest that, although the "magic words" were not incanted, the concept of the statute, ORS 656.325(2), was not met by employer's proof.

ORS 656.325(2) relates to suspension of temporary total disability benefits. There is no question that, aside from the possible suspension of benefits for refusal to submit to the recommended surgery, claimant is entitled to temporary total disability benefits. Suspension of those benefits takes away claimant's means of living until a determination of his permanent benefits. In that context, suspension of benefits ought not to be lightly regarded. An employer seeking suspension of temporary benefits has the burden of establishing that the recommended medical procedure is "reasonably essential to promote recovery." That phrase must have some meaning beyond simply a recommended procedure.

Comparing ORS 656.325(2) with ORS 656.325(4), the phrase "reasonably essential to promote recovery" takes on added meaning. ORS 656.325(4) provides essentially, that if an injured worker has failed "to follow medical advice from the attending physician," benefits awarded may be reduced.

See Clemons v. Roseburg Lumber Co., 34 Or App 135, 578 P2d 429 (1978).[1] Reduction of permanent benefits is far different

[1] *Clemons* was decided as a matter of proof as to the extent of disability. It was decided before the effective date of the present version of ORS 656.325(4), but apparently reflects the analysis appropriate under ORS 656.325(4).

than total suspension of benefits otherwise payable. The different elements an employer must establish reflect the relative severity of the different results under the two subsections.

We should not equate recommended medical procedures with procedures "reasonably essential to promote recovery." The lead opinion appears to say that, because the doctors recommended the diagnostic procedure, it therefore is reasonably essential to promote recovery. This perhaps is based on an assumption that the doctors would not make such a recommendation unless it was reasonably essential. I am not privy to the vast array of medical procedures recommended by physicians in response to a particular medical problem. I am, however, unwilling, in the light of the statutory language, to affirm a suspension of benefits because a physician merely recommends a medical procedure. If a recommended procedure is the same as a procedure reasonably *essential* to promote recovery, then the legislature unnecessarily used different criteria in ORS 656.325(2) and 656.325(4). The difference is essentialto the legislative scheme reflected in the two statutes, but it is blurred to extinction by the lead opinion.

In this case employer has not met its initial burden of establishing that the recommended procedure is reasonably essential to promote recovery. All that can be discerned from the sparse medical record is that the doctors, out of frustration in being unable to diagnosis claimant's condition, recommended a myleogram to determine if claimant has a spinal stenosis. The reports state that claimant probably has spinal stenosis. Much is left to conjecture as to what spinal stenosis is and whether corrective surgery would necessarily follow or whether such surgery would improve claimant's condition or merely alleviate his pain. Employer submitted the reports as the basis for requesting suspension of benefits and there is no indication that the doctors were presented with the question whether the recommendations were based on a conclusion that surgery was reasonably essential to promote claimant's

recovery. We should not supply the deficient evidence by inferring that the doctors must have been addressing the statutory standard. The lead opinion suggests the doctors would be surprised at the conclusion reached in this concurring opinion. The doctors may well be surprised by what they were deciding in recommending a myleogram as "the next move."

I conclude that employer has not met its burden to establish that the rquested myleogram is reasonably essential to promote claimant's recovery. I would not reach the other issues decided.

Buttler, Rossman and Newman, JJ., join in this concurring opinion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of William M. Still, Claimant.

STILL,
Petitioner - Cross-Respondent,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Respondent - Cross-Petitioner,
PETER KIEWIT & SONS,
Respondent - Cross-Petitioner -
Cross-Respondent.

(WCB Nos. 80-03041, 80-01909; CA A26570)

Judicial Review from Workers' Compensation Board.

Argued and submitted September, 26, 1983.

Quintin B. Estell, Salem, argued the cause for petitioner - cross-respondent. With him on the briefs was Emmons, Kyle, Kropp & Kryger, P.C., Salem.

LaVonne Reimer, Portland, argued the cause for respondent - cross-petitioner - cross-respondent. With her on the brief was Lindsay, Hart, Neil & Weigler, Portland.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund, Salem, argued the cause and filed the brief for respondent - cross-petitioner.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed on appeal; affirmed on both cross-appeals.

ROSSMAN, J.

This is a workers' compensation case in which an appeal was filed by claimant and cross-appeals have been filed by the carrier for the first employer and by the second employer. We reverse on claimant's appeal and affirm on both cross-appeals.

The issue that must be decided first is contained in SAIF's cross-appeal. SAIF appeals the Board's order on reconsideration, which held that an aggravation had occurred and that, therefore, SAIF was responsible for claimant's condition. All parties agree that the case is controlled by *Boise Cascade Corp. v. Starbuck*, 61 Or App 631, 638, 659 P2d 424, *rev allowed* 294 Or 792 (1983), in which this court stated:

> " ' "If the second [*i.e.*, last] injury takes the form merely of a recurrence of the first, and if the second incident does not contribute even slightly to the causation of the disabling condition, the insurer on the risk at the time of the original injury remains liable for the second. In

this class would fall most of the cases discussed in the section on range of consequences in which a second injury occurred as the direct result of the first, as when claimant falls because of crutches which his first injury requires him to use. This group also includes the kind of case in which a man has suffered a back strain, followed by a period of work with continuing symptoms indicating that the original condition persists, and culminating in a second period of disability precipitated by some lift or exertion.

" ' "On the other hand, if the second [*i.e.*, last] 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 contributes the major part to the final condition. This is consistent with the general principle of the compensability of the aggravation of a preexisting condition." ' 27 Or App at 364-65, quoting 4 Larson, Workmen's Compensation Law 17-71 — 17-78, § 95.12 (1976).

"Although that rule imposes total liability for a disability on the employer for whom the claimant worked at the time of the last injury, that liability is not imposed (as it would be in the case of an occupational disease) because the work exposure *could* have caused the disability; it is imposed because there was a traumatic incident that contributed independently to the claimant's disability. * * *" (Emphasis in original.)

Claimant was initially injured on September 13, 1978, when, while working as a flagman, he was hit by a mobile home and thrown across a highway and into a ditch. His claim was accepted by SAIF, and it was closed in September, 1979, with payment of temporary total disability but no award of permanent disability. He was released for work with a lifting limitation of 25 pounds and in mid-November, 1979, began work for Kiewit as a flagman. On November 20, 1979, he entered into a stipulated agreement with SAIF, under which he was paid 15 percent unscheduled disability for his low back and hip injury. Claimant continued to have back pain during the period of time when he was employed by Kiewit but was able to work full-time as a flagman. On November 27, 1979, he lifted a light standard at work and experienced increased pain in his back. On December 9, 1979, he lifted some plywood at work and again experienced increased back pain. He left work on December 14, 1979. The parties disagree whether he quit because of an argument at work or because of difficulties caused by his disability.

On the issue of responsibility, all parties rely on the reports and deposition of Dr. Cookson,[1] which are inconsistent and imprecise. However, if all of his reports and deposition are read together, it is apparent that the incidents in November and December of 1979, merely temporarily increased claimant's pain but did not worsen his disability.

[1] Claimant cites in addition a report of Dr. Martens. Because this report indicates that Dr. Martens was only informed of claimant's injury in September, 1978, and does not indicate that the doctor was even aware that claimant ever worked for a second employer, his conclusion that the initial accident was a material contributing cause to claimant's present complaints is not entitled to any weight and we do not rely on it.

That is consistent with Dr. Cookson's testimony that, immediately after claimant quit work on December 14, he could have returned to work as a flagman with the same weight restrictions that had been placed on him before either of the incidents. The preponderance of the evidence supports the Board's determination that claimant suffered an aggravation of his 1978 injury and not a new injury. Therefore, the Board correctly concluded that SAIF is responsible for claimant's condition.

Kiewit cross-appeals, assigning as error:

> "If Peter Kiewit is found to be the responsible employer, it contends that the Board erred in finding that claimant is entitled to an additional award of 35 percent unscheduled permanent partial disability."

As noted above, SAIF is the responsible carrier. SAIF did not cross-appeal on this issue or argue it in any manner in its brief. We therefore affirm the Board's holding that claimant is entitled to an additional award of 35 percent unscheduled permanent partial disability.

Next, we examine claimant's appeal, in which he contends that the Board erred on reconsideration in holding that he was not entitled to any temporary disability benefits and in changing the date on which he was medically stationary. SAIF answered these arguments in its brief by stating:

> "Respondent State Accident Insurance Fund Corporation (SAIF) will accept claimant's statement of the case, and argument set forth in claimant's brief."

Because of SAIF's concession on claimant's arguments, we reverse on claimant's appeal as to SAIF and hold that he is entitled to temporary total disability from December 14, 1979, until closure under ORS 656.268, as provided in the Board's original opinion.

Reversed on the appeal; affirmed on both cross-appeals.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Fred Hanna, Claimant.

HANNA,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(WCB No. 80-04719; CA A26147)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 14, 1983.

Elliott Lynn, Beaverton, argued the cause and filed the brief for petitioner.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed; referee's order reinstated.

WARREN, J.

Claimant appeals from an order of the Workers' Compensation Board that reversed the referee's finding of permanent total disability. He assigns as error the Board's admission of two exhibits, which were not admitted at the hearing, and the Board's finding that he is not permanently and totally disabled. We reverse and reinstate the referee's order.

Claimant is a 61-year-old man who has a long history of employment-related back injuries. His employment has been limited to heavy manual labor and work in restaurants as a dishwasher. On April 30, 1979, after a hearing on April 3, he was awarded 50 percent permanent partial disability, for a March 26, 1978, injury. No appeal was taken from that order. Thereafter, he began an approved vocational rehabilitation program at St. Vincent dePaul. On March 9, 1980, in connection with the termination of vocational rehabilitation, a determination order was issued awarding additional temporary total disability and reaffirming the permanent partial disability awarded in the earlier order. Claimant appealed from that determination order by requesting a hearing. On November 14, 1980, a referee issued an opinion and order finding claimant to be permanently and totally disabled and declining to consider exhibits 98 and 99, which had been submitted by SAIF after the hearing. On September 29, 1982, the Board issued its order on review reversing the referee, admitting the exhibits and holding that claimant was not entitled to any additional permanent disability.

The initial issue raised is the admissibility of exhibits 98 and 99. After reviewing the exhibits, we conclude that those exhibits have little probative value and our decision in the case would not be affected by either exhibit. We therefore need not decide if the exhibits were properly admitted. We proceed to our *de novo* review of the evidence for a determination of the extent of claimant's disability.

Both the referee and the Board concluded that claimant was permanently and totally disabled. His treating physician, Dr. Hummel, has concluded that he is permanently and totally disabled. Our review of the other medical and nonmedical evidence supports the conclusion. However, the Board held that, although claimant is permanently and totally disabled,

he is not entitled to an award for that disability for three

reasons: (1) his condition has not worsened since the last (unappealed) opinion and order; (2) his complaints are exaggerated; and (3) evaluation of his complaints should be limited to those related to his March, 1978, injury and not include those related to an April, 1977, injury which resulted in a disputed claim settlement.

ORS 656.268(5) provides that a new determination be made when a worker ceases to be enrolled in a program of vocational rehabilitation.[1] The new determination would necessarily be based on the medical and other evidence available at that time, including that concerning the success or failure of the vocational rehabilitation program. A claimant's disability may be determined to be more or less than previously supposed after vocational rehabilitation, even absent a change in his medical condition. A change in a claimant's condition is not required to obtain a redetermination of extent of disability on termination of a program of vocational rehabilitation.

The Board's second argument, that claimant's complaints are exaggerated, is unsupported by the record. The referee, who was the only one with the opportunity to see the claimant and evaluate his testimony, stated: "After hearing and observing claimant, I have no reason to question his credibility." Although there is some indication in the Vocational Rehabilitation reports that claimant was becoming dependent on their personnel, they consistently report claimant as being cooperative. He may well have a functional overlay; however, the preponderance of the evidence is that, regardless of any such overlay, he is unable to return to any gainful employment.

The final reason given by the Board for failing to award permanent total disability is more difficult to understand. It appears that the Board reasoned that, because

claimant resolved his April, 1977, injury by a disputed claim settlement, any later determination of permanent total disability must ignore any injury or condition before that date. We see no reason why a work-related injury which results in a disputed claim settlement should be given less effect than an off-the-job injury. It is axiomatic that an employer takes the worker as he finds him so far as the effect of a later employment-related injury is concerned. In a determination of disability, a claimant is entitled to have considered his entire physical condition, including that resulting from off-the-job injuries as well as on-the-job injuries that occurred before the date of the last injury chargeable to the current carrier, regardless of how claims relating to those injuries were resolved. When a claimant claims permanent total disability, the only issue before the referee or the Board is the extent of total disability after the injury at issue. We agree with the

[1] ORS 656.268(5) provides:

"If, after the determination made pursuant to subsection (4) 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 the worker 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 (4) of this section unless ther worker's condition is not medically stationary."

referee that claimant is entitled to an award of permanent total disability. The Board improperly considered other factors in reversing that award.

SAIF contends that claimant has not met his burden under ORS 656.206(3) to prove that he made a reasonable effort to seek gainful employment. His treating physician, Dr. Hummel, has consistently told him that he cannot perform any type of work and cannot be retrained. His union refused to consider him for employment because of his back disability. During the sheltered workshop experience at St. Vincent's, he was being evaluated by Vocational Rehabilitation. The record of contacts between claimant and Vocational Rehabilitation from December 28, 1979, to May 2, 1980, indicates that nearly every contact was initiated by claimant. During that period of time, he called Vocational Rehabilitation 77 times.

On February 4, 1980, Sandy Pinches reported that her psychological review had revealed that claimant's full-scale I.Q. was 70, which was "considered to be on the borderline between the dull normal and retarded ranges of intelligence." Further tests reveal that claimant reads at a second or third grade level. Although Pinches reported that he cooperated, he was unable to complete several tests because of his mental deficiency. Maudy Chaney of Vocational Rehabilitation reported: "It is our feeling that Mr. Hanna lacks the stamina and judgment to hold and keep a job in a competitive labor market. * * *" Pinches later reported that claimant

> "is not suitable for any sort of employment, including sheltered workshops. Because of his poor judgment, however, he may indeed attempt to return to work at some point in the future. We are attempting to discourage this action on his part * * *."

Under those facts, it would have been futile for him to seek work. Therefore, he does not need to establish that he has actively sought work to meet the requirement of ORS 656.206(3). *Morris v. Denny's*, 50 Or App 533, 623 P2d 1118 (1981); *Butcher v. SAIF*, 45 Or App 313, 608 P2d 575 (1980). Claimant has met his burden of proof and has established that he is entitled to an award of permanent total disability.

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

KEMP,
Petitioner,
v.
WORKERS' COMPENSATION DEPARTMENT,
Respondent.
(5-1982; CA A24274)

Judicial Review of Rules of Workers' Compensation Department.

Argued and submitted January 28, 1983.

David Force, Eugene, argued the cause for petitioner. On the brief were Peter W. McSwain and Malagon & Velure, Eugene.

William F. Nessly, Jr., Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, Stanton F. Long, Deputy Attorney General, and William F. Gary, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

OAR 436-69-201(2) and 436-69-401(1) and (2) held valid; OAR 436-69-301(3), 436-69-501 and 436-69-801(4) held invalid.

WARREN, J.

This is an original proceeding brought pursuant to ORS 183.400(1), seeking a declaration as to the validity of five rules established by the Workers' Compensation Department. Pursuant to ORS 183.400(1), this court can find a rule invalid only if it finds that it violates the constitution of the State or the United States, exceeds the statutory authority of the agency or was adopted without compliance with the Administrative Procedures Act. ORS ch 183. Review in this court is limited to consideration of the rule, the applicable statutes and constitutions and the documents evidencing compliance with the APA.

Petitioner first challenges two aspects of OAR 436-69-201(2).[1] She argues that the portion that states that insurers have the right to require evidence of the efficacy of treatment is invalid. That part appears to be nothing more

than a statement that the insurer may require that the treatment be reasonable and necessary. As such, it is authorized under ORS 656.245. *Wetzel v. Goodwin Brothers,* 50 Or App 101, 108, 622 P2d 750 (1981).

Petitioner next alleges that the rule alters the administrative standards established by ORS 656.245 in that it limits the number of office visits a claimant may have to any and all attending physicians. If a claimant exceeds the limit of 24 office visits in the first 60 days and four visits per month thereafter, the physicians involved are required to submit a report documenting the need for such services and setting forth a detailed plan of treatment. If there is "a judgment by the insurer that the report does not set forth sufficient grounds for the frequency of treatment in excess of the standard," the physician may request referral to the Medical Director "who may rule in favor of the physician. If the Medical Director does not so rule, the matter shall be submitted to a committee of the physician's peers for an opinion."

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. Such medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical and rehabilitative services. The duty to provide such medical services continues for the life of the worker."

In *Springfield Education Assn. v. School Dist.*, 290 Or 217, 621 P2d 547 (1980), and *McPherson v. Employment Division*, 285 Or 541, 591 P2d 1381 (1979), the Supreme Court defined the authority of an agency to implement a statute by rule. Under *Springfield*, the standard of judicial review of agency rules varies according to the type of term used in the statute:

> "1.) Terms of precise meaning, whether of common or technical parlance, requiring only factfinding by the agency and judicial review for substantial evidence;

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[1] OAR 436-69-201(2) provides:

"(a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Insurers have the right to require evidence of the efficacy of treatment. The usual range of the utilization of medical services does not exceed 24 office visits by any and all attending physicians in the first 60 days from first date of treatment, and 4 visits a month thereafter. This statement of fact does not constitute authority for an arbitrary limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. Physicians requesting reimbursement for visits in excess of this amount must submit upon request a report documenting the need for such services, setting forth a plan of treatment which will state:

"A. The name or description of specific correctable conditions towards which the therapy is directed.

"B. Specific measurable treatment objectives.

"C. Measurement indicators for each objective.

"D. The specific treatment modalities to accomplish the objectives.

"E. The frequency and duration of treatments estimated to accomplish the objectives;

"F. Upon completion of the treatment program, progress notes on the measurement indicatives; and

"G. Measured outcomes at the completion of the treatment plan.

"(b) A reasonable fee is payable for this report. A judgment by the insurer that the report does not set forth sufficient grounds for the frequency of treatment in excess of the standard may be referred by the physician to the Medical Director, who may rule in favor of the physician. If the Medical Director does not so rule, the matter shall be submitted to a committee of the physician's peers for an opinion."

"2.) Inexact terms which require agency interpretation and judicial review for consistency with legislative policy; and

"3.) Terms of delegation which require legislative policy determination by the agency and judicial review whether that policy is within the delegation." 290 Or at 223.

ORS 656.245(1) is in the third category, because it contains general terms limiting treatment to "such period as the nature of the injury or the process of the recovery requires." That language delegates to the agency the power to determine policy consistent with the delegation and to implement that policy by rulemaking. This court must therefore determine whether the Department's action in adopting OAR 436-69-201(2) was within the power delegated by the legislature.

We find nothing in this or any other statute that authorizes any limitations on the number of treatments that a claimant can receive. If this administrative rule actually permits a limitation of the treatment which a claimant can receive, it is not authorized by the statute. We agree however with the Director's argument that the rule does not limit treatment but merely requires that, if the treatment exceeds the prescribed number of visits, the physician must submit a report justifying further treatment. That is consistent with the legislative policy of requiring medical service to be provided only for the period of time necessary for recovery. OAR 436-69-201(2) is within the Department's delegated authority and is valid.[2]

Petitioner next challenges OAR 436-69-301(3),[3] which she concedes is virtually identical to ORS 656.010 and

is therefore clearly authorized by the statute. However, petitioner contends that the provisions of both the statute and the rule which allow claimants to refuse to undergo any medical or surgical treatment without suspension of benefits only when a worker relies "in good faith" on treatment by a "duly accredited" practitioner of a "well-recognized church" violate the First Amendment to the federal Constitution and Article I, sections 2 and 3, of the Oregon Constitution.

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[2] OAR 436-69-201(2) does not set forth any penalty for violation of this rule, and petitioner does not challenge the general penalty provisions of OAR 436-69-901. We therefore do not address the issue of the validity of imposing any penalty for violation of the rule.

[3] OAR 436-69-301(3) provides:

"Nothing in these rules shall be construed to require a worker who in good faith relies on, or is treated by, prayer or spiritual means by a duly accredited practitioner of a well-recognized church to undergo any medical or surgical treatment. Such worker or his dependents shall not be deprived of any compensation payments to which he would have been entitled if medical or surgical treatment were employed. The insurer may pay for treatment by prayer or spiritual means."

ORS 656.010 provides:

"Nothing in this chapter shall be construed to require a worker who in good faith relies on or is treated by prayer or spiritual means by a duly accredited practitioner of a well-recognized church to undergo any medical or surgical treatment nor shall such worker or his dependents be deprived of any compensation payments to which he would have been entitled if medical or surgical treatment were employed, and the employer or insurance carrier may pay for treatment by prayer or spiritual means."

Under *State v. Kennedy,* 295 Or 260, 666 P2d 1316 (1983), this court must consider the provisions of the Oregon Constitution before determining petitioner's rights under the federal Constitution.[4] Article I, section 2 states: "All men shall be secure in the natural right, to worship Almighty God according to the dictates of their own consciences." Article I, section 3 states: "No law shall in any case whatever control the free exercise, and enjoyment of religeous *[sic]* opinions, or interfere with the rights of conscience." The Oregon Supreme Court has held that the rights granted under these provisions of the Oregon Constitution are "identical in meaning" with the guarantee of religious freedom contained in the First Amendment to the federal Constitution. *City of Portland v. Thornton,* 174 Or 508, 512, 149 P2d 972 (1944), *cert den* 323 US 770 (1945); *Jehovah's Witnesses v. Mullen, et al,* 214 Or 281, 291, 330 P2d 5 (1958), *cert den* 359 US 436 (1959). Therefore, we turn to interpretations of the federal Constitution.

Although the United States Supreme Court has never dealt directly with the issue, it has generally been recognized that an individual has the right to refuse medical treatment on religious grounds. *Holmes v. Silver Cross Hospital of Joliet, Illinois* 340 F Supp 125 (ND Ill 1972); *Winters v. Miller,* 446 F2d 65 (2d Cir 1971); *In Re Osborne,* 294 A2d 372 (DC 1972); *In Re Brooks Estate,* 32 Ill 2d 361, 205 NE2d 435 (1965); *but see Application of President and Directors of Georgetown College,* 331 F2d 1000 (DC Cir 1964). In this case, however, that right is recognized by statute and by administrative rule, but it is accorded without penalty only to those persons who

can establish that they have a "good faith" belief in treatment by a "duly accredited practitioner" of a "well-recognized church." An individual who is not a member of any church but who has a sincere belief against medical treatment as a matter of religious conviction could be deprived of benefits. Likewise, an individual who is a member of a small, not "well-recognized" church that teaches that medical treatment should not be used could be deprived of benefits. The question in this case, therefore, is not whether benefits can be denied because someone follows a religious belief but whether benefits can be denied to a certain class of persons following religious beliefs and given to another class of persons following identical religious beliefs, the only difference being that the second class are members of a "well-recognized church" having "a duly accredited practitioner." When the issue is viewed in this manner, it is obvious that the rule cannot be sustained.

In *Larson v. Valente,* 456 US 228, 102 S Ct 1673, 72 L Ed 2d 33 (1982), the United States Supreme Court held:

> "The clearest command of the Establishment Clause is that one religious denomination cannot be officially preferred over another. * * *" 456 US at 244.

The court further held:

[4] Neither party in this case has argued that the statute and the administrative rule case do not constitute state action. We note that under our recent decision in *Carr v. SAIF,* 65 Or App 110, ___ P2d ___ (1983), state action is involved at least when, as here, the discriminatory exception is mandated by statute.

"* * * Free exercise thus can be guaranteed only when legislators—and voters—are required to accord to their own religions the very same treatment given to small, new, or unpopular denominations. * * *" 456 US at 245.

"* * * [W]hen we are presented with a state law granting a denominational preference, our precedents demand that we treat the law as suspect and that we apply strict scrutiny in adjudging its constitutionality." 456 US at 246.

The Supreme Court has also held that laws may not draw a distinction between personally held beliefs and beliefs of an organized religion or between theistic and non-theistic religious beliefs and secular beliefs. *Welsh v. United States,* 398 US 333, 90 S Ct 1792, 26 L Ed 2d 308 (1970). The common denominator of belief "must be the intensity of moral conviction with which a belief is held. * * *" 398 US at 358.

The only justification given by the Department for the rule is: "The agency has a compelling interest in ensuring

that compensation recipients do not malinger by unreasonably refusing rehabilitative treatment under the guise of religious beliefs." The Department gives no reason why that goal could not be met without drawing the suspect distinction between beliefs. OAR 436-69-301(3) cannot survive the strict scrutiny mandated by the Supreme Court for cases which grant a denomination preference or create a preference between eligious and non-religious beliefs.

Assuming that a state has the right to condition a right to benefits on a person's undergoing medical treatment in violation of his religious beliefs, a state still may not exempt, as here, some categories of people with religious beliefs, *i.e.,* members of "well-recognized churches" who are being treated by "duly accredited practitioners," and deny benefits to those of less well-recognized churches or to those whose personal conscience without the dictates of a formal religious belief mandate no medical treatment. OAR 436-69-301(3) violates the First Amendment to the United States Constitution and Article I, sections 2 and 3, of the Oregon Constitution and is invalid.

Petitioner next challenges OAR 436-69-401(1) and (2) on the ground that they exceed the authority of the Department. OAR 436-69-401 states:

"(1) A newly selected attending physician shall notify the insurer not later than five (5) days after the date of change of first treatment, using Form 829 (Change of Attending Physician).

"(2) The patient may have only one attending physician at a time. Treatment by other physicians shall be at the request of the attending physician. Fees for treatment by more than one physician at the same time are payable only when the medical conditions present are related to the treatment of the compensable injury or illness and are sufficiently different that separate medical skills are needed for proper treatment."

This rule is an apparent attempt to enforce the provisions of ORS 656.245(3):

"The worker may choose an attending doctor or physician within the State of Oregon. The worker may choose the initial attending physician and may subsequently change attending physician four times without approval from the director. If the worker thereafter selects another attending physician the

insurer or self-insured employer may require the director's approval of the selection and, if requested, the director shall determine with the advice of one or more physicians, whether the selection by the worker shall be approved."

The inexact terminology of ORS 656.245(3) requires a determination by this court as to whether OAR 436-69-401 is consistent with legislative policy. *Springfield Education Assn. v. School Dist., supra.*

ORS 656.245(3) implies that a claimant can have only one attending physician at a time. OAR 436-69-401(1) and (2) are consistent with that implication. The only additional requirement, that a new attending physician notify the insurer not later than five days after the date of first treatment, is merely one method of enforcing the implied directive of ORS 656.245(3) and is consistent with the legislative policy.[5] OAR 436-69-401(1) and (2) are within the authority of the Department and are valid.

Petitioner challenges OAR 436-69-501 on the ground that it exceeds the statutory authority of the agency. OAR 436-69-501[6] basically requires a surgeon to give an insurer

actual notice at least five working days before the date of proposed surgery. It also gives the insurer the right to require an independent consultation with a physician of its choice, and it allows for a third opinion to be sought if there is disagreement between the first two physicians. Finally, the rule provides that a physician who performs elective surgery without providing the insurer with prior notification and a

[5] Although it could be argued that the third sentence of subsection (2) bars payment for treatment at the same time by a specialist and by the attending physician, the previous sentence specifically states that treatment by other physicians shall be at the request of the attending physician. The clear implication is that insurer/employer must pay for such treatment of other physicians requested by the attending physician.

[6] OAR 436-69-501 provides:

"(1) When the attending surgeon believes elective surgery is needed for occupational injury or illness, the surgeon shall give the insurer actual notice at least five (5) working days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, and an estimate of the surgical date. The notice of intent to perform surgery must come from the surgeon actually performing the operation and having hospital privilege to perform the operation. Authorization of payment for the performance of major orthopedic or neurological surgery shall be made only to surgeons certified or eligible for certification by a specialty board approved by the American Board of Medical Specialties or Advisory Board for Osteopathic Specialties. Surgeons currently licensed and holding hospital privilege to perform major orthopedic or neurological surgery who do not have these qualifications may request exemption from this rule from the Medical Director. Physicians licensed in the state after the enactment of this rule shall not be exempt.

"(2) When elective major orthopedic or neurological surgery is recommended, the insurer may require an independent consultation with a physician of their *[sic]* choice. A physician performing a second opinion consultation for major orthopedic or neurological surgery shall be certified or eligible for certification by a specialty board approved by the American Board of Medical Specialties or Advisory Board for Osteopathic Specialties, in fields related to the surgery to be

reasonable opportunity for securing a consultation in advance of the surgery shall be subject to penalties. OAR 436-69-901 lists the penalties for violation of OAR 436-69-501, which are enforced by the director of the Workers' Compensation Department:

"(a) Reprimand by the director;

"(b) Nonpayment or recovery of fees in part, or whole, for services rendered;

"(c) Referral to the appropriate licensing board; or

"(d) Civil penalty not to exceed $1,000 for each occurrence."

No specific authority for these rules is contained in the statute. Rather, ORS 656.245 merely states that a claimant shall be

"* * * provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires * * *. Such medical services shall include medical, surgical, hospital * * *."

The provisions of ORS 656.245 as they relate to this administrative rule are also terms of delegation which require implementation by the agency. This court must review OAR 436-69-501 to determine if it is within the Department's delegated power. *Springfield Education Assn. v. School Dist.*, *supra*. The fact that the statute merely provides that medical benefits shall be provided does not mean that the Department may not place reasonable conditions on such benefits to enable the system to work more effectively and which are consistent with the policy of the statute. In this case, however, a twist on the usual administrative enforcement of a statute is found. The statute gives certain rights to claimants, including the right to a hearing on the denial of any benefits. OAR 436-69-501 provides directives, not to the claimant, but to the physician and allows the director to refuse to pay any fee for medical services performed by the physician who does not follow the dictates of the rule. There is nothing in the rule which indicates that a claimant would not be held to be responsible for those medical bills if they are refused by the Department due to the failure of the physician to follow the requirements of the rule.

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performed.

"(3) Upon receipt of the consultant's report, the insurer shall promptly notify the physician whether payment will be made for the proposed surgery. If the surgeon and the consultant disagree about the need for surgery, another opinion shall be sought from a consultant mutually agreeable to the two physicians.

"(4) A physician who proceeds to perform elective major orthopedic or neurological surgery without providing the insurer with the required prior notification and a reasonable opportunity for securing a consultation in advance of the surgery with a physician of their *[sic]* choice shall be subject to the penalties of these rules. Upon receipt of the notice of intent to perform surgery, the insurer shall promptly notify the physician of their *[sic]* intent to seek independent consultation, if they *[sic]* so desire. Such consultation shall not be delayed.

"(5) Surgery which must be performed promptly, i.e. before five (5) days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases, the surgeon should endeavor to notify the insurer of the need for emergency surgery."

In effect, the rule punishes a claimant by refusing to pay duly incurred medical bills that are the result of a compensable injury, because the physician failed to follow the Department's rule. Of course, under ORS 656.283, the claimant could request a hearing on the Department's refusal to pay for the medical services. However, at a hearing, the only issue would be whether the physician followed the rule and whether the director was acting within his discretion under the rule in punishing the physician by failing to allow payment. A claimant, under the rule, would not be able to defend on the basis that the treatment was reasonable, necessary and resulted from a compensable injury, which is all that is required under the statute.

By enacting OAR 436-69-501, the Department has created a direct penalty against physicians and an indirect penalty against claimants for actions over which claimants have no control. Neither of these actions is authorized by statute, and both are inconsistent with the clear policy of the Workers' Compensation Act that a claimant be compensated for reasonably necessary medical bills incurred as a result of a

compensable injury. ORS 656.245(1). OAR 436-69-501 exceeds the authority of the agency and is invalid.

Petitioner challenges OAR 436-69-801(4) on the ground that it also exceeds the statutory authority of the Department. The rule states:

> "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."

ORS 656.263(4) requires that the first installment of compensation be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. ORS 656.263(6) provides:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days aftr the emloyer has notice or knowledge of the claim. Pending acceptance or denial of a claim, compensation payable to a claimant does not include the cost of medical benefits or burial expenses."

Petitioner also cites ORS 656.262(9), which provides for a penalty of 25 percent of the amount then due, plus attorney fees, if an insurer or employer unreasonably delays acceptance or denial of a claim. These statutory provisions are terms of delegation which require a determination by this court as to whether the policy expressed in OAR 436-69-801(4) is within the delegation. *Springfield Education Assn. v. School Dist., supra.*

OAR 436-69-801(4) does not take away from a claimant the right to recover for unreasonable delay in acceptance or denial of a claim, but, rather, adds an additional right to recover for medical services rendered prior to the denial if the insurer fails to deny within 60 days from the date of receipt of the first medical report, a right not granted to claimants under any statute. The legislature created a penalty for insurers for unreasonable delay in denying a claim. The Department

exceeded its authority in providing an additional penalty when one had already been expressly authorized by the legislature. OAR 436-69-801(4) is invalid.

Petitioner next challenges the rules as a whole on the grounds that they violate constitutional provisions, exceed the statutory authority of the agency and were adopted without

compliance with applicable rule-making procedures as required by ORS 183.400(4). The primary argument under both the constitutional and statutory authority is that the Department enacted the rules after it had attempted to obtain the changes through legislation and the legislature had refused to adopt the changes that it suggested. Under ORS 183.400(1), which governs direct review of administrative rules, judicial review of the rules is specifically limited to an examination of:

"(a) the rule under review;

"(b) the statutory provisions authorizing the rule; and

"(c) copies of all documents necessary to demonstrate compliance with applicable rule-making procedures."

We have no power to consider the effect, if any, of the fact that the Department originally sought to make these changes through legislative action and failed.

Petitioner's final argument is that the rules were adopted without compliance with applicable rule-making procedures. She contends that the Department violated ORS 183.335(3), because it failed to consider fully written submissions designated RJR Exhibit EE and RJR Exhibit FF and to consider fully or give good faith attention to the oral submission of Representative Kerans at the hearing. All of these submissions are testimony by members of the House Labor Committee to the effect that the subject rules exceed the statutory authority of the agency.

Exhibit C to the order adopting the subject rules summarizes the testimony considered by the Department. Included in this summary are several comments which directly or indirectly challenge the statutory authority for the rules. In response to each, the Department stated that the rule is authorized. The fact that the director rejected the testimony does not mean that he violated ORS 183.335(3). Exhibit C supports the director's argument that the Department considered and rejected testimony to the effect that the rules are not authorized by statute. The Department complied with applicable rule-making requirements in adopting the challenged rules.

OAR 436-69-201(2) and 436-69-401(1) and (2) are valid, and OAR 436-69-301(3), 436-69-501 and 436-69-801(4) are invalid.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ROSBORO LUMBER COMPANY,
Appellant,
v.
EMPLOYEE BENEFITS INSURANCE COMPANY,
Respondent,

(16-82-01824; CA A25849)

Appeal from Circuit Court, Lane County.

F. Gordon Cottrell, Judge.

Argued and submitted March 28, 1983.

Lewis Hoffman, Eugene, argued the cause for appellant. With him on the briefs were Michael F. Fox and Hoffman, Morris, Van Rysselberghe & Giustina, Eugene.

James N. Westwood, Portland, argued the cause for respondent. With him on the brief were Fredric A. Yerke, P. Conover Mickiewicz and Miller, Nash, Yerke, Wiener & Hager, Portland.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

VAN HOOMISSEN, J.

Reversed and remanded.

VAN HOOMISSEN, J.

Plaintiff Rosboro Lumber Company (Rosboro) brought this action to recover the difference between its cost for workers' compensation insurance written by defendant Employee Benefits Insurance Company (EBI) and what it would have cost Rosboro had it not discontinued its insurance with a different carrier during a two-year period.

Rosbor's four claims for relief were based on fraud in the inducement, breach of warranty, unconscionable conduct and outrageous conduct.[1] Following entry of an order dismissing Rosboro's claims for failure to state ultimate facts sufficient to constitute a claim, the trial court entered a judgment of dismissal. The issue is whether the trial court erred in allowing EBI's ORCP 21A(8) motions to dismiss.

Rosboro contracted with EBI to secure workers' compensation insurance for a two-year period. The agreement provided for a rebate to Rosboro at the end of the period. Rosboro alleged in its complaint that EBI promised to retain 19 percent of premiums charged, but that in the two years EBI had retained, respectively, 48 percent and 53 percent. Rosboro

[1] Rosboro also made a fifth claim for negligence against defendant Rollins Burdick Hunter of Oregon, Inc., the insurance agent involved. Although served, that defendant has not appeared, and the judgment here does not involve that claim. The trial court made appropriate findings pursuant to ORCP 67B.

further alleged that it was induced to change its carrier by EBI's promise of lower cost, and based its claims for relief on that inducement.

The rebate agreement was oral. It was not included in the insurance policy as required by ORS 746.035 and 746.045, and closely parallels the one we found to be illegal in *Mountain Fir Lbr. Co. v. EBI Ins. Co.*, 64 Or App 312, 667 P2d 567, *rev allowed* 295 Or 840 (1983). The parties here acknowledge that the rebate agreement is illegal.

Rosboro first contends that the trial court erred in allowing EBI's motions to dismiss Rosboro's fraud and breach of warranty claims. Claims for fraud and breach of warranty arising from this type of illegal rebate agreement are viable. *Mountain Fir Lbr. Co. v. EBI Ins. Co., supra.* Therefore, the trial court erred in dismissing Rosboro's claims.

Rosboro next contends that the trial court erred in allowing EBI's motion to dismiss Rosboro's unconscionable conduct claim. Restatement (Second) of Contracts 107, § 208 (1981), provides:

> "If a contract or term thereof is unconscionable at the time the contract is made a court *may refuse to enforce* the contract, or *may enforce the remainder* of the contract without the unconscionable term, *or* may so *limit the application* of any unconscionable term as to avoid any unconscionable result." (Emphasis added.)

The doctrine of "unconscionability" is often used to avoid *enforcement* of any unconscionable provisions of a contract. However, Rosboro cites no authority holding that an affirmative claim for damages may be maintained when unconscionability permeates a contract, and our independent research has found none.

> "One of the reasons why the unconscionability doctrine finds acceptance is that the remedy attached to it is a limited one, mainly a defense. There is no more affirmative remedy for damages here than there is in a case of duress or undue influence. When unconscionability is established, a contracting party loses his 'expectancy,' that is, any gains he might have made from the transaction. But he is not mulcted for damages. * * *
>
> "* * * * *
>
> "* * * the remedy remains essentially defensive, for the plaintiff does not recover damages; he will only be relieved of the contractual obligation, or, possibly, if he has already paid an unconscionable sum, will be allowed restitution to the limits of conscionability." *Dobbs on Remedies* 707 (West Ed., 1973.)

We conclude that, although unconscionability may be a defense to the enforceability of a contract, it is not a basis for affirmative relief. Therefore, the trial court did not err in dismissing Rosboro's claim.

Rosboro's final claim was based on outrageous conduct. It contends that EBI's deliberate intent to defraud is enough to show outrageous conduct. In *Hall v. The May Dep't Store Co.*, 292 Or 131, 637 P2d 126 (1981), the Supreme Court identified three issues facing a trial court when an outrageous conduct claim is presented:

> "The first is whether the relationship between a defendant and the victim of the alleged tort is one that imposes on the defendant a greater obligation to refrain from subjecting the victim to abuse, fright, or shock than would be true in arm's length encounters among strangers. The character of the relationship bears on the mental element required to impose liability * * * and also on the next issue, the offensiveness of potential liability."
>
> "The second * * * is whether the acts alleged against the defendant, if proved, qualify as extraordinary conduct which a reasonable jury could find beyond the farthest reaches of socially tolerable behavior, in whatever condemnatory terms this may be characterized. The third * * * is whether there is evidence from which a reasonable jury may find that a disputed relationship in fact existed and that the defendant in fact engaged in conduct meeting the second test." 292 Or at 137. (Citation omitted.)

See Rockhill v. Pollard, 259 Or 54, 60, 485 P2d 28 (1971).

The relationship between EBI and Rosboro was not one that imposed on EBI a greater obligation to refrain from subjecting Rosboro to abuse, fright or shock than would be true in arm's length encounters among strangers. The parties engaged in arm's length negotiations. Rosboro already had coverage with another carrier that it could have maintained and does not claim that it was in a weaker bargaining position than EBI. It knowingly entered into an illegal contract with EBI in expectation of saving money on its insurance premiums. If Rosboro's allegations are true, EBI had no intention of keeping the rebate provision of the agreement. That allegation alone cannot support a claim for outrageous conduct. The trial court did not err in dismissing Rosboro's outrageous conduct claim.

Because EBI's motions to dismiss were granted, the issues of punitive damages and attorney fees were not before the trial court and, accordingly, are not now considered by us.

Reversed and remanded.

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728 November 30, 1983 No. 613

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Earl A. Safstrom, Claimant.

SAFSTROM,
Petitioner,

v.

RIEDEL INTERNATIONAL, INC.,
Respondent.

(82-02213; A26960)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 22, 1983.

Alan M. Scott, Portland, argued the cause for petitioner. With him on the brief were John M. Pitcher, and Galton, Popick & Scott, Portland.

Michael G. Bostwick, Portland, argued the cause for respondent. With him on the brief was Lindsay, Hart, Neil & Weigler, Portland.

Before Gillette, Presiding Judge, and Warden and Young, Judges.

WARDEN, J.

Reversed; referee's order reinstated.

WARDEN, J.

Claimant appeals from an order of the Workers' Compensation Board (Board) reversing the referee and upholding the employer's insurance carrier's partial denial of claimant's compensation claim. We reverse.

Claimant was injured on July 29, 1981, when he received a high voltage and high amperage electrical shock while working on employer's rock crushing machine. His claim was accepted by employer on August 31, 1981. He received temporary total disability compensation until March 1, 1982, when employer's insurance carrier issued what it characterizes as a partial denial of claimant's claim. The denial letter stated:

> "As you may be aware, we have accepted your claim for an electrical shock injury of July 29, 1981. However, after investigation into this matter, we find that continuing time loss and your present symptomatology are unrelated to the condition for which the claim was originally accepted.
>
> "We must, therefore, respectfully deny any further time loss and medical benefits relative to your present symptomatology."

Claimant requested a hearing pursuant to ORS 656.283. The referee overruled the denial on the basis that the medical evidence did not justify denial of the claim. He remanded the matter to the carrier for immediate processing, ordering reinstatement of time loss benefits until termination was authorized under ORS 656.268. Employer sought review of that order by the Board. The Board reversed the referee, affirmed the carrier's partial denial and directed employer to submit the claim for closure pursuant to ORS 656.268. This appeal followed.

The denial letter of March 1, 1981, does not deny claimant's claim *ab initio*, but attempts to deny responsibility for time loss, as well as medical benefits, relative to claimant's symptomatology from that day forward. Even assuming that such a denial might be appropriate where the evidence established that there was both a discrete, noncompensable condition and a compensable injury, and the claimant had fully recovered from the compensable injury, *see Aquillon v. CNA Insurance*, 60 Or App 231, 235, 653 P2d 264 (1982), *rev den* 294 Or 460 (1983), the medical testimony here establishes that

claimant's symptoms are a continuation of the symptoms

arising from his original compensable injury.[1] The action of the carrier, although characterized as a partial denial, is essentially an attempt to terminate its liability for the original injury as of a specific time. *Cf. Bauman v. SAIF*, 295 Or 788, ___ P2d ___ (1983) (once an insurer or self-insured employer accepts a claim, it cannot subsequently deny the claim and litigate the compensability of the claim in the absence of fraud and the like. The primary question is whether the carrier used the appropriate procedure to do that. We conclude that it did not.

When an employer or its insurer denies the compensability of all or any portion of a claim for medical services, it must notify the medical service provider, who must then cease billing the employer or insurer. ORS 656.313. That action, however, does not terminate the employer's obligation to pay temporary disability benefits or to request determination of permanent disability. An employer cannot stop making payments for temporary disability before the worker's condition is medically stationary. ORS 656.268(1). When a worker's condition has become medically stationary, the claim may be closed by the Evaluation Division, on request by the employer or insurer pursuant to ORS 656.268(2). Alternatively, if medical reports indicate that the worker's condition has become medically stationary and the employer or insurer decides that the claim is nondisabling or without permanent disability, the claim may be closed without a determination order by the Evaluation Division, subject to the Evaluation Division's authority later to issue a determination order on its review of the closure or at the request of the worker pursuant to ORS 656.268(3). Under either procedure, the Evaluation Division has the ultimate responsibility to determine whether a claim is ready for closure and, if so, the extent of the claimant's

permanent disability. Any party may request a hearing under ORS 656.283 on that determination.

The employer's insurance carrier here did not submit the claim to the Evaluation Division for closure pursuant to ORS 656.268(2), nor did the partial denial it issued purport to be an employer-insurer closure in compliance with ORS 656.268(3). Conversely, the carrier's denial for all future time loss and medical benefits related to claimant's continuing symptoms effectively terminated all benefits without an opportunity for the Evaluation Division to determine the extent of his disability, if any. A denial under these circumstances impermissibly circumvents the provisions of ORS 656.268. Accordingly, the carrier's denial was improper.

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[1] Claimant first sought medical attention on August 3, 1981, at the Meridian Park Hospital emergency room, for complaints of aching neck, muscles and joints and ear drainage. The examining doctor noted a small burn on his left wrist, as well as tenderness of the muscles in his neck and extremities, and treated him for ear wax. Claimant next saw Dr. William Larson on August 6, 1981, complaining of aching in his joints, left shoulder and back and a stiff, painful neck; on August 11, 1981, he also reported episodes of light-headedness. He continued frequent treatment with Dr. Larson for those symptoms until November, 1981, when he began seeing Dr. Ho. In a written report on November 4, 1981, Dr. Ho detailed similar symptoms. At the hearing before the referee, claimant testified that the symptoms continued through the date of the carrier's partial denial letter.

The order of the Board is reversed, and the order of the referee is reinstated.[2]

[2] Although we find that the carrier's partial denial was improper, we do not decide the merits of claimant's claim. The extent to which claimant's present symptoms may indicate a compensable continuing temporary disability injury or permanent disability is to be decided in the first instance by proceedings under ORS 656.268.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Leon Cowart, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Petitioner,

v.

COWART,
Respondent.

(CA A26834)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 24, 1983.

Donna M. Parton, Associate Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the briefs for petitioner.

Willard E. Merkel, Portland, argued the cause for respondent. With him on the brief were Gary M. Galton, and Galton, Popick & Scott, Portland.

Before Gillette, Presiding Judge, and Warden and Young, Judges.

WARDEN, J.

Reversed and remanded for reconsideration.

WARDEN, J.

The State Accident Insurance Fund (SAIF) appeals from a "third party settlement" order of the Workers' Compensation Board that permitted allocation of $15,000 of a $65,000 settlement of claimant's action against a third-party tortfeasor to claimant's wife for her claim for loss of consortium. We reverse.

In June, 1981, claimant was injured in a motor vehicle accident while temporarily in California in the course and scope of his employment. He filed a workers' compensation claim and also elected to pursue his third party cause of action against the California tortfeasors. ORS 656.154. SAIF was claimant's employer's insurer. It associated a California attorney to represent its interest in its statutory right to a lien against claimant's recovery. *See* ORS 656.593(1).

Claimant and his wife filed a complaint in California, alleging two causes of action, one for personal injury and wage loss to claimant and the other for loss of consortium to claimant's wife. In August, 1982, claimant and his wife agreed to settle their tort actions for $65,000, the policy limits of the defendants' liability insurance. Information of that settlement apparently was related orally to SAIF's California attorney, Lambert. On August 27, 1982, Lambert wrote a confirming letter to claimant's California attorney, Ginsburg, acknowledging Ginsburg's "communication of August 24, 1982, advising of settlement of Mr. Cowart's third party lawsuit arising out of the subject motor vehicle accident for * * * $65,000." In that letter, Lambert advised that SAIF had been apprised of the settlement and had approved it. SAIF approved the settlement in writing on September 7, 1982. On September 17, Ginsburg wrote to Lambert, advising that he was allocating $15,000 of the settlement to claimant's wife's claim for loss of consortium. On September 21, Lambert advised that that allocation was unacceptable, because SAIF's initial approval of the settlement was based on the understanding that Mr. Cowart's recovery was $65,000. SAIF's total costs for benefits already paid and anticipated future benefits exceeded that amount.

Both parties requested the Board to determine a just and proper distribution of the proceeds of the settlement,

pursuant to the Board's authority under ORS 656.593(3).[1] The Board concluded that the matter was more accurately a dispute between claimant and SAIF regarding the compromise of claimant's action against the third parties, which the Board had authority to approve under ORS 656.587.[2] It treated the proceeding as one arising on a petition by claimant requesting the Board to approve settlement of his cause of action against the third-party tortfeasor which had been negotiated with the third parties' insurers and which SAIF had refused to approve because of a disagreement with claimant's proposed apportionment of the proceeds. The Board found that the proposed settlement of $50,000 for claimant's third party action was reasonable and approved the settlement for that amount. SAIF appeals.

SAIF first contends that the Board lacked authority under ORS 656.587 to modify the parties' prior agreement that claimant's claim would be settled for $65,000. It also contends that distribution of $15,000 of claimant's settlement proceeds to claimant's wife, a party outside the workers' compensation system, is not authorized by statute. We sepa-

[1] ORS 656.593(3) provides:

"(3) A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board."

[2] ORS 656.587 provides:

"Any compromise by the worker or other beneficiaries or the legal representative of the deceased worker of any right of action against an employer or third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the board. ORS 656.236 does not apply to compromises and settlements under ORS 656.578 to 656.597."

rately discuss these contentions.

When there is a dispute between a claimant and an employer or the employer's insurer regarding the appropriateness of a proposed settlement of a third-party action, the Board may order approval of the settlement. ORS 656.587. Although the Board treated this proceeding as a disputed settlement, we do not agree with that characterization. Unfortunately, the record does not contain all of the communications between the parties, but we are able to discern from what there is that there was no dispute as to the amount of the

settlement for claimant's cause of action when SAIF's approval of the settlement was sought or when SAIF gave its express written approval. SAIF's letter of August 27, 1982, acknowledged claimant's communication of a proposed settlement of "Mr. Cowart's" claim for $65,000. SAIF's formal approval letter of September 7, 1982, although referring to the matter of "Leon Cowart, et al," outlined a proposed distribution of the settlement proceeds consistent with an understanding that *claimant's* recovery was $65,000.[3]

Ginsburg's letter of September 17, 1982, announcing that he was allocating $15,000 of the settlement to claimant's wife's claim, was the first indication to SAIF that any of the $65,000 was to be so applied, and that letter contains an acknowledgement that previous discussions did not include her claim. Its injection into the terms of the settlement appears to have been prompted by belated discussions between claimant's California and Oregon attorneys. A letter, also dated September 17, 1982, signed by Ginsburg and addressed to claimant's Oregon attorney, states:

> "I am very glad * * * you thought of this phase of the settlement. Mrs. Cowart, in my opinion, is entitled to a share of the settlement. I feel sure that if this case had gone to a trial the court, or jury, would have awarded her a portion of the total damages. Naturally, we cannot know at this time what amount it would be, but in view of the considerable injury to her husband, she could make out a strong case for a substantial award in her favor.
>
> "While it is true that heretofore all discussions have been concerned with Leon's share of the total recovery of $65,000.00, that has been due to our oversight of the right of

> Mrs. Cowart to a part of the settlement. Whether SAIF will agree to $15,000, or to some other amount, will, of course, remain to be seen."

Although claimant's attorneys may have overlooked

[3] In his brief, claimant takes the position that, because SAIF's letter of approval refers to the case as "Leon Cowart, et al," SAIF was giving its consent to settlement of the entire action and that it follows that the dispute over allocation of part of the settlement proceeds to Mrs. Cowart's claim for loss of consortium had existed from the beginning. We find that argument unpersuasive. A paying agency's statutory power to approve a settlement is limited to a settlement resulting from third-party actions brought by the worker or other beneficiary. A "beneficiary" is a person entitled to receive payments under the workers' compensation laws. ORS 656.005(3). Obviously, claimant's wife is not a beneficiary for purposes of ORS 656.587, because she would not be entitled under the workers' compensation laws to payment for loss of consortium. Therefore, there was no reason for claimant to seek SAIF's approval of a compromise of her cause of action; SAIF had no statutory right to approve or disapprove settlement of that claim. Claimant's request that SAIF approve the $65,000 settlement, therefore, indicates that claimant also originally considered the entire amount attributable only to his cause of action.

Mrs. Cowart's right to a part of the settlement when negotiating with SAIF for its approval, SAIF was entitled to rely on claimant's initial representation that the entire settlement was for his cause of action. Clearly, the parties agreed to a settlement of claimant's cause of action for $65,000; he thereafter attempted to change the agreement. Separate provision could have been made for claimant's wife's claim for loss of consortium prior to the time claimant sought SAIF's approval of the settlement, but it was not. Claimant's unilateral decision that $15,000 of the proceeds be allocated to her claim came too late. Under those circumstances, the Board was without authority under ORS 656.587 to restructure the parties' actual agreement to settle claimant's cause of action for $65,000 so as to permit recognition of claimant's wife's claim for loss of consortium. Consequently, the Board lacked authority to exercise any judgment regarding any settlement of claimant's cause of action against the third party for $50,000.

We turn now to what the Board could do. SAIF's second contention focuses on the provisions of ORS 656.593, which establishes the distribution scheme for proceeds of third-party-damage actions.[4] It argues that the statutory

scheme does not authorize distribution of any portion of a claimant's recovery to a party who, like claimant's wife, has a separate claim outside the workers' compensation system.[5] We agree.

Reversed and remanded for reconsideration.

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[4] ORS 656.593(1) provides:

"(1) If the worker or the beneficiaries of the worker elect to recover damages from the employer or third person, notice of such election shall be given the paying agency by personal service or by registered or certified mail. The paying agency likewise shall be given notice of the name of the court in which such action is brought, and a return showing service of such notice on the paying agency shall be filed with the clerk of the court but shall not be a part of the record except to give notice to the defendant of the lien of the paying agency, as provided in this section. The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section and the total proceeds shall be distributed as follows:

"(a) Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the board for such actions.

"(b) The worker or the beneficiaries of the worker shall receive at least 33-1/3 percent of the balance of such recovery.

"(c) The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. Such other costs include assessments for reserves in the Administrative Fund and any reimbursements made pursuant to ORS 656.728(3), but do not include any compensation which may become payable under ORS 656.273 or 656.278.

"(d) The balance of the recovery shall be paid to the worker or the beneficiaries of the worker forthwith. Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the board.

[5] As noted in n 3, *supra*, claimant's wife is not a "beneficiary," because she is not entitled under the workers' compensation laws to benefits for loss of consortium.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ray Armstrong, Claimant.

ARMSTRONG,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(80-01476; CA A26582)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 11, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause for respondent. On the brief was Donna M. Parton, Associate Appellate Counsel, State Accident Insurance Fund Corporation, Salem.

Before Gillette, Presiding Judge, and Warden and Young, Judges.

PER CURIAM.

Remanded for further evidence.

PER CURIAM

This case is before us for the second time. We dismissed a previous appeal on the ground that it was not brought within 30 days from the mailing of the order of the Workers' Compensation Board as required by ORS 659.295(8). *Armstrong v. SAIF,* 58 Or App 602, 649 P2d 818, *rev den* 293 Or 801 (1982). After our action claimant filed a petition for review in the Supreme Court. As part of the petitioning process, claimant's attorney submitted an affidavit to the court stating that the Chairman of the Workers' Compensation Board had informed him, after our decision, that the Board had discovered that it never in fact mailed the order, contrary to the assumption in our opinion that it had done so. The Board filed a response to the petition for review in which it stated that the facts in the affidavit were essentially correct. The Supreme Court denied review. The Board thereafter "republished" its order, and the present appeal is from that "republished" order. Our first consideration is whether we have jurisdiction of this appeal.

If the Board never mailed its first order, this court never had jurisdiction of the first appeal, even for the purpose of dismissing it as untimely. We should have dismissed it as not from a final order. ORS 183.480(1); 656.295(8). Thus, our previous decision would not be controlling, and the only

appealable final order would be the "republished" one which is currently before us. However, because SAIF has refused our request in the present case to stipulate that the first order was not properly mailed, we cannot decide the preliminary question of our jurisdiction over the present appeal on the record before us. This court has authority to remand. ORS 656.298(6) provides:

> "The review by the Court of Appeals shall be on the entire record forwarded by the board. The court may remand the case to the referee for further evidence taking, correction or other necessary action. However, the court may hear additional evidence concerning disability that was not obtainable at the time of the hearing. The court may affirm, reverse, modify or supplement the order appealed from, and make such disposition of the case as the court determines to be appropriate."

We exercise that authority and remand the case to the referee for taking further evidence, limited to whether the

Board mailed its order of December 31, 1981, as required by law and, if so, when it mailed the order. We direct the referee to report the evidence to us directly within 60 days of the effective date of this decision. We will then, under our *de novo* review authority, determine the necessary facts. We retain jurisdiction over the appeal pending the referee's report.

Remanded for further evidence.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William J. Frame, Claimant.

FRAME,
Petitioner - Cross-Respondent,

v.

CROWN ZELLERBACH,
Respondent - Cross-Petitioner.

(WCB Case 80-07617; CA A24057)

Judicial Review from Workers' Compensation Board.

On respondent - cross-petitioner's petition for reconsideration filed August 8, 1983. Former opinion filed July 6, 1983, 63 Or App 827, 665 P2d 879.

Robert E. Joseph, Jr., Ridgway K. Foley, Jr., P.C., and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland, for petition.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Petition for reconsideration allowed; former opinion adhered to.

ROSSMAN, J.

We grant employer's petition for reconsideration, because it has been brought to our attention that we did not have all of the exhibits before us when the case was originally considered. We now have received and reviewed the exhibits. We do not find it necessary to change our previous decision, in which we held that claimant had proven that he is entitled to a program of rehabilitation.

Claimant, before his injury, had held a job paying substantially more than the minimum wage. Under the circumstances of this case, we concluded that there is no compelled conclusion that a claimant, who has been offered a minimum wage is gainfully employable and, therefore, ineligible for retraining.

Employer argues that the missing exhibits disclose that claimant refused to take a job at $6.00 per hour, which is in excess of the minimum wage. However, as we read the exhibits, the job offer was never a reality. On May 6, 1981, claimant had an interview for a position in commercial landscape maintenance with Hubbard Landscaping & Spraying, which was interested in hiring him and scheduled an appointment to negotiate a wage subsidy with Field Services Division on May 18, 1981. On that same date, claimant had told his counselor at Cascade Rehabilitation Counseling that the referee had approved him for a training program and had awarded him additional benefits. On the basis of the fact that claimant thought that he was entitled to vocational rehabilitation, which would qualify him for a position for which his pay would be close to what he would have been making had he not been injured, he decided he was not interested in pursuing the job with Hubbard. Later that day, claimant's counselor discovered that the referee had suggested a training program that was not an authorized one. The next day, claimant contacted his counselor and told him that he was still interested in the landscaping job. However, Hubbard declined to negotiate the wage subsidy and then decided that, because its business was too slow, it did not have an opening. There is no evidence in the record that claimant declined an actual and existing $6.00 per hour job. The additional exhibits have not persuaded us to the contrary.

Employer's petition for reconsideration raises other issues as well. We do not feel it necessary to respond to them, except to clarify one part of our original opinion, in which we compared claimant's minimum wage job offers to the $10.50 per hour he would have been making at the time of the hearing had he not been injured. Admittedly, he was earning less than $10.50 per hour at the time of his injury. However, it was appropriate to focus on what his former job had come to pay, not what it paid in the past. We reiterate our opinion that the workers' compensation statutes were not intended to force an injured worker to take a drastic cut in pay instead of being trained for a job paying a comparable wage to what the worker would have been making had he not been injured.

Petition for reconsideration allowed; former opinion adhered to.

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Castimore, Jeanette M., 81-06411 (8/83)
Chambers, Clint, 82-11049 (12/83)
Champ, Sherman L., 81-06786 (2/83)
Chandler, William, 81-08446 (2/83)
Chappell, Leslie H., 81-00881 (3/83)
Charitar, Ram, 81-10223 (1/83)
Cheek, Troy, 81-07031 (8/83)
Childers, Faye, 78-01507 (11/83)
Childress, Hank R., 82-06153 (11/83)
Christensen, Cecil A., 82-06889 (11/83)
Chubbuck, Curtis G., 82-00057 (5/83)
Cissna, John J., 82-05775 (8/83)
Clinton, Orville K., 81-11392 (11/83)
Clooten, Joseph D., 82-03940 (8/83)
Clow, Angela V., 80-10693 (11/83)
Colcord, Ronald, 82-07958 (3/83)
Conken, Chester S., 81-10093 (6/83)
Connell, Ida P., 82-02931 (8/83)
Connelly, Robert, 82-00754 (8/83)
Conner, Gary B., 82-08472 (5/83)
Conner, Roger, 82-06848 (9/83)
Cook, John A., 82-02897 (6/83)
Cooper, Edward D., 82-07829 (9/83 & 10/83)
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)
Couturier, Richard, 82-00501 (7/83)
Covert, Phillip L., 82-11544 (11/83)
Cox, Charley N., 82-02066 (5/83)
Cox, Sandra J. (Mills), 82-01892 (5/83)
Coyle, Milton H., 82-08565 (11/83)
Crain, Joyce I., 80-05405 (10/83)
Cregeen, Beverly M., 81-00475 etc. (7/83)
Cribbins, George T., 83-03616 & 83-03617 (12/83)
Crook, Richard L., 82-07750 (12/83)
Croxell, Norma J., 82-00676 (8/83)
Culley, Robert J., 80-09954 (6/83)
Culp, Charles L., 81-03091 (2/83)
Culwell, Edward L., 82-04567 (8/83)
Cureton, Lonnie, 81-04237 (3/83)
Currin, Robert A., 81-07800 (5/83)
Cutler, Max, 83-00908 (11/83)
Cutsforth, Shaun M., 83-01194 (11/83)
Cutsforth, Shawn, WCB n/a (5/83)
Dahlheim, Arthur, 80-03968 (8/83)
Daniels, Wilbur R., 82-03722 (7/83)
Daugherty, Charles W., 80-09223 & 81-01183 (1/83)
Davenport, Kang L., 81-08629 & 82-00903 (12/83)
Davidson, Floyd S., 82-03670 (10/83)
Davidson, Vernal M., 81-07246 (8/83)
Davis, Charles O., 82-06682 & 82-11305 (12/83)
Davis, Homer J., 81-08968 (10/83)
Davis, Janet D., 81-01117 (3/83)
Davis, Patsy, 82-02404 (8/83)
Davis, William A., 81-08455 (1/83)
Day, Lorri K., 81-09685 (3/83)

Name, WCB Number (Month/Year)
Deatherage, Dwayne, 82-10294 (10/83)
DeBolt, Maudie M., 82-05929 (8/83)
DeCleve, Frank M., 82-08336 (12/83)
DeGroot, Robert J., 82-06167 (8/83)
DeLaRosa, Bense, 82-06199 (8/83)
DeLong, Barbara J., 82-01571 & 82-01154 (5/83 & 6/83)
Deos, Jack, 81-02829 (2/83)
Desau, David R., 81-05375 (2/83)
Dewitz, Clyde W., 82-10211 (7/83)
Dials, Crayton J., 81-08908 (4/83)
Dinucci, John A., 82-05921 (10/83)
Dodge, Theodore J., 82-02559 (5/83)
Donnelly, Eileen F., 82-03122 (7/83)
Dooley, Douglas, 81-06280 (5/83)
Dotson, Harold L., 82-05493 (8/83)
Doty, Melvin T., 82-02060 (9/83)
Downs, Linda L., 82-04703 (12/83)
Drennan, Carol L., 82-08850 (8/83)
Driggers, Roger A., 82-07883 (7/83)
Dubisar, Elizabeth, 82-05304 & 82-10987 (9/83)
Dunlap, Joyce A., 82-01614 (7/83)
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)
Dyson, Tommie E., 82-10402 (11/83)
Early, Linda M., 82-09045 (9/83)
Edge, Ervin, 79-04080 (12/83)
Eichler, Jeffry S., 82-08333 (10/83)
Ellenbecker, Linda L., 82-09441 (11/83)
Elliott, Norma J., 82-04519 & 82-04520 (6/83)
Ellis, Jocelyne M., 82-07710 (7/83)
England, Wayne A., 82-01433 (8/83)
Erickson, Wayne A., 82-04001 (9/83)
Erwin, Richard A., 82-07619 (10/83)
Esquivel, Juventino, 82-03874 (3/83)
Estes, Juanita M., 82-09765 (11/83)
Everson, Ernest E., 80-09191 & 80-09192 (3/83)
Farfan, Gig B., 81-00138 (7/83)
Farrell, Evelyn P., 83-02367 (11/83)
Feasel, Ronald D., 82-04618 (11/83)
Fien, Richard J., 82-04404 (10/83)
Fischer, Michael R., 81-10100 (11/83)
Fisher, Laurel T., 82-00769 (3/83)
Flick, Mike R., 81-11402 (5/83)
Forrest, Ray, 81-02535 (7/83)
Forsyth, James, 81-02716 (1/83)
Foster, Leo M., 82-06056 (12/83)
Franzel, Joan P., 81-02107 (1/83)
Frederick, Randy D., 82-04807 & 82-06061 (11/83)
Freeman, Leslie (Sanders), 81-06083 (1/83)/83)
Fuller, Lori A., 82-07857 (11/83)
Gaddis, Lois G., 82-08867 (12/83)
Galusha, Mable I., 81-04567 & 81-04568 (8/83)
Garcia, Elva, 82-06765 (10/83)
Gascon, Lori, 81-11622 (8/83)
Gatchell, Richard Earl (Beneficiary), 82-06349 (11/83)

Name, WCB Number (Month/Year)
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)
Getman, Gary A., 82-10962 & 82-03707 (9/83)
Getner, Donald P., 82-08353 (11/83)
Gibson, Elna M., 81-07928 (11/83)
Gibson, James E., 82-09595 (11/83)
Gilbert, Rory F., 82-04820 (7/83)
Gilkey, Arlene, 82-03413 (7/83)
Gill, Thomas P., 81-02329 (6/83)
Gilliam, Chester J., 80-01701 (11/83)
Giofu, Robert, 81-09105 (3/83)
Glanz, Charles, 81-03794 (10/83)
Glover, Bernice, 81-05776 (5/83)
Godell, Gregory L., 82-06244 (11/83)
Goldstein, George A., 82-09776 (8/83)
Goodstein, David R., 82-09438 (8/83)
Gormley, Dennis H., 81-09531 (8/83)
Gorrell, Kathryn M., 82-11674 (12/83)
Gorringe, Philip M., 82-01434 (8/83)
Gray, Jack L., 82-05123 (7/83)
Greer, Dimidy A., 80-08353 (3/83)
Griffin, Kim M., 82-09764 (10/83)
Griffiths, Dorothy J., 82-10344 & 82-11436 (11/83)
Gross, Leon F., 81-06755 (1/83)
Gusinow, John E., 82-03592 (8/83)
Gutierrez, Clemente E., 82-03054 (3/83)
Hackett, Julia, 82-02055 (1/83)
Haines, Robert J., 82-0316M (1/83)
Hains, Colleen E., 82-09630 (7/83)
Hall, Jay, 81-011495 (1/83)
Hall, Terri A., 82-07584 (9/83)
Hamilton, Betty A., 82-02236 (7/83)
Hankins, Roy L., 82-04944 (5/83)
Hannick, Robert A., 82-02736 & 82-01846 (6/83)
Harmon, Theresa, 81-06777 (10/83)
Harris, Carl F., 82-01036 (3/83)
Harris, James O., 82-04999 (11/83)
Harris, Lawrence A., 81-04058 & 79-06822 (11/83)
Hash, Stanley, 82-01452 (7/83)
Hassler, Maxine, 81-03872 (2/83)
Hatcher, Patricia, 81-11234 (11/83)
Hauser, Benton L., 82-00700 (3/83)
Hawes, Charlene D., 82-00049 (5/83)
Hayes-Godt, Ruth B., 81-08445 & 82-11751 (12/83)
Heath, Patricia H., 82-04328 (8/83))
Heffner, Elmer, 82-06628 (12/83)
Helsel, Marvin E., 81-10338 (11/83)
Helzer, Joanne M., 81-07340 (3/83)
Hendren, Madeline C., 81-01990 (4/83)
Henry, Ralph A., 82-06864 (12/83)
Hershey, Thomas E., 82-06263 & 82-06324 (9/83)
Hess, Candy J., 82-02550 (6/83)
Hilderbrand, James, 82-00123 (3/83)
Hill, Byron E., 82-08232 (11/83)
Hill, Del Ray, 81-00862 (1/83)

Name, WCB Number (Month/Year)
Hill, James L., 82-00204 (7/83)
Hill, Richard E., 82-07568 (12/83)
Hoban, Jerry, 81-11726 (1/83)
Hodges, Norman S., 81-09590 (8/83)
Hoffman, Joseph J., 82-03600 (7/83)
Holden, Charles J., 83-00166 (11/83)
Holland, Suzanne A., 82-09875 (10/83)
Holme, Marie D., 82-01917 (11/83)
Hoover, Esther, 81-02324 (2/83)
Hope, Patrick C., 82-07127 (9/83)
Hopkins, Hannah E., 82-05672 (12/83)
Hoppe, Lois, 81-10080 & 80-06520 (2/83)
Horner, Lloyd J., 80-02020 (3/83)
Horstman, John D., 82-08806 (10/83)
Hort, Albert E., 80-11056 (2/83)
Householder, Dan L., 82-08414 (8/83)
Hove, Carolyn, 82-07357 (8/83)
Howard, Joseph W., 82-09043 (9/83)
Howard, Josh L., 81-05025 & 82-11740 (11/83)
Howitt, Mae I., 82-11058 (11/83)
Hunnel, Sandra J., 81-10600 (2/83)
Hunt, Forest E., 83-01358 (11/83)
Hunt, Katherine L., 81-08562 (11/83)
Hunter, Jeffrey K., 82-05878 (7/83)
Hurt, John M., 82-00329 (3/83)
Huston, Walter A., 82-10063 (11/83)
Hutchinson, Marc, 81-01715 (1/83)
Hyde, Laird, 81-07913 (12/83)
Isaacs, David R., 81-01071 (5/83)
Isarraras, Javier R., 82-06994 (9/83)
Jaikin, Joseph R., 81-01022 (11/83)
James, Willa M., 82-10574 & 82-11667 (12/83)
Jefferies, Melvin W., 82-07501 & 82-10058 (9/83)
Jeffries, Frances M., 81-11401 (3/83)
Jenkins, Debra S., 83-01846 (11/83)
Jensen, Charles T., 82-04282 (10/83)
Johnson, Elsie J., 82-02349 (11/83)
Johnson, Jack, 80-09455 & 81-06623 (7/83)
Johnson, Larry, 82-05088 (11/83)
Johnson, Paula J., 82-00838 (7/83)
Johnson, Raymond P., 81-11074 & 82-04730 (6/83)
Johnston, Cheryl A., 82-05651 (5/83)
Jones, Linda G., 82-07565 (9/83)
Jones, Murl E., 81-06864 (1/83)
Jones, Stoddard, 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)
Kalivas, Salomi, 82-06442 (9/83)
Kallimanis, William S., 81-04832 (6/83)
Kappitz, William H., 81-08674 (3/83)
Kassahn, Jerry E., 82-08351 (6/83)
Keene, Roy H., 82-05175 (9/83)
Kelly, James R., 82-06154 (5/83)
Kelso, Vernon D., 82-04424 (10/83)
Kemp, Robert E., 81-08549 (9/83)

Name, WCB Number (Month/Year)
Kessen, Jerry W., 82-03287 (12/83)
Ketchum, Frank, 81-04706 (1/83)
Keyes, Kevin W., 82-04338 (5/83)
Kight, Lee M., 81-11508 (6/83)
King, Ernest L., 82-09623 (10/83)
King, Randy, 82-03625 (3/83)
Kinsey, Robert R., 82-05701 (8/83)
Kintz, Susan M., 80-02978, 80-11233 & 81-07950 (7/83)
Kirkpatrick, Jerry H., 79-05300 (5/83)
Kiser, Delroy, 82-06010 (6/83)
Kitt, Jack, 82-06233 (8/83)
Kivisto, Harold A., 81-01752 (6/83)
Kleiven, Danny J., 82-11530 (10/83)
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)
Kujawinski, Edward, 82-06342 (11/83)
Kutch, Gerald, 82-00202 (2/83)
Kyllo, Hilda E., 81-05118 (5/83)
Lamela, Laurence J., 81-01523 (10/83)
Lane, George W., 82-02357 (6/83)
Lang, Dan K., 82-07474 (9/83)
Langley, Billey L., 81-06997 (1/83)
LaQue, Bernard, 82-04830 (5/83)
Larson, Clifford A., 82-04543 (10/83)
Larson, Ole E., 82-02152 (9/83)
Latham, Donald, 82-10925 (7/83)
Lawrence, Terry P., 82-08969 (11/83)
Lawson, Wesley A., 81-09032 (3/83)
Lawver, Charles E., 81-07097 (6/83)
Leap, Dale L., 81-07262 (2/83)
Ledford, Viola F., 80-02951 (10/83)
Lemay, James P., 82-07306 (5/83)
Leuzinger, Helen E., 82-02725 (10/83)
Lewis, D.H & E.M., 81-05850 (3/83)
Lewis, Paul E., 78-04577 (3/83)
Lingard, Roger, 82-11244 & 83-01637 (11/83)
Lingo, Wanda J., 82-05958 & 81-10925 (5/83 & 8/83)
Lipe, William, 81-06071 (5/83)
Little, Larry L., 82-09031 (10/83)
Littlefield, Raymond S., 81-10191 & 81-06530 (3/83)
Londo, Beulah I., 81-03379 (2/83)
Long, Jere L., 82-05460 (12/83)
Long, Robert, 82-03372 & 82-03029 (11/83)
Lorence, Michael, 81-11404 (12/83)
Lucht, Elizabeth, 82-07807 (12/83)
Lundy, Eyvonne, 81-04501 (1/83)
Lyon, Claude, 81-11497 (3/83)
Maarefi, Margaret, 82-00194 (8/83)
MacIvor, Frank H. (Deceased), 82-02901 (6/83)
Macon, Wyman L., 81-11568 (2/83)
Madden, Essie F., 80-00127 (2/83)
Maddocks, Elmer, 82-01631 (8/83)
Malinen, Zona F., 82-03216 & 82-02253 (12/83)
Malone, Glen A., 82-09798 (11/83)
Manning, Ronald, 81-10733 (3/83)

Name, WCB Number (Month/Year)
Margison, Harold A., 81-07478 (3/83)
Marker, Ethel, 82-06111 (8/83)
Marquardt, David L., 82-05034 (7/83)
Marshall, Danny C., 81-07627 (2/83)
Martin, Elson, 81-01463 (10/83)
Martin, Walter, 81-03895 (8/83)
Mary, Jerry D., 81-05956 (5/83)
Mason, Sammy J., 82-01982, 82-01784 & 81-10922 (6/83)
Masoumpanah, Ahmad, 81-02934 (1/83)
Matthews, Gary D., 82-02994 (11/83)
Matthews, Martin L., 82-04580 (8/83)
Matthews, Ned T., 80-10828 (8/83)
Maunus, Jaydell E., 82-03619 (11/83)
Maxwell, Carl, 79-00195 (1/83)
McArthur, John W., 82-03781 (9/83)
McCann, Albert, 81-11537 & 82-02702 (3/83)
McCarty, Jean, 82-02576 (5/83)
McClure, Anita L., 82-10002 (10/83)
McConnell, Gregory S., 82-02750 (11/83)
McCormick, Richard J., 82-10444 (11/83)
McCormick, Timothy I., 81-06127 (3/83)
McCoshum, Gary, 81-09301 (2/83)
McCune, Michael P., 81-10051 (8/83)
McDevitt, Timothy J., 81-07972 (6/83)
McDonald, Eugene L., 82-07434 (10/83)
McDonald, William F., 82-04486 (7/83)
McGinnis, Monty D., 82-01697 (5/83)
McGril, Thomas H., 81-10781 (5/83)
McKenzie, James L., 82-03836 (11/83)
McKinlay, William E., 82-11717 & 83-01834 (10/83)
McKinney, Kenneth N., 79-02868 (1/83)
McLaughlin, Thomas P., 81-11623 (3/83)
McMillan, Patrick D., 83-00190 (12/83)
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)
Mendez, Anita, 82-04388 (10/83)
Mespelt, Beverly, 81-07030 & 82-01317 (5/83)
Meyer, Gary S., 82-04237 (10/83)
Meyer, Richard J., 81-08305 (12/83)
Miles, Harold W., 81-06954 (7/83)
Miles, Leonard, 82-04446 (10/83)
Miles, Ray M., 81-07012 (6/83)
Miller, Junior B., 82-04812 (9/83)
Miller, Sharon, 82-01711 (3/83)
Mills, Leroy B., 82-10088 (7/83)
Mills, Rhonda G., 81-10908 (3/83)
Millsap, Noreen A., 82-08466 (12/83)
Millus, Debra, 82-02443 & 81-00941 (2/83)
Minnick, William, 81-04753 (3/83)
Mitchell, Ronald L., 81-06868 (7/83)
Montgomery, Eautie P., 82-04946 (5/83)
Moore, Albert W., 82-03451 (12/83)
Moore, Debra J., 82-09752 (12/83)
Moore, Lorrena M., 82-10191 (11/83)
Morgan, Clifford E., 80-11483 (10/83)

Name, WCB Number (Month/Year)
Morris, David D., 83-00687 (9/83)
Morris, Gordon, 82-08109 (11/83)
Morris, James R., 82-01899 (5/83)
Moser, Mary F., 81-04008 (2/83)
Mosqueda, Geraldo, 82-07945 (10/83)
Mosqueda, Sylvia, 82-03563 (12/83)
Mullaney, Danny J., 81-04454 & 81-05600 (8/83)
Muthersbauch, William B., 82-08243 (12/83)
Nacoste, James A., 81-00180 (5/83)
Nall, Shelby J., 81-08980 (6/83)
Neal, Charles A., 81-07414 (10/83)
Nixon, Tom A., 82-04343 (6/83)
Nordberg, Marion, 81-07851
Norris, Charl M., 82-07655 (9/83)
Norton, Billy D., 82-01771 (7/83)
Nunes, George W., 82-10725 (10/83)
O'Neal, Billy L., 81-02144 (5/83)
O'Neel, Joyce E., 82-05905 (11/83)
Olinghouse, Ronald S., 82-04653 (6/83)
Oliver, Cheryl K., 80-10666 & 81-06952 (5/83)
Olson, Eric E., 82-10671 (12/83)
Olson, Robert O., 82-06019 (7/83)
Orth, Michael J., 82-08717 (6/83)
Ortiz, James, 82-05281 & 82-05280 (11/83)
Osborn, Georgia M., 82-10933 & 82-08753 (11/83)
Osborne, Sylvester, 81-11265 & 81-11266 (7/83)
Osorio, Martha O., 82-01241 (3/83)
Oswald, Richard J., 81-07609 (12/83)
Owen, David C., 81-08660 (1/83)
Owens, Donald L., 81-10633 (5/83)
Palmisano, Pat, 82-02601 (9/83)
Parazoo, Frances W., 82-11845 (11/83)
Parker, Thomas D., 80-10438 (3/83)
Parkinson, Robert J., 82-05500 (8/83)
Parks, William N., 81-06839 (1/83)
Parr, Gloria J., 82-06069 (12/83)
Patton, Vanice A., 82-06198 (12/83)
Paul, Vesta G., 81-01113 (2/83)
Payne, Rosalie Bauman, 81-00152 (6/83)
Pearson, Kathie, 82-01284 (6/83)
Peck, Franklin J., 80-00280 & 81-07571 (8/83)
Pelroy, Debra C., 82-08281 (10/83)
Pence, Russell, 80-10831 (3/83)
Pendergraft, Laurna, 82-09124 & 82-02968 (11/83)
Penfold, Donald G., 82-02646 (8/83)
Pennington, Carolyn M., 81-10352 (8/83)
Pennington, Mollie A., 82-02875 (3/83)
Perchez, Ramon R., 81-03169 (9/83)
Perez, Fernando R., 82-04143 & 82-08374 (12/83)
Perez, Jose, 80-03457 (5/83)
Perkins, Opal, 82-04458 (6/83)
Persad, Clarence B., 82-08619 (7/83)
Petersen, Olive M., 82-10832 (12/83)
Peterson, Kenneth M., 80-06187 (1/83)
Pettijohn, Lewis D., 82-01599 (3/83)
Peyton, Gary B., 81-11299 (3/83)
Peyton, Gwen A., 82-02345 (2/83)

Name, WCB Number (Month/Year)
Phillips, Richard, 80-9518 (5/83)
Plumb, Robert B., 83-00274 (11/83)
Poe, Theodis E., 82-0324M (1/83)
Pollard, Keaver H., 82-02898 (4/83)
Pope, Frank A., 83-01614, 83-01421 & 82-10788 (11/83)
Popoff, Floreen A., 82-01327, 82-00116 etc. (3/83)
Porter, Milton, 81-06024 (7/83)
Porter, Wayland A., 82-11772 & 82-09211 (10/83 & 11/83)
Potorff, Donald L., 81-05299 (11/83)
Potts, Marvin L., 82-04885 (5/83)
Pournelle, Julian E., 82-04317 (10/83)
Powell, Jess S., 82-02657 (7/83)
Power, Barbara A., 82-03870 (8/83)
Powers, Colleen G., 80-02368 (3/83)
Price, Jack M., 82-01970 (8/83)
Purifoy, Bordy, 81-09206 (2/83)
Purscelley, Roxanne, 81-11259 (11/83)
Quade, Rosalyn M., 81-01963 (12/83)
Raddatz, Daune, 82-02307, 81-09718 & 81-09719 (12/83)
Ramm, Leroy L., 81-08806 (2/83)
Rasmussen, Warren F., 81-11138 (6/83)
Reavely, Dolores, 81-09587
Redmond, Dana, 81-09761 (9/83)
Redwing, Edward J., 82-03439 (5/83 & 6/83)
Reed, Rick R., 81-00172 (3/83)
Reef, Jack, 81-10713 (11/83 & 12/83)
Reeves, Alvin M., 82-05643 (11/83)
Rekow, Michael R., 82-08263 (11/83)
Rentz, Winona J., 82-10849 (11/83)
Rice, Diana R., 82-01886 & 82-01885 (5/83)
Richards, David M., 82-06001 (10/83)
Richter, Katharine, 81-09260 (5/83)
Ricketts, Louis D., 81-07320 (and six others) (12/83)
Riddle, Charles W., 82-04901 (5/83)
Rietkerk, Dick, 82-02490 (5/83)
Rightnar, Robert, 82-00177 (10/83)
Rigot, Cindy, 80-10186 (1/83)
Rinck, Robert, 82-08696 (6/83)
Ritter, Scott W., 82-07705 (12/83)
Robbins, Teresa, 82-00224 (2/83)
Robertson, Jesse, 80-00717 (2/83)
Robertson, Larry L, 82-06718 & 82-06719 (12/83)
Robison, Nancy, 82-05445 (7/83)
Rodriguez, Eustolio, 81-08074 (9/83)
Rodriguez, Lupe, 81-06244 (1/83)
Rogers, June, 82-05367 (12/83)
Rosean, Kenneth J., 82-00996 (12/83)
Ross, Edward T., 82-09044 (8/83)
Ross, Teddie, 80-05039 (7/83)
Rowe, Ronald L., 82-02355 & 82-06338 (9/83)
Russworm, Hubert D., 82-03960 & 82-06406 (6/83)
Rust, Robert H., 81-07665 & 81-07666 (8/83)
Ruzicka, Mary E., 82-02222 (3/83)
Salas, Esperanza T., 82-02151 (10/83)
Sampson, Charles, 81-06270 (2/83)
Sams, Marilyn Y., 82-07217 (11/83)
Sanders, Juanita M., 81-08252 (5/83)

Name, WCB Number (Month/Year)
Sarich, Judy A., 82-02672 (1/83)
Sassmen, Jerry L., 82-06927 (8/83)
Saville, Nellie M., 82-04607 & 82-05922 (6/83)
Sax, Mamie M., 82-11655 (10/83)
Schaffer, Karl, 81-09005 (2/83)
Schrader, Denise L., 82-09662 (12/83)
Schroeder, Charles T., 82-08864 (11/83)
Schultz, Marie, 81-07798 (3/83)
Schuster, Carrie L., 82-03084 (3/83)
Schwanke, Marvin, 81-04820 & 80-08259 (5/83)
Schwartzoph, Larry C., 82-08995 (12/83)
Schwengel, Robert L., 82-09954 & 82-09955 (11/83)
Schwichtenberg, Linda, 82-06654 (7/83)
Scofield, Dale, 82-02777 (5/83)
Scott, Bernard F., 82-00290 (9/83)
Scruggs, Maggie, 81-09732 (1/83)
Seaton, Robert A., 81-04023 (11/83)
Shampang, Murray, 81-08434 (12/83)
Sharp, Jesse, 81-04002 & 82-01934 (1/83)
Shaw, Gerald W., 82-05364 (5/83)
Sherburne, Ruth, 82-08145 (8/83)
Sherrill, Tim, 80-11067 (2/83)
Shipman, William, 81-10119 (6/83)
Shotsky, Linda, 81-11135 (3/83)
Silvius, Bonne A., 83-01064 (12/83)
Simmons, Stephen J., 82-11386 (10/83)
Singleton, Roy, 82-03047 (5/83)
Sisemore, Jeffrey, 81-05374 (3/83)
Skinner, Holly A., 81-09171 (3/83)
Slack, June E., 82-08228 (11/83)
Smith, Gary J., 82-00934 (10/83)
Smith, Jerry O., 81-02225 (11/83)
Smith, Richard, 81-07640 (2/83)
Smith, Robert V., 82-07745 & 82-07746 (8/83)
Smith, Roy L., 82-01544 (2/83)
Smith, Velma D., 82-05406 (10/83)
Smith, Walter M., 81-05462 & 81-05463 (6/83)
Sold, Frederick J., 81-03459 (3/83)
Solomon, Reginald B., 81-10476 (2/83)
Sperling, Ronald G., 82-04058 (12/83)
Spiering, Betty J., 81-09303 (6/83)
Spilde, David, 82-01266 (2/83)
Spillman, Maude H., 81-06350 & 81-04963 (11/83)
Stallings, Leslie E., 82-01763 (12/83)
Stalnaker, Betty B., 82-06699 (11/83)
Stanberry, Donald C., 82-06416 (12/83)
Stanwood, Edna L., 82-02914 (7/83)
Steadman, Craig, 82-02717 (10/83)
Stedman, Robert W., 81-01763 (5/83)
Steele, George, 81-06823 (2/83)
Steele, Helen J., 81-11420 (6/83)
Stemwedel, David A., 81-06913 (12/83)
Stenkamp, Robert, 82-02579 (6/83)
Stephens, John L., 82-06492 (8/83)
Stevens, Doris M., 81-08495 (1/83)
Stone, Douglas R., 82-07028 (12/83)
Stratemeyer, William P., 82-09617 (12/83)

Name, WCB Number (Month/Year)
Strawn, Darrell G., 80-06395 (1/83)
Strickland, Donald, 78-06887 (3/83)
Strohecker, Ken L., 81-10398 (5/83)
Stulken, John H., 81-10770 (8/83)
Suk, Paul J., 82-09455 (10/83)
Sumpter, Lee E., 82-04874 (12/83)
Sunseri, Gerald J., 82-00729 & 82-03147 (2/83)
Swales, Betty J., 82-06397 (12/83)
Taylor, Gene R., 81-10917 & 82-04748 (3/83)
Taylor, Larry C., 82-06811 (9/83)
Taylor, Sarah S., 82-00120 & 82-08171 (10/83)
Temple, Beatrice M., 82-08097, 82-08098 & 82-04528 (9/83)
Tennant, Kevin E., 82-07689 (5/83)
Tester, Chet W., 82-01933 & 82-04912 (11/83)
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)
Thomas, Myrtle L., 82-04330 (7/83)
Thomas, Richard R., 82-09953 (7/83)
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)
Tompkins, Tom D., 82-10024 (11/83)
Torres, Fidel G., 80-11661 (12/83)
Tow, Robert E., 82-07544 (8/83)
Townsend, Karalee M., 83-00974 (12/83)
Travis, Paula, 81-11054 (3/83)
Treanor, Mary J., 82-02891 (5/83)
Trusty, Joel, 82-00790 & 82-04101 (12/83)
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)
Tyger, William R., 82-03585 (9/83)
Tyler, Simone A., 82-08528 (10/83)
Ueltzen, Steven R., 82-06090 (10/83)
Uzcanga, Eduardo, 81-06556 & 83-01248 (11/83)
Vaden, Tracy, 81-10222 (5/83)
Valentic, Alson R., 82-06646 (12/83)
Vann, David A., 82-00417 (9/83)
VavRosky, Michael S., 82-07470 (10/83)
Vierra, Carol A., 81-04322 & 81-04547 (1/83)
Villanueva, Pedro, 83-00727 (10/83)
Volkers, Edgar B., 82-03455 (3/83)
Volkers, Edgar, 81-04175 (2/83)
Wager, Russell W., 81-11590 (1/83)
Wagner, Joseph M., 81-11350 & 82-02321 (12/83)
Waldron, Duane E., 81-04702 (3/83)
Walker, Sandra, 81-10314 (2/83)
Wallace, Harvey M., 80-05364 (2/83)
Wallace, Jonathan, 81-11546 (4/83)
Walls, Anthony B., 82-09133 & 83-00810 (11/83)
Walter, Clark M., 81-11714 (5/83)

MEMORANDUM OPINIONS

Name, WCB Number (Month/Year)

Warnes, Randall A., 82-03279 (11/83)
Washburn, Oddis H., 82-01416 (10/83)
Washington, Jeffrey L., 82-09452 (10/83)
Weddle, James D., 82-03713 (8/83)
Weir, John R., 81-06324 (2/83)
Welborn, Shirley, 81-09686 (3/83)
Welburn, Ronald W., 82-04399 (9/83)
Welsch, Patrick, 81-08131 (12/83)
West, Carl F. 80-00288 (3/83)
Westfall, Marvin D., 81-02120 (1/83)
Whitley, James E., 80-06085 (2/83)
Wideman, Dorothy J., 83-01796 & 83-02358 (11/83)
Widenmann, Leo, 81-05767 (2/83)
Wiese, Virgil W., 82-07110 (10/83)
Wight, Betty W., 78-08991 (1/83)
Wilcox, Alice C., 82-10523 (11/83)
Wilhelm, Adam N., 82-02705 (6/83)
Williams, Donis M., 82-02386 (12/83)
Williams, Edward J., 82-06230 & 82-05992 (10/83)
Williams, Joe, 80-11225 (11/83)
Willison, Athena c., 81-06051 (7/83)
Williver, Phillip M., 82-00425 (9/83)
Wilson, Bettie L., 82-10400 (10/83)
Wilson, Norman L., 82-07078 (8/83)
Wine, Richard L., 82-07627 (11/83)
Winkler, Karen M., 81-04022 (2/83)
Winnett, Cecil W., 82-08759 (9/83)
Wittlake, Carolyn, 82-05642 (8/83)
Wood, Edward H., 82-06201 (11/83)
Wood, Pat L., 82-09884 (9/83)
Wood, Winston, 81-11385 (6/83)
Woody, Steven W., 80-09690 (10/83)
Wright, Norman, 82-01105 & 82-02772 (4/83)
Wright, Rick E., 82-04866 & 82-06075 (10/83)
Wright, Steven L., 79-10371 (5/83)
Young, Chester J., 82-01186 (10/83)
Young, Timothy A., 82-09359 & 83-01343 (12/83)
Zandofsky, John S., 81-00185 (2/83)
Zeek, Norman K., 82-01475 (12/83)
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)
Adams, Kenneth, 82-0308M (11/83)
Alexander, Robin, 83-0211M (9/83)
Allen, Emery, 83-0298M (11/83)
Allmon, Thomas, 83-0121M (5/83 & 7/83)
Anderson, Dianna, 81-0182M (3/83)
Anderson, Joseph, 83-0160M (9/83)
Anderson, Nolan D., 81-0238M (9/83)
Arechiga, Jose, 82-0163M (12/83)
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)
Barber, Vivian I., 83-0124M (8/83)
Barnes, Diane, 82-0042M (3/83 & 8/83)
Barnes, Harvey, 83-0023M (2/83)
Barnes, Rita M., 83-0154M (6/83)
Barnett, Keith, 81-0212M (9/83)
Bass, Corrie, 83-0005M (1/83)
Bates, Harold W., 83-0200M (10/83)
Bayne, William D., 83-0169M (9/83)
Beatty, Lyn, 81-0056M (5/83 & 9/83)
Been, Norman, 83-0021M (1/83)
Belecz, Frank J., 83-0240M (9/83)
Betker, Larry D., 83-0026M (4/83 & 12/83)
Betterton, Jim, 83-0339M (12/83)
Bewley, George, 83-0275M (12/83)
Bex, Marshal, 83-0151M (7/83)
Bissonette, Timothy, 83-0272M (11/83)
Black, Douglas, 83-0286M (10/83)
Blevins, Jack, 83-0076M (4/83)
Bolander, Patrick, 83-0224M (9/83)
Bones, Leonard W., 83-0006M (1/83)
Booker, Arbon J., 83-0273M (10/83)
Borders, Robert O., 83-0155M (9/83)
Boutwell, Emma Juanita, 83-0318M (11/83)
Brandaw, David A., 83-0197M (9/83)
Brewis, Evelyn P., 83-0142M (6/83)
Briley, Carroll, 83-0185M (9/83)
Briley, Pat, 83-0212M (9/83)
Brister, Lloyd, 82-0247M (8/83 & 9/83)
Britt, William T., 83-0202M (9/83)
Brittson, Charles B., 83-0173M (9/83)
Britzius, Daryl M., 81-0098M (9/83)
Brod, William M., 83-0163M (9/83)
Brooks, Donald, 83-0102M (5/83)
Brown, Dale C., 81-0018M (9/83)
Brown, Frank, 83-0129M (5/83)
Brown, Larry, 83-0146M (7/83)

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)
Brown, Raymond, 83-0063M (3/83)
Bruce, Walter J., 83-0137M (6/83)
Bryan, Karen J., 83-0230M (9/83)
Buchanan, Patrick L., 80-0003M (9/83 & 12/83)
Buck, Nicholas, 83-0296M (10/83)
Buckshnis, Rick, 83-0135M (5/83)
Buffum, Marvon C., 83-0045M (5/83)
Burck, Geraldine, 83-0300M (10/83)
Bush, Dorothy, 81-0333M (3/83 & 4/83)
Bustamante, Enrique, 83-0167M (6/83)
Buxton, Oliver, 83-0258M (9/83)
Cabal, Robert C., 82-0259M (1/83)
Campbell, Betty J., 83-0235M (9/83)
Campbell, Donald T., 83-0159M (8/83)
Cardoza, Linda, 83-0009M (1/83)
Carrillo, Ray, 83-0198M (9/83)
Castoe, Ezra Eugene, 83-0190M (7/83 & 12/83)
Caudell, Leonard, 82-0131M (9/83)
Chambers, Steve, 83-0270M (12/83)
Champlin, Mauri, 83-0002M (1/83 & 3/83)
Charley, Rick, 83-0311M (11/83)
Childers, Faye, 81-0137M (11/83)--two orders
Christensen, Marian, 83-0091M (4/83)
Christensen, Marian, 83-0091M (7/83)
Christy, Patty, 82-0195M (9/83)
Clemons, Richard E., 82-0185M (3/83)
Clough, Robert, 83-0199M (9/83)
Coble, Steven, 83-0028M (2/83)
Combs, Harold, 83-0015M (3/83 & 12/83)
Cooper, Edward E., 82-0148M (1/83)
Cooper, John, 83-0177M (9/83)
Crafton, Wallace D., 83-0187M (8/83)
Creamer, Eugene, 83-0213M (10/83)
Crocker, Peter E., 83-0059M (3/83 & 11/83)
Cunningham, Josette, 83-0139M (5/83)
Curry, Harold, 81-0215M (1/83)
Daniel, Frederick G., 83-0234M & 83-0236M (9/83)
Davis, Denise, 82-0175M (1/83)
Davis, Leslie E., 83-0324M (12/83)
Davis, Wallace J., 83-0029M (2/83 & 3/83)
Deffenbaugh, John, 83-0257M (9/83)
Delgado, Joseph, 83-0036M (3/83 & 10/83)
DeMarsh, Sandra, 83-0336M (11/83)
Denzer, Albert, 83-0204M (9/83)
Deos, Jack, 83-0112M (5/83)5/83)
Deross, Willie M., 83-0328M (11/83)
Dick, Ralph, 83-0085M (4/83)
Dickerson, Ruby, 82-0098M (12/83)
Donaldson, Richard, 81-0167M (9/83)
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)
Dowell, John R., 82-0183M (12/83)
Driggers, Roger, 82-0298M (7/83)
Duffy, Patrick, 83-0050M (3/83)

Name, WCB Number (Month/Year)
Duran, Nancy A., 83-0357M (12/83)
Edwards, Lloyd H., 83-0226M (9/83)
Edwards, Winona, 83-0252M (9/83)
Ellerbroek, Harvey, 83-0128M (5/83)
Elwell, John, 81-0320M (2/83)
Erofeeff, Nazarii, 82-0256M (9/83)
Ethridge, Roy D., 83-0186M (7/83 & 8/83)
Fairchild, Reynold S., 83-0290M (10/83)
Fast, Donald D., 82-0318M (1/83)
Featherly, James, 83-0149M (7/83)
Fennell, Patricia S., 83-0326M (12/83)
Fennimore, Edgar, 83-0221M (9/83 & 10/83)
Fifer, Eva, 83-0138M (5/83 & 9/83)
Fischer, Michael R., 81-0259M (11/83)--two orders
Fones, Edward, 83-0099M (4/83)
Forrester, Billy, 83-0071M (3/83)
Foust, George, 83-0087M (3/83)
Fraley, Lewis, 83-0381M (12/83)
Franke, Donald, 83-0039M (11/83)
Franks, William Allen, 83-0038M (3/83)
Frear, James, 82-0291M (3/83 & 12/83)
Freauf, Lillian, 83-0117M (5/83)
Fritz, Leonard, 83-0134M (7/83 & 10/83)
Gaither, Lela E., 83-0181M (8/83)
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)
Geenty, Richard, 83-0313M (12/83)
Giffin, Jerry D., 83-0079M (3/83 & 4/83 & 6/83)
Gilman, Charles, 83-0370M (12/83)
Gold, Crystal, 82-0270M (6/83)
Gorman, Oma, 83-0089M (4/83)
Gossman, Ronald, 82-0162M (9/83)
Grant, Frederick, 83-0042M (3/83)
Gray, Edward, 83-0266M (9/83)
Greenwalt, James D., 83-0251M (10/83)
Griffey, Brian, 83-0223M (9/83)
Grijalva, Pat, 83-0292M (10/83)
Groesbeck, Chris, 83-0380M (12/83)
Guarisco, Margaret J., 83-0297M (10/83)
Hacker, Roy L., 83-0066M (3/83)
Haines, Robert J., 82-0316M (1/83)
Haley, Dolores, 83-0359M (12/83)
Hamilton, Walter J., 83-0106M (5/83)
Hamm, James, 81-0303M (10/83)
Hammer, Charley, 83-0254M (9/83)
Hampton, Frank, 83-0100M (5/83)
Hannick, Robert, Sr., 83-0294M (12/83)
Hannon, James, 83-0218M (9/83)
Hansen, Kathleen, 81-0262M (1/83 & 3/83)
Hansen, Richard, 83-0114M (5/83)
Haron, Louis, 83-0348M etc. (12/83)
Hartill, Gene A., 83-0210M (8/83)
Hartl, Thomas C., 83-0174M (9/83)
Harvey, James, 82-0214M (10/83)

Name, WCB Number (Month/Year)
Harvey, Walter J., 83-0289M (10/83)
Heart, Betty, 82-0303M (12/83)
Heidenreich, Karl F., 83-0056M (3/83)
Hemminger, Clayton, 83-0164M (8/83)
Hetrick, Gregory, 83-0032M (3/83)
Hill, David R., 83-0260M (10/83)
Hills, Frank, 82-0232M (1/83)
Hinzman, Bernie, 83-0097M (4/83)
Hollamon, Ezekial A., 83-0183M (9/83)
Holland, Morris, 82-0121M (11/83)
Holliday, Richard, 83-0024M (3/83)
Holmes, Joe, 81-0034M (4/83, 5/83 & 10/83)
Holmstrom, Paul, 81-0277M (3/83)
Howard, Terry O., 83-0084M (3/83)
Howell, Michael, 83-0107M (5/83, 11/83 & 12/83)
Hubbs, Warren, 82-0171M (3/83)
Hudman, Emmett M., 83-0172M (9/83)
Hudson, Nancy, 83-0086M (5/83 & 11/83)
Hudspeth, William R., 83-0268M (9/83)
Hughes, Leland G., 83-0293M (10/83)
Hulbert, David, 83-0075M (3/83 & 6/83)
Hunter, Harry Leroy, 83-0267M (10/83)
Hunter, Larry, 83-0291M (10/83)
Huntsucker, Donald R., 83-0320M (12/83)
Hurley, Garold, 81-0134M (12/83)
Hurley, Howard, 83-0018M (1/83)
Hutchinson, James W., 82-0052M (9/83 & 10/83)
Idlewine, James R., 81-0197M (6/83 & 9/83)
Jackson, David, 83-0105M (4/83)
Jackson, Eugene, 83-0153M (6/83)
Jackson, Robert D., 83-0025M (1/83 & 5/83 & 9/83)
Jelineo, James M., 83-0148M (6/83)
Jensen, August, 83-0263M (9/83)
Jerome, David, 82-0137M (2/83 & 3/83)
Johns, George D., 83-0246M (9/83)
Johns, Joseph D., 82-0065M (9/83)
Johnson, Carl, 81-0065M (10/83 & 11/83)
Johnson, Jack, 83-0308M (11/83)
Johnson, Ronald L., 83-0165M (9/83)
Jones, Johnnie, 83-0284M (10/83)
Jones, Leo, 82-0164M (1/83 & 3/83)
Juhola, Eunice, 83-0222M (10/83)
Kallay, Dezo, 83-0118M (5/83)
Karstens, Harvey K., 83-0067M (3/83)
Kaser, Steven D., 80-0002M (12/83)
Kaufman, Ivan, 82-0297M (3/83 & 8/83)
Keen, Gwen, 83-0116M (5/83)
Kemmerer, Kenneth E., 82-0189M (8/83)
Kennedy, Michael H., 83-0334M (12/83)
Keyser, John P., Jr., 82-0191M (9/83)
Kildow, Karen, 82-0208M (3/83 & 4/83)
Kimbrel, Sadie M., 81-0317M (2/83)
Kirchoff, Rex, 82-0089M (9/83)
Kloehn, Donald, 83-0096M (4/83)
Knupp, Patricia, 83-0304M (11/83)
Koenig, Tom, 83-0061M (3/83)

Name, WCB Number (Month/Year)
Kosack, Dolores a., 82-0246M (8/83)
Kreamier, Fred W., 83-0041M (3/83)
Laing, George, 83-0219M (9/83)
Landers, Arthur, II, 81-0265M (3/83)
Larsen, Jorgen, 83-0288M (10/83)
Larson, Donald, 83-0108M (4/83)
Larson, Shirleen, 83-0077M (3/83 & 10/83)
Lavelle, Lawrence L., 83-0170M (9/83)
Lawhead, Stephen, 81-0066M (9/83)
Lawrence, Patrick, 83-0307M (11/83)
Leas, Teresa L., 83-0003M (1/83 & 9/83)
Lesh, Lynn, 83-0092M (4/83)
Lewis, Russell, 81-0295M (3/83)
Lewis, Wilbur A., 82-0160M (3/83)
Linder, Janice K., 83-0068M (3/83 & 8/83)
Lindsley, Stanley, 81-0064M (3/83 & 6/83)
Lister, Yvonne, 83-0378M (12/83)
Lloyd, Audley, Jr., 83-0182M (7/83)
Loftus, Samuel P., 83-0322M (12/83)
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 & 10/83)
Lyon, Claude, 83-0243M (9/83)
Mabe, William R., 83-0195M (10/83, 11/83 & 12/83)
Mack, John, 83-0034M (3/83)
Maddox, Gary, 83-0321M (12/83)
Mansker, Melba, 83-0083M (3/83)
Marcott, Kevin L., 83-0040M (3/83)
Markus, Marvin, 83-0354M (12/83)
Martisak, Jerrold, 83-0179M (9/83 & 10/83)
Massey, John, 83-0253M (9/83)
Matott, Donald, 83-0279M (10/83)
McBride, Patricia, 83-0201M (9/83)
McCasland, Margie, 81-0226M (3/83)
McClay, Dennis, 83-0265M (9/83)
McClay, Taylor L., 82-0309M (2/83)
McCluskey, Skyler R., 82-0307M (11/83)
McConly, Richard, 83-0017M (1/83)
McDaniel, Shelley A., 83-0150M (6/83)
McFadden, William H., 83-0122M (5/83 & 6/83)
McKeag, Pat L., 83-0347M (12/83)
McKean, Raymond, 83-0259M (9/83)
McKelvey, Ronald, 83-0014M (3/83)
McKinney, Mary, 83-0057M (3/83)
McNair, Dale, 83-0132M (9/83)
Merrigan, Michael, 83-0119M (5/83)
Metzger, Don, 83-0295M (10/83)
Michael, Vernon, 81-0201M (10/83)
Milano, Catherine, 82-0230M (5/83)
Miller, Bruce, 81-0163M (12/83)
Miller, Calvin, 83-0262M (9/83)
Miller, Lynn, 83-0074M (3/83)
Miller, Raymond, 83-0047M (3/83)
Mix, Anthony C., 83-0316M (12/83)

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)
Moffitt, Joseph, 83-0264M (9/83)
Monroe, Dean C., 81-0245M (7/83)
Monroe, Jack G., 83-0335M (12/83)
Monteith, Norris C., 83-0310M (11/83)
Moore, Clyde, 83-0299M (12/83)
Moore, Gerald S., 81-0196M (9/83, 10/83 & 12/83)
Moreno, Erica, 83-0152M (6/83)
Morgan, Robert W., 83-0344M (12/83)
Morin, Elizabeth J., 83-0239M (9/83)
Morton, William, 83-0111M (5/83 & 9/83)
Mosko, Michael E., 83-0315M (12/83)
Muehlhauser, Eugene, 83-0027M (2/83)
Munroe, Allan B., 83-0180M (9/83)
Myers, Lavene M. Reigard, 83-0062M (3/83)
Nahorney, Frank, 81-0008M (12/83)
Neault, Marjie M., 83-0392M (12/83)
Neller, George Karl, 83-0037M (11/83)
Netland, Janis, 83-0352M (12/83)
Nicks, Edward, 83-0158M (6/83)
Nixon, Elmer, 81-0230M (12/83)
Noah, Edward, 83-0060M (3/83)
North, Mike, 83-0232M (9/83)
Noyes, Darrel, 83-0022M (3/83)
Nunez, Ray, Jr., 83-0065M (4/83)
Nylin, Jean, 83-0193M (9/83)
Olson, Allan D., 83-0194M (9/83)
Orman, Louis, 83-0113M (5/83, 7/83, 9/83 & 11/83)
Owens, Leroy James, 83-0227M (9/83)
Oxford, Anderson G., 82-0158M (7/83)
Palmer, Mary B., 83-0081M (3/83, 4/83 & 11/83)
Parazoo, Marshall G., 83-0101M (4/83)
Park, Thomas D., 83-0133M (5/83)
Parmenter, Ruby, 83-0244M (9/83)
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)
Pelto, Gene, 83-0355M (12/83)
Perry, Wayne, 83-0103M (4/83)
Peyton, Gary, 82-0253M (1/83 & 5/83)
Phillips, Annie J., 83-0168M (8/83)
Phillips, Clifford, 80-0156M (5/83)
Pilgrim, Joyce, 83-0309M (11/83)
Pinney, John, 82-0264M (5/83 & 6/83)
Poe, Theodis E., 82-0324M (1/83)
Pope, Robert R., 83-0136M (6/83)
Preston, Donald G., 83-0162M (9/83)
Profitt, David, 83-0372M (12/83)
Pullen, Edward, 83-0033M (2/83)
Quinn, Bruce, 82-0073M (9/83 & 12/83)
Randall, Nathan, 83-0127M (5/83)
Rapp, Terry, 83-0287M (10/83 & 12/83)
Reed, Allen L., 82-0155M (4/83)
Reed, Michael, 83-0358M (12/83)
Reed, Robert R., 83-0301M (10/83)
Rentz, Dennis, 83-0001M (4/83)

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Name, WCB Number (Month/Year)

Reynolds, Edna, 83-0189M (9/83)
Rimer, Robert L., 83-0166M (9/83)
Rinck, Robert, 82-0295M (5/83)
Ripplinger, Evelyn C., 83-0338M (12/83)
Robertson, David, 81-0130M (2/83) (4/83)
Robinette, Gary D., 83-0093M (4/83)
Robison, Bill, 82-0207M (8/83)
Romero, Oscar, 82-0313M (1/83 & 12/83)
Rosin, Oscar, 83-0306M (11/83)
Ross, Robert, 83-0094M (4/83)
Rothenberger, Albert, 83-0171M (8/83)
Rowley, Steven, 83-0156M (6/83 & 10/83)
Russell, James, 83-0282M (10/83 & 11/83)
Salvetti,Roy, 81-0223M (2/83 & 9/83)
Savage, Fred, 83-0131M (6/83)
Sawyer, Donald R., 83-0144M (8/83 & 9/83)
Schafer, Glenn E., 83-0161M (9/83)
Schaffer, Lucine, 83-0255M (10/83)
Schenck, Robert A., 81-0198M (1/83)
Schneider, Curtis, 83-0225M (9/83)
Schra, James, 82-0281M (1/83)
Schuster, Carrie, 82-0299M (4/83, 5/83 & 10/83)
Seehawer, Lyle, 83-0277M (9/83)
Serbick, Laura, 83-0055M (4/83)
Shine, Patrick, 82-0228M (5/83)
Shinn, Herbert K., 83-0344M (12/83)
Short, Lloyd, 83-0120M (5/83)
Siewell, Noel R., 83-0013M (1/83 & 6/83)
Skophammer, Juanita, 81-0234M (10/83 & 11/83)
Slater, Roy R., 83-0215M (9/83)
Smith, Bob B., 83-0109M (4/83)
Smith, Lorene, 82-0272M (9/83)
Smith, Phillip R., 83-0073M (3/83 & 5/83)
Smith, Walter G., 82-0181M (2/83 & 6/83 & 9/83)
Snyder, Milton, 83-0203M (9/83)
Socia, Michael, 83-0143M (6/83 & 9/83)
Souza, James, 83-0366M (12/83)
Spillman, Maude H., 81-0232M (11/83)--two orders
Spooner, Carlton, 81-0060M (5/83)
Sprague, Elnora M., 83-0205M (8/83 & 8/83)
Stallsworth, James, 83-0271M (10/83)
Stianson, Milton, 83-0247M (10/83 & 12/83)
Stillwell, Sharon, 83-0327M (12/83)
Stockton, Jack, 81-0296M (4/83)
Stoffal, Nancy, 83-0231M (9/83)
Stringer, Ronald D., 83-0216M (9/83)
Suverly, Raymond T., 82-0238M (4/83)
Swanberg, Betty J., 83-0281M (10/83)
Swanberg, Max S., 83-0332M (12/83)
Swartwout, Sara, 83-0341M (12/83)
Sykes, Robert Foster, 83-0020M (1/83 & 6/83)
Tall, Donald, 82-0095M (1/83)
Taylor, Nancy, 83-0019M (10/83 & 12/83)
Thies, Harold L., 83-0176M (8/83)
Thomas, John Edwin, 83-0325M (12/83) (2 orders)

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Name, WCB Number (Month/Year)

Thompson, Lawrence, 83-0044M (3/83)
Thompson, Leaton, 83-0346M (11/83)
Thornsberry, Raymond, 83-0228M (10/83)
Thurston, Arden, 83-0249M (9/83)
Tinner, Carvel R., 81-0181M (9/83)
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)
Turner, Joyce M., 83-0126M (8/83)
Turpen, Charles, 83-0016M (5/83)
Vanderschuere, Victor, 82-0025M (5/83)
VanSickle, James L., 83-0305M (11/83)
Vaughn, Harry C., 83-0369M (12/83)
Vinsonhaler, Melvin, 83-0039M (3/83)
Waller, Gladys Marie, 83-0351M (12/83)
Want, Deborah, 83-0303M (11/83)
Wantowski, John W., 82-0235M (9/83)
Waring, Kenneth V., 83-0238M (9/83)
Warkentin, Jerry, 83-0046M (3/83 & 8/83)
Warnock, R. Keith, 81-0186M (10/83)
Weber, Donald, 81-0089M (3/83)
Weckerle, Joe, 81-0221M (1/83)
Wells, Herbert J., 81-0276M (1/83 & 6/83)
Wentz, Kenneth D., 83-0233M (9/83)
Whisenhunt, Andrew, 83-0083M (3/83)
White, James Carlos, 82-0213M (3/83)
Whitmore, Alene P., 83-0317M (12/83)
Widener, Lucille M., 83-0012M (2/83)
Wilken, Keith, 83-0008M (1/83)
Wilkinson, Melvin F., 83-0070M (3/83)
Williams, Edward J., 82-0117M (10/83)
Williams, James O., 83-0280M (12/83)
Williams, Joe, 83-0191M (8/83)
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 (7/83)
Wimmer, Max H., 83-0217M (9/83)
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)
Young, Rose A., 82-0017M (10/83)
Zeleznik, John M., 81-0139M (4/83)
Zimmerman, Julia, 83-0285M (10/83)
Zongker, Leland L., 83-0175M (8/83)
Zorko, Richard A., 83-0261M (9/83)

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