VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 36

Pages 1-558

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

JANUARY-MARCH 1984

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

CONTENTS

CITE AS:

36 Van Natta ___ (1984)

WALTER E. GINN, Claimant
Peter Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 81-11562
January 11, 1984
Order Denying Approval of Stipulated Settlement

Claimant and the employer/insurer, by and through their respective counsel, have submitted a stipulated settlement agreement to the Board for approval. We find the proposed settlement agreement violates the statutory prohibition against releases, ORS 656.236(1), and, therefore, decline to grant our approval.

Claimant sustained a crushing injury to his left knee on August 8, 1980. Two surgical procedures were performed for arterial injury to the knee. The claim was closed by Determination Order dated November 5, 1981, which awarded compensation for temporary total disability, 75° of scheduled permanent partial disability for a 50% loss of the left leg (knee), and an award of 32° for 10% unscheduled permanent partial disability for injury to claimant's heart. Claimant requested a hearing contesting the Determination Order, claiming entitlement to additional compensation, including additional permanent disability. The employer/insurer gave notice of its intent to contest that portion of the Determination Order awarding compensation for unscheduled permanent partial disability for injury to claimant's heart. The parties subsequently entered into a settlement agreement subject to the approval of a Referee.

A stipulation originally was submitted to Referee Pferdner under cover of a May 18, 1983 letter from claimant's attorney. This stipulation was referred to the Presiding Referee for consideration. It referred to the facts that claimant's left knee/leg injury claim was accepted by the employer/insurer and closed by Determination Order which awarded compensation for scheduled and unscheduled permanent disability; that claimant contended that he suffered atrial fibrillation, or an aggravation thereof, and a heart-related injury or aggravation thereof as a result of his industrial injury; that the employer "has, and does hereby deny responsibility for claimant's heart condition or atrial fibrillation, or aggravation thereof;" that claimant contended he was permanently and totally disabled; that the employer denied that claimant was permanently and totally disabled as a result of his industrial injury or the sequelae thereof; and that the parties wished to resolve this matter "on a settlement basis."

The stipulation recited the parties' agreement that the employer/insurer would pay claimant in excess of $31,000, in consideration for which claimant agreed that his atrial fibrillation or heart condition would remain "in its denied status," and that claimant would take no workers' compensation benefits on account of that condition. It was further agreed that any and all permanent residual damage to claimant's heart was not the result of claimant's industrial injury but was a subsequent event for which no compensation would be allowable. It was agreed that the settlement resolved "all issues regarding the Determination Order;" that claimant was permanently and totally disabled as a result of conditions unrelated to his industrial injury; and that claimant's total disability "now and in the future is and will be due to unrelated conditions and not due to the industrial injury." The parties

agreed that claimant had retired from the labor market for reasons unrelated to his industrial injury, and further:

> "In consideration of this settlement, it is agreed that not now or any time in the future shall claimant receive temporary total disability or permanent total disability as a result of the industrial injury, either by way of aggravation or Own Motion relief. It is agreed that all future medical care, which is causally related to the industrial injury, shall be paid pursuant to ORS 656.245 without reopening of the claim . . . . "

The Presiding Referee corresponded with counsel for the parties by letter of May 24, 1983, questioning the factual or medical basis asserted for the dispute concerning claimant's heart condition and suggesting that the document constituted a prohibited release in view of the provision that claimant waived his right to receive future temporary or permanent disability benefits. Apparently in response to this letter, the parties submitted a revised stipulated settlement agreement, which the Presiding Referee declined to approve. This stipulation was forwarded to the Board for consideration. It differs from the parties' original stipulation only insofar as it deletes any reference to claimant's atrial fibrillation or heart condition.

We have considered both stipulated settlement agreements for the purpose of determining whether either one can be approved. The pertinent statutory provisions are as follows.

> "No release by a worker or his beneficiary of any rights under ORS 656.001 to 656.794 is valid." ORS 656.236(1).

> "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." ORS 656.289(4).

The original settlement agreement recites that there is a dispute concerning the compensability of claimant's atrial fibrillation or heart condition. This dispute concerning compensability, standing alone, might be the subject of a disputed claim settlement agreement, assuming the existence of a "bona fide dispute." As the remainder of the original stipulation and the revised stipulation indicate, however, the parties' intent is to resolve a dispute concerning not only the compensable consequences of claimant's accepted industrial injury, but also the extent of permanent disability attributable to the admittedly compensable condition resulting from this accepted industrial injury, i.e. claimant's knee injury. Both proffered agreements suffer from the same defect: In consideration of claimant's present receipt of a substantial sum of money, claimant agrees that he will make no claim for temporary or permanent disability benefits in connection with

his original, accepted industrial injury claim. Although the terms of the parties' agreement preserves claimant's right to future medical services pursuant to ORS 656.245, the effect of the agreement is to release claimant's right to receive other benefits to which he may be entitled under the Workers' Compensation Act, in violation of the prohibition against releases. ORS 656.236(1). As we recently have stated in a case involving a similar settlement agreement: "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." Warren C. Bacon, 35 Van Natta 1694, (November 16, 1983). See also 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.

ROBERT B. WILLIAMS, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Schwenn, et al., Attorneys
Carl M. Davis, Ass't. A.G.

WCB 82-08105 & 82-07200
January 11, 1984
Order on Reconsideration

The noncomplying employer requested review of Referee Braverman's order which found claimant's low back claim compensable and ordered that the employer pay a penalty and attorney's fee. By Order on Review dated December 8, 1983, we affirmed and adopted those portions of the Referee's order finding the claim compensable. We remanded the issue of penalties and attorney fees to the Referee for further proceedings.

Claimant has requested that we reconsider our Order on Review and award his attorney a reasonable fee on Board review for prevailing on the issue of compensability. See ORS 656.382(2). We consider it appropriate to award claimant's attorney a fee at this stage of the proceeding and, therefore, modify our prior order accordingly. A substantial portion of the claimant's submission on Board review addresses the issue of penalties and attorney fees, an issue which will be the subject of further proceedings before the Referee. The fee awarded herein is only for services rendered in connection with the compensability issue.

ORDER

On reconsideration of our Order on Review (Remanding) dated December 8, 1983, we modify that order to award claimant's attorney $350 as a reasonable attorney's fee on Board review. Except as modified, we adhere to our prior order, which hereby is readopted and republished.

JAMES B. ARNDT, Claimant
Gary K. Jensen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 81-05655
January 13, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Wilson's order which affirmed the Determination Order dated August 15, 1982, which awarded no permanent disability over that previously awarded. Claimant contends he is entitled to a greater award of unscheduled permanent disability.

Claimant is a 36-year-old graderman who compensably injured his low back in 1978. He had a bilateral laminectomy and discectomy at L5/S1 in 1979. In August 1980, claimant and the insurer stipulated that claimant's extent of unscheduled permanent disability was 30% (96°). Claimant's claim was reopened in March 1981 and closed by Determination Order dated July 1, 1981, which awarded no additional permanent disability. Claimant appealed this Determination Order. Claimant entered into a pain program in March 1982 and into a vocational program in May 1982. After completion of the vocational program, a Determination Order dated August 13, 1982 issued, which awarded no additional permanent disability. Claimant appealed this Determination Order also. Both Determination Orders were at issue at the hearing.

The Referee found no evidence that claimant's loss of earning capacity was greater than that in August 1980 when claimant stipulated that his permanent disability was 30%. Since the Referee issued this order, however, the Oregon Court of Appeals has decided Hanna v. SAIF, 65 Or App 649 (1983), which reversed the Board's decision in Fred Hanna, 34 Van Natta 127 (1982). In Hanna, the court held that a change in a claimant's condition is not required to obtain a redetermination of extent of disability on termination of a program of rehabilitation. Inasmuch as this case involves redetermination after termination of a vocational program, we believe we are bound by Hanna, and we review the record to determine extent of disability at the time of the hearing.

Our analysis begins with application of the guidelines found in OAR 436-65-600 et seq. Although no doctor rates claimant's impairment, we find his impairment to be 20%. This is based on the restrictions placed on claimant's activities of no bending, prolonged sitting, walking, standing or driving and no lifting over 40 pounds, and on claimant's lay testimony regarding his pain and limitations. Claimant's age of 36 and high school education yield factors of 0. The vocational preparation required to perform the graderman job gives claimant a factor of +5 for work experience. Because claimant formerly performed heavy work and is now restricted to light, we assign +10 for adaptability. For labor market findings we assign a factor of -1.

Combining these factors as provided in the rules yields a disability rating of 30% (96°). Comparing that finding with other similar cases, we conclude that an award of 30% permanent disability is appropriate in this case. Inasmuch as claimant received a total award of 30% unscheduled permanent disability by the August 1980 stipulation, no additional award of permanent disability is warranted. Accordingly, we affirm the order of the Referee.

ORDER

The Referee's order dated April 22, 1983 is affirmed.

WILLIAM R. CARR, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-00053
January 13, 1984
Order on Remand

On review of the Board's order dated February 5, 1982, the Court of Appeals reversed that order and remanded for entry of an order awarding claimant additional temporary total disability compensation.

Now, therefore, the above-referenced Board order is vacated, and claimant is awarded additional temporary total disability compensation from June 5, 1980 until July 25, 1980, said compensation to be paid in accordance with the rate prescribed by former OAR 436-54-212(2)(i), presently set forth at OAR 436-54-212(3)(i).

Claimant's attorney is allowed 25% of this additional compensation as a reasonable attorney's fee for services rendered before the Court of Appeals. Morris v. Denny's, 53 Or App 863, 866 (1981).

IT IS SO ORDERED.

CARLOS IGLESIAS, Claimant
Marvin S. Nepom, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-06774
January 13, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Leahy's order which found claimant was medically stationary on March 18, 1982 rather than on May 4, 1982, and which affirmed a Determination Order's award of 48° for 15% unscheduled disability. The insurer argues that claimant was actually medically stationary on December 22, 1981.

Claimant was compensably injured on April 24, 1981 when an air hose broke loose and struck him on the back. He was treated conservatively for dorsal and lumbar strain.

In December 1981 claimant entered the Northwest Pain Center. The center documented temperature changes in the thoracic-lumbar area which were thought to be consistent with myofascitis. The center staff felt claimant was well motivated to benefit all he could. They felt claimant was medically stationary.

On January 11, 1982 Dr. Cockburn, claimant's treating physician, released claimant to part time work. On January 25, 1982 Dr. Cockburn released claimant to full time work with no heavy lifting.

On March 26, 1982 Orthopaedic Consultants evaluated claimant. They documented contusion and strain at L-3 to D-10 inclusive. They noted a mild degree of functional interference. They placed his impairment in the dorso-lumbar spine as minimal. They felt he

could return to his regular work though prognosis for successful return was guarded. They felt claimant was medically stationary.

On April 16, 1982 Dr. Cockburn wrote that he concurred with Northwest Pain Center that claimant was medically stationary. He noted that claimant continued in a light job, that on April 8 claimant had "exacerbated" his condition and been unable to work for about one week. Dr. Cockburn stated:

> "Even though his condition is essentially stable he will continue to have exacerbations and remissions depending on how hard he stresses himself."

On May 4, 1982 Dr. Cockburn concurred with Orthopaedic Consultants' report except he disagreed that claimant would ever be able to return to his former job.

A Determination Order issued on May 28, 1982 which awarded claimant temporary disability benefits through May 4, 1982 and 48° for 15% unscheduled disability. At hearing the Referee found that claimant was medically stationary at the time of the Orthopaedic Consultants' report. The Referee also affirmed the Determination Order's award of permanent disability.

We disagree with the Referee on the issue of when claimant became medically stationary. Northwest Pain Center found claimant medically stationary on December 22, 1981. The treating physician concurred in that finding. He actually released claimant to full time work on January 25, 1982. Although the release was not for return to his previous occupation, it is obvious that Dr. Cockburn believes that claimant is permanently precluded from returning to his previous occupation. Accordingly, we find that claimant was medically stationary on January 25, 1982.

We also disagree with the Referee on the issue of permanent disability. We agree with the values the Referee assigned on the factors of age, education, work experience, adapatability and impairment. However, we disagree with the Referee's assigning a -25 factor for emotional and psychological findings. While there is some indication of functional interference, we do not agree with the Referee that claimant is "unwilling to adjust." We also decline to assign a -25 for intelligence. Instead, we assign a zero value for both intelligence and emotional/psychological factors. Combining all of these factors we arrive at a disability rating of 80° for 25% unscheduled disability.

ORDER

The Referee's order dated June 29, 1983 is modified in part and reversed in part. That portion of the Referee's order which ordered the insurer to pay temporary total disability benefits through March 18, 1982 is modified to require the insurer to pay temporary disability benefits through January 25, 1982. That portion of the Referee's order which affirmed the Determination Order award of 48° for 15% unscheduled permanent partial disability is reversed. Claimant is awarded an additional 32° for 10% unscheduled permanent partial disability, for a total unscheduled award of 80° for 25% of the maximum allowable. Claimant's attorney is awarded 25% of the increased permanent disability compensation payable pursuant to this order, not to exceed $3,000.

ROBERT E. PARKER, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-00509
January 13, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Daron's order which: (1) Upheld the SAIF Corporation's partial denial of compensation (medical services or time loss) for claimant's spondylolisthesis, spondylolysis and degenerative disc disease; and (2) reduced the permanent disability award granted by the February 12, 1982 Determination Order from 80° for 25% unscheduled disability to 32° for 10% unscheduled disability.

Two different statutes use different words to express what is really the single issue in this case. ORS 656.245(1) provides for continuing medical treatment "for conditions resulting from" an industrial injury. (Emphasis added.) ORS 656.214(5) provides for permanent disability awards based on "loss of earning capacity due to the compensable injury." (Emphasis added.) Thus, the question is whether claimant has established that his various preexisting spinal diseases were worsened by his July 1981 back-strain injury so that it can be said that further treatment for these diseases "results from" that injury and all of claimant's current disability is "due to" that injury.

We agree completely with the Referee's preliminary assessment of the record: "The medical record is somewhat conflicting, to say the least, and, in my opinion, confusing and ambiguous." For example, most opinions about the causal link, or lack thereof, between claimant's preexisting spinal diseases and his July 1981 compensable back strain come from Dr. Campagna, and his most recent opinion is:

> "It does not necessarily follow that because the myelogram was negative, that no pathological change occurred in the [claimant's] spine as a result of the [July 1981 injury]. Also, it is not necessarily so that the [claimant's] current complaints are a result of a pre-existing back problem."

While we have no reason to quarrel with Dr. Campagna's logic, we are unable to conclude that this kind of statement, considered in light of the entire record and the several other comparably ambiguous statements of medical "opinion" therein, are sufficient to sustain claimant's burden of proof.

ORDER

The Referee's order dated April 22, 1983 is affirmed.

DOUGLAS E. THOMAS, CLAIMANT
Myrick, et al., Claimant's Attorneys
Frohnmayer, et al., Defense Attorneys

WCB 82-02498
January 13, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Brown's order which awarded him 12.6° scheduled disability, that being an increase of 3° over and above the March 9, 1982 Determination Order. The issue for review is extent of claimant's disability.

Claimant, who was 24 years of age at the time of the hearing, was born with a congenitally short right arm. The ulna of his right arm extends approximately three inches distal to the elbow joint. At the age of nine months claimant participated in a special program under the auspices of the UCLA Medical School. At that time claimant was fitted with a prosthesis and participated in training programs to help him gain skill in the use of his prosthesis.

As time passed claimant became quite skilled in the use of his prosthesis. While in grade school, claimant participated in various sporting activities including baseball, basketball and swimming. While in high school claimant wrestled and lifted weights. Claimant also became an avid motorcycle and dirt-bike rider. Claimant testified that his first job involved bucking hay, which he did for two summers while in high school. Claimant also worked for the Josephine County Park Service as a conservation aide and firefighter, a job which required him to operate power equipment of various types.

When he was 16 years of age claimant began working in the meat department of an Albertson's store. Eventually, claimant became an apprentice meatcutter. While employed as a meatcutter for Albertson's, on November 17, 1978, claimant sustained a crushing injury to his right upper elbow when a box of meat he was lifting fell, hyperextending claimant's elbow and crushing the stump under the prosthesis.

Claimant was treated conservatively by Dr. Potter and released to return to work on December 11, 1978. Claimant returned to work on a light duty basis initially, and subsequently engaged in his regular duties until June 1980 when he suffered increased pain and stopped working.

A Determination Order issued on January 25, 1979 awarding claimant benefits for temporary total disability only.

On June 23, 1980 Dr. Renaud reported that claimant was experiencing pain in the right arm. Dr. Renaud's examination, however, revealed only tenderness at the medial and lateral epicondyle. Dr. Renaud felt that claimant had too much stress placed on his arm and that, if he tried to continue on as a meatcutter, he would not be able to tolerate it.

On July 2, 1980, Dr. Potter recommended that claimant cease working as a meatcutter, despite the fact that claimant wanted to continue in that capacity. On July 23, 1980 Dr. Potter reported that claimant was released to return to work but that he was able

to return only to a one-handed job. Dr. Potter felt that this was a permanent restriction.

A second Determination Order issued on September 17, 1980. Again, claimant was awarded benefits for temporary total disability only.

Despite Dr. Potter's recommendations, claimant returned to work as a meatcutter for Shop-Rite Markets on a part-time basis. Claimant testified that he relied heavily on his left arm while working for Shop-Rite. Claimant left Shop-Rite after a short time and went to work for Mayfair. Claimant worked as a meatcutter for Mayfair for approximately one month when pain and swelling in his right arm forced him to stop.

Claimant was thereafter unemployed for a period of time. Eventually he obtained a position as an assistant manager trainee for Joseph's Storehouse, a business which specialized in obtaining or preparing food, supplies, material, equipment, merchandise or tools requested by customers. Claimant worked for Joseph's Storehouse for the next one-and-one-half years.

On May 8, 1981 Dr. Potter indicated that claimant would be able to perform the duties required at Joseph's Storehouse, but cautioned that claimant "has essentially one arm," and that claimant could use his prosthesis to an advantage so long as there was not excessive stress placed on it.

On May 28, 1981 claimant was examined by Dr. Matthews of the Medford Orthopedic Group. Dr. Matthews indicated claimant's complaints of pain, aching in the elbow and inability to engage in heavy work sounded "rather reasonable." Dr. Matthews expressed surprise that claimant had been able to engage in such heavy work before his injury, and agreed with Dr. Potter that claimant had a normal working capability except that he was now unable to do heavy work with his right upper extremity. Dr. Matthews was of the opinion that claimant's performance before his injury suggested that he would have been able to engage in meat cutting work permanently had it not been for the injury.

On March 9, 1982 a third Determination Order issued. Claimant was awarded additional benefits for temporary total disability and 5% (9.6°) permanent disability for loss of the right arm.

The Referee stated:

> "The . . . problem in this case is not how to evaluate loss of use, but rather how to frame the award. On the one extreme one can argue that claimant had no forearm before the accident, so his loss is limited to the percentage of the difference between the arm (192 degrees), and a forearm (150 degrees); i.e., claimant's loss is 30 percent of 42 degrees. On the other extreme, claimant argues that he had 90 percent 'corrected' use of a normal arm before the injury. * * *"

The Referee found that statutory and case law offered little

guidance on the issue of whether, and to what extent, a preexisting disability or impairment is to be considered in making an award of permanent disability. After analyzing the question, the Referee concluded claimant was only entitled to an award based on the incremental loss of use of his right arm. As the difference between forearm and the entire arm is 42° (192° minus 150°), and since he found claimant suffered a 30% loss of use, the Referee concluded that claimant was entitled to an award equal to 30% of 42°, or 12.6°.

Claimant contends on review that the Referee erred in basing his award of permanent partial disability on his incremental loss of use, and that he is entitled to have his loss computed on the basis of "whole" arm. Claimant argues that there is no distinction in the law between a prosthetic arm and a "normal" biological arm unless the prosthetic arm was the result of a prior industrial injury for which compensation has been paid or awarded. ORS 656.222. We agree.

As the Referee correctly noted, there is little to no statutory or case law which sheds any light on the issue in this case. The only statute which specifically addresses the question to what extent preexisting impairments must be considered in making an award of disability is ORS 656.222:

> "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 for 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."

However, as we stated in Terry D. Swindell, 32 Van Natta 151 (1981):

> "For scheduled disability awards, ORS 656.222 properly comes into operation when a claimant has already received compensation for a permanent disability, but suffers a further accident to the injured member. In this case, however, since no previous awards of permanent disability were made to claimant for his left knee, this application of the statute is not required or warranted."

See also, Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983). As the claimant in the current case has not previously received compensation for his right arm, ORS 656.222 is inapplicable.

Case law dealing with the issue currently before us is scant. The only cases which even remotely deal with the issue are Wilson v. State Ind. Acc. Comm., 189 Or 114 (1950); and Scarpellini v. Blue River Veneer, 11 Or App 497 (1972). Both cases dealt with a situation involving claimants with a preexisting non-industrial visual deficit who sustained a compensable injury resulting in complete loss of their already severely impaired vision. In Wilson,

the Commission argued that there could be no recovery for the loss of sight of an eye that was industrially blind before the compensable injury. 189 Or at 117 (The law in effect at the time of Wilson provided that a claimant receive an award equal to 80° for complete loss of vision in one eye. §102-1760, OCLA.). Since claimant had a complete loss of vision, the court concluded that claimant was entitled to an award for 100% loss of vision without regard to whether or not his vision was perfect before the accident. 189 Or at 119.

A virtually identical situation was presented in Scarpellini. By that time, however, the statutes dealing with loss of vision had changed to provide:

> "For partial or complete loss of vision of one eye, that proportion of 100 degrees which the loss of monocular vision bears to normal monocular vision. * * * ." (The current version of this statute, ORS 656.214(2)(h) is virtually identical.)

The court concluded that the statutory changes did not affect the validity of the rule announced in Wilson and affirmed the award of 100% loss of vision in one eye. 11 Or App at 500, 501.

The Referee stated that Wilson and Scarpellini were distinguishable from the current case because the statute provides that loss of vision is measured after maximum correction, and the statute specifically requires measurement of vision after loss as it bears to normal vision. The Referee also stated:

> "The legislature, having used specific language in one section, obviously intended that language to apply to that section only. Its failure to use comparable language in a similar section demonstrates an obvious intent that 'normal' use is not to be the basis of comparison."

Although we agree with that statement, we believe that the Referee misapplied the concept, for he concluded that when an industrial injury results in the loss of a worker's ability to use his prosthesis, the employer is not required to pay for that loss.

Although it may be a somewhat subtle distinction, it is apparent that the Referee confused the question of whether claimant is entitled to any award for loss of his ability to use his prosthesis, with the separate and distinct question of rating the extent of that loss. There is no question in our minds that claimant is entitled to an award for loss of his ability to use his prosthesis. The fact of the matter is that, in this case, claimant's arm just happens to be a prosthesis. The statute makes no distinction between prosthetic arms, "normal" biological arms or, for example, withered arms. The fact that a major portion of claimant's arm in this case happens to be a prosthesis, is irrelevant to the question of his entitlement to an award. Claimant's prosthesis is his arm. The only time that this could be a relevant consideration under the statute would be if claimant's prosthesis was the result of a prior industrial injury for which claimant previously had received compensation. ORS 656.222.

The real issue in Wilson and Scarpellini was the question of how an award of disability was to be measured. Any question of entitlement in those cases was simply a variation of the question of rating the extent of the loss. Since the statutes relevant to loss of vision provided (and still provide) that an award was to be based on the loss as it related to normal vision, the fact that the claimants in both cases had preexisting visual impairment (although neither of them had a complete impairment prior to their injuries), was irrelevant. Since the claimants had a 100% loss after their injuries, they were entitled to an award for 100% loss of vision. (ORS 656.214(2)(g), relating to loss of hearing, is similar.)

ORS 656.214(2) deals specifically with the rating of disability for loss of use or function of an injured member. That statute provides:

> "When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury. * * *" (Emphasis added.)

Thus, unlike ORS 656.214(2)(h), which deals with loss of vision, and ORS 656.214(2)(g), which deals with loss of hearing, ORS 656.214(2) specifically provides that with regard to injured members, a claimant is only entitled to the loss of function or use that is due directly to the industrial injury.

Terry D. Swindell, supra, is in accord with this interpretation. In that case the claimant had a preexisting knee disability for which he previously had received no awards for permanent disability. The Referee found that claimant suffered a 25% disabilty as a result of his compensable injury, and when claimant's preexisting knee disability was considered, that he had a total loss of 50%. The Referee concluded that claimant was entitled to an award of 50% scheduled disability. On review we stated:

> "ORS 656.214(2), dealing with scheduled injuries, only requires that the claimant receive permanent partial disability that results from the current industrial injury. We agree with the Referee that the current injury resulted in a 25% permanent partial disability to claimant's left knee. * * * The claimant has already received awards amounting to 10% permanent disability from Determination Orders dated June 13, 1979 and January 8, 1980. Therefore, we allow an additional 15% disability producing a total of 25% disability resulting from the January 23, 1979 industrial injury."

Claimant apparently agrees with this method of rating the extent of his loss as he states in his brief:

> "Claimant seeks compensation only for the loss of use or function from the arm that claimant was able to develop since age 9

months, by trial of different prosthetics in different employment situations."

and:

"In all fairness to the carrier in the case at bar, claimant did not have 100% use of a biological arm at the time of the injury."

Needless to say, however, the question of how much function a claimant may have possessed before his industrial injury will, in most cases, be a very difficult question of fact. We are confident, however, that with adequate preparation (which would preferably include competent medical evidence), such questions are soluble.

Although the figure is necessarily somewhat arbitrary, we conclude, based on the evidence in this record, that claimant's arm function prior to his industrial injury was approximately 80%. We further conclude that as a result of his industrial injury, claimant sustained a 40% loss of use of his arm. Claimant is thus entitled to an award equal to 61.44° (192° x 80% X 40%) for loss of use of his right arm.

ORDER

The Referee's order dated November 10, 1982 is modified. Claimant is awarded an additional 48.84° for loss of use of his right arm, for a total award of 61.44° of scheduled permanent partial right arm disability. Claimant's attorney is awarded 25% of the increased compensation made payable by this order. In no event, however, is claimant's attorney's total fee for services before the Referee and the Board to exceed $3,000. OAR 438-47-040(1).

JOHN R. THOMAS, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-10051
January 13, 1984
Order on Remand

Reviewed by Board Members Lewis and Ferris.

We issued our Order on Review herein on September 10, 1982, vacating and dismissing for lack of jurisdiction that portion of the Referee's order which directed the SAIF Corporation to accept claimant's aggravation claim with respect to surgery for low back fusion in April of 1981. 34 Van Natta 1207 (1982). On review the Court of Appeals reversed and remanded for our consideration of the merits of claimant's claim. Thomas v. SAIF, 64 Or App 193 (1983).

On remand and on de novo review, we agree with the result reached by the Referee and, therefore, affirm his order.

Claimant petitioned the court for judicial review of the Board's order and prevailed. Claimant has prevailed before the Board on remand. Claimant's attorney, therefore, is entitled to an award of attorney fees for services rendered before the Referee, the Board and the Court of Appeals. ORS 656.388(1). Claimant's attorney has submitted a petition to the Board detailing the hours expended in claimant's behalf during the course of this litigation,

together with a copy of claimant's petitioner's brief filed with the court. Claimant has requested that he be allowed to submit written argument to the Board regarding an appropriate award of attorney fees. We believe that claimant should be allowed this opportunity and, therefore, establish the following schedule for written argument.

Within ten (10) days of receipt of this order, claimant may submit written argument in support of his claim for a reasonable attorney's fee; SAIF may file a response within ten (10) days of claimant's submission; claimant will be allowed five (5) days thereafter within which to submit a reply, if deemed appropriate. Upon receipt of the parties' submissions, the Board will enter a Supplemental Order on Remand awarding claimant's attorney a reasonable attorney's fee pursuant to ORS 656.388(1).

ORDER

On remand and on further review of the Referee's order dated February 23, 1981, the Referee's order is affirmed. The Board reserves ruling on claimant's attorney's fee as set forth more fully above.

MICHAEL E. FRANKS, Claimant
Petersen, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-02593
January 16, 1984
Order on Reconsideration

The employer requests reconsideration of our Order on Review dated December 27, 1983 on the grounds that we failed to rule on its cross-request for review on the issue of its entitlement to an overpayment.

On reconsideration, we note that we did fail to rule on the overpayment issue. The Referee held that the employer had failed to prove that it had, in fact, overpaid claimant. We agree with the Referee and affirm his order on that issue. The employer's documentary evidence is simply insufficient to persuade us that it has overpaid claimant.

ORDER

The Board's order on review dated December 27, 1983 is affirmed and republished with the following addition: That portion of the Referee's order which refused to allow the employer to credit an overpayment is affirmed.

HENRY C. ADOVNIK, Claimant
Enfield, et al., Claimant's Attorneys
Hibbard, et al., Defense Attorneys

WCB 82-00377
January 19, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of those portions of Referee Seymour's order which held that: (1) Claimant was a subject worker rather than an independent contractor on the date of his injury; and (2) he need not reach the issue of whether or not Eldon Haney was a noncomplying employer at the time of claimant's injury.

Additionally, SAIF has made a motion for an order remanding

the claim to the Hearings Division for the purpose of taking additional evidence on the issue of whether Eldon Haney was a noncomplying employer. We find, like the Referee, that it was not necessary to resolve that issue at the hearing. Whether the employer was complying can be established by a separate order of the Director of the Workers' Compensation Department under ORS 656.052(2) and is not essential to the decision of compensability. Therefore, we deny SAIF's motion to remand.

Finally, we agree that this claim is compensable because the claimant's status at the time of his August 1980 injury was that of an employe rather than that of an independent contractor.

ORDER

The Referee's order dated February 25, 1983 is affirmed. Claimant's attorney is awarded $500 as a reasonable attorney's fee on Board review, to be paid by the SAIF Corporation.

MARTY BRANNAGAN, Claimant
Rolf Olson, Claimant's Attorney
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-06899 & 80-05245
January 19, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

EBI Companies requests review of Referee Baker's order which awarded claimant an additional 144° for 45% unscheduled disability for a total of 240° for 75% unscheduled disability.

EBI argues that most of claimant's current impairment is due to an earlier injury when the SAIF Corporation was on the risk. However, the Referee took the previous disability awarded based on the prior injury into account when rating this claim. ORS 656.222. We too take the previous award into account in determining the extent of claimant's disability. Compare Cascade Steel Rolling Mills v. Madril, 57 Or App 398 (1982), with American Building Maintenance v. McLees, 64 Or App 602 (1983).

We conclude claimant is not entitled to an award of 75% unscheduled disability. Applying the guidelines found in OAR 436-65-600 et seq supports the following analysis. Claimant is 47 years old which yields a +4 factor. Claimant has a sixth grade education which yields a +10 factor. Claimant's work experience as a boring machine operator requires over 30 days to learn; this yields a factor of +3. Claimant's adaptability yields a +5. We decline to assign any values to the mental capacity or emotional/psychological factors. Labor market findings yield a +2 factor. We rate claimant's impairment due to this injury at 20% which yields a +20 factor. Combining these factors and rounding off we arrive at a 40% disability rating. Comparing this case with similar cases, we conclude that claimant's award is 40% for this injury.

ORDER

The Referee's order dated April 21, 1983 is modified. Claimant is awarded 128° for 40% unscheduled permanent disability; this award is in lieu of all prior awards. Claimant's attorney's fee should be adjusted accordingly.

DARREL W. CARR, Claimant
David C. Force, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 82-00911 & 82-00912
January 19, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer requests review of Referee Seymour's order which: (1) Awarded claimant 7.5° for a 5% scheduled loss of the right forearm due to his carpal tunnel syndrome and resulting surgeries; and (2) awarded claimant's attorney $500 for his services enforcing his client's right to a notice of closure required by ORS 656.268(3).

We affirm the Referee's award of permanent disability for claimant's right forearm but reverse the Referee's award of a $500 attorney's fee.

There are two injury claims involved in this case. The first injury occurred on July 11, 1980 when claimant sustained a laceration on the back of his right wrist. In the course of his treatment for that injury, it was determined that claimant had carpal tunnel syndrome of the right hand. Both conditions were accepted, and were treated as separate claims. The right wrist laceration claim was never closed by the employer as a nondisabling injury under ORS 656.268(3), nor was it submitted as a disabling injury to the Evaluation Division of the Workers' Compensation Department for closure. The carpal tunnel claim was closed by the employer on January 18, 1982 under ORS 656.268(3), as a nondisabling injury.

The Referee found that claimant did not suffer permanent disability due to his right hand (wrist) laceration, but that claimant did sustain some permanent disability as a result of his carpal tunnel syndrome. We agree with those findings.

At hearing, claimant sought penalties and attorney fees for the insurer's failure to process his right hand laceration claim to closure. The Referee determined that there was no compensation due on the laceration claim and, since there were no amounts due on that claim, there was no amount upon which to assess a penalty pursuant to ORS 656.262(9). However, he did award claimant's attorney a $500 fee, reasoning as follows:

> "No such notice [of closure] was issued in this case. The claimant had a right to know the status of his claim. This 'right to know' is a right similar to his right to have a claim either accepted or denied within 60 days and his right to receive compensation in a prompt manner. Cf Hewes v. SAIF, 36 Or App 91 (1978).
>
> "The next question is what sanctions can be imposed upon the employer for its violation of the claimant's right to know. All penalties are based upon a percentage of compensation of the 'amount due.' There was no 'amount due' to the claimant for his hand laceration at the time the closure should have been made. To this extent, the

> Legislature's granting claimant a 'right' is rather meaningless because no mechanism has been provided to enforce that right. However, the claimant has retained an attorney to enforce his right, and that attorney should be paid for his efforts in enforcing that right. The Board has upheld the award of an attorney fee for enforcement of a 'right to know' when no penalty could be awarded because no money was due. See Opal Triano, 15 Van Natta 127 (1975).
>
> "In this aspect of the case, I will award the claimant's attorney $500 for the enforcement of the claimant's 'right to know' which was violated when the employer, in violation of ORS 656.268(3), did not close the claim when the claimant became medically stationary."

Since the Referee's order was issued, the Court of Appeals decided EBI Companies v. Thomas, 66 Or App 105 (1983). That case also involved an insurer's failure to properly and promptly process a claim, for which the claimant sought penalties and attorney fees. Similarly, there were no amounts due in that case. The court stated that since there were no amounts then due, no penalty could be assessed pursuant to ORS 656.262(9). The court further determined that claimant's attorney was not entitled to an award of attorney fees. 656.382(1) authorizes an award of attorney fees "[i]f an insurer or self-insured employer refuses to pay compensation . . . or otherwise unreasonably resists the payment of compensation . . . ." Subsection (2) of that statute allows an award of attorney fees "[i]f a request for hearing, request for review or court appeal is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced. . . ." Since the unreasonable claims processing by the insurer in EBI Companies v. Thomas, supra, did not fit under either subsection, the court determined it was not possible to award an attorney's fee.

Similarly, in this case the failure of the employer to issue a notice of closure did not result in any loss of payment or delayed payment of compensation that was due claimant, although it did result in the loss of notice of: (1) The amount of permanent and temporary disability benefits to which claimant was entitled, if any; (2) the right of the worker to request a Determination Order from the Evaluation Division; and (3) a statement of his aggravation rights. ORS 656.268(3).

There being no compensation due, we conclude that under EBI Companies v. Thomas, supra, and ORS 656.382(2), claimant's attorney is not entitled to an attorney's fee. See also Frances Knoblauch, 35 Van Natta 218 (1983).

ORDER

The Referee's order dated October 5, 1982 is reversed in part. That portion which awarded claimant's attorney $500 in relation to the penalty issue is reversed. The remainder of the Referee's order is affirmed.

BETTY L. COUNTS, Claimant
Bischoff, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-01199
January 19, 1984
Order on Reconsideration

On September 28, 1983 the SAIF Corporation requested reconsideration of our Order on Review dated September 22, 1983. On October 7, 1983 claimant responded to SAIF's motion for reconsideration. On October 19, 1983 we entered an Order of Abatement. On reconsideration we adhere to our prior Order on Review with the following comments.

In our original order, we held that because this was an injury case, the Weller test of a worsening of an underlying condition was not applicable in determining whether claimant's claim is compensable. We stated that the only issue was whether claimant's increase in pain was caused by her on-the-job incident. We found that it was. In so finding, we stated: "Dr. Adams states unequivocally that claimant's increase in pain was caused by her injury of February 25, 1981." SAIF's motion for reconsideration states that Dr. Adams' opinion is, at best, equivocal.

On reconsideration, we agree that Dr. Adams was not unequivocal. However, an examination of his statements indicates that he believed within a reasonable medical probability that claimant's increase in pain was caused by her on-the-job injury.

In his initial report, Dr. Adams stated: "These conditions are preexisting and were not caused by her lifting accident of February 1981, but certainly that could aggravate her condition." In response to a question from SAIF, Dr. Adams stated: "My definition of aggravation is increased pain. It is my opinion that the lifting incident of February 1981 could have caused Mrs. Counts to have increased pain . . ." Finally, in response to a question from claimant's attorney, Dr. Adams noted that he thought part of claimant's pain symptoms might be due to functional overlay. However, he said: "I believe that the incident of February 25, 1981 would probably have aggravated her back."

In view of Dr. Adams' earlier definition of aggravation as increased pain, it is apparent that his latest correspondence indicates his belief that claimant's increase in pain was probably caused by her on-the-job incident. Claimant has established the compensability of her claim by a preponderance of the evidence. Accordingly, we adhere to our original order.

ORDER

On reconsideration of our Order on Review dated September 22, 1983, we adhere to our prior order, which hereby is reaffirmed and, except as modified herein, republished.

JOHN G. FLETCHER, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Claim # D 213159
January 19, 1984
Order of Dismissal

This matter came before the Board on the SAIF Corporation's request that the Board enter an order distributing the proceeds of a third party recovery obtained by claimant, pursuant to ORS 656.593. On January 5, 1982, the Board issued its order. On review the Court of Appeals reversed and remanded for further proceedings. Fletcher v. SAIF, 60 Or App 496 (1982). On remand this third party distribution proceeding was deferred pending the outcome of litigation in claimant's workers' compensation claim involving the extent of claimant's permanent disability. See generally John J. O'Halloran, 34 Van Natta 1101, 34 Van Natta 1196, 34 Van Natta 1504 (1982). The Board requested that, upon final resolution of the permanent disability issue, the parties notify the Board as to how they wished to proceed in this third party distribution proceeding. By Order on Review dated April 29, 1983, the Board affirmed a Referee's order which awarded claimant compensation for permanent total disability. That order now is final by operation of law.

The Board now has been advised by the SAIF Corporation that it desires to withdraw its request for entry of an order distributing the proceeds of claimant's third party recovery. Based thereon, this proceeding is dismissed.

ORDER

The SAIF Corporation's request for an order distributing the proceeds of claimant's third party recovery, now having been withdrawn, hereby is dismissed.

TERRIE B. FRANSSEN, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01672
January 19, 1984
Order on Reconsideration

Claimant requests reconsideration of our Order on Review of December 28, 1983. Claimant contends that we erred in concluding that the issue raised by claimant on review was different from that submitted to the Referee for a decision.

Claimant argues that the specific issue before the Referee was whether there had been a worsening of claimant's underlying spondylolisthesis and spondylolysis conditions as a result of her industrial injury of November 3, 1982. In our Order on Review we stated:

> "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."

Thus, even if we were incorrect in finding that the issue presented for review was different from that presented to the Referee, it is clear from our Order on Review that we nevertheless addressed the

exact issue which claimant contends was the issue raised on review.

With regard to the merits of the claim, claimant has directed our attention to nothing which would change our decision.

ORDER

On reconsideration of our Order on Review dated December 28, 1983, we adhere to our order which is hereby reaffirmed and republished.

ALTHALIA W. HESTER, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-02181
January 19, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Nichols' order which upheld the SAIF Corporation's denial of claimant's aggravation claim. Claimant also argues that the Referee abused her discretion in refusing to admit an exhibit.

On the evidentiary issue, we reverse the Referee. The exhibit in issue, Exhibit 10a, is a report written by Dr. Rosenbaum, who had examined claimant at SAIF's request.

On February 28, 1983 claimant's attorney received a packet of exhibits from SAIF which included Exhibit 16, a report from Dr. Rosenbaum. In that report Dr. Rosenbaum referred to a "reexamination" of claimant. The report also notes: "Symptoms have not changed significantly over the last six months." Claimant's attorney concluded from these hints that Dr. Rosenbaum had previously examined claimant, so he wrote to Dr. Rosenbaum requesting a report of the earlier examination. The report was received by claimant's attorney on March 19, 1983. The hearing in this matter was on March 23, 1983. The Referee excluded the exhibit based on the grounds that it was not submitted within 10 days of hearing as required by OAR 436-83-400(3) and that SAIF was prejudiced by the late submission.

Under the circumstances of this case, we find that the Referee abused her discretion in excluding Exhibit 10a. While it is true that the exhibit was not submitted within 10 days, once claimant's attorney became aware of the possible existence of such a report, he promptly attempted to obtain it. We find that Exhibit 16, a report from SAIF's own consultant, was sufficient to alert SAIF that there may have been a report from an earlier examination. Consequently, we find that SAIF was not prejudiced by the late submission of Exhibit 10a. Certainly, this is not one of those situations in which one of the parties deliberately "hid the ball" in an effort to gain an unfair advantage over the other party. We hold that, considering the circumstances and balancing this agency's purpose of searching for accurate facts and conclusions against our desire to prevent gamesmanship, Exhibit 10a should have been admitted. Accordingly, we have considered Exhibit 10a in our review. Edward Morgan, 34 Van Natta 1590 (1982).

Even considering Exhibit 10a, however, we conclude that claimant has failed to sustain her burden of proving a compensable worsening. Accordingly, we affirm the Referee on the merits.

ORDER

The Referee's order dated April 15, 1983 is affirmed.

PATRICIA LONG, Claimant
English & Metcalf, Claimant's Attorneys
Moscato & Meyers, Defense Attorneys

WCB 81-06522 & 81-07006
January 19, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of those portions of Referee Gemmell's order which: 1) Set aside its June 5, 1981 denial issued in connection with claimant's May 5, 1980 injury and ordered claimant's aggravation claim, including proposed surgical treatment, accepted and processed according to law; 2) set aside the insurer's June 10, 1981 denial issued in connection with claimant's March 31, 1981 injury and remanded that injury claim to the insurer for proper processing pursuant to the provisions of ORS 656.268; and 3) awarded claimant's attorney $2,500 as a reasonable attorney's fee for prevailing on the three denials issued by the insurer. A third denial dated May 19, 1981 was set aside by the Referee, and the insurer has not requested review of that portion of the Referee's order.

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

The main issue on review is the interrelationship of claimant's preexisting spondylolisthesis and her two industrial sprain/strain type injuries. The insurer has argued that claimant has failed to satisfy the requirements set forth in Weller v. Union Carbide, 288 Or 27, 35 (1979), in terms of establishing that claimant's injury or injuries have caused a worsening of her preexisting underlying spondylolisthesis condition, as opposed to the mere increase in symptoms of that condition. The Referee found Weller inapplicable to the facts of this case, since this case involves an industrial injury, and alternatively found that a preponderance of the medical evidence established that the standards of Weller, if applicable, had been met. Subsequent to the Referee's order in this case, we held that, based upon recent Court of Appeals decisions, we would apply Weller and the standards enunciated therein only in cases involving claims for occupational disease and not in claims for industrial injuries. Betty L. Counts, 35 Van Natta 1356 (1983), 36 Van Natta 18 (decided this date); Paul Scott, 35 Van Natta 1215 (1983). We also have held, however, that an injury which interacts with a preexisting underlying condition and thereby causes that condition to become symptomatic, to the extent that the symptoms result in disability and/or require medical attention, does not necessarily render the insurer liable for treatment of or disability resulting from the underlying condition itself. Betty L. Counts, supra; Betty L. Fryer, 35 Van Natta 1257 (1983). We agree with the Referee's assessment of the medical evidence of record in this case, and her conclusion that claimant's industrial

injury or injuries have materially interacted with claimant's pre-existing spondylolisthesis, causing a worsening of that condition and thereby rendering the insurer liable for reasonable and necessary medical treatment of the underlying condition itself and disability resulting therefrom.

In addition to agreeing with the Referee's ruling on the merits of the insurer's June 5, 1981 (May 5, 1980 injury) and June 10, 1981 (March 31, 1981 injury) denials, we note that she correctly stated that the insurer could not avoid its obligation to properly process the accepted portion of claimant's March 31, 1981 injury claim by issuing a denial of claimant's present, continuing or ongoing medical problems, as it attempted to do in issuing its June 10, 1981 partial denial. The insurer was entitled to issue its partial denial of claimant's present symptomatology and thereby raise the issue of the causal connection between claimant's March 1981 injury and her present problems; however, the insurer could not unilaterally terminate claimant's compensation by the mechanism of this denial and was required to submit the accepted portion of the claim for closure and evaluation pursuant to ORS 656.268. Phillip A. Bertrand, 35 Van Natta 869, 873, 35 Van Natta 1087 (1983). See also Safstrom v. Riedel International, Inc., 65 Or App 728 (1983).

With regard to the reasonableness of the Referee's award of attorney fees, we find that the award was not excessive. Claimant requested hearings contesting three separate denials issued by the insurer and prevailed on all three. As a result, claimant has been found to be entitled to substantial medical treatment, including surgery, and she has established that she may be entitled to receive benefits in addition to those previously granted. To a certain extent the three denials involve overlapping factual issues; however, different legal principles were called into question by each denial. In terms of the length of the hearing, number of exhibits, and the evidence generated through the efforts of claimant's counsel, this is not an unusual case; however, the medical question presented is somewhat complicated, particularly in view of the disparate opinions by the various treating, examining and consulting physicians. Considering the efforts expended by claimant's attorney and the results obtained in claimant's behalf, we believe that the attorney's fee awarded by the Referee is reasonable.

ORDER

The Referee's order dated October 22, 1982 is affirmed. Claimant's attorney is awarded $550 for services rendered on Board review, to be paid by the insurer.

FREDERICK A. WEBB, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-05010
January 19, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Quillinan's order which affirmed the SAIF Corporation's April 16, 1981 aggravation claim denial by which SAIF denied that claimant's low back condition was related to his compensable May 2, 1978 right shoulder injury. The issues for review are compensability and timeliness of claimant's

request for hearing pursuant to ORS 656.319(1)(a) and (b).

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

Although we agree that what evidence there is indicates that this claim is compensable, claimant unfortunately failed to request a hearing in relation to SAIF's denial in a timely manner. As claimant correctly points out, Sekermestrovich v. SAIF, 280 Or 723 (1977) indicates that negligence of an attorney is not excusable neglect unless the attorney's failure to file would have been attributable to the claimant. 280 Or at 726. Even if attorney neglect did constitute a valid excuse, however, it would not aid the claimant in the current case. The good cause exception of the statute only applies if the request for hearing is filed within 180 days of notification of denial. Thereafter, the denial is final. In this case the request for hearing was filed nearly seven months beyond the ultimate period of repose. The good cause exception is thus inapplicable and, unfortunately for claimant, the denial must, therefore, be affirmed.

ORDER

The Referee's order dated May 16, 1983 is affirmed.

MYRTLE E. YORK, Claimant
James P. Bradley, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-00336
January 19, 1984
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 affirmed SAIF's denial of responsibility for claimant's continued back problems and admitted into the record two previously excluded exhibits. Claimant contends her continued back problems are related to her compensable ankle injury. SAIF contends the Referee's admission of the two exhibits was error.

After the briefs were filed, claimant filed an Amended Appeal and Amended Request for Review, attached to which were two new medical reports that were not a part of the record. We regard claimant's Amended Request for Review and submission of additional evidence as a motion for remand for consideration of additional evidence.

The issue before the Referee was whether claimant's continuing low back problems are related to claimant's compensable ankle injury. In 1978 claimant had a laminectomy and a discectomy at L5/S1. In January 1981 claimant suffered a compensable ankle injury. Dr. Hill, claimant's family physician, noted that claimant was having buttock pain within a few weeks of her ankle injury. Claimant eventually began treatment for her back pain with Dr. Dunn, who treated claimant for her back problems in 1978. Claimant also was referred to Dr. Strukel for treatment of her ankle problems.

Dr. Hill noted that claimant had had chronic numbness since the low back surgery. Dr. Hill opined that sciatic nerve involvement possibly was still present from the surgery and was brought

to his attention when claimant twisted her ankle, or that claimant had suffered a muscle strain by favoring her right leg because of the ankle injury. Dr. Dunn first said that claimant suffered a nerve root contusion secondary to torsion of her spine from her sprained ankle. Dr. Strukel noted that Dr. Dunn had reported that claimant's ankle injury reactivated claimant's sciatic problem. Later, Dr. Dunn opined that claimant probably contused her low back as a result of her fall when she injured her ankle, but that the persistence of the symptoms over the months made him doubtful that the symptoms were related to her fall and were more likely related to her old low back injury, with progressive scarring and possibly some aggravation from the fall when she hurt her ankle. Claimant testified that when she injured her ankle, she caught herself and did not actually fall to the ground.

Claimant was examined by a panel of doctors at the Southern Oregon Medical Consultants at the request of SAIF. The panel of doctors stated that claimant's ankle injury probably temporarily exacerbated her low back problem, but that her continuing low back problems were related to her 1978 back problems and surgery and not to her ankle injury. Dr. Dunn indicated that he concurred with the opinion of the Southern Oregon Medical Consultants.

After the hearing, claimant consulted with Dr. Widen, a podiatrist whom she had not previously seen, regarding her ankle, leg and hip pain. Dr. Widen prepared two reports regarding claimant's condition and its relationship to her ankle injury and near fall. Claimant moves for remand for consideration of Dr. Widen's post-hearing reports.

The Board may remand a case to the Referee for further evidence taking if it determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5); see Bailey v. SAIF, 296 Or 41 (1983). In Egge v. Nu-Steel, 57 Or App 327 (1982), the Court of Appeals found remand appropriate. The court noted that since the hearing, claimant's new doctor found a hairline vertebral fracture, which could provide objective basis for claimant's pain and for a permanent disability award. None of claimant's previous doctors had found this vertebral fracture. The Egge court found that those circumstances constituted an explanation of why the evidence could not reasonably have been discovered and produced at the hearing as required by OAR 436-83-480(2). Although Bailey, supra, held that OAR 436-83-480(2) applies to "newly discovered evidence" and not to "newly created evidence" such as that at issue in Egge, we find that Egge nevertheless represents circumstances in which a remand is appropriate under ORS 656.295(5).

Likewise, we remanded a case to the Referee where, after the hearing, claimant's doctor found previously undiscovered intervertebral obstructions which explained claimant's symptoms. Casimer Witkowski, 35 Van Natta 1661 (1983). In Witkowski the Referee had found the aggravation noncompensable based on the reports of doctors who opined that claimant had suffered a stroke. Also, the record contained no medical report offering a better explanation. As we stated there, Witkowski and Egge involve the rare situation of a claimant who never obtained a diagnosis of the cause of a medical problem. In those situations we believe a remand is generally appropriate because the record has been incompletely developed.

In the present case, however, claimant's post-hearing medical reports only offer another opinion as to the relationship between claimant's back problems and her ankle problems. We find no new diagnosis or new explanation for either problem. The record contains several cogent opinions from claimant's family physician, claimant's treating doctor for her back who also treated claimant for her 1978 back problem, claimant's treating doctor for her ankle and the Southern Oregon Medical Consultants. These doctors examined claimant and offered their opinions regarding the relationship between claimant's back and ankle problems. In this case we cannot say that the record has been improperly, imcompletely or otherwise insufficiently developed by the Referee. Therefore, we deny the motion for remand. We have not considered the additional evidence submitted by claimant. ORS 656.295(5).

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated January 19, 1983 is affirmed.

CLETIS H. BELCHER, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10033
January 24, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee McCullough's order which directed that SAIF pay claimant's outstanding bills for chiropractic treatment and related travel expenses. SAIF contends that there is no jurisdiction in the Referee or the Board to resolve the matter in controversy, which relates to the frequency of claimant's chiropractic treatments. SAIF contends that this dispute is governed specifically and exclusively by the administrative rules promulgated by the Workers' Compensation Department. OAR Chapter 436, Division 69. In the alternative, SAIF contends that claimant has failed to satisfy his burden of proving that his chiropractic treatments are reasonable and necessary.

In Lloyd C. Dykstra, WCB Case No. 81-11570, 36 Van Natta 26 (decided this date), we considered and addressed the jurisdictional issue raised by SAIF in this case. We held that the issue of claimant's chiropractic treatment is "a matter concerning a claim," and as such is subject to claimant's right to request a hearing pursuant to ORS 656.283. ORS 656.704(3); see also Waunita M. Walker, WCB Case No. 81-05204, 36 Van Natta 44 (decided this date).

On the merits of claimant's entitlement to the chiropractic treatments in issue, we affirm and adopt the Referee's well-reasoned order.

ORDER

The Referee's order dated May 20, 1983 is affirmed. Claimant's attorney is awarded $100 for services rendered on Board review, to be paid by the SAIF Corporation.

LLOYD C. DYKSTRA, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-11570
January 24, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Wilson's order which failed to impose penalties and attorney fees for the SAIF Corporation's nonpayment of chiropractic treatments in excess of the guidelines provided by OAR 436-69-201(2), or for SAIF's failure to formally deny the claims in the absence of timely payment. The SAIF Corporation contends that the Referee should have dismissed this proceeding for lack of jurisdiction and requests that this case be remanded with instructions to enter an order of dismissal. The issue in this case involves the procedural effect to be given the Workers' Compensation Department rule concerning frequency and extent of medical or other treatment, which provides for referral to and review by the Director of the Workers' Compensation Department in the event of a dispute between a medical provider and an industrial insurer concerning the charges being billed to the insurer. As used herein, the terms "medical provider" and "medical services" include chiropractors and chiropractic care.

The Referee held that the dispute in this case -- the frequency of claimant's chiropractic treatments -- is one between the medical vendor and SAIF, and that under the applicable administrative rules, SAIF had no duty or obligation to formally deny payment of charges billed by claimant's chiropractor in excess of the administrative guidelines, as it would in the event of a refusal to pay on some other grounds, such as a denial of causal relationship between the treatment and the original injury. Causal connection is conceded, and the only issue is the reasonableness and necessity of treatments in excess of the administrative guidelines. The Referee held that the onus was upon the medical vendor to justify the treatment rendered in excess of the guidelines, that the insurer's dispute was with the medical vendor and not claimant, and that claimant was not a "party to the dispute."

Claimant contends that the Referee's holding is in error and inconsistent with our decision in Billy J. Eubanks, 35 Van Natta 131 (1983), decided subsequent to the issuance of the Referee's order in this case. SAIF contends that the Referee did not go far enough in merely denying claimant's request for penalties and attorney fees; that Eubanks is inapposite insofar as it can be construed to require that an insurer deny medical charges where compensability is conceded and the only issue is the frequency of treatment; and that the Referee should have dismissed claimant's request for relief on the basis of lack of jurisdiction in the Hearings Division or the Board for claimant's failure to exhaust the administrative remedies provided by the department rules.

We have considered the jurisdictional issue raised in this case in conjunction with our review of three other cases involving the same or similar issues. In Cletis H. Belcher, WCB Case No. 82-10033, 36 Van Natta 25 (decided this date), the jurisdictional issue was raised and decided adversely to SAIF's position in the same procedural context: SAIF, the insurer in that case also, failed to pay for chiropractic treatments rendered in excess of the administrative guidelines; claimant requested a hearing claiming entitlement to the unpaid chiropractic treatments, penalties and

attorney fees for SAIF's alleged unreasonable failure to formally deny payment. The Referee in that case determined that the question of SAIF's nonpayment of the chiropractic treatments was a matter concerning a claim and, therefore, a matter within the jurisdiction of the Hearings Division and the Board which could be raised by claimant's hearing request pursuant to ORS 656.283 independently of the procedures provided by the department administrative rules. The Referee in Belcher went on to rule in claimant's favor on the merits of the chiropractic treatment issue, and SAIF has requested review of that order.

Waunita M. Walker, WCB Case No. 81-05204, 36 Van Natta 44 , and James H. Maxwell, WCB Case No. 82-04358, 36 Van Natta 40 (both decided this date), involved the same exhaustion of administrative remedies/jurisdictional issue. In Maxwell the insurer issued a formal denial of chiropractic treatment, and claimant contended that the denial was invalid as a matter of law, and therefore unreasonable, in view of the "mandatory procedure" provided by the departmental rules for contesting the frequency and extent of medical treatment. Walker involves a similar issue arising in a slightly different procedural context, although, in that case as well, claimant contends that the insurer (the SAIF Corporation in that case) was required to submit the controversy to the Director of the Workers' Compensation Department.

Because these four cases involve overlapping arguments and issues, we have considered them jointly. We hold:

(1) The procedures outlined in OAR Chapter 436, Division 69 for bringing disputes concerning frequency and extent of treatment or, in other words, reasonableness and necessity of a particular treatment or diagnostic mode, are permissive, not mandatory, and may be invoked either by an industrial insurer or an aggrieved medical vendor;

(2) an insurer has a duty to formally deny disputed medical charges where the issue is frequency and extent of treatment, in accordance with our decision in Eubanks, supra, independent of the insurer's right, which it may or may not choose to exercise, to invoke the administrative procedures provided by the department rules; and

(3) claimant has a right to request a hearing pursuant to ORS 656.283 and, in the event a denial has been issued by the insurer, an obligation to do so in a timely fashion, independent of the insurer's right to invoke the applicable administrative procedures, or the right granted to the medical vendor to do the same. This right to request a hearing includes the right to Board and judicial review of the Referee's decision pursuant to ORS 656.295 and 656.298.

The pertinent administrative rules are as follows:

"436-69-201 Medical Services

> "(1)(a) The insurer will pay for all medical services which the nature of the compensable injury and the process of recovery requires. The insurer will not pay for care unrelated to the compensable

injury. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable. Billings for services which appear to the insurer to be in excess of the standards set forth in these rules, or of generally accepted medical standards, may be referred to the Department for referral to a committee of the physician's peers. Such a request must be submitted within 45 days of receipt of the billing and must be accompanied by a statement from an appropriate consultant that the request is reasonable. Such review means an evaluation by a committee of the appropriateness, quality, and cost of health care and health services provided to a patient based on medically accepted standards. Such committee shall be composed of health care providers licensed under the same authority as the health care provider who rendered the services being reviewed. Consulting committees of a physician's peers may be established by the Department to provide advice to the Medical Director and to evaluate the appropriateness, quality and cost of health care and health services provided to a patient based on medically accepted standards.

(b) Such committees shall be appointed by the Director who shall select persons known and recognized within their profession as competent and experienced in matters referred to the committee. The Director may solicit recommendations from professional associations, licensing authorities and professional schools. Members shall serve at the pleasure of the Director. The committee shall meet upon request of the Medical Director to consider matters referred by the Medical Director.

(c) The committee shall select its chairman and adopt its own procedures for internal operation based on ethical standards. The formal review procedure must include at least the following:

(A) No case shall be considered until the physician has been notified by the Medical Director that the case has been presented to the committee and the physician has been informed of a right to present relevant material to the committee.

(B) If after the initial examination of the record by the committee the case has not been resolved in favor of the physician,

notification shall be given to the physician of the right to appear before the committee at a time and place certain. The committee shall have the same right to require relevant information, including X-rays and chart notes as is granted to the Department in these rules.

(d) The report of such committee shall be submitted to the Department which may: (A) issue an order compelling compliance with the judgment of the committee, or (B) forward the report to the insurer for appropriate action.

"(2)(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 objective.

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.

* * *

(9) When a worker seeks medical care after the claim has been closed, the attending physician shall promptly inform the insurer stating in sufficient detail the complaints and conditions that require medical care and their relationship to the compensable injury.

"(10) Insurers and claimants are not responsible for payment for treatment procedures rendered in connection with the compensable injury that are not approved and taught by accredited institutions of the licentiate's profession. If the insurer believes procedures to be inappropriate, of unproven value or experimental in nature, the issue may be referred to the department for referral to a committee of consultants of the physician's peers."

"436-69-701 Charges and Fees

* * *

"(3) In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker is not liable for payment for any services for the treatment of that injury or illness. The vendor of medical services may charge the patient directly only for the treatment of conditions that are unrelated to the accepted compensable injury or illness.

"(4) The insurer may not pay any more than the vendor's usual fee to the general public and, under ORS 656.248, shall in no case pay more than the 90th percentile of usual and customary fees. The vendor may not attempt to collect from the injured worker any sums deleted by the insurer as being in excess of the 90th percentile.

* * * *

"436-69-801 Insurer's Rights and Duties

* * *

"(6) In claims which have been denied and are on appeal, the insurer shall notify the vendor promptly of any change of status of the claim.

(8) In the event a vendor of medical services feels aggrieved by the conduct of an insurer, the vendor may request the assistance of the department. If the matter cannot be resolved informally, the Director may issue an order compelling compliance and setting forth the appropriate appeal rights of the parties.

"436-69-901 Complaint Procedure and Penalties

"(1) Complaints shall be directed to the Medical Director. Complaints shall be in writing and fully documented. If the Medical Director believes the complaint may have merit, the Medical Director may investigate the matter and afford the party complained of an opportunity to respond to the allegations. The Medical Director may consult with an appropriate committee of the physician's peers before presenting a recommendation to the Director.

"(2) The Medical Director shall upon completion of his investigation recommend an appropriate disposition to the Director. The Medical Director may recommend, and the Director may elect, not to investigate the matter or issue an order but rather refer the matter to a referee. Notwithstanding ORS 183.315(1) 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 the referee shall be a final order of the Director;

(b) The Director shall have the same right to a judicial review of the order of a referee as any person who is adversely affected or aggrieved by such final order.

(3) If the Medical Director finds any violation of rule 69-201, 69-301, 69-401, 69-701 or 69-801(3) 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;

(c) referral to the appropriate Licensing Board.

* * *

"(5) A hearing relating to a proposed order issued under these rules shall be held by a referee of the Hearings Division of the Workers' Compensation Board. A hearing shall not be granted unless a request for hearing is filed within 30 days of receipt of the proposed order. If a request for hearing is not so filed, the order, as proposed, shall be a final order of the Department. Notwithstanding ORS 183.315(1) 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 the referee shall be a final order of the Director; and

(b) The Director shall have the same right to judicial review of the order of a referee as any person who is adversely affected or aggrieved by such final order.

* * * *"

ORS 656.245 provides:

"(1) 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 restorative services. The duty to provide such medical services continues for the life of the worker.

"(2) When the time for submitting a claim under ORS 656.273 has expired, any claim for medical services referred to in this section shall be submitted to the insurer or self-insured employer. If the claim for medical services is denied, the worker may submit to the Board a request for hearing pursuant to ORS 656.283."

"(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."

It seems appropriate at this juncture to state that our holding does not apply to disputes which clearly arise under ORS 656.248, where the issue is whether a medical vendor is charging the usual and customary medical service fee. These are disputes involving the fee charged by a medical provider for a particular office visit or treatment, as opposed to the number of treatments rendered and whether the frequency or extent of the treatments is reasonable and necessary. Medical fee disputes, when they can be clearly identified as such, arise under ORS 656.248 and the applicable administrative rules and are solely within the province of the Director of the Workers' Compensation Department. ORS 656.704(3). Admittedly, there may be cases in which the distinction between a dispute concerning medical service rates and a dispute concerning excessive charges, where frequency and extent of treatment is in issue, may not be readily apparent; however, the dispute in this case, and the other cases considered herewith, do not arise under ORS 656.248. These disputes arise under ORS 656.245.

Shortly after the Referee issued his order in this case and before the parties submitted their briefs, we decided Billy J. Eubanks, supra, in which we considered problems related to disputes concerning claims for medical services and the proper procedures for processing such claims after the worker's initial claim has been accepted. We distinguished claims for medical services already rendered, where the bills for such services were submitted to the insurer for payment; versus claims for future medical services, where the medical provider was recommending a particular treatment mode and soliciting the insurer's authorization for such treatment. In the case of rendered medical services, we held:

"The appropriate responses are to either pay the bill or to issue notice of denial or partial denial to the claimant and the medical provider. Such a denial should advise the claimant of his or her hearing rights. If the insurer or self-insured employer has previously issued notice of claim acceptance, it need not issue any additional notice of acceptance every time it pays a medical bill." 35 Van Natta at 135.

We held that claims for rendered medical services require payment or denial by the insurer within 60 days.

SAIF's contention that our holding in Eubanks does not apply to situations involving nonpayment for treatments in excess of the administrative guidelines is simply wrong. In fact, the substantive issue in Eubanks was whether claimant had established a need for chiropractic treatments in excess of the applicable administrative guidelines. We held that claimant had established that additional palliative treatment for his low back pain was "justified and reasonable." 35 Van Natta at 136. The fact is, however, that the exhaustion of administrative remedies/jurisdictional issue was not raised in Eubanks, and we have not had the opportunity to address that issue before. The Referees' orders relied upon by SAIF address issues which were not before the Board on review of those Referees' orders.

I.

The Hearings Division and the Board have jurisdiction to consider disputes concerning frequency and extent of treatment independently of the procedures provided by the above-quoted administrative rules. Subject to timeliness requirements, any party or the Director of the Workers' Compensation Department may at any time request a hearing "on any question concerning a claim." ORS 656.283(1). Hearing requests are filed with the Board, and the Board is obligated to refer the request for hearing to a Referee "for determination as expeditiously as possible." ORS 656.283(2), (3).

> "For the purpose of determining the respective authority of the Director and the Board to conduct hearings, investigations and other proceedings under ORS 656.001 to 656.794, and for determining the procedure for the conduct and review thereof, matters concerning a claim . . . are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. * * * *" ORS 656.704(3).

We do not agree with SAIF's argument that claimant has no interest in the controversy, or that the dispute is one solely between SAIF and the medical provider. The dispute concerns the frequency of claimant's chiropractic treatments. SAIF contends that the treatments in excess of the number provided by the applicable administrative guidelines are not justified or justifiable, and SAIF has refused to pay for such treatment. These treatments are a form of compensation to which claimant is entitled if claimant establishes that the treatments are related to his injury, and they are reasonable and necessary for treatment of a condition resulting therefrom. ORS 656.005(9); 656.245(1). Milbradt v. SAIF, 62 Or App 530 (1983); Wetzel v. Goodwin Brothers, 50 Or App 101 (1981). The issue of the frequency and extent of treatment being provided to an injured worker is, phrased differently, the issue of whether the treatment being provided is reasonable and necessary. This is a question concerning a claim because it is a question concerning the amount of compensation that a claimant is entitled to receive as a result of the claimant's compensable industrial injury. This is a matter in which the claimant has a substantial interest.

The administrative guidelines which, in their present form, provide for four visits per month is just that -- a guideline. The rule clearly states: "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." OAR 436-69-201(2)(a). See also Kemp v. Workers' Compensation Department, 65 Or App 659 (1983). As the Referee in Cletis H. Belcher, supra, correctly observed:

> "This is necessarily so, since the particular need for medical services is bound to vary with each individual case. The workers' compensation law entitles the injured worker to treatment designed to either improve his condition (curative treatment) or at least give him temporary relief from the effects of his condition so that he can more easily continue his daily activities (palliative care). Even in situations involving only palliative care, some injured workers might well require very frequent (perhaps several times per week or even daily) visits to their therapist or chiropractor in order to be able to continue working or, if unable to work, to at least allow them to tolerate the demands of their daily routine. Other injured workers might need some form of therapy only once a week, once a month or even less frequently. Each case has to be assessed individually as to what frequency of treatment is necessary. The worker has the burden of establishing the need for the frequency of treatment."

The administrative procedure established by the department rules may be invoked by the insurer or by an aggrieved medical provider. The insurer may file a complaint with the Medical Director pursuant to 436-69-901. A physician who "feels aggrieved by the conduct of an insurer" may request assistance of the department, whereupon an informal resolution is attempted; and in the event that this fails, the Director is authorized to "issue an order compelling compliance and setting forth the appropriate appeal rights of the parties." OAR 436-69-801(8). A physician also has the right to contest an insurer's judgment that treatment in excess of the administrative guidelines has not been justified by the physician, by referring the insurer's judgment to the Medical Director, who is authorized to submit the matter to a committee of the physicians peers for an opinion in the event that the Medical Director does not decide the issue in the physician's favor. OAR 436-69-201(2)(b). These procedures are available to insurers and medical vendors if they choose to invoke the Director's authority to resolve a dispute. Nowhere in these rules is it stated that, when an issue concerning frequency and extent of treatment arises, the insurer is required to submit the matter to the Director; nor is a physician required to invoke the Director's authority to resolve any such dispute. Furthermore, these rules do not provide claimants with the right to invoke the procedures or intervene in any proceeding initiated by an insurer or aggrieved physician.

It is possible that a claimant may have a right to request a hearing contesting an order entered by the Director which adversely affects the claimant's right to receive compensation, or to petition for judicial review of a Referee's order entered on referral of the Director or on review of a Director's order, 436-69-901(2), (5); however, this is an unsatisfactory basis for finding that the administrative remedy provided by the department rules must be exhausted before a claimant can request a hearing contesting the insurer's nonpayment of medical bills.

To begin with, the legislature clearly intends that injured workers have available to them an efficient and expedient administrative remedy when there is a dispute over a matter concerning a claim. Thus, the Board is required to refer a claimant's request for hearing to a Referee "for determination as expeditiously as possible." ORS 656.283(3). See also ORS 656.012(2)(a), which states one of the objectives of the Workers' Compensation Law to be the provision of "sure, prompt and complete medical treatment for injured workers . . . ." (Emphasis added.) There is a certain amount of delay inherent in the processing of claimants' requests for hearing in matters concerning their claims. We seriously doubt that the legislature or the department intended to create further delay in the determination of a claimant's right to receive compensation by requiring the claimant to await the outcome of an ancillary proceeding that may never be initiated and, in the event that it is, may itself require lengthy and protracted administrative and judicial proceedings. To interpret or apply the department's administrative rules in such a manner as to effect this result, would be in contravention of a clearly expressed legislative policy.

In addition, the procedure outlined in the department rules for issues concerning frequency and extent of treatment could not be applied in such a manner as to deprive the claimant of his or her right to request a hearing pursuant to ORS 656.283 because this would result in the deprivation of the claimant's right to de novo review at the Board and Court of Appeals levels pursuant to ORS 656.295 and 656.298. The department rules provide that an order of the Referee entered pursuant to the rules is a final order of the Director, and that judicial review thereof is as provided in ORS 183.310 to 183.550. OAR 436-69-901(2), (5). See generally ORS 183.315(1), ORS 656.704. Assuming that a claimant has a right to review of a Referee's order entered pursuant to the department rules, review of the Referee's order would be by the Court of Appeals, the scope of review being "substantial evidence," as opposed to de novo review.

The facts of this case exemplify one of the flaws in SAIF's exhaustion of administrative remedies argument. SAIF's legal examiner testified at the hearing. He testified that he requested that claimant's treating chiropractors justify the frequency of the treatments being provided, in accordance with the department rules. His understanding of the rules is that in the absence of justification from the medical vendor, the insurer is required to pay only the number of treatments provided by the department rule, and that the initiative for contesting the insurer's decision not to pay for additional treatment must be taken by the medical vendor pursuant to the rules. He testified that the matter was not referred to the

Medical Director by SAIF. The hearing was held in late September 1982. At issue were chiropractic treatments rendered beginning in early December of 1981. SAIF's legal examiner apparently requested justification for the treatments being provided by letter to claimant's chiropractor in late January of 1982. Correspondence was exchanged, but SAIF was not satisfied that treatments in excess of those provided by the applicable administrative rules had been justified. Claimant initially requested a hearing in late December 1981 requesting penalties and attorney fees for SAIF's refusal to pay for medical treatment and related travel expenses. At no time prior to the hearing in September 1982 did either SAIF or claimant's physicians invoke or attempt to invoke the administrative procedures provided by the department rules.

The claimant has a right to an expeditious hearing on any matter concerning a claim. We do not believe that the legislature would countenance requiring the claimant to await the outcome of an administrative procedure to which the claimant is not a party and which, therefore, could not determine the claimant's rights under the Workers' Compensation Law. This, of course, gives rise to the possibility that the Director, pursuant to the department rules, and a Referee and/or the Board, pursuant to ORS 656.283 and 656.295, may reach divergent results on what appears to be the same issue, i.e. the frequency and extent, or the reasonableness and necessity, of medical or other treatment that is being provided to an injured worker. Although this may present a problem in any given case, this possibility does not provide the basis for depriving a claimant of a right clearly granted by law.

II.

Interrelated with the question of the claimant's right to request a hearing pursuant to ORS 656.283 in order to contest the insurer's nonpayment of medical bills, is the question of the insurer's obligation to process the claim or claims for compensation, independently of any procedures which may be or have been initiated pursuant to the above-referenced administrative rules. The Referee in this case determined that the issue of the frequency and extent of claimant's chiropractic treatments was one between the insurer and the medical vendor and that, therefore, SAIF had no obligation to formally deny payment. As mentioned previously, the Referee in this case did not have the benefit of our decision in Billy J. Eubanks, supra. Eubanks is dispositive; however, we consider it appropriate to further comment on the question concerning the insurer's obligation to process a claim or claims for medical services as it relates to the administrative procedure provided by the department rules, an aspect not discussed in Eubanks.

Of guidance in this regard is our decision in Max Madden, 34 Van Natta 1014 (1982), and the Court of Appeals decision on review, Madden v. SAIF, 64 Or App 820 (1983). In Madden SAIF's medical consultant had initiated a complaint with the Medical Director alleging a violation of physicians' reporting requirements and a violation of SAIF's right to an independent evaluation of the claimant prior to performance of proposed surgery. The administrative rule that established the procedure allegedly violated by claimant's physician in Madden, OAR 436-69-501, recently has been declared invalid by the Court of Appeals, Kemp v. Workers' Compensation Department, supra, 65 Or App at 667 - 670; however, our holding and the Court of Appeals holding in Madden is appli-

cable and remains the law with respect to the interrelationship of the complaint procedures established by the department rules which are still valid, including OAR 436-69-201(2), and the insurer's independent claims processing obligations.

The issue as framed by the Board in Madden was: "[A]ssuming arguendo that SAIF reasonably believed it had a legitimate complaint against the treating physician, whether SAIF had the right to suspend payment of all medical bills arising from the allegedly unauthorized surgery pending resolution of the complaint." 32 Van Natta at 1015. The Referee in Madden held that SAIF was not required to pay the physician's surgery fee, and further imposed a penalty for SAIF's nonpayment of the bill for claimant's hospitalization and related costs. We held that SAIF was required to pay the physician's surgery bill in addition to the other outstanding medical bills; however, we concluded that no penalty was warranted with respect to SAIF's delayed payment, based upon our conclusion that the administrative rules upon which SAIF relied were ambiguous, and that SAIF had a legitimate doubt concerning its duty to pay under those rules. The Court of Appeals disagreed with our decision that SAIF should not be penalized for the delayed payment of claimant's hospital bill, concluding that SAIF had unreasonably refused to pay claimant's medical bills. The court stated: "Nothing in the statutes or in the administrative rules justifies a unilateral decision by an insurer to refuse to pay medical bills;" and that "[t]he Board was clearly correct in holding that SAIF erred in refusing to pay the medical bills and in ordering SAIF to pay them." 64 Or App at 824. The court's reference to "medical bills" includes the outstanding bill for the treating physician's services in connection with claimant's surgery.

In reaching our conclusion in Madden that SAIF was required to process claimant's medical service claims independently of any procedures invoked pursuant to the department rules, we were assisted by an amicus brief submitted at our request by the Workers' Compensation Department. It was the department's position that "A disciplinary complaint under OAR 436-69-501 et seq. is in the nature of a civil penalty proceeding and is wholly separate from the claim of an injured worker. The department submitted that under its rules filing a complaint against a medical vendor does not toll the insurer's duty to process the claimant's compensation claim...." 34 Van Natta at 1015-1016. We found the department's position persuasive in that case, as the department drafted the medical service rules in question.

The issues arising under the presently invalid rule concerning elective surgery, OAR 436-69-501, are somewhat different from the issues that may arise where the insurer raises a question concerning frequency and extent of treatment and brings the matter before the Director; however, whereas the substance of the complaint may differ, the procedural issue of the insurer's obligation to process the claimant's claim remains the same.

Further support for our conclusion lies in the facts of this case, which, as previously noted, disclose that SAIF's legal examiner was under the impression that the onus was upon the medical vendor to initiate a proceeding in order to compel payment of treatments in excess of the administrative guidelines. SAIF initiated no such proceeding; nor did it notify claimant of its

intent to refuse payment. Claimant, who has the right to know the status of his claim for compensation, was not properly notified by SAIF that the frequency and extent of his chiropractic treatments, or the reasonableness and necessity thereof, was in issue.

For the reasons stated herein and in Billy J. Eubanks, supra, we hold that when an insurer wishes to challenge the frequency and extent of medical or other treatment being provided a claimant, the insurer has a statutory duty to deny the claim or claims submitted by claimant or in claimant's behalf, which is not affected by the insurer's right, or the corresponding right of an aggrieved physician, to invoke the administrative procedure provided by the above-referenced department rules. Because the insurer is obligated to advise the claimant of its refusal to pay a claim for medical services, in accordance with our decision in Eubanks, it follows that a denial appropriately issued by an insurer raising a question concerning frequency and extent of treatment is not subject to attack by the claimant on the basis that the insurer has failed to invoke the procedure provided by the department rules. To the extent that the claimants in James H. Maxwell, supra, and Juanita M. Walker, supra, have made this contention, it is expressly rejected.

III.

In conclusion, the Hearings Division and the Board have jurisdiction to consider the issue of frequency and extent of medical treatment being provided to an injured worker, and the claimant may bring such issues before this agency by requesting a hearing pursuant to ORS 656.283. Insurers are obligated to notify the claimant in accordance with our decision in Billy J. Eubanks, supra, when an insurer believes that the frequency and extent of treatment is excessive and, therefore, neither reasonable nor necessary for treatment of a condition resulting from claimant's industrial injury. The insurers' duty to notify claimant, and claimant's physician as well, and the claimant's corresponding right/duty to timely request a hearing contesting the denial exist independently of the insurer's right, or the right granted to medical vendors, to invoke the administrative procedures provided by the applicable department rules governing medical services. For clarity we reiterate that issues arising under ORS 656.248 are not matters concerning a claim and, therefore, are within the sole province of the Workers' Compensation Director; and disputes arising under that statutory provision are to be resolved in accordance with the procedures established by the director, rather than by way of a hearing request pursuant to ORS 656.283.

The major portion of the Referee's order dealt with the jurisdictional/exhaustion of administrative remedies issue. Because of the Referee's conclusion that this dispute should be resolved through the administrative procedure provided by the department rules, we believe that he did not adequately consider or address the substantive issue of whether claimant had satisfied his burden of proving by a preponderance of the persuasive evidence that the chiropractic treatments in issue were reasonable and necessary. We deem it appropriate to remand this case to the Referee for consideration of the merits of claimant's hearing request, including claimant's request for penalties and attorney fees.

Claimant has submitted two reports from his chiropractic physician which were generated subsequent to the date of the

Referee's order, and claimant has requested that the Board consider this additional evidence on review. This Board is without authority to consider evidence which was not made a part of the record of the proceedings before the Referee. ORS 656.295(5). Bailey v. SAIF, 296 Or 41, 45 n3. If the Referee deems it appropriate on remand, he may allow the claimant to supplement the previously developed evidentiary record by including these proffered reports from claimant's physicians, as well as any other additional evidentiary material the parties may elect to submit.

If the claimant ultimately prevails before the Referee on remand, the Referee should take into consideration the efforts expended by claimant's attorney and the results obtained in claimant's behalf as a result of this proceeding on Board review in awarding counsel a reasonable attorney's fee. ORS 656.388(1).

ORDER

The Referee's order dated November 16, 1982, is reversed and this case is remanded for further proceedings consistent with this order.

JAMES H. MAXWELL, Claimant
Rolf Olson, Claimant's Attorney
Bottini & Bottini, Defense Attorneys

WCB 82-04358
January 24, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Thye's order which upheld the insurer's denial of claimant's chiropractic treatment. The Referee found and held that: "[F]urther chiropractic care is not reasonably necessary, and therefore the denial of April 28, 1982 as it applies to palliative care thereafter should be affirmed."

Claimant contends that the insurer's denial is invalid as a matter of law because the insurer is required to resort to the administrative procedures established by the Workers' Compensation Department rules governing medical services, OAR Chapter 436, Division 69, in order to contest the frequency and extent of claimant's chiropractic treatments, or the reasonableness and necessity thereof. In the alternative, claimant contends that he has established the chiropractic treatments in issue as being reasonable and necessary for treatment of a condition resulting from his compensable injury.

In Lloyd C. Dykstra, WCB Case No. 81-11570, 36 Van Natta 26 (decided this date), and Waunita M. Walker, WCB Case No. 81-05204, 36 Van Natta 44 (decided this date), we considered and addressed the jurisdictional issue raised by claimant. The issue has been decided adversely to claimant's position herein.

On the merits of claimant's entitlement to further palliative chiropractic treatment, we affirm the order of the Referee.

ORDER

The Referee's order dated February 24, 1983 is affirmed.

WANITA F. ROBERSON, Claimant
Michael Dye, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 80-05203
January 24, 1984
Order on Review

Reviewed by the Board en banc.

The employer/insurer requests review of Referee Seymour's order which awarded claimant permanent total disability benefits. The issues on review are extent of disability and the propriety of the Referee's refusal to leave the record open to allow the insurer to depose a doctor.

Claimant is a 52 year old former mill worker who sustained a compensable back injury in April 1973. Since that time her claim has been reopened and reclosed numerous times, primarily in connection with surgery in 1976, surgery again in 1977 and various vocational rehabilitation efforts since the latter surgery. A series of Determination Orders have awarded claimant a total of 112° for 35% unscheduled disability.

Since the claim is so old, some of the medical reports are equally old. However, no doctor has ever opined that claimant is totally disabled. The most recent (1982) reports from claimant's primary physician, Dr. Poulson, describe limitations of back motion that equal about a 16% impairment and document chronic moderately disabling back pain. Dr. Poulson's most recently expressed opinion is: "She is, at present, restricted to sedentary work and probably will be on a permanent basis. She should avoid repetitive bending, stooping, climbing and crawling."

Claimant also has preexisting problems which must be considered in determining whether she is permanently and totally disabled. She has limited flexion and extension of the left elbow, limited movement of the fingers of her left hand and nearly complete loss of function of the index finger of her right hand. She is left handed.

In addition, claimant has a knee condition which apparently preexisted her 1973 back injury. The knee condition was denied by the insurer just prior to the hearing. The compensability of the knee condition was not at issue in this proceeding, but the Referee noted that in determining permanent total disability the knee condition was irrelevant because, according to the evidence, it would do no more than restrict claimant to sedentary work which her back condition also did. We agree and, therefore, do not consider the knee in determining permanent total disability.

Claimant's work history includes mill work, bartending, waiting tables, cooking and managing a restaurant. Claimant participated in a vocational rehabilitation program in 1980 and early 1981 to train her as an industrial equipment representative. However, she left the program before completion because of medical problems unrelated to this claim.

Claimant testified that approximately one year prior to the hearing she talked to several prospective employers about employment possibilities, but that during the year prior to the hearing she had not contacted anyone about possible employment.

A vocational expert, Byron McNaught, testified at the hearing

that claimant was unemployable based on the restrictions contained in Dr. Poulson's reports. We do not find this testimony persuasive. Mr. McNaught's direct testimony was extremely conclusory, and was significantly impeached in some regards on cross examination. For example, he testified that he believed claimant had only very limited supervisory experience in restaurants. Claimant, on the other hand, testified that she leased and managed a restaurant with a friend for one year. She testified that they had four employes and that she was involved in daily record keeping and in ordering supplies.

In summary, the medical opinion is unanimous that claimant is physically capable of sedentary work and that claimant has considerable experience in restaurant work, including management and supervision -- work that certainly could be toward the sedentary end of the spectrum. We are not persuaded from this record that claimant established that she is unable to return to this type of work. This conclusion alone precludes an award for total disability. In addition, however, we think that the likelihood that claimant could successfully work in the area of restaurant management is sufficiently high that we certainly cannot conclude that a reasonable work-search, as required by ORS 656.206(3), would be futile.

Having determined that claimant is not entitled to a total disability award, we proceed to rate her partial disability. Claimant is 52 years old with a ninth grade education. Her IQ is rated as 120. We have previously described her work experience. She is restricted to sedentary work. Dr. Poulson considers her impairment moderate. After considering the guidelines in OAR 436-65-600 et seq, we conclude that claimant would be appropriately compensated by an unscheduled permanent disability award of 75%.

On the evidentiary issue, we conclude that the Referee did not err in refusing to leave the record open for the insurer to depose Dr. Poulson. Dr. Poulson was claimant's treating physician and the record is replete with reports from Dr. Poulson. Ten days before the hearing claimant's attorney submitted an additional report from Dr. Poulson. The insurer's attorney apparently thereafter attempted to arrange to have Dr. Poulson testify at the hearing, but Dr. Poulson was unavailable. The insurer's attorney at hearing requested the Referee to leave the record open to allow deposition of Dr. Poulson. The insurer's attorney admitted at the hearing that even absent the exhibit offered ten days prior to the hearing he would want to depose Dr. Poulson. Claimant's attorney then withdrew the offered exhibit and the Referee declined to leave the record open for a deposition of Dr. Poulson.

Under these circumstances, in which the insurer's attorney knew that Dr. Poulson's reports were critical and stated that even absent the latest report he would have wanted to depose Dr. Poulson, we find that the Referee did not err in refusing to leave the record open to allow deposition of Dr. Poulson. The insurer's attorney had a full opportunity to arrange for the testimony or deposition of Dr. Poulson well before the hearing.

ORDER

The Referee's order dated September 20, 1982 is reversed. Claimant is awarded an additional 128° for 40% unscheduled permanent partial disability for a total award to date of 240° for

75% unscheduled disability. In lieu of the fee allowed by the Referee's order, claimant's attorney is allowed 25% of the additional compensation awarded herein, not to exceed $2,000, payable from claimant's compensation and not in addition thereto.

Board Member Lewis Dissenting:

I respectfully dissent. I would affirm the Referee's well-reasoned order and find claimant permanently and totally disabled.

MARY STONE, Claimant
Galton, et al., Claimant's Attorneys
Bruce Byerly, Defense Attorney

WCB 83-00044
January 24, 1984
Interim Order of Remand

Claimant requested review of Referee Knapp's order entered herein on November 1, 1983. In accordance with ORS 656.295, the Board requested a transcription of the oral proceedings before the Referee, which in this case were electronically recorded. During the course of preparing a transcript, it became apparent that a portion of the recorded testimony had been erased and, therefore, was not available to the parties and the Board. A partial transcript of the oral proceedings has been made available to the parties. The partial transcript is inadequate for purposes of Board review; therefore, it is necessary to remand this case to the Referee in order to obtain a full and complete record of the oral proceedings.

Accordingly, this case is remanded to the Referee with instructions to reconvene the hearing and obtain a complete record of the testimony taken at the hearing on October 18, 1983. The limited purpose of this hearing is to obtain a transcription of the oral proceedings previously developed, to the extent that this is possible, without the taking of any new or additional evidence. The Board retains jurisdiction over this case, and upon the completion of the reconvened hearing, the Referee shall obtain a transcription of the oral proceedings which shall be forwarded to the Board within thirty (30) days of the date of hearing. Upon receipt of the transcript, the Board will provide copies to the parties together with a revised briefing scheduled. The briefing schedule previously established herein is rescinded.

IT IS SO ORDERED.

WAUNITA M. WALKER, Claimant
Roll & Westmoreland, Claimant's Attorneys
Brian Pocock, Defense Attorney

WCB 81-05204
January 24, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests and claimant cross-requests review of Referee Daron's order which awarded claimant 48° for 15% unscheduled permanent partial disability for injury to her low back on review of a Determination Order dated May 29, 1981, which awarded no compensation for permanent disability; and ordered SAIF to pay certain outstanding medical and related expenses, together with a penalty and attorney's fee for SAIF's unreasonable delay in payment. SAIF contends that claimant is not entitled to any award for permanent disability based upon a preponderance of the persuasive evidence, and that the Referee erred in requiring SAIF to pay for the medical and related expenses in issue, a penalty and attorney's fee. Claimant contends that she is entitled to a greater permanent disability award.

SAIF has filed two separate motions for remand to the Referee for further evidence taking. ORS 656.295(5). The first motion is addressed to the issue of the extent of claimant's permanent disability, if any. We agree with the claimant's assertion to the effect that the proffered evidence is neither relevant nor material to the issue before us; therefore, we refuse to remand to the Referee on the basis of this evidence.

SAIF's second motion for remand relates to an issue that was belatedly raised by SAIF during the proceeding before the Referee, and one which the Referee refused to consider. SAIF assigns as error the Referee's refusal to consider this issue, which relates to a defense concerning a more recent injurious exposure, and moves for remand for further proceedings on the issue. We deny SAIF's motion for remand and hold that under the facts and circumstances of this case it was appropriate for the Referee to refuse to consider this belatedly-raised issue.

We first will address the procedural issue raised by SAIF's second motion for remand. Claimant filed a request for hearing in early June 1981 contesting the May 29, 1981 Determination Order which awarded no permanent disability. In early October of 1981 the Board received SAIF's response to claimant's hearing request, which stated that the Determination Order "was correct and should be affirmed." See generally OAR 436-83-245. In December 1981 claimant filed a supplemental request for hearing designating as issues refusal to pay medical services and related travel expenses, unreasonable delay or resistance in the payment of compensation, and penalties and attorney fees. These hearing requests were followed-up by claimant's attorney's letter of March 30, 1982, which clarified the issues for hearing to include an unreasonable de facto denial.

The first of two hearing sessions convened on April 12, 1982. Due to a number of procedural complications, no evidence was taken on that day, and the proceeding was continued. The hearing reconvened on June 24, 1982, at which time the parties presented their witnesses' testimony. This session of the hearing was not

concluded until 8:00 P.M. that evening. At the conclusion the evidentiary record was closed and the proceeding was continued for receipt of counsel's written closing argument. Claimant waived opening argument, and on or about the date that SAIF's argument was due, a letter from SAIF's attorney was submitted to the Referee, with a copy to claimant's attorney. This letter, dated July 6, 1982, states in part:

> "We wish to give notice that the Murphy Company and SAIF Corporation deny responsibility for claimant's condition and any time loss, medical treatment, permanent disability or other expense incurred subsequent to the issuance of the Determination Order of May 29, 1981, except for the evaluation by Dr. Nash of July 29, 1981. The grounds for this denial are as follows:
>
> * * *
>
> "(4) If claimant has a compensable claim for medical treatment, time loss, permanent disability or other expense since the issuance of the [May 29, 1981] Determination Order, responsibility for that claim lies with the Mapleton School District under the 'last injurious exposure rule.'
>
> "Since item (4) of this denial was not hitherto expressly raised, we are deferring submission of our written argument until claimant or her attorney have determined whether or not to issue a response to that portion of the denial."

Claimant's attorney stated his objection to SAIF's "after-the-fact" or "post-hearing" denial, requesting that the Referee advise whether any new issue raised by SAIF's attorney's letter would be considered by the Referee. At the same time, claimant requested a hearing, apparently in response to this letter, by which claimant raised issues concerning refusal to pay for medical services, unreasonable delay or resistance, penalties and attorney fees. We take notice of the fact that claimant's hearing request was assigned WCB No. 82-06208, which since has proceeded to hearing and decision by Referee Howell during the pendency of this proceeding on Board review. Our records further reflect that the Referee's order in WCB Case No. 82-06208 presently is pending on Board review. No request for consolidation has been made by any party, and we have not deemed it appropriate to consolidate sua sponte.

Referee Daron advised the parties that he would not consider the validity of SAIF's July 6, 1982 letter, and that he would rule on all issues presented by claimant's hearing requests on the basis of the evidence presented during the course of the prior proceedings. After receipt of the parties' written argument, the Referee advised that, in view of the references in the written arguments to certain rulings made by him during the hearings, he was ordering a transcript of the oral proceedings. During the time that the transcription of the oral proceedings was being processed,

SAIF's attorney advised the Referee that claimant had requested a hearing "from our denial of responsibility issued after the hearing, in which we alleged a later injurious exposure," requesting that claimant's recent hearing request be consolidated with the present case and the matter rescheduled for hearing. Claimant stated his opposition to SAIF's request, correctly noting that the Referee previously had decided not to include the belatedly-raised responsibility issue as part of the present proceeding. The Referee further advised the parties by letter that: "Except insofar as the same subjects may be a part of the present proceeding, the issues specified by SAIF in the July 6, 1982 letter will not be considered in this present proceeding." The Referee's order issued thereafter on December 22, 1982.

We have authority to remand the case when we find that a case has been "improperly, incompletely or otherwise insufficiently developed or heard by the referee . . . . " ORS 656.295(5). Bailey v. SAIF, 296 Or 41, 44 (1983). We believe the question presented by SAIF's motion for remand, therefore, is whether the Referee's refusal to consider the belatedly-raised responsibility issue and to reopen the evidentiary record for development of that issue, resulted in an improper, incomplete or otherwise insuffient development of the case by the Referee. We believe that the answer to this question is "no." We find that the Referee correctly declined to consider this issue and, accordingly, we deny SAIF's motion for remand.

There are potential hazards in litigating issues concerning employer/insurer responsibility when only some and not all of the potentially responsible employers/insurers are party to a proceeding. In some instances, it may be preferable to allow an insurer to join another possibly responsible insurer to a proceeding already in progress by utilization of the administrative procedures promulgated pursuant to ORS 656.307. OAR 436-54-330, et seq; see also OAR 436-83-280; Inkley v. Forest Fiber Products Co., 288 Or 337, 346 (1980); Bracke v. Baza'r Inc., 293 Or 239, 250 n 5 (1982). This may be true even in certain instances where the evidentiary record has been closed, the Referee has rendered a decision, and a party requests reconsideration and reopening of the record in order to develop evidence concerning a belatedly-discovered employer/insurer responsibility issue. See, e.g., Donald M. VanDinter, 34 Van Natta 1485 (1982), 35 Van Natta 1574 (1983). Although such action might be appropriate in certain cases, under the facts and circumstances of this case it was not.

This hearing convened essentially for two purposes: To determine the extent of permanent disability, if any, attributable to claimant's accepted industrial injury; and to determine whether SAIF should be required to pay for claimant's visits to Dr. Nash and other medical expenses related to Dr. Nash's "treatment" and diagnostic testing. Claimant's original hearing request on the issue of extent of permanent disability was filed in June of 1981. A supplemental hearing request taking issue with SAIF's non-payment of medical services was filed in December of 1981. The initial hearing did not convene until April of 1982; and this hearing was continued for another session, which did not convene until the latter portion of June 1982. These proceedings were protracted and, quite obviously, vigorously litigated. It is apparent from the transcript of the oral proceedings, as well as the documentary evidence that was offered by SAIF (some of which was admitted into the record, some of which was not), that SAIF

was well-aware of claimant's work activities subsequent to her employment with SAIF's insured, including the nature and extent of this more recent work activity. If SAIF had wished to raise an issue in this proceeding concerning a subsequent injurious exposure, this certainly could have and should have been accomplished prior to the closure of the evidentiary record. For this reason, it was entirely proper for the Referee to decline to consider the additional issue raised by SAIF at such a late stage in this proceeding.

We do not intend to hold that, by failing to raise this issue at an earlier date, SAIF has waived this defense entirely; nor do we intend to hold to the contrary. We are deciding only that issue which has been presented by SAIF's motion for remand, which is the propriety of Referee Daron's refusal to consider SAIF's 11th-hour defense of a subsequent injurious exposure. Whether this ruling will determine the outcome of the proceeding on Board review of Referee Howell's order in WCB Case No. 82-06208 remains to be seen in that proceeding.

Turning to the merits of the issues before us, and addressing the question of the extent of claimant's permanent partial disability, we find that claimant has established by a slight preponderance of the evidence that she suffers permanent impairment as a result of her accepted industrial injury. Cf Juena K. McGuire, 35 Van Natta 1053 (1983); James G. Thomas, 35 Van Natta 714, 35 Van Natta 827 (1983). Considering the administrative guidelines set forth at OAR 436-65-600, et seq. and comparing this case with cases involving similarly situated injured workers, we find that the Referee's award of 48° for 15% unscheduled permanent partial disability for injury to the low back adequately and appropriately compensates claimant for the residual effects of her industrial injury. Accordingly, we affirm this portion of the Referee's order.

The procedural and substantive issues concerning payment of claimant's medical and related expenses were correctly decided by the Referee. Claimant consulted with Dr. Nash on referral by her attorney after having been examined and treated by several other physicians. As the Referee noted, the largest number of the doctors involved with this claim, including the doctors who could be considered "treating physicians," have been physicians chosen for claimant by SAIF or its insured and have not necessarily been physicians of claimant's choice. SAIF initially refused to pay for any of claimant's office visits with Dr. Nash, as well as the costs of a CT scan performed at his behest, for the reason that SAIF or its insured did not believe that Dr. Nash's "treatment" was necessary. It was stipulated by the parties at the first session of this hearing that claimant's initial office visit with Dr. Nash had been paid in January 1982, and that the unpaid travel expenses incurred in connection with that office visit would be paid by SAIF. All other medical expenses incurred in connection with claimant's examinations and treatment by Dr. Nash are disputed by SAIF on the apparent premise that there is nothing wrong with claimant as a result of her accepted industrial injury; and that considering the "reality" of claimant's current condition, the examinations and treatment rendered by Dr. Nash, including the diagnostic procedure ordered by him, were neither reasonably nor necessarily incurred by claimant as a result of her injury. As

evidence in support of these contentions, SAIF relies upon the testimony and written reports of Drs. Englander and Degge, which seriously impeach Dr. Nash's findings on his examinations of claimant. Claimant has argued, apparently in the alternative, that SAIF is either required to pay or deny the medical and hospital bills related to claimant's treatment with Dr. Nash, or obtain authorization from the Director of the Workers' Compensation Department to withhold payment pursuant to the department rules regulating medical services. OAR Chapter 436, Division 69.

We have considered the interrelationship of the procedures established by OAR 436-69 and the insurer's obligation to process a claim for medical services pursuant to ORS 656.245 in Lloyd C. Dykstra, WCB Case No. 81-11570, 36 Van Natta 26 (decided this date). Dykstra involves an issue concerning the frequency and extent of the claimant's chiropractic treatment or, in other words, the reasonableness and necessity thereof. We have held in Dykstra that the insurer's statutory duty to accept/pay or deny a claim for medical services, and the claimant's corresponding right/duty to timely request a hearing in the event of a denied claim, exist independently of the procedures provided by the department rules governing medical services, where the issue regarding the claimant's medical treatment is a matter concerning a claim as defined by ORS 656.704(3): "* * * [T]hose matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." In Dykstra we observed that there are issues related to a claimant's medical treatment which clearly involve "a matter concerning a claim" and, on the other hand, other issues which clearly involve matters which are not within the province of the Board, which have been delegated to the Director for regulation, such as disputes arising under ORS 656.248, relative to medical service rates. Where a medical service issue involves a matter concerning a claim, the insurer's duty is to process the claim in accordance with our decision in Billy J. Eubanks, 35 Van Natta 131 (1983), a duty which is not affected by the insurer's independent right to invoke the administrative procedures provided by the applicable department rules. We also noted that there may well be situations in which it is difficult to determine whether the issue involving the claimant's medical services is a matter concerning a claim or is a matter which is within the sole province of the Director. Like the dispute in Dykstra, this case involves medical service issues which are matters concerning a claim.

By virtue of the Referee's award of permanent disability, with which we agree, it is now established that claimant, in fact, suffers some residual effects as a result of her accepted industrial injury. Even if claimant was not entitled to an award for permanent disability, she nevertheless would be entitled to continuing medical care for conditions resulting from her injury "for such period as the nature of the injury or the process of the recovery requires." ORS 656.245(1); Bowser v. Evans Product Company, 270 Or 841 (1974). This right does not terminate upon the date of claim closure; and the insurer's duty to provide reasonable medical services which are necessarily incurred continues for the remainder of claimant's life.

Claimant has the right to choose her initial attending physician, and she may subsequently change attending physicians four times without approval from the Director. ORS 656.245(3).

Claimant has not exhausted her rights under this "five-physician rule." We agree with the Referee's conclusion that claimant, who continued to experience pain as a result of her injury, consulted Dr. Nash in the hopes that he could provide some form of treatment which might afford claimant relief from her continuing symptoms. Claimant's office visits with Dr. Nash and the related travel expenses, therefore, are compensable medical services.

If the evidence reflected that claimant went to see Dr. Nash solely for purposes of preparing for litigation, Dr. Nash's office visits and the expenses related thereto would not be compensable medical services pursuant to ORS 656.245. Joean Cisco, 34 Van Natta 1030 (1982). SAIF does not appear to make this argument as a defense to payment of Dr. Nash's medical bills, although it is very apparent that SAIF is disturbed by the fact that claimant was referred to Dr. Nash by her attorneys. Even if SAIF had made this contention, the evidence would not support such a finding. The Referee found that Dr. Nash's examination of April 23, 1982 was made for evidentiary purposes and, therefore, was not a compensable medical service. Claimant has not taken exception with this finding; therefore, we will not disturb this portion of the Referee's order.

The procedural/jurisdictional issue relative to the diagnostic procedure ordered by Dr. Nash (the CT scan), and the compensability of these medical services present somewhat different considerations.

Dr. Nash's first examination of claimant in July 1981 disclosed an absent left ankle reflex. Dr. Nash's findings on this examination made him "highly suspicious" that her pain had a discogenic origin. He, therefore, arranged for a computerized axial (CT) scan of the third, fourth and fifth levels of claimant's lumbar spine. The CT scan was normal. When Dr. Nash examined claimant in January 1982, he stated his impression in a letter to SAIF, that claimant had the "clinical signs and symptoms of preforaminal compression involving the first sacral nerve root on the left." He advised claimant that if her complaints did not resolve, some consideration should be given regarding a myelogram. Apparently a myelogram was not performed. Dr. Nash reexamined claimant in April 1982. In the report of his April 23, 1982 examination, Dr. Nash stated his findings, which included bilaterally absent ankle reflexes. He concluded that claimant had achieved "maximum medical benefit."

At hearing SAIF produced Drs. Englander and Degge, who previously had examined claimant on several occasions. A great deal of testimony was taken regarding Dr. Nash's findings of absent ankle reflex(es); the gist of the doctors' testimony being that Dr. Nash's findings, in particular the finding of absent ankle reflex(es), were of questionable validity. Both doctors testified that if they had made the same findings as Dr. Nash, hospitalization and further diagnostic procedures would be appropriate.

In every case involving the frequency and extent of treatment, or the reasonableness and necessity thereof, or as in this case, the reasonableness and necessity of a particular diagnostic procedure, there may be issues which involve considerations of physician competence, judgment or technique. Issues of physician competence are peculiarly subject to review by the Director through utilization of the administrative procedures established by the department

rules, particularly the peer review procedure. As a result of these procedures, it may be established that medical services are "unnecessary or inappropriate according to accepted professional standards," OAR 436-69-201, in which case the Director might, for example, decide that the medical vendor should be penalized in the form of nonpayment of a fee in whole or in part, OAR 436-69-901(3)(b). Such matters are between the insurer and the vendor, overseen by the Director. The same evidence that is submitted to a peer review committee might also be submitted in a proceeding before a Referee, in support of the insurer's contention that the claimant's treatment is not reasonable or necessary. The Referee would be required to determine, based upon the evidence presented, whether the claimant had established his or her right to look to the industrial insurer for payment of this medical or other service being claimed as compensation. The insurer's right, on the other hand, is to pursue the procedures provided by the applicable administrative rule in order to have appropriate measures taken against an offending physician, who may find that he or she is "left holding the bag" for a particular medical service. As we noted in Lloyd C. Dykstra, supra, the two separate proceedings may lead to different or inconsistent results; but this would appear to be an unavoidable problem, given our present statutory and regulatory scheme.

The Referee properly concluded that claimant established her right to the medical services in issue, including the CT scan and radiologist bill. Claimant had the right to be examined by Dr. Nash in the pursuit of treatment directed toward a resolution of her chronic pain problem. ORS 656.245(3). In the course of identifying an appropriate treatment mode, Dr. Nash found it proper, based upon his findings on examination, to order a diagnostic procedure. SAIF's medical experts testified that if their findings had been the same as Dr. Nash's, they would have followed the same or similar procedures. We understand from this testimony that the CT scan was reasonable and necessary based upon the findings reported by Dr. Nash. Whether Dr. Nash can or should be disciplined based upon the apparent allegations made by SAIF -- which are to the effect that Dr. Nash's findings resulted from inadequate or incompetent examination technique or, simply, prevarication -- is a matter for resolution through the administrative procedures in OAR Chapter 436, Division 69. The record reflects that before the second session of the hearing convened, SAIF exercised its right to invoke such proceedings by filing a formal complaint with the Medical Director.

We agree with the Referee's analysis and conclusions concerning penalties and attorney fees and, therefore, affirm and adopt that portion of his order.

ORDER

The Referee's order dated December 22, 1982 is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the SAIF Corporation.

THEODORE P. BROWN, Claimant
Tamblyn & Bush, Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 82-00672 & 82-06820
January 25, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

EBI Companies requests and claimant cross-requests review of Referee Mulder's order which set aside EBI's January 15, 1982 partial denial issued on behalf of Pepsi-Cola Company (Pepsi/EBI); apparently set aside Pepsi/EBI's August 18, 1982 oral denialof an aggravation claim made by claimant at the time of the hearing; affirmed the July 6, 1982 denial issued by Pepsi in its capacity as a self-insured employer; and concluded that there was insufficient evidence to rate the extent of claimant's disability and, therefore, referred that question to the Evaluation Division for issuance of a new Determination Order.

Claimant, a 22 year old amateur boxer and professional warehouse worker, suffered a compensable injury on June 5, 1981 while employed by Pepsi-Cola Company, then insured by EBI. Claimant was injured when an empty pop bottle case fell and struck him in the right temple area. Claimant was apparently knocked unconscious for a brief period and was transported to Providence Hospital. A skull x-ray series was done and a one-quarter inch superficial abrasion near the temple was noted. Claimant remained in the hospital for two or three days for purposes of observation. In his report of June 6, 1981 Dr. Franks diagnosed claimant as suffering from a mild cerebral concussion with no evidence of an expanding intracranial process. Dr. Franks stated that claimant had no symptoms of weakness, double vision or vertiginous spinning. A CT scan performed on June 16, 1981 was interpreted as being normal.

The claim for injuries sustained on June 5, 1981 was accepted by EBI. Claimant was released to return to regular work on June 22, 1981 with no medical restrictions. Claimant returned to work and sought no further medical treatment for the next three months.

On September 23, 1981 claimant was driving home from work when he was involved in a severe motor vehicle accident. Claimant's van struck a utility pole and claimant was thrown through his windshield for a distance of approximately 15 feet. The emergency room admitting report indicates that claimant had several lacerations but did not have a loss of consciousness. Claimant's lacerations were sutured (claimant's hip required 48 stitches), and he was discharged that same day.

On September 25, 1981 claimant was readmitted to the hospital. Dr. Reynolds reported that on the day following this motor vehicle accident claimant's wife found him unconscious on the floor of his home. Dr. Reynolds diagnosed claimant as suffering from a cerebral concussion, contusion and strain of the low back and right hip, laceration of the right hip and acute diffuse upper respiratory disease. Further diagnostic tests, including another CT scan and an electroencephalogram were interpreted as being normal. Claimant was discharged four days later.

Exactly what caused the September 1981 motor vehicle accident

is unclear. There were no witnesses to the incident and claimant was uncertain about the cause of the accident. On January 15, 1982 Pepsi/EBI denied benefits relating to the September 1981 motor vehicle accident.

On December 29, 1981 Dr. Holland reported claimant was continuing to have low back and left knee pain, but that he had no further "syncopal" episodes. Dr. Holland stated that claimant did report having some increased forgetfulness and headaches. Dr. Holland diagnosed a persistent lumbar strain and referred claimant to Dr. Grossenbacher.

On January 1, 1982 Pepsi became a self-insured employer.

On January 19, 1982 claimant was examined by Dr. Grossenbacher. Dr. Grossenbacher reported that: "There was a history of syncopal type episode which led to the single vehicle accident." Dr. Grossenbacher diagnosed a lumbar strain and a medial meniscus tear and released claimant to return to work on February 22, 1982.

On March 5, 1982 Dr. Holland reported claimant was experiencing memory difficulties and a hesitation in his speech. Dr. Holland referred claimant to Dr. Orton for psychological testing in order to determine if claimant sustained any organic brain damage.

Dr. Orton performed a psychological evaluation of claimant and reported on March 23, 1982 that:

> "In summary, [claimant] is a 22 year old male who has been employed as a manual laborer for PepsiCola for the last four years. He has a recent history that involves two injuries to his head, the first of which required hospitalization and medical follow-up with Lawrence Franks, M.D. Additionally, he has been involved in amateur and, apparently, professional boxing but denied ever being knocked unconscious in the ring. It is my impression, based on the findings of this evaluation, that Mr. Brown is suffering a post-concussional syndrome that seems to have followed his first head injury in June, 1981."

Apparently in response to several questions posed by claimant's attorney, Dr. Leonard reported on April 9, 1982 that:

> "In response to question number 1, I do not believe that there is a significant medical probability that [claimant's] automobile accident on September 22, 1981 was related to his on-the-job injury of June 5, 1981.
>
> "In answer to question number 2, there is a reasonable medical probability that Mr. Brown's present problems resulted directly from his on-the-job injury of June 5, 1981."

On May 17, 1982 Dr. Orton reported that there was a "possibility" that claimant's September 1981 motor vehicle accident was related to his prior industrial injury but that, "it is again a point that can be argued from numerous perspectives."

On June 3, 1982 EBI issued another aggravation denial, stating that claimant's then present conditon was the result of the September 1981 motor vehicle accident.

Claimant had previously returned to work in February 1982. On June 18, 1982 another incident occurred. Although the incident occurred at work, claimant could not remember how it happened and so stated on the 801 form. However, claimant reported to the emergency room physician that he was "knocked out" at work when he was struck by a pallet jack.

On July 6, 1982 the claim for injuries sustained in June 1982 was denied by Fred S. James and Company on behalf of Pepsi as a self-insured employer.

On July 9, 1982 claimant was examined by Dr. Rosenbaum, a neurologist. Dr. Rosenbaum noted that claimant had some post-concussive symptoms following his injury of June 1981, but that claimant was able to continue working with no difficulty. However, claimant had increased symptoms following his motor vehicle accident in September. Dr. Rosenbaum felt that claimant would have been able to continue working had the motor vehicle accident not occurred. Dr. Rosenbaum further stated:

> "The cause of the September 22, 1981 accident is unclear. The patient is amnesic for the details as might be expected following a head injury. If he simply lost control of his van or fell asleep at the wheel, I could not relate the . . . injury to the June 5 injury. On occasion, unexplained accidents represent instances of a seizure leading to the accident. The patient's lack of previous seizures, normal EEG, and lack of typical post-seizure findings . . . are against this possibility. In addition, the severity of the June 5, 1981 accident was probably not sufficient to induce a seizure disorder. Therefore, the medical probability is that the September 22, 1981 injury was an independent event and not caused by his June 5, 1981 injury."

Dr. Rosenbaum offered no opinion concerning the June 1982 incident.

On July 12, 1982 Dr. Holland reported that the circumstances surrounding the June 1982 incident were unclear. Dr. Holland reported that there were no witnesses to the incident and that claimant thought he had been knocked down by another employe pulling a pallet jack, but that the details of the incident were very hazy. Dr. Holland felt that the incident was best considered an unexplained syncopal episode.

On August 6, 1982 Dr. Leonard reported that there were two possibilities with regard to the June 1982 incident: that claimant simply blacked out and fell to the ground, or that claimant was

inadvertently struck from behind and knocked down. Dr. Leonard noted that the possibility of epilepsy was considered but there was not sufficient evidence to support such a diagnosis. Dr. Leonard stated: "I find it difficult to conclude that Mr. Brown's industrial injury of June 5, 1981, predisposed him to future blackout episodes, such as the fall on June 18, 1982." Dr. Leonard also stated there was insufficient information to conclude that the June 1982 incident was an aggravation of the June 1981 injury.

At the hearing claimant testified that his headaches and dizziness never totally disappeared in the period between the June 1981 injury and the September 1981 motor vehicle accident. Claimant testified that he could remember virtually nothing about the September 1981 accident. With regard to the June 1982 incident, claimant testified that he remembered seeing another employe operating a pallet jack close to where he was working, and that was the last thing he remembered before regaining consciousness. The employe who was operating the pallet jack testified that he remembered passing within several feet of claimant with the pallet jack, but that he did not remember striking claimant. He did remember claimant complaining of dizziness on prior occasions.

The Referee found that the evidence did not establish that claimant was struck by or tripped over a pallet jack in June 1982, but that: "It seems much more likely that claimant suffered a fainting or vasovagal event which would have occurred with or without the presence of the jack in claimant's immediate area." We agree. The Referee found that Pepsi, as a self-insured employer, was not responsible for the incident. We agree with this also. The Referee then concluded that in view of claimant's history of dizziness occurring since the June 1981 incident, it was likely claimant's condition in late 1981 and 1982 was the result of the June 1981 injury, and that it was likely that this injury resulted in the September 1981 motor vehicle accident and the June 1982 incident. We disagree.

As a general rule, injuries sustained by an employe while going to or coming from work are not compensable. Gumbrecht v. SAIF, 21 Or App 389 (1975); Brown v. SAIF, 43 Or App 447 (1979). There is no contention that the September 1981 motor vehicle accident occurred while claimant was acting in the course of his employment. Therefore, in order to establish the compensability of this incident, claimant must establish that the compensable June 1981 injury was a material contributing cause to the accident. We conclude that the evidence does not establish this.

The record in this case indicates that there are basically three possible causes of the September 1981 motor vehicle accident: (1) That claimant suffered a syncopal episode related to the June 1981 incident; (2) that claimant fell asleep at the wheel of his vehicle; and (3) that the accident was the result of mechanical difficulty claimant was having with his vehicle. Of these three possibilities, the evidence in this record indicates that the first possibility is the least likely explanation.

Following the injury of June 1981 claimant was diagnosed as suffering from a mild concussion and a one-quarter inch abrasion over his right ear. All diagnostic testing was normal. Claimant was released to and did return to regular work with no restrictions as of June 22, 1981. Claimant thereafter received no medical treatment until the September 1981 motor vehicle accident.

The medical opinions concerning the causation of the September 1981 accident do not support compensability. Dr. Leonard was of the opinion that it was not within the realm of reasonable medical probability that there was a connection between the June 1981 compensable injury and the motor vehicle accident. Dr. Orton stated that there was only an arguable "possibility" that the September 1981 incident was related to the June 1981 injury. After examining claimant and reviewing his records, Dr. Rosenbaum concluded that he could not relate the motor vehicle accident to claimant's compensable injury of June 1981. We are uncertain what medical evidence, if any, the Referee relied upon in concluding that the June 1981 injury was a material contributing cause of the September 1981 motor vehicle accident.

Although there was testimony that claimant continued to experience some intermittent headaches and dizziness in the period following the June 1981 injury and prior to the September 1981 motor vehicle accident, the preponderance of the evidence, medical and otherwise, does not establish the June 1981 injury as a material cause of that motor vehicle accident. The Referee's conclusion to the contrary is both unsupported in the record and contrary to the medical evidence. Therefore, Pepsi/EBI's January 15, 1982 denial must be affirmed.

The next question presented for review is the compensability of the June 1982 incident. As was the case with claimant's September 1981 motor vehicle accident, there are basically three different possible answers to the question of the causation of this incident. The first possibility is that claimant was struck by a pallet jack while at work. We completely agree with the Referee that the evidence supporting this theory is little more than speculation on the part of the claimant. In fact, claimant virtually admitted as much at the hearing. The second possibility is that claimant sustained an unexplained fall at work, which would be the responsibility of Pepsi in its capacity as a self-insured employer. See Phil A. Livesley Co. v. Russ, 290 Or 25 (1983). The evidence indicates that the fall was not unexplained.

The third possibility is that claimant experienced a syncopal episode related to the June 1981 injury. The question of the relation of the June 1981 incident to the June 1982 incident necessarily involves a consideration of the effect of the non-compensable September 1981 motor vehicle accident. Grable v. Weyerhaeuser, 291 Or 387 (1981). In view of the intervening non-compensable motor vehicle accident, has claimant established that the June 1981 injury was a material contributing cause of the June 1982 incident? We think not. We conclude that, if claimant had a syncopal episode in June 1982, it was more likely the result of residuals from the September 1981 motor vehicle accident than from the June 1981 work injury.

As related above, although there was testimony to the effect that claimant continued to experience intermittent headaches and some occasional problems with memory and concentration in the period between the June 1981 injury and the September 1981 motor vehicle accident, claimant continued working with no restrictions, lost no time from work, and required no additional medical treatment. Subsequent to the motor vehicle accident, however, claimant

received nearly continuous treatment and suffered from constant and severe headaches, had a great deal of difficulty concentrating, and experienced dizziness to the point of feeling as though he might pass out. Following the collision, claimant was diagnosed as suffering from a concussion, and unlike the diagnosis following the June 1981 injury, it was not stated to be "mild."

Although Dr. Leonard stated on April 9, 1982 that he believed claimant's current difficulties were due to the June 1981 injury, it would appear that Dr. Leonard changed his position after further consideration of the matter. On August 6, 1982 Dr. Leonard reported that he found it difficult to conclude that claimant's June 1981 injury predisposed him to future blackouts. Dr. Leonard also concluded (as did Dr. Rosenbaum) that claimant did not suffer a seizure disorder as a result of the June 1981 injury.

Dr. Holland's opinion is not to the contrary. On August 11, 1982 Dr. Holland reported that if a seizure disorder could not be documented, he could "think of no reason why the injury of June 5, 1981 should predispose [claimant] to future black-out episodes." Dr. Holland further reported that he was not certain exactly what caused claimant to fall at work in June 1982.

In summary, the evidence indicates claimant suffered a mild concussion as a result of the June 5, 1981 incident. Claimant returned to work two weeks later with no restrictions after all diagnostic testing proved negative, and he sought no additional medical treatment and experienced no syncopal episodes thereafter. In September 1981 claimant was involved in a non-compensable motor vehicle accident in which he ran his van into a utility pole, was thrown through the windshield and traveled a distance of about 15 feet, suffering a concussion and lacerations severe enough to require at least 48 stitches. Claimant described the damage to his van as follows:

> "The damage to the van I would say -- to start off, it was a $14,000 van, totally custom. The front end of the van was knocked all the way back to the middle of the van. The van was brought forward and out of all this I was thrown out of the windshield."

Thereafter, claimant experienced substantially more severe and continuous symptoms which required consistent medical attention. Thus, even without the medical evidence which supports the same conclusion, common sense would seem to indicate that assuming claimant experienced a syncopal episode in June 1982, it was more likely related to the September 1981 motor vehicle accident than the June 1981 injury which occurred nearly a year before. We, therefore, conclude that Pepsi/EBI's August 18, 1982 denial must be affirmed.

Since no party to this review has challenged the Referee's referral of the extent of disability question to the Evaluation Division, we affirm that portion of his order.

ORDER

The Referee's order dated November 17, 1982 is affirmed in

part and reversed in part. Those portions of the Referee's order which set aside the January 15, 1982 denial issued by EBI/Pepsi and the subsequent oral denial of an aggravation claim are reversed and the denials are reinstated and affirmed. Those portions of the Referee's order which affirmed the July 6, 1982 denial issued by Fred S. James and Company on behalf of Pepsi and which referred the question of the extent of claimant's disability to the Evaluation Division are affirmed.

BOBBIE L. MACKI, Claimant
Kenneth D. Peterson, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 82-10850
January 25, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Mulder's order which upheld the insurer's denial of claimant's claim for her right shoulder condition and which refused to order payment of interim compensation or a penalty and associated attorney's fee for failure to pay interim compensation.

We affirm the Referee's order with the following comment. The Referee made a specific finding that claimant was not credible. The medical reports which link claimant's current condition to an alleged on-the-job injury are based on claimant's history. Because claimant is not credible, those reports are suspect. Accordingly, we find that claimant has failed to sustain her burden of proving by a preponderance of the credible evidence that her condition is work related.

ORDER

The Referee's order dated June 15, 1983 is affirmed.

MARLYN A. ANDERSON, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-02995
January 26, 1984
Order Denying Motion for Remand

Claimant requested review of Referee Thye's order and thereafter moved the Board to remand for further evidence taking. ORS 656.295(5). In support of her motion, claimant relies upon the recent Supreme Court decision Bailey v. SAIF, 296 Or 41 (1983).

Claimant's motion states:

> "If the claimant had known that the Referee would decide the case on such grounds in face of a clear statement of the treating physician and no contradictory evidence or medical opinion, or had the Referee indicated to the parties his decision would turn on such grounds, the claimant would have sought a further medical report, depositions, had the doctor testify, or moved that the record remain open for such medical statement."

The Referee decided that SAIF was not required to pay claimant's medical services for the reason that claimant had failed to establish by a preponderance of the evidence that her 1967 industrial

injury was a material contributing cause to the need for medical services.

The "grounds" upon which the Referee decided this case was the presence or absence of a causal connection between claimant's original injury and this claim for medical services.

Claimant's argument in support of her motion for remand is more appropriately addressed to the merits of the issue of causation, and whether the Referee correctly evaluated the evidence of record, matters which will be considered by the Board on de novo review of the Referee's order. We do not understand Bailey to require, or even suggest, remand under these circumstances.

ORDER

Claimant's motion for remand to the Referee for further evidence taking is denied.

STEVEN J. BAUMAN, Claimant
Doblie, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-04870
January 26, 1984
Order on Remand

On review of the Board's order dated May 25, 1982, the Court of Appeals which reversed that order, holding: "[I]t was not permissible for SAIF to reconsider and deny the previously accepted claim . . . ." Bauman v. SAIF, 62 Or App 323, 329 (1983). The court reversed and remanded with instructions to reinstate SAIF's acceptance of claimant's original claim and for further proceedings on the issues related to claimant's aggravation claim, which were not addressed by the Referee or the Board based upon the conclusion that SAIF's retroactive denial was allowed by Frasure v. Agripac, 290 Or 99 (1980), and it's progeny. On review of the Court of Appeals decision, the Supreme Court affirmed and held that a claim may not be retroactively denied once it has been accepted pursuant to ORS 656.262(6), except under certain circumstances:

> "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." Bauman v. SAIF, 295 Or 788, 794 (1983).

The Supreme Court's order now is final, and this case is before us on remand. Because the Referee did not rule on the compensability of claimant's aggravation claim, we deem it appropriate to remand this case for further proceedings consistent with the Court of Appeals and Supreme Court opinions, on the issues related to claimant's aggravation claim.

IT IS SO ORDERED.

RICHARD N. COUTURIER, Claimant
Ackerman, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11307
January 26, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Seymour's order which: (1) Acknowledged the party's stipulation at hearing that SAIF owes claimant an additional sum of $104.35 temporary total disability due to miscalculation of benefits by SAIF; (2) awarded claimant a penalty equal to 25% of that sum for SAIF's failure to pay the correct amount of time loss; and (3) awarded claimant's attorney an attorney fee of $150 payable by the SAIF Corporation.

SAIF argues: (1) Claimant did not give SAIF adequate notice of its error in calculation of his time loss benefits; (2) SAIF immediately corrected the problem as soon as it was called to its attention; and (3) therefore, a penalty for "unreasonable" resistance to the payment of compensation is not warranted. Parts of the Referee's order can be interpreted as adopting parts of SAIF's position.

Abstractly, we too agree with much of SAIF's position. See Walter C. Phillips, 33 Van Natta 505, 507 (1981): "[The Referee] awarded a minimum attorney fee to cover the claimant's first visit to his attorney and a reasonable allowance for the estimated time the attorney should have spent contacting the [insurer] and working out a conclusion to this extremely minor matter without the necessity of a formal hearing."

The flaw, in our opinion, in SAIF's position is factual. By letter dated March 18, 1983 claimant's attorney clearly and specifically notified SAIF of its error in the calculation of claimant's time loss. When the hearing convened on April 14, 1983, SAIF then acknowledged its error and agreed to pay the correct amount of time loss. We do not regard the delay of a month from specific notice of the deficiency to agreement to pay -- necessarily followed by some additional delay until actual payment -- to be immediate correction of a problem once notified of the problem.

Claimant's attorney filed a brief more than three months after the deadline established by the briefing schedule. Because the brief reached us so late, the review process proceeded without assistance of the brief; therefore, no attorney's fee is awarded on Board review.

ORDER

The Referee's order dated April 19, 1983 is affirmed.

STEVE C. DOOLEY, Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05068
January 26, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee McCullough's order which: (1) Affirmed the October 19, 1982 Determination Order, thereby finding claimant was medically stationary and not entitled to an award of permanent disability; and (2) refused to reopen the case for inclusion of Dr. Degge's report. Claimant contends he either is entitled to an award of permanent disability or is entitled to a finding that he was not medically stationary on April 26, 1982. Alternatively, claimant moves the Board for remand of this matter to the Hearings Division for consideration of Dr. Degge's report.

As discussed by the Referee in his Order on Request for Reconsideration, SAIF scheduled claimant to see Dr. Degge on the day after the hearing. At hearing, SAIF requested that the record be held open for receipt of Dr. Degge's forthcoming report. Claimant objected to holding the record open and the Referee sustained claimant's objection. After the report was prepared, claimant apparently found the report to be favorable to his case and sought to have it included in the record. Under these circumstances, where claimant was aware that a report was to be prepared but objected to its admission, we agree that inclusion of the report upon claimant's post-hearing request would be inappropriate. The Board denies claimant's motion to remand and affirms the order of the Referee.

ORDER

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

CAROL A. DUREN, Claimant
Michael B. Dye, Claimant's Attorney
Keith Skelton, Defense Attorney

WCB 82-06304
January 26, 1984
Order on Reconsideration

The Board issued its Order on Review herein on December 29, 1983. Claimant has requested reconsideration of that order, correctly noting that the order erroneously failed to award claimant's attorney a fee for prevailing on an issue on review. Claimant also requests clarification of the order. On reconsideration we modify our prior order.

The insurer issued a denial of claimant's aggravation claim, headaches and continuing complaints, which the Referee set aside. On review the Board affirmed the denial insofar as it purported to deny claimant's aggravation claim and headache condition. The Board noted, however, that claimant's January 1980 industrial injury remains compensable, entitling claimant to continued benefits with regard to that compensable injury. Inasmuch as the denial purported to deny all future benefits, the effect of the Board's order was to reverse the portion of the denial that denied benefits relating to claimant's January 1980 compensable injury. Therefore, we modify our Order on Review to state that the Referee's order is affirmed in part and reversed in part, that the insurer's denial is affirmed in part and reversed in part as

discussed above, and that claimant's attorney is awarded $450 for services before the Board on review, to be paid by the insurer.

ORDER

On reconsideration of the Board's December 29, 1983 Order on Review, the Board modifies its order as set forth more fully above. Except as modified, the Board adheres to its former order, which hereby is republished and reaffirmed.

VIRGINIA A. FRASER, Claimant
Hansen & Wobbrock, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-00741
January 26, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review and the insurer cross-requests review of Referee Fink's order which upheld the insurer's denial of claimant's left knee condition and which awarded claimant an additional 22.5° of scheduled disability for a 15% loss of her right hand and forearm.

The Board affirms and adopts those portions of the Referee's order concerning the issue of compensability of claimant's left knee condition.

The Board reverses on the issue of extent of disability. Based on our review of the record and considering the guidelines contained in OAR 436-65-500 et seq., we conclude that claimant has been adequately compensated for the residual effects of her compensable injury by her previous award of scheduled disability for partial loss of her right thumb.

ORDER

The Referee's order dated June 8, 1983 is affirmed in part and reversed in part. That portion which awarded claimant additional scheduled disability is reversed and the Determination Order dated March 2, 1983 is affirmed. The remainder of the Referee's order is affirmed.

MARTIN A. FULFER, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11030
January 26, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Baker's order which: (1) Awarded claimant an additional 32° for 10% unscheduled disability resulting in a total award of 64° for 20% unscheduled permanent disability; and (2) ordered SAIF to pay temporary total disability benefits in connection with an approved training program from September 30, 1982 through January 31, 1983. SAIF contends that claimant must show changed circumstances since the last permanent disability award in order to obtain an increased award of permanent disability after completion of a vocational rehabilitation program. SAIF also contends that the Referee lacked jurisdiction to decide the temporary disability benefits issue in that claimant

did not exhaust his administrative remedies provided in OAR 436-61-998.

The Board affirms the order of the Referee with the following comments. SAIF argues that in order for claimant to obtain an additional award of permanent disability after completion of his vocational program, he must show a change in his condition since the last award or arrangement of compensation. SAIF's argument fails in light of the Court of Appeals recent decision, Hanna v. SAIF, 65 Or App 649 (1983).

Regarding the temporary disability issue, SAIF's second argument, we note that claimant participated in an approved training program at Merritt Davis that was scheduled to end, according to Merritt Davis and claimant, December 31, 1982. The completion date was extended to January 31, 1983. The Vocational Rehabilitation Division refused to request payment of temporary disability benefits beyond September 30, 1982. Claimant raised the issue of temporary disability benefits in the hearing on the Determination Order dated November 24, 1982, which awarded temporary disability benefits through September 30, 1982. SAIF argued that claimant was required to first raise the temporary disability issue before the Director as provided in OAR 436-61-998, and having failed to do so, was not able to raise that issue for the first time before the Referee. The Referee found that claimant could raise the issue for the first time before the Referee inasmuch as claimant requested a hearing on the Determination Order, which determined the extent of claimant's temporary disability and on which claimant had a right to request a hearing.

We agree with the Referee. OAR 436-61-998 and ORS 656.728(6) require a claimant to first apply to the Director for review of a decision regarding the claimant's eligibility to receive vocational assistance or the nature or quality of the assistance the claimant is receiving. Neither claimant's eligibility to receive vocational assistance nor the quality or nature of the vocational assistance is disputed here. Claimant's participation in the Merritt Davis program had been approved and claimant's tuition had been paid for the entire Merritt Davis program. Claimant would not have been eligible to receive a diploma for the program had he terminated his participation in September 1982.

In addition, claimant's receipt of temporary disability benefits while enrolled in an authorized training program is not a matter within the discretion of the insurer or the department, as are many decisions concerning eligibility for or participation in a program. ORS 656.283(1); John W. Davidson, 34 Van Natta 240 (1982). Claimant's receipt of temporary disability compensation for the period in question is a right granted by statute. ORS 656.268(5). This lends further support to the conclusion that the Referee had jurisdiction to decide the issue.

ORDER

The Referee's order dated July 26, 1983 is affirmed. Claimant's attorney is awarded $500 for services before the Board on review, to be paid by the SAIF Corporation.

EDITH GRIMSHAW, Claimant
Davis, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-03319
January 26, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Brown's order which: (1) Affirmed the Determination Order dated March 10, 1982 which awarded no permanent disability benefits due to an aggravation of her low back injury; and (2) affirmed the insurer's July 20, 1982 denial of an aggravation claim made subsequent to the above Determination Order.

In the alternative, claimant requests that the Board remand this case to the Hearings Division in order to admit newly discovered medical evidence regarding the cause of claimant's current low back condition.

A hearing was held in this case on September 13, 1982. On October 19, 1982 claimant requested Board review of the Referee's order dated October 13, 1982. There was a delay in getting the hearing transcribed for Board review proceedings and, during that delay, claimant sought further medical evaluation of her condition from a new physician which resulted in newly created objective evidence and diagnosis of claimant's low back condition. This new evidence included medical opinion regarding the relatedness of that new diagnosis to claimant's original compensable injury.

We liken the facts of this case to those in Egge v. Nu-Steel, 57 Or App 327 (1982), and Casimer Witkowski, 35 Van Natta 1661 (1983), in which remand was found appropriate. Similarly, in this case, we find remand to be the appropriate course of action. See Myrtle E. York, WCB Case No. 82-00336, 36 Van Natta 23 (January 19, 1984).

In Egge v. Nu-Steel, supra, the Court of Appeals remanded the case to the Referee to consider a medical report which was generated after the Referee's final order was issued, but before Board review was completed. The new report revealed objective evidence of a hairline fracture of the L1 vertebra, whereas no objective evidence had been discovered before that time. The only excuse for the late generation of that report was that the claimant had continued to seek medical evaluation and treatment from a different physician because his prior physician had been unable to discover an objective cause of his pain. The court found that excuse adequate to explain why the evidence could not reasonably have been discovered and produced at the hearing.

In Casimer Witkowski, supra, we relied on Egge to remand a case for admission of new medical evidence. In Witkowski, the claimant had not produced objective evidence of his left side paresthesia until his new doctors performed new tests which revealed cervical myopathy. Up to that time, there had been no objective evidence to substantiate that diagnosis.

In this case, at the time of the hearing, the only evidence which supported claimant's argument that her current low back condition was related to her 1978 back injury was a chiropractor's opinion that her back strain incurred on that date had never healed.

The other medical evidence at the time of hearing indicated that claimant's current condition was most probably due to progression of preexisting osteoarthritis. However, x-rays had revealed that the arthritis had not progressed since the time of the original injury. The Referee determined that it was more reasonable that claimant's pain was due to her arthritis, rather than to an unresolved back strain, and affirmed the insurer's denial. Not until the interim after the hearing and before Board review when claimant sought treatment with a new doctor, Dr. Morrison, was it decided that claimant should undergo a CAT scan. That new test revealed an obvious herniated disc at the L4-L5 level which, Dr. Morrison states, requires surgery. It is Dr. Morrison's opinion that this condition is related to the 1978 injury.

Like the claimants in Egge and Witkowski, this case involves a claimant who had never obtained a satisfactory explanation of the cause of her medical condition, who continued to seek an explanation and who was finally rewarded for her diligence with an objective medical explanation of the problem. Whether claimant will be able to sustain her burden of proving that her herniated disc is related to her original injury is a matter for hearing on remand, which is required in this case so that all the relevant facts may be considered and a just conclusion reached.

ORDER

The Referee's order dated October 13, 1982 is vacated and this case is remanded to the Hearings Division for further proceedings in accordance with this order.

VICKI Y. HARDING, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04080
January 26, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which refused to grant the relief requested by claimant. Claimant contends that the SAIF Corporation should be ordered to pay temporary total disability benefits, to process claimant's claim to closure and to pay penalties and attorney fees.

The Board affirms the order of the Referee with the following comments.

Claimant argues that SAIF failed to process her aggravation claim after it was ordered to be accepted in a prior proceeding. Claimant does not contend that SAIF has failed to pay her medical bills. Further, we agree with the Referee that the record contains no medical authorization for claimant to receive temporary disability benefits. SAIF's failure to pay temporary disability benefits, therefore, was warranted. Moreover, the most recent reports by claimant's treating doctor indicate that claimant was not medically stationary at the time of hearing. Under these circumstances, we cannot agree that SAIF has failed to process claimant's claim. The medical bills apparently have been paid, no temporary disability has been authorized and claimant has not been found medically stationary. SAIF is not authorized to process the claim to closure until claimant's condition is medically stationary. ORS 656.268.

ORDER

The Referee's order dated July 8, 1983 is affirmed.

ROBERT KRAUS, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-10080
January 26, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Williams' order which upheld the insurer's denial of claimant's aggravation claim for ulnar neuropathy.

Claimant compensably injured his left elbow on July 25, 1977 when he banged it into a mobile home upon which he was working. On October 17, 1977 Dr. Hazel opined:

> "I have advised this gentleman that he does have mild post-traumatic arthritis and more importantly he has the onset of tardy ulnar palsy. I do not believe that this is related directly to this industrial injury but is rather related to the fracture that he sustained some eight or nine years ago. He is going to require an anterior transfer of the ulnar nerve at sometime in the future...."

On October 20, 1977 a Determination Order issued which granted claimant no award for permanent disability.

In 1978 claimant's problems increased. He was diagnosed as having "joint mice." Dr. Hazel related the joint mice to an injury in the 1960's rather than to the compensable injury. The insurer then issued a denial which in relevant part stated:

> "It is our contention that your present condition is a result of your injury in 1966 or 1967 and the injury sustained on July 6, 1978 while working for Buchanan Sellers. Accordingly, we must respectfully deny your application to reopen your claim for compensation and medical benefits."

In September 1979 a Referee's order upheld the insurer's denial. On review the Board affirmed the Referee's order.

In July 1982 claimant filed another aggravation claim for loose bodies in the elbow and tardy ulnar palsy. The insurer again denied the claim. The Referee held that claimant's aggravation claim was barred by the res judicata effect of the earlier orders upholding claimant's earlier aggravation claim. We disagree with the Referee on the res judicata effect of the earlier orders. An aggravation denial which is upheld does not necessarily bar further aggravation claims. Lewis Twist, 34 Van Natta 290 (1982).

On the merits, the medical evidence indicates that claimant's "joint mice" are related to his childhood injuries rather than to his compensable injury. The medical evidence is much less clear

concerning claimant's tardy ulnar palsy. Dr. Hazel opined that it is not related to the compensable injury, while claimant's current treating physician, Dr. Neblett, opined that it was related. We find the evidence on the relationship between the compensable injury and the tardy ulnar palsy to be in equipoise. Claimant has the burden of proving compensability and, we conclude that he has failed to sustain his burden. Accordingly, we affirm the insurer's denial on the merits.

ORDER

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

KRISTA LARSON, Claimant
W.D. Bates, Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 82-02063
January 26, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Quillinan's order which found her claim was barred due to failure to give notice in a timely manner pursuant to ORS 656.265, and refused to award penalties and attorney fees for unreasonable refusal to pay compensation and unreasonable delay in denying the claim. The insurer contends that the Referee correctly concluded that claimant failed to comply with ORS 656.265, and argues alternatively that the claim is not compensable.

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

ORS 656.265(1) requires that notice of an accident resulting in injury or death be given by the worker or a dependent to the employer not later than 30 days after the accident. ORS 656.265(4) states that failure to give such notice bars a claim unless:

> "(a) The employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice; or
>
> * * *
>
> "(c) The notice is given within one year after the date of the accident and the worker or beneficiaries of the worker establish in a hearing that the worker had good cause for failure to give notice within 30 days after the accident."

There is little question in this case that claimant did not give notice to her employer of an accident resulting in an injury within 30 days of the accident. Therefore, the claim is barred unless one of the statutory exceptions applies.

ORS 656.265(4)(a) provides that the claim is not barred if the employer had knowledge of the injury. Claimant contends that the employer did have knowledge of the injury as the incident was witnessed by her floor manager. She also contends that she discussed

the incident with one of her supervisors. However, the floor manager denied knowledge of the incident and the supervisor testified that she had no conversations with claimant concerning the alleged incident. Rather than engaging in an unnecessary recitation of the testimony pro and con, we need only state that based on this record, we are unable to conclude that the employer had notice.

Claimant, however, argues that it is not necessary that the employer be aware that she sustained an injury on the job, but that it only need be aware that claimant is injured. Since claimant wore a bandage on her knee following the injury, she argues that it should have been obvious to her employer that she had an injury and that this is sufficient under the statute.

The Referee stated that the mere fact that a claimant is in pain or shows other signs or symptoms is not enough to establish that the problems arose from the work environment. We agree. ORS 656.265 specifically refers to an accident which results in an injury. The fact that a claimant may show up for work one day wearing a bandage does not necessarily alert anyone that he or she had a work-related injury. Baldwin v. Thatcher Construction, 49 Or App 421, 425 (1980). Michael T. Kinsey, 34 Van Natta 1072 (1982).

ORS 656.265(4)(a) also provides that even though the employer did not have knowledge of the injury the claim will not be barred if there is no prejudice to the employer or insurer. Satterfield v. Compensation Dept., 1 Or App 524 (1970), provides that the employer or the insurer bears the burden of establishing prejudice. That burden has been carried in this case. Neither claimant's floor manager nor her supervisor had any recollection of claimant's alleged accident, and there was testimony as to the difficulty in investigating the claim as notice was given nearly a full year after the alleged incident. Claimant testified that several fellow employes who were aware of the incident no longer worked for the employer and they were not produced at the hearing. Moreover, between the time of the alleged incident and the time the claim was filed, claimant underwent two surgical procedures to her knee and sustained an off-the-job injury to the same knee. Extremely similar facts were found to have resulted in prejudice in Vandre v. Weyerhaeuser, 42 Or App 705 (1979).

With regard to the good cause exception of ORS 656.265(4)(c), we need only state that we are not satisfied on this record that claimant established good cause for her failure to give notice.

Since we agree with the Referee with regard to the timeliness issue, it is not necessary to address the employer's arguments concerning compensability.

We next address the issue concerning penalties and attorney fees. Although nearly a full year after the alleged injury, a Form 801 was filed with claimant's employer on October 26, 1981. No interim compensation was paid and the claim was never formally accepted or denied by the insurer. Claimant's attorney at that time filed a request for hearing on March 8, 1982.

The insurer argues that, as the claim was not filed in a timely manner, it had no duty to process the claim. No authority

is cited for that proposition, however, and we are aware of none. The fact that a claim may not be filed in a timely manner does not relieve the insurer of its statutory duties pursuant to ORS 656.262. The insurer is responsible for paying claimant interim compensation from October 26, 1981 through March 8, 1982, and it is liable for a penalty and an associated attorney fee.

ORDER

The Referee's order dated May 11, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which refused to award claimant interim compensation, penalties and attorney fees are reversed. The insurer is ordered to pay claimant interim compensation from October 26, 1981 through March 8, 1982, a 25% penalty on such amounts and a $450 attorney's fee. The remainder of the Referee's order is affirmed.

BILL W. MACK, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 80-05084
January 26, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Reservation Ranch requests review of Referee Daron's order which: (1) Found that claimant's low back condition in February 1980 was a compensable aggravation of claimant's 1976 compensable injury and, therefore, the responsibility of Reservation Ranch, and was not an occupational disease arising out of claimant's employment with Gold Mountain Logging Company (Gold Mountain); and (2) ordered Reservation Ranch to pay claimant interim compensation from March 11, 1980 to the date of the hearing. Reservation Ranch contends that claimant's employment at Gold Mountain is responsible for claimant's back condition in February 1980 and thereafter. Reservation Ranch also contends that it should not have to pay claimant interim compensation for periods of time during which claimant was employed.

The Board affirms the order of the Referee as to the interim compensation issue. Bono v. SAIF, 66 Or App 138 (1983). Regarding the responsibility issue, however, the Board agrees with Reservation Ranch and reverses the Referee.

Claimant injured his low back in September 1976 while working for Reservation Ranch as a choker setter. Later, claimant went to work for Gold Mountain as a rigging slinger, which was substantially more strenuous than setting chokers. In March 1980 claimant returned to his treating physician, Dr. Bert, whom he had not seen for three years, complaining of increased back pain. Dr. Bert reported that claimant's chronic back strain was directly related to claimant carrying heavy weights, jacks, etc. in his job as a rigging man. No other medical report addresses the cause of claimant's February 1980 back condition. We rely on Dr. Bert's opinion and find that claimant suffered an occupational disease while working for Gold Mountain and not an aggravation of his 1976 injury. We remand the claim to SAIF for payment of compensation under the claim against Gold Mountain, including temporary disability compensation beginning February 21, 1980.

ORDER

The Referee's order dated June 13, 1983 is affirmed in part and reversed in part. That portion finding Reservation Ranch responsible for an aggravation claim is reversed and Gold Mountain is found responsible for claimant's occupational disease claim. The balance of the Referee's order is affirmed. Claimant's attorney is awarded $200 for services on Board review, to be paid by the SAIF Corporation under the Reservation Ranch claim, for prevailing on the interim compensation issue.

BENJAMIN G. PARKER, Claimant
Dean Heiling, Claimant's Attorney
Walker & Johnson, Defense Attorneys

WCB 82-09534
January 26, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Baker's order which upheld the insurer's denial of claimant's back condition. Claimant has moved to remand to the Referee for consideration of newly developed evidence; the insurer has moved to dismiss portions of claimant's request for review and to strike additional evidentiary material submitted by claimant in support of his motion for remand.

All motions are denied. On de novo review, we have considered only the evidence contained in the record of the proceeding before the Referee. ORS 656.295(5).

The Board affirms the order of the Referee with the following comments.

The insurer initially accepted claimant's claim. It attempted to retroactively deny the claim more than sixty days after receiving notice thereof. The Supreme Court recently has held that such backup denials are impermissible, "unless there is a showing of fraud, misrepresentation or other illegal activity." Bauman v. SAIF, 295 Or 788, 794 (1983). We have interpreted Bauman to impose upon the insurer the burden of proving fraud, misrepresentation or other illegal activity when the insurer attempts to deny a previously accepted claim. Lawrence D. French, 35 Van Natta 1837 (1983). We also held in French, based upon our decision in Patricia G. Davis, 35 Van Natta 635 (1983), that the burden of proof is upon the insurer to establish that the claim is not compensable, as opposed to the burden being on the claimant to prove that his or her claim is compensable. Davis was decided after the Court of Appeals decision in Bauman, 62 Or App 323 (1983), and before the Supreme Court's decision. In French, having the benefit of the Supreme Court's decision, we stated: "[O]ur holding in Patricia G. Davis, supra, that the insurer has the burden of proving non-compensability in a backup denial case was not altered by the Bauman decision." 35 Van Natta at 1837.

We believe the above-quoted statement in French is true with regard to the Supreme Court's consideration of the burden of proof issue; however, two very recent decisions from the Court of Appeals cast some doubt upon the continuing validity of our holding in Davis. In Wilkins v. SAIF, 66 Or App 420 (1984), on reconsideration of its original decision, 64 Or App 826 (1983), the Court of Appeals apparently agreed with our holding in French that the insurer, in the context of litigating a backup denial, has the bur-

den of proving fraud, misrepresentation or other illegal activity. It is apparent, however, that once the insurer has established such conduct on the part of the claimant and, therefore, has established its right to issue the backup denial in question, it is the claimant's burden to prove the merits of the claim and the compensability thereof. This is made somewhat clearer by another case involving a backup denial decided the same date as Wilkins. Skinner v. SAIF, 66 Or App 467 (1984). Whereas in Wilkins, the court was satisfied that a preponderance of the evidence supported the insurer's contention that the claim was fraudulent, which in turn disposed of the compensability issue; in Skinner, the court found that the employer was entitled to deny the claim based upon a misrepresentation made by the claimant, but the claimant nevertheless established the compensability of her claim.

> "Claimant may still prevail over the denial if she can establish by a preponderance of the evidence that, although she had a pre-existing condition, the injury which she sustained at work materially worsened her condition. * * * We conclude that under the facts of this case claimant has met her burden of proof." 66 Or App at ___ (citation omitted).

Accordingly, we understand the rule in burden of proof cases involving backup denials to be that the burden of going forward with some evidence of fraud, misrepresentation or other illegal activity lies with the insurer. Once this burden of going forward is met, it is the claimant's ultimate burden to prove the compensability of the claim. Until the court states otherwise, therefore, our holding in Davis is modified accordingly.

We find that the insurer sustained its burden of proving fraud, misrepresentation or other illegal activity. We further find that, as in Wilkins, supra, this finding is dispositive of the substantive issue concerning the merits of this claim. Therefore, we affirm the Referee's order which upheld the insurer's denial.

ORDER

The Referee's order dated July 6, 1983 is affirmed.

ALBERTO G. PATINO, Claimant
Elliott Lynn, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 83-01003
January 26, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The self-insured employer requests review of that portion of Referee Shebley's order which granted claimant additional time loss benefits from December 24, 1981 through February 15, 1982 and compensation for permanent disability for 64° or 20% unscheduled disability for injury to the right shoulder. The employer contends claimant has failed to show entitlement to the additional time loss and that the Determination Orders' awards totaling 10% are sufficient. Claimant has requested the award be increased to 50%.

The Board accepts the facts as recited by the Referee in his order. The Board affirms and adopts those portions of the

Referee's order concerning additional time loss benefits. However, we disagree with his assessment of claimant's permanent disability.

Considering the guidelines contained in OAR 436-65-600 et seq. we conclude that claimant is entitled only to an award of 32° for 10% unscheduled disability. We rate claimant's impairment at 5% of the whole person based on range of motion findings and claimant's disabling pain. Claimant's age (28) yields -5 and his eighth grade education yields +10. His specific vocational preparation is valued at 2 with an impact of 0. Claimant's past work as a grinderman was considered to be heavy, but claimant has been given a full release to work so his adaptability is also rated at 0. Given the fact that claimant has been released to full work, there is considered to "be an immediate and continuing demand" for his services which yields a -25 value. Combining these values and rounding off equals a permanent disability rating of 10%. We conclude that claimant has been adequately compensated by earlier awards and the Referee's award of 20% should be reversed.

ORDER

The Referee's order dated March 14, 1983 is affirmed in part and reversed in part. That portion of the order which granted claimant compensation for 20% unscheduled right shoulder disability is reversed. The January 14, 1983 Determination Order which granted no additional permanent partial disability in excess of the 10% (32°) previously awarded is affirmed. The remainder of the Referee's order is affirmed.

CLIFFORD RENFROW, Claimant
Bischoff, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10835
January 26, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of that portion of Referee Johnson's order which approved the SAIF Corporation's December 29, 1982 denial of claimant's mental stress claim.

We affirm and adopt that portion of the Referee's order relating to the denial.

On a different issue, SAIF contends that the Referee erred in ordering it to pay claimant interim compensation benefits from the date of disability rather than from the date claimant filed his claim for benefits. Claimant was off work beginning April 15, 1982, allegedly due to work-related mental stress. However, he did not file his claim for benefits until October 12, 1982. Although the employer obviously knew that claimant had left work in April 1982 due to stress and heart problems, the employer did not know that claimant related one or more of his conditions to his work until he filed his claim in October 1982.

In a denied claim situation, an insurer need only begin paying compensation from the day it had notice or knowledge of the claim. It need not pay from the date the alleged disability began. Donald Wischnofske, 32 Van Natta 136 (1981), 34 Van Natta 664 (1982); Stone v. SAIF, 57 Or App 808, 1812 (1982). Therefore, we modify that portion of the Referee's order awarding interim compen-

sation to provide that SAIF shall pay claimant interim compensation beginning October 12, 1982.

ORDER

The Referee's order dated May 12, 1983 is affirmed in part and modified in part. The SAIF Corporation is ordered to pay claimant interim compensation benefits beginning October 12, 1982 rather than from April 15, 1982. The penalty assessed in the Referee's order shall be modified accordingly to reflect 25% of the interim compensation due from October 12, 1982 through December 29, 1982. We affirm the remainder of the Referee's order.

JAMES R. VINING, Claimant
Foss, Whitty & Roess, Defense Attorneys

WCB 82-05863
January 26, 1984
Order on Dismissal

Claimant requests review of Referee Danner's order which awarded 32° for 10% unscheduled permanent partial disability on review of a Determination Order dated March 30, 1983, which awarded no compensation for permanent disability.

The Referee's order is dated August 1, 1983. Claimant's request for review, designated as a "Notice of Appeal," is dated January 12, 1984, apparently was mailed the following day, and was received by the Board on January 16, 1984. The Referee's order contains the standard Notice to Parties, advising of the 30-day period for requesting Board review of a Referee's order in accordance with ORS 656.289(3), which provides in pertinent part:

> "The Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests a review by the board under ORS 656.295. * * * The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.295."

The Referee's order now is final by operation of law, and we lack jurisdiction to review it. Accordingly, claimant's request for review must be dismissed.

ORDER

Claimant's request for review is dismissed as not timely filed.

RICHARD HARRIS, Claimant
Robert Udziela, Claimant's Attorney
LaVonne Reimer, Defense Attorney

WCB 78-07592
January 30, 1984
Order on Remand

On review of the Board's Order dated September 14, 1982 the Court of Appeals reversed the Board's Order.

Now, therefore, the above-noted Board Order is vacated, and this claim is remanded to the insurer for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

KENNETH F. ALEXANDER, Claimant
Minturn, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-00555
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Daron's order which set aside its denial of claimant's right shoulder injury claim.

The employer contends claimant's lack of credibility should preclude a finding of compensability. We agree claimant was not a credible witness. Since the validity of his unwitnessed claim primarily rests upon his testimony, we find claimant has not met his burden of proving compensability. Therefore, we reverse.

The Referee found the claim compensable despite claimant's failure to disclose prior injuries and difficulties with his right shoulder to the doctor who treated him at the time. The Referee found there to be no conflicting or contradictory evidence that the unwitnessed "popping sensation" incident claimant contended he experienced at work did not occur. No credibility finding was made.

Credibility is a critical factor in determining validity of an unwitnessed claim. Anthony Mims, 34 Van Natta 97 (1982); Ruth M. Case, 33 Van Natta 490 (1981).

There are a number of instances which call claimant's credibility into question. We shall mention only the highlights, any one of which would seriously impugn claimant's credibility.

Specifically, claimant denied having any problems or treatments for his right shoulder prior to the alleged industrial injury. When confronted with impeachment evidence, claimant admitted he sought chiropractic treatment for his right shoulder periodically in 1976, 1978 and in 1981. One of the 1981 visits was nine days before the alleged injury.

Claimant described the condition the chiropractor treated as a "muscle spasm" in the back of his right shoulder. He described the alleged injury as centralized in the front of the right shoulder, inside the joint. Following the alleged injury, claimant continued his periodic chiropractic treatments. However, there is no record that the alleged injury was ever discussed. Further, there is no record that his chiropractic treatments were ever mentioned to Dr. Carlsen, an orthopedist who was treating claimant for the alleged injury.

Claimant testified he had experienced no prior injuries except for the alleged shoulder injury and a few prior non-work related injuries. Claimant was then presented with a copy of an 801 claim form concerning a 1979 back injury. He admitted the signature was his, but didn't recall injuring his back.

There are also inconsistencies in claimant's history as related at hearing and as described in Dr. Carlsen's chart note and report. Dr. Carlsen's first note states claimant had an old injury while weightlifting in high school that had prevented him from lifting beyond 20 pounds over his right shoulder. Claimant denied

both the high school injury and this history. He testified he talked to Dr. Carlsen about this "high school reference." Dr. Carlsen's letter folowing this conversation apologized for the confusion. The doctor wrote that apparently claimant had been weightlifting up until his last injury and did not have an injury due to weightlifting. Claimant testified this history was also incorrect. He stated he had not lifted weights since high school, but he did have some dumb bells in his garage. Following the alleged injury and before seeking Dr. Carlsen for treatment, claimant testified that he had attempted to lift the dumb bells to determine how his injured shoulder would react. When pain ensued, he promptly saw Dr. Carlsen.

The following exchange on re-direct between claimant and his own counsel serves to capsulate why we question claimant's credibility as a witness and historian:

> "Q: Did you, at any time, tell Dr. Cunningham [his chiropractor] about your right shoulder injury?
>
> "A: No, I have never discussed any injury with Dr. Cunningham.
>
> "Q: Not at all?
>
> "A: I don't know."

For the reasons detailed above, we find claimant has not met his burden of proving compensability.

ORDER

The Referee's order dated June 20, 1983 is reversed. The self-insured employer's denial of January 7, 1983 is reinstated and afffirmed.

DONALD R. BAILEY, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Mitchell, et al., Defense Attorneys
Moscato & Meyers, Defense Attorneys
Lindsay, et al., Defense Attorneys

WCB 82-06336, 83-00773, 83-00774 & 83-00969
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer, WNI Service Systems, and its insurer, Farmers Insurance Group (hereafter "WNI"), requests review of Referee Fink's order which set aside its January 6, 1983 denial of responsibility for claimant's low back condition. The issue for review is responsibility for claimant's May 17, 1982 back condition.

Briefly, the facts are as follows.

Claimant suffered a compensable injury to his low back in July 1978 while employed as a carpenter by CECO. Conservative treatment was instituted by Dr. Gritzka. Dr. Gritzka believed that claimant had a developing intervertebral disc protrusion or rupture combined

with a lumbosacral strain, and that heavy work would be detrimental to his condition. Dr. Gritzka felt that if claimant, nevertheless, persisted in heavy labor, he would eventually develop a complete herniation.

Determination Orders dated March 28, 1979 and November 28, 1980 awarded claimant benefits for temporary total disability from July 1978 through February 1979, and from May 1979 through November 1980 plus 20% unscheduled permanent partial disability. By stipulation of May 15, 1981, claimant received an additional 23.52° for a total of 27.35% permanent partial disability.

Claimant was retrained as a truck driver and began working for Cotter. Claimant worked for Cotter from December 1980 through September 1981. Claimant's duties included loading and unloading items from his truck. Although claimant continued to experience back pain while working for Cotter, he nevertheless lost no time from work.

In October 1981 claimant went to work for Mitchell Brothers as a long-haul truck driver. Claimant's duties at Mitchell included covering loads with a tarp that weighed approximately 150 pounds. Claimant continued to experience back pain while working for Mitchell. Claimant last worked for Mitchell in February 1982.

Claimant began working for WNI on April 29, 1982 and worked there for a total of 59-1/2 hours. On May 17, 1982 claimant was watching his truck being loaded when he began to experience "tingling" in his leg and his back pain increased. Claimant was seen at the emergency room of Emanuel Hospital where a diagnosis of back strain was made. Claimant did not return to work.

Claimant was hospitalized in June 1982, and Dr. Gritzka's discharge diagnosis was a herniated lumbar disc. A CT scan was interpreted as showing a protruded disc at the L4-5 level. Although somewhat questionable, an October 8, 1982 myelogram was interpreted as showing a moderate to large defect at L4-5. On October 27, 1982 claimant underwent bilateral decompressive laminotomies and discectomies at the L4-5 interspace.

Claimant filed claims against CECO, Cotter, Mitchell Brothers and WNI. All of the claims were denied.

On September 8, 1982 Dr. Gritzka reported that claimant's back difficulty was "related to his truck driving occupation." On October 7, 1982 Dr. Gritzka reported that claimant's L4-5 disc was not necessarily an inevitable consequence of his 1978 injury, although it did appear probable that claimant had a herniated L4-5 disc at that time. Dr. Gritzka felt claimant probably had a tear of the annulus fibrosis in 1978 without a frank protrusion of the nucleus pulposus. Essentially, Dr. Gritzka felt that all of claimant's truck driving work contributed to his current condition. After a clarification of the nature and length of claimant's work at WNI, Dr. Gritzka later reported that claimant's work at WNI made only a de minimus contribution to claimant's back disorder.

On February 28, 1983 claimant was examined by Dr. Rosenbaum. Dr. Rosenbaum indicated that although he did not have the lumbar myelogram or operative reports to review, that:

> ". . . it appears as if the [claimant] had a lumbosacral strain superimposed upon lumbar degenerative disc disease in his injury of 1978. He had periodic minor exacerbations and remissions with a probable significant exacerbation of 5/17/82 not essentially associated with an injury but simply watching his truck being loaded. He subsequently underwent lumbar disc surgery, but from the history I have obtained as well as the medical records, I am certainly not convinced that this [claimant] had any significant disc pathology that was accounting for his symptoms."

Dr. Rosenbaum stated that without any good history of a trauma in May 1982, he was of the opinion that claimant's current difficulty represented an aggravation of the 1978 injury. If the myelogram demonstrated an "extremely large disc protrusion," Dr. Rosenbaum felt this would be more indicative of a new injury.

Claimant testified at the hearing that he did not engage in any loading or unloading activities on May 17, 1982. He stated that he was counting freight as it was being loaded and this did involve some stooping and bending. Additionally, claimant stated the warehouse had a wooden floor which would vibrate when forklifts drove across it.

Relying on Valtinson v. SAIF, 56 Or App 184 (1982), the Referee concluded that claimant sustained a new injury while employed by WNI. We disagree.

The issue in this case is, as between CECO, Cotter, Mitchell Brothers and WNI, who is responsible for claimant's current condition? We are convinced by WNI's arguments that the evidence in this case establishes merely that claimant's employment subsequent to CECO was capable of causing his current condition. The Supreme Court has recently indicated that in situations where a compensable injury at one employment contributes to a disability occurring during a later employment involving work conditions capable of causing the disability, but which did not contribute to the disability, the first employer is liable. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). This is the exact situation presented herein, and we are convinced that the evidence in this case establishes that claimant's current "disability" is not the result of his employment with WNI, nor for that matter, with Cotter or Mitchell Brothers. Rather, we find the evidence establishes that CECO remains responsible for claimant's condition.

It was at least suspected that from the time of claimant's 1978 injury, he may have been suffering from a herniated disc. As a result of that injury, it was determined that claimant had a 27.35% disability, and the claim was not finally closed until November of 1980. Although claimant's low back condition did not cause him to seek additional medical treatment from September 1980 until May 1982, he nevertheless experienced unremitting chronic pain for that entire period of time. Moreover, we are not convinced that there was any form of trauma preceding or associated with claimant's increased symptoms in May 1982. The medical

reports indicate that claimant was doing nothing more than simply standing and watching his truck being loaded when his leg began to tingle. Although clamant did testify that the wooden floor vibrated while his truck was being loaded, and that he did some bending while counting freight, there is no such history contained in any medical report, and we do not find this testimony (which seemed to emphasize the minimal nature of the exposure) sufficient to allow us to draw a causal connection.

Although Dr. Gritzka's reports are not particularly clear enough to be of great assistance in resolving the question of responsibility, Dr. Rosenbaum's report is. Dr. Rosenbaum was of the opinion that if claimant exhibited an extremely large herniation upon myelogram or surgery, it would most likely be the result of a new injury; and that if the findings were minimal (which he predicted), it would most likely constitute an aggravation of claimant's chronic condition. An examination of the operative report indicates that Dr. Rosenbaum was correct in his prediction. Dr. Gritzka related that upon surgery, although claimant did have a central L4-5 herniation, it was quite minor, and that the amount of disc material removed was "not very impressive."

In summary, we have a situation where claimant sustained a low back injury in 1978 which was diagnosed to be a developing disc rupture, constant unremitting pain from the time of claim closure in late 1980 until May 1982, and no good history of any new work incident. There is no objective evidence that claimant's employment with Cotter, Mitchell Brothers or WNI actually contributed to claimant's condition. Dr. Gritzka's statements indicate nothing more than that the conditions at claimant's later employments were of the type that were capable of causing a disability. There is no evidence of any actual contribution. Rather it appears to be a situation where claimant's original injury never completely cleared, and that his condition in May 1982 represented simply another exacerbation of his 1978 injury. See Fireman's Fund Ins. Co. v. Ore. Ptld. Cement Co., 63 Or App 63 (1983); United Pacific Reliance Insurance Company v. Banks, 64 Or App 644 (1983); Boise Cascade Corp. v. Starbuck, 61 Or App 631 (1983), aff'd 296 Or 238 (1984).

ORDER

The Referee's order dated April 12, 1983 is reversed. Farmers Insurance's January 6, 1983 denial is reinstated and affirmed. The October 28, 1982 denial issued on behalf of CECO is set aside, and the attorney fee awarded by the Referee shall be paid by CECO.

ZELLA R. BAXTER, Claimant
Rolf Olson, Claimant's Attorney
Minturn, et al., Defense Attorneys

WCB 82-02655
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Williver's order which set aside its February 26, 1982 denial for continuing physical therapy treatment. The stated reason for the denial was that claimant's condition was medically stationary as of February 26, 1982 with no further material improvement reasonably to be expected from treatment or the passage of time. At hearing, SAIF argued an even broader reason for the denial, contending that the physical therapy is controversial and even harmful to claimant.

The issue in this case is the reasonableness and necessity of claimant's physical therapy treatments. ORS 656.245(1). We note at the outset that both the Workers' Compensation Board and the Workers' Compensation Department have jurisdiction to issue orders in cases of this nature. The Board's authority for considering such cases derives from ORS 656.283 which allows any party or the director at any time to "request a hearing on any question concerning a claim" within the timelines set out at ORS 656.319. The Department's authority to issue orders in these cases is found at OAR 436-69-201 and OAR 436-69-901.

In this case, the insurer was simultaneously seeking a remedy through the Department's procedure while claimant was seeking a remedy through the Board procedure. After the Referee had issued his order within thirty days of that order, SAIF moved for reconsideration, advising that she expected to soon receive an opinion from the Department's Psychiatric Peer Review Committee regarding this case. Thereupon, the Referee temporarily set aside his order. On October 19, 1982 SAIF requested admission of three medical reports by physicians who apparently were part of the Department's Peer Review Committee. Claimant objected to the late admission of the reports. On January 10, 1983 the Referee ordered that SAIF's motion for reconsideration be dismissed and that his September 2, 1982 order be republished in its entirety. It does not appear that the Referee admitted these medical reports into evidence. Nor has SAIF specifically requested that they be admitted into evidence, and neither party has referred to these specific documents in their arguments to the Board. Accordingly, we have not considered them on review. It is necessary for the Board to review this case in a timely fashion regardless of related, ongoing proceedings before the department; therefore, we have proceeded with our review despite the fact that the record does not contain a final order from the department in the related matter. Lloyd C. Dykstra, 36 Van Natta 26 (January 24, 1984). On the substantive issue in this case, we affirm the Referee's order disapproving the denial of continuing physical therapy treatment.

Claimant was compensably injured on April 30, 1970 sustaining a severe lumbar and psoas muscle strain causing secondary effects in bowel and kidney function. A myelogram and subsequent exploratory lumbolaminectomy and excision of herniated disc at L1-2 were performed. Dr. Jens, psychiatrist and neurologist, began treating claimant in 1973. Dr. Jens diagnosed a severe back strain and post-traumatic depression. In 1977 Dr. Wood, M.D., prescribed physical therapy for claimant's low back condition. Later, Dr. Rinehart, M.D., also prescribed physical therapy for claimant. On August 11, 1981 Wallace Boe, licensed physical therapist, wrote to the insurer:

> "I have been treating Mrs. Baxter with physical therapy for her back since 11-21-77. She was initially referred for treatment by Elon Wood, M.D., later by Harry Rinehart, M.D., and during the last eight months by Ruth Jens, M.D.
>
> "Treatment procedures and modalities have varied during this time, but currently she

is receiving heat, massage, and ultrasonic, coupled with electrical stimulation, at Dr. Jens' request. She is currently receiving treatment twice weekly.

"Initial treatment goals were relief of spasm and pain, improvement of spinal range of motion, and restoration of function to the joints that she might return to employment. These goals certainly have not been accomplished, and for the past year, at least, she has been receiving palliative treatment with symptomatic relief so that she might maintain her current activity level, which seems to be the only realistic goal."

On November 13, 1981 Dr. Jens wrote SAIF:

"During [physical therapy] visits she is to have heat, massage, and electrical stimulation. Physiotherapy is designed to reduce muscle spasm, and attendant pain and allow her to be up and out of bed.

"The treatments have accomplished the desired goals. If Mrs. Baxter becomes a bed patient, not only will her care be more costly, but she will not again become ambulatory. It is therefore imperative that she receive medication, physiotherapy and encouragement to the degree necessary to keep her ambulatory."

At hearing, claimant testified that the physical therapy treatments are of benefit to her low back condition. She testified it relieved the stiffness in her back and allowed her to move more easily. Without the treatment her back becomes rigid and causes more pain, requiring her to spend more time in bed.

SAIF placed emphasis on its contention that the physical therapy treatments do not seem to be curing claimant's low back condition, but is only of palliative benefit. However, a claimant is entitled to medical expenses for purely palliative purposes when such expenses are necessarily and reasonably incurred in the continuing treatment of an injury. Wait v. Montgomery Ward, Inc., 10 Or App 333 (1972).

Mr. Boe, physical therapist, wrote SAIF again on December 4, 1981 stating:

"I would classify [claimant's] treatment goal at this time as 'maintenance' to prevent further stiffening of her spine and to enable her to be as active as possible by relieving her pain. Physical therapy has been helpful in accomplishing this. She has demonstrated no real improvement during this period, and I don't belive [sic] that 'restorative' goals would be realistic for her at this stage."

In short then, claimant's treating physicians, Drs. Wood, Rinehart and Jens, and the licensed physical therapist have all noted the need for physical therapy as an aid to claimant in managing her chronic pain problem. We have examined the adverse medical opinion in the record, all of which which has come from non-treating physicians. In this case involving long-term conservative management of a considerable disability, we have given more weight to the treating physicians' opinions and, on that basis, affirm the Referee's order.

ORDER

The Referee's orders dated September 2, 1982 and January 10, 1983 are affirmed. Claimant's attorney is awarded $450 for services on Board review, to be paid by the SAIF Corporation.

ROBERT A. BEAL, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-01799
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Foster's order which upheld the SAIF Corporation's denial of claimant's aggravation claim for his low back condition. Claimant also moves for remand to receive a report which was obtained after the hearing.

On the remand issue, we find that the case has not been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Accordingly, we do not remand.

On the merits, we find the facts as follows: Claimant compensably injured his low back in May 1977. He received a total award of 64° for 20% unscheduled disability from Determination Order and stipulation. Claimant saw Dr. Woolpert, his treating physician, in June 1978 and then did not see him again until December 1982. On December 21, 1982, claimant reported to Dr. Woolpert that he had begun to experience an increase in back pain as well as a recurrence of left leg pain. Dr. Woolpert opined:

> "[T]he patient is having an aggravation which I think is directly related to his previous injury."

In January 1983, Dr. Woolpert stated:

> "I am relying on the patient's description of his increased activity on the job which the patient states he has been having to do more driving and use of equipment, compared to before....This is what is causing his increased discomfort and increased symptoms in respect to his back which has produced at least a temporary worsening."

In May 1983, Dr. Woolpert referred claimant for another consultation. In the referral letter he noted:

> "The patient still feel [sic] that 'there

> is still something wrong'. The patient is a very pleasant and co-operative individual but may be looking for a simple solution to his problem which I suspect is not there. He does have some narrowing at the 4-5 as well as at the 5-1 area."

We find that Dr. Woolpert believed claimant's statements that the low back condition was worse and that Dr. Woolpert found some objective evidence to indicate that claimant's condition was worse.

Accordingly, we reverse the Referee's holding that claimant has failed to prove a compensable worsening. The Court of Appeals has stated:

> "An aggravation claim based solely on a claimant's statement that his condition has deteriorated is statutorily insufficient. Likewise, a medical report which only sets forth claimant's statement that his condition has deteriorated is insufficient. At the very least, an expression of opinion by the doctor that he believes the claimant or that he finds objective evidence from a medical standpoint to substantiate claimant's history is necessary." Oakley v. SAIF, 63 Or App 433, 436 (1983).

In this instance, Dr. Woolpert not only indicates his belief in claimant's history, but indicates that he has found objective evidence to substantiate that history. Based on the uncontroverted evidence from Dr. Woolpert, we conclude that claimant has proven a compensable worsening.

ORDER

The Referee's order dated August 11, 1983 is reversed. SAIF's denial dated February 2, 1983 is set aside, and the claim is remanded to the SAIF Corporation for processing according to law. Claimant's attorney is awarded $2000 for services at hearing and on Board review, to be paid by the SAIF Corporation.

DENNIS M. BLOOMFIELD, Claimant
Peter Hansen, Claimant's Attorney
Morrison, et al., Defense Attorneys

WCB 82-07387
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Shebley's order which overturned its denial of claimant's right knee condition.

Claimant injured his knee on June 28, 1982. The evidence indicates that claimant initially injured his knee playing golf with his son that day. The factual dispute is whether claimant further injured his knee that same day stepping on a pallet at work.

On July 2, 1982 Dr. Dineen filed a Form 827 with the insurer

in which he checked a box indicating that he believed claimant's condition was work related. On the same form claimant described the cause of his injury: "Stepped on pallet and twisted right knee." Dr. Dineen voiced no other opinion on causation and never mentioned claimant's golfing injury in any of his reports. Dr. Dineen's report on causation is a bare opinion without any explanation. The fact that only claimant's alleged on the job injury is mentioned on the form indicates that Dr. Dineen did not even consider the golfing incident in forming his opinion. We give Dr. Dineen's reports little weight in deciding whether claimant has proven the compensability of his knee condition.

The only other physician whose opinion appears in the record is Dr. Pasquesi who examined claimant for the insurer. He recited the history of both the golfing injury and the pallet incident. He then opined:

> "(1) The cause of the patient's right knee condition is undoubtedly that of a twist, but when and how the twist occurred, I cannot state....
>
> "(3) I do not feel that the patient had a pre-existing condition or at least one is not documented and feel that some event, either at Miller Brands or playing golf probably caused the discomfort and that his injury probably occurred on 6-28-82."

Dr. Pasquesi's report does not positively link claimant's alleged on the job incident with his knee condition. It merely indicates that the on the job incident could have caused claimant's knee condition.

The Referee felt that both physicians thought that the pallet incident could have caused claimant's knee problem. He felt that it was more likely that the golf incident played a more significant role, but that the pallet incident contributed somewhat. He, therefore, found the claim compensable. We disagree.

We find that claimant injured his knee in a twisting incident while playing golf on June 28, 1982. There is insufficient evidence to indicate that any incident at work on the same day materially contributed to claimant's knee condition. Accordingly, claimant has failed to prove a causal connection between his work and his knee condition. The insurer's denial should be reinstated.

ORDER

The Referee's order dated June 3, 1983 is reversed. The insurer's denial of July 9, 1982 is reinstated and affirmed.

JUNIOR J. BRYAN, Claimant
Robert Hamilton, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07423
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Brown's order which upheld the SAIF Corporation's denial to the effect that claimant's left shoulder condition was not a compensable consequence of his June 1980 left arm injury.

In June 1980 claimant's left arm was injured when it was caught between the rollers of a bag making machine. The resulting crushing injury did not cause any fracture, but did produce nerve damage. The compensability of this crushing injury to claimant's arm is not disputed.

Claimant testified that, as his arm was being pulled into the rollers, he exerted quite a bit of force trying to pull his arm out of the rollers. We find this testimony completely credible because we think that any human being, in panic or near-panic, would respond to such a situation in exactly the way claimant said he did.

It was almost two years later, after claimant had recovered from his arm injury and returned to work, when the first medical report was submitted documenting shoulder disability. SAIF then sent claimant back to Dr. Casey, who treated claimant after his arm injury. Dr. Casey opined there was no relationship between the original 1980 arm injury and claimant's 1982 shoulder disability: "one finds it difficult to say that [the shoulder disability] was caused by his crush injury to the hand."

Dr. Lilly expressed a contrary opinion:

> "I think the complaint of the paresthesia and numbness involving all of the fingers and the left hand is most likely a result of a traction type injury to the nerves, that is probably the brachial plexus [which is located in the shoulder]. This also occurred at the time of his [1980] injury. . ."

We agree with the Referee that much of the medical opinion in the record is far from clear. For example, Dr. Casey seems to be focusing on whether a crushing injury to the lower arm can cause shoulder disability. However, we understand the principal thrust of claimant's theory not to be that the crushing injury per se caused shoulder disability; but, rather, that his struggle to free his arm from the rollers at the time of the crushing injury most likely caused the shoulder disability. Although still not quite hitting the nail on the head, Dr. Lilly's hearing testimony comes the closest to reflecting an understanding of this theory and seems to basically support it.

We find it totally reasonable and completely plausible that claimant would have suffered a stretching injury in the brachial plexus area of his left shoulder as he was trying to pull his left arm out of the machine rollers that were crushing it. We thus

accept Dr. Lilly's opinion that claimant's current shoulder disability is causally related to his original arm injury.

ORDER

The Referee's order dated April 1, 1983 is reversed. The SAIF Corporation's denial June 2, 1982 is set aside and this claim is remanded to SAIF for acceptance and processing. Claimant's attorney is awarded $850 for services before the Referee and $450 for services before the Board, to be paid by the SAIF Corporation.

RAYMOND BRYANT, Claimant
Pozzi, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 81-11454
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Neal's order which modified the December 16, 1981 Determination Order by increasing claimant's permanent disability award from 240° for 75% unscheduled permanent partial disability to permanent total disability benefits for his compensable myocardial infarction. The insurer contends claimant is not permanently and totally disabled because: (1) The medical evidence in the record stating that claimant is permanently and totally disabled is outdated; (2) the OAR guidelines rate claimant's Class III impairment from his organic heart disease at only 60% impairment of the whole person; (3) at times the medical reports have indicated that claimant may only be in the Class II heart impairment category and Class II impairment equals only 30% impairment of the whole person; (4) Mr. King, a vocational rehabilitation expert, testified that given claimant's limitations and work experience, there were jobs that he could perform; and (5) Mr. Woolley, from claimant's former place of employment, testified that there might be a job as construction manager assistant that claimant could perform.

Our review of the record shows that claimant's treating cardiologist, Dr. Grover, found claimant to be in the Class III category of organic heart disease and to be permanently and totally disabled from performing any work at a gainful and suitable occupation. Dr. Grover stated his opinion in March and April of 1981. Claimant continued to be treated by Dr. Grover at intervals of approximately three months, and Dr. Grover's opinion never changed. The category of Class III means that claimant cannot walk more than one or two blocks on the level, climb one flight of ordinary stairs, or perform the usual activity of daily living without producing symptoms of his heart disease. We note that the AMA Guides to the Evaluation of Permanent Impairment rate a Class III impairment as 50% to 75% impairment.

At the insurer's request, claimant was examined by Dr. Griswold, cardiologist, on June 23, 1981. Dr. Griswold recited the following history:

> "* * * Mr. Bryant is presently on the following medicaton: Nitroglycerin, 100 tablets, lasts six to eight months, Dyazide 25 mg. daily, and a research medication which Dr. Grover is giving him at Kaiser. He definitely gets angina if he climbs one

> flight of stairs at a normal pace or lifts 15 pounds. He also develops angina when exposed to excessively hot or cold weather and at times may actually become somewhat dizzy.
>
> "He states that he is still under the care of Dr. Grover and is basically unchanged for some months. His primary complaints are those of angina and fatigue. He states that he is even unable to fish anymore. He mows his lawn, but in the following manner: He has a self-propelling power machine. He is able to mow the yard for 10-15 minutes at the slow setting of the power mower and then must rest 30 minutes. He continues this off and on until he completes this job. He states he cannot vacuum the house or help his wife with housework. He cannot spade in the garden because of significant angina pectoris."

Dr. Griswold concluded: "At the present time it would be my medical opinion that Mr. Bryant is functional Class III, i.e. symptoms on minimal physical activity."

The chart notes from Kaiser Hospital (Dr. Grover) continue up through March 15, 1982 and there is no indication that Dr. Grover's opinion of the extent of claimant's disability changed during that time. At hearing, claimant stated his condition has not changed since that time and his uncontradicted testimony as to his limitations and activities reflected as much. There is no contrary medical evidence in the record giving the opinion that claimant is not permanently and totally disabled.

Further, when determining whether a claimant is permanently and totally disabled, it is necessary to examine social and vocational factors as well as physical impairment. Claimant was 63 at the time of the hearing. He has a high school education with approximately two years of civil engineering courses. His work experience has consisted of farm work, auto mechanics, auto parts worker and millwright. He is unable to return to any of these former jobs. Claimant testified he has been told by his doctor not to work. There is no evidence that he has refused any vocational help from private or public sources, such as the Field Services Division or the Vocational Rehabilitation Division.

Although Mr. King, rehabilitation counselor, testified that he felt there were some jobs claimant could perform in the light work category, we find Mr. King's opinion unpersuasive. At hearing, Mr. King could not recall the severity of claimant's heart attack. After being shown medical records, Mr. King admitted that claimant's second heart attack was a massive anterior-wall myocardial infarction requiring multiple defibrillations. Mr. King had not interviewed claimant to determine his job skills, nor did he administer any tests to determine claimant's aptitudes or abilities. He knew nothing about claimant's employment history other than the job captions used by claimant in filling out a job application.

Mr. Woolley, construction manager at claimant's former employment, suggested that claimant could perform the duties of a construction manager assistant taking phone calls, time keeping and doing typical paperwork. However, Mr. Woolley testified that his company has employed only one such assistant in the past two years, that that individual had been laid off over a year ago due to lack of work and his company has no prospects for any construction contracts that would allow this job to again become viable. He testified that the one assistant that was laid off suffered from no disability, and that his company had never had an assistant in construction who had disabilities.

We conclude that, on this record, where the medical evidence is that claimant is permanently and totally disabled and there is no contrary evidence, and where the possibility of claimant's employment is speculative, at best, claimant has proven he is permanently and totally disabled.

We affirm the Referee's order.

ORDER

The Referee's order dated February 4, 1983 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

WILLIAM R. CARR, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-00053
January 31, 1984
Corrected Order on Remand

On review of the Board's order dated February 5, 1982, the Court of Appeals reversed that order and remanded for entry of an order awarding claimant additional temporary total disability compensation.

Now, therefore, the above-referenced Board order is vacated, and claimant is awarded additional temporary total disability compensation from June 5, 1980 until July 25, 1980, said compensation to be paid in accordance with the rate prescribed by former OAR 436-54-212(2)(i), presently set forth at OAR 436-54-212(3)(i).

Claimant's attorney is allowed 25% of this additional compensation as a reasonable attorney's fee for services rendered before the Court of Appeals. Morris v. Denny's, 53 Or App 863, 866 (1981).

IT IS SO ORDERED.

RUSSELL E. COUSINS, Claimant
Virgil E. Dugger, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-02115
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Shebley's order which overturned its denial of claimant's recurrent inguinal hernia.

Claimant compensably injured his stomach in April 1982 lifting

a "suitcase" of tools. Dr. Gustavson diagnosed a bilateral inguinal hernia. Dr. Gustavson performed a bilateral herniorrhaphy in May 1982. A Determination Order awarded temporary disability benefits but no permanent disability benefits.

Claimant returned to welding, but the work was never as heavy as he had done previously. In November 1982 claimant again began experiencing burning pain in the right groin. Dr. Brant, an associate of Dr. Gustavson, diagnosed "recurrent right inguinal hernia" and checked a box on a form indicating that the condition was work related. A second herniorrhaphy was then performed. Following the second surgery, Dr. Gustavson opined:

> "On examination he was found to have a recurrent hernia. He described no direct incident that I am aware of as a cause for this recurrence....
>
> "I would think that this would have to be treated as a new injury. His prognosis should be good. I cannot state with certainty why the hernia recurred."

SAIF sent the medical records to its consultant, Dr. Girod. Dr. Girod reviewed the medical records and opined:

> "Individuals who are predisposed to developing inguinal hernias are those who recurrently increase their intra-abdominal pressure. This can occur in persons with chronic coughing, sneezing and constipation, large amounts of intra-abdominal fluid and in persons who recurrently lift heavy objects over long periods of time....
>
> "The early recurrence of his right inguinal hernia could have been the result of several possible causes. It is possible that he did not rest properly following his surgery in May, and that the suture lines broke down resulting in recurrent herniation. It is also possible that the operation in May simply failed to appropriately repair his inguinal hernia. If either of these mechanisms were responsible for the recurrence of his hernia, then that recurrence would be related to his initial hernias and not the result of a new incident.
>
> "It is also possible, however, that the repair was adequate and that the claimant did not break the suture lines by early activity or other activity. If the claimant was engaged in significant heavy lifting between July and November, then it is possible that that lifting could have resulted in the recurrence of his right inguinal hernia. To clarify this matter, I would recommend obtaining a careful history of claimant's work activities between July and November."

SAIF subsequently denied the recurrent hernia.

The Referee overturned the denial. He relied in part on Dr. Brant's checked box. In addition he stated:

> "Finally, Dr. Gerod [sic] mentions several possibilities and concludes that an accurate history of claimant's activities between July and November 1982 is needed to determine the etiology of his recurrent hernia. I had an accurate and detailed history presented to me at hearing and with the benefit of that history conclude that claimant's recurrent hernia more probably was caused by the first operation than by any new injury or incident. Accordingly, I conclude that claimant has met his burden of proof."

We disagree.

Dr. Girod's report speaks merely in terms of possibilities. He stated that it was possible that claimant's recurrent hernia was caused by the compensable injury, but he would need a complete history to decide. The fact that the Referee had a complete history is inconsequential. The Referee is not a physician and, therefore, should not attempt to predict what a physician's opinion would be if he had the same information as the Referee. Dr. Girod's expression of possibilities is not enough to establish causation even with the history claimant gave at hearing. Dr. Brant's opinion, the only other opinion which links the recurrent hernia to the compensable injury is totally conclusory, so we give it no weight. Accordingly, we find that claimant has failed to sustain his burden of proving the compensability of his recurrent inguinal hernia.

ORDER

The Referee's order dated August 16, 1983 is reversed. SAIF's denial dated January 12, 1983 is affirmed and reinstated.

MICHAEL G. CRAGUN, Claimant
Flaxel, et al., Claimant's Attorneys
Atherly, et al., Defense Attorneys

WCB 82-08199, 83-04525 & 82-11427
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of those portions of Referee Foster's order which awarded claimant's attorney a fee of $1,200. The sole issue for review is whether the fee awarded claimant's attorney is excessive.

The only issue resolved at the June 20, 1983 hearing in this matter was whether SAIF, as insurer for Special Security Investigators, was responsible for claimant's condition on the basis of aggravation of his June 1980 injury, or whether SAIF, as insurer for Wardrobe Cleaners, was responsible for claimant's condition on the basis of a new injury. SAIF denied both claims on May 6, 1983 and simultaneously requested that an order designating a paying agent pursuant to ORS 656.307 be entered. Such an order

was issued on May 13, 1983.

SAIF argues that as the only issue to be determined at the hearing was responsibility and, since the efforts expended by claimant's attorney were minimal, the fee awarded by the Referee was excessive.

We generally agree with SAIF's position, and it is unnecessary to reiterate everything that has been stated in other cases concerning this question. See National Farmers' Union Insurance v. Scofield, 56 Or App 130 (1982); Hanna v. McGrew Bros. Sawmill, 45 Or App 757 (1980); Wilfred Pultz, 35 Van Natta 684 (1983). Claimant's attorney's fee is reduced accordingly.

ORDER

The Referee's order dated July 11, 1983 is affirmed in part and modified in part. That portion of the Referee's order which awarded claimant's attorney a fee of $1,200 is modified and in lieu of that, claimant's attorney is hereby awarded a fee of $700. The remainder of the Referee's order is affirmed in all respects.

STEVEN A. DRAKE, Claimant
Allen & Vick, Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 82-10048
January 31, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Howell's order which set aside its denial of claimant's aggravation claim.

Claimant suffered a compensable low back injury in April 1981. After a period of conservative treatment, claimant was able to return to regular work and rather strenuous recreational activities. Claimant contends that in September 1982, about 18 months after the industrial injury, he fell while hunting and reinjured the same area of his low back. The issue is the compensability of this incident and subsequent disability under the test of Grable v. Weyerhaeuser, 291 Or 387 (1981).

The Referee found that: (1) Claimant's hearing testimony was not credible; (2) medical opinions based on claimant's reports of subjective symptoms were thus to be discounted; and (3) nevertheless, claimant had established the compensability of his aggravation claim. We agree with the Referee's first two conclusions; we disagree with the third.

Claimant's vocational and recreational activities before the September 1982 hunting incident suggest a complete recovery from the April 1981 industrial back strain. Claimant's activities in October 1982, as depicted on surveillance films, suggest that any incident that occurred the prior month while hunting did not cause any disability. But even if there was a worsening of claimant's back condition in September 1982, we find no persuasive evidence that the April 1981 industrial injury was a material cause of any worsening, as required by Grable.

ORDER

The Referee's order dated March 4, 1983 is reversed. The insurer's denial dated October 20, 1982 is reinstated and affirmed.

BETTY FISHER, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-05805
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Seymour's order which set aside its June 19, 1981 denial. SAIF contends that the Referee erred in setting aside its denial and, alternatively, that the attorney fee awarded by the Referee is excessive.

Claimant began working for Lane County Department of Assessment and Taxation in 1977. Claimant performed well in her job and advanced to the position of Clerk 2 after a short period of time. Claimant's initial merit ratings were above average.

In 1979 claimant's supervisor left and was replaced by a Ms. Fetsch. In 1979 Ms. Fetsch gave claimant an above-average merit rating and praised her performance.

In January 1980 claimant was suspended from work for ten days without pay for alleged abuse of sick time. Claimant had left work on January 15, 1980 to go home to care for a sick child. When claimant failed to show up for work the next day, claimant's supervisor called claimant at home and was apparently informed by claimant's son that claimant had gone to Portland the day before and would not be back until that evening. Despite this incident, claimant received another above-average merit rating from Ms. Fetsch in 1980.

Sometime in late 1980 claimant began to feel that she had not been given an adequate opportunity to advance in her job. She believed that other employes who had been working for the agency for shorter periods of time were getting better assignments.

In late 1980 claimant was given permission by her employer to work the "4/10" schedule (four days per week, ten hours per day), rather than the regular five day per week, eight hours per day schedule. It was reported to the employer by other employes that there was a suspicion that on several occasions claimant had worked less than the required ten hours per day. Based on this suspicion, claimant was suspended from work on February 24, 1981 for two weeks without pay. Claimant filed a grievance as a result of this action and apparently prevailed.

Approximately one month after her suspension, claimant telephoned Dr. Church and complained about headaches she was experiencing. Claimant had been treating with Dr. Church since 1978 when she suffered hives which had been aggravated by stress related to a divorce proceeding. In 1980 Dr. Church treated claimant with Soma compound (a muscle relaxant) for tension and anxiety related to difficulties she was having with one of her neighbors.

Dr. Church's chart notes indicate that claimant was suffering from "stress" headaches which were sucessfully treated with Tylenol, Soma Compound and reassurance. Claimant apparently informed Dr. Church that she felt her headaches were related to the

grievance she had filed against her employer. Claimant testified that she began suffering from headaches in December 1980 or January 1981. She stated that the headaches occurred during the time she was at work but that there was nothing regular about when they occurred. Claimant also stated that she "didn't have them very much" during the weekends.

On March 23, 1981 claimant was given her regular merit evaluation. Claimant's overall rating was average to above-average. It was noted that she had problems with attendance and observance of work hours.

On April 13, 1981, claimant saw Dr. Church and complained of continued headaches.

On April 14, 1981 claimant gave notice to her employer that she was going to accept an employment offer that grew out of a previous job interview. Claimant indicated that her last day of employment would be April 24, 1981.

On April 17, 1981 claimant filed a Form 801 with her employer alleging that harassment by her supervisor had caused emotional distress and resulted in headaches. Claimant thereafter left her employment with Lane County and proceeded to her new job.

On June 19, 1981 SAIF denied the claim.

In a brief note dated October 16, 1981, Dr. Church reported that she had seen claimant on April 13, 1981, that claimant was complaining of headaches and that Tylenol and muscle relaxants had been prescribed. Dr. Church stated that claimant had expressed the feeling that her headaches were related to the grievance process going on at work. Dr. Church adopted claimant's statement concerning the cause of her headaches.

At the request of the insurer claimant was examined by Dr. Holland, a psychiatrist. Dr. Holland reported that claimant was feeling depressed and that she had been unfairly dealt with in relation to her grievance and separation from her employment with Lane County. Dr. Holland stated:

> "When I asked Betty what her goals were for legal assistance, she responded she was not sure, but for the first time in her life she felt she was the victim of very unfair treatment."

Dr. Holland concluded:

> "[Claimant] seems to be a reasonably healthy person psychologically, who has been involved in an employment situation which seems to me can be best understood from the format of a grievance process."

The Referee indicated that the demeanor of the witnesses left one with the impression that there was a personality clash between the parties which had perpetuated a vendetta. The Referee concluded that claimant had established the compensability of her claim. We accept the conclusion the Referee drew in relation to

his observation of the witnesses; we disagree on the issue of compensability.

A review of the entire record leads us to the conclusion that this claim was basically filed by the claimant in retaliation for what she perceived to be unfair treatment at the hands of her supervisor. The timing of the claim, the events which occurred prior to the claim being filed, Dr. Holland's statements and conclusions and the Referee's observations of the parties at the hearing all lend support to this conclusion.

We do not find any medical evidence supporting compensability to be particularly convincing. Edwin Bolliger, 33 Van Natta 559 (1981). In point of fact, the only evidence which does support compensability is Dr. Church's brief letter of October 16, 1981. However, it is quite apparent that Dr. Church is doing little more than repeating what claimant had told her was the cause of her headaches. In view of claimant's motive for filing this claim, such statements must necessarily be viewed with skepticism. In short, we are not convinced that claimant actually suffers from any work-related condition other than hurt feelings. Olive B. Elwood, 35 Van Natta 205 (1983). That being the case, we find that she has not established the compensability of her claim.

ORDER

The Referee's order dated October 25, 1982 is reversed. The SAIF Corporation's June 19, 1981 denial is reinstated and affirmed.

PATRIC S. HARKINS, Claimant
Royce, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-08607
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Leahy's order which modified the August 16, 1982 Determination Order by increasing claimant's award of permanent disability benefits from 15% permanent partial disability to permanent total disability for his brain injury.

On May 6, 1981 claimant suffered a compensable concussion when he was knocked to the floor, became unconscious and subsequently experienced two epileptic seizures. Claimant has suffered from epilepsy since childhood. However, it had been controlled to an average of four or five seizures a month prior to this incident. After his injury, his epileptic seizure disorder was severely worsened. He testified to having seizures almost daily, requiring greatly increased amounts of medication with varying side effects. Additionally, the injury caused a post-concussion syndrome. Therefore, in addition to claimant's daily seizures, which can leave him fatigued from eight to twelve hours, his problems now include inability to focus his eyesight, poor memory, inability to concentrate, nausea and affected hearing. He has severe and frequent headaches. He has been left with a slight decrease of his senses in the entire left side of his body with regard to pain, temperature, proprioception and vibration. He has coarse nystagmus at the extremes of lateral gaze and brief fine nystagmus on superior gaze. He has decreased facial sensation on the left and his speech is slightly slurred.

Claimant attempted to return to work in July 1981. However, he testified that on his return he found he had forgotten how to do his job. He had been acting as an assistant to the director of the Loaves and Fishes program in Portland. He found he was unable to do the daily paperwork that was required. They allowed him to forego the paperwork and try to work on a one-on-one basis as a counselor, but, eventually, they had to discontinue his services after three months. Since that time he has had no gainful employment and his days consist mainly of volunteer work as he is able at the Union Gospel Mission.

His treating neurologist, Dr. Olmscheid, when questioned whether claimant could find gainful employment, replied, "I think the patient, first of all, is a very resourceful individual. I think that he could probably find some variety of gainful employment. Whether or not that's a practical consideration is open to question." The doctor ruled out any work except "some variety of sedentary work providing that the circumstances were appropriate." The "circumstances" are that claimant has to be able to find an employer with a sedentary job who would be willing to countenance repeated grand mal seizures during the work day, who would understand that often during work claimant would be lethargic as a result of his seizures, who would understand absences from work due to his condition, who would not be disturbed by the unreliability of data generated by claimant due to confusion and memory loss, who would be willing to allow claimant to take a rest period during the day and, in the words of Dr. Olmscheld, who would take the risk of "poor publicity" if claimant was to experience an epileptic seizure while at work.

Besides working for Loaves and Fishes and the Union Gospel Mission, claimant's only work experience has been working one summer as a janitor in his parent's church. He worked five days as a janitor at another job, but was fired because he had a seizure. Although claimant is young at the age of thirty and intelligent, we find that given his extreme medical condition, his severely limited pre-injury work experience, and the resulting extreme limitations on any work that he might now be able to perform, the Referee correctly awarded permanent total disability benefits to claimant. We, therefore, affirm his order.

ORDER

The Referee's order dated June 17, 1983 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

LEONARD B. HURTT, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-09970
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of that portion of Referee Danner's order which set aside its denial of claimant's aggravation claim for his low back condition. Claimant cross-requests review of that portion of the order which found the effective date of reopening was December 22, 1982.

The Referee found claimant had carried his burden of proving a worsening of his condition. We disagree.

Claimant initially compensably strained his lumbar spine on March 2, 1980. The evidence indicates the lumbar strain was superimposed on degenerative arthritis and degenerative disc disease at L5-S1. A myelogram showed a small L-3, L-4 defect. All treatment was conservative. Orthopaedic Consultants evaluated claimant and rated his permanent impairment, attributable to the industrial injury, as mildly moderate. The claim was closed by Determination Order dated February 19, 1981, which awarded him 64° for 20% unscheduled permanent partial disability.

On March 30, 1982 claimant enrolled in a vocational rehabilitation training program. In mid-August 1982, approximately one month before the program was due to conclude, claimant complained of low back and leg pain. The vocational rehabilitation counselor's notes document these complaints which apparently forced claimant to miss two days of training. Claimant was able to complete the program as scheduled on September 30, 1982.

On August 23, 1982 claimant first began treatments with Dr. Burdell, a chiropractor. Dr. Burdell diagnosed "suggested L5 compression and degenerative disc disease with grade II bilateral sciatica more marked on the left." He offered no opinion regarding causation. Late in March 1983 Dr. Burdell did conclude claimant's lumbar and leg pain was a result of his industrial injury.

Dr. Burdell referred claimant to Dr. Donald T. Smith, a neurologist. Dr. Smith examined claimant, for the first and only time, on December 21, 1982. Dr. Smith believed claimant's symptoms could readily be explained by the extensive nature of his lumbosacral degeneration and/or disc protrusion at the L4-5 level. He opined that claimant was nearly, if not completely, incapacitated by his current condition. Dr. Smith felt the claim should be reopened and that a complete set of lumbar spine x-rays, a CT scan and probably another myelogram were in order.

In finding a compensable aggravation, the Referee was persuaded by the "strong statements" of Dr. Smith. These statements were contained in a letter dated May 9, 1983:

> "...It would be my opinion that the patient's injury of 3 March 1980, produced a severe aggravation of his previous lumbosacral osteoarthritic condition, resulting either in frank discal protrusion at the

L4-5 level and/or rendering symptomatic those areas of the lumbar spine with resultant chronic pain as a result of tissue irritation, inflammation and possible nerve compression.

"On the basis of the acute onset of the patient's history, the possibility of significant protrusion as the immediate cause of his pain is certainly probable. Insofar as his degenerative disc disease being the cause of his postinjury pain, I do not believe that the history suggests the patient was in fact having intractible pain problems prior to the injury in question. Insofar as the hastening or worsening of the underlying degenerative disease, on the basis of clinical impression, the injury of 3 March 1980, rendered the condition "severely symptomatic" and therefore has produced a worsening.

"Although this issue seems to come forward constantly, I believe there is little question within either the orthopedic or neurosurgical literature that most responsible physicians would agree that trauma superimposed on the presence of degenerative changes of joints and other tissues and structures is extremely likely to worsen that condition particularly as it refers to a progressing and/or intractible pain condition...."

Claimant was reexamined by Dr. Wilson, a neurologist, on October 4, 1982. Dr. Wilson had last examined claimant on December 15, 1980. Based on claimant's history, Dr. Wilson felt claimant had sustained an exacerbation of his chronic lumbosacral strain resulting in some increase of his symptoms. Dr. Wilson found claimant to be medically stationary. Dr. Wilson concluded that claimant's condition was related to his industrial injury, but was only a temporary flare-up. Dr. Wilson's statements indicate that claimant's condition did not actually worsen, but he merely experienced the fluctuations which can be expected in a person with a 20% unscheduled disability award.

The medical evidence on the question of whether claimant has proven a compensable worsening is conflicting and we find no opinion more convincing than the other. Dr. Smith's "strong" statements are counterbalanced by the contrary statements of Dr. Wilson, the physician who examined claimant both before and after the last award of compensation.

In addition, in March 1983 claimant was examined by another neurologist, Dr. Cruickshank. It was Dr. Cruickshank's opinion claimant had not suffered a material worsening of his condition because of the industrial injury. The doctor felt claimant's complaints were related to his underlying arthritic and degenerative disc disease.

As further support for his finding, the Referee referred to claimant's subjective complaints and statements which were made to his vocational rehabilitation counselor. We do not find these statements persuasive. It is not surprising to us that claimant would occasionally experience flare-ups of excruciating back pain. He had incurred a mildly moderate permanent impairment to his low back which had resulted in a 20% permanent partial disability award, and was suffering from degenerative disc disease and osteo-arthritis. This prior award contemplates recurrent fluctuations of symptoms. Harmon v. SAIF, 50 Or App 121, 126 (1981); Jo Wanda Orman, 35 Van Natta 650 (1983).

Furthermore, we note the Referee did conclude that claimant was guilty of some manipulation of his claim. After claimant testified that he had experienced no back pains prior to his 1980 industrial injury, he was confronted with medical reports which contained histories of his complaints of chronic low back pain since 1955.

Because we are not persuaded by the medical evidence nor by claimant's testimony, we conclude claimant has failed to carry his burden of proving a worsening of his condition since the last award of compensation.

Since we reinstate the denial, the issue of the correct date for reopening is moot.

ORDER

The Referee's order dated June 24, 1983 is reversed. The SAIF Corporation's denial dated March 24, 1983 is reinstated and affirmed.

ARLISS D. INGRAM, Claimant
Kenneth D. Peterson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-06472
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Menashe's order which upheld the employer's denial of claimant's carpal tunnel syndrome. Claimant argues that the Referee erred in upholding the denial. She also argues that the Referee erred in excluding certain documents pursuant to OAR 436-83-400(3) and (4), the ten day rule.

On the evidentiary issue, we reverse. Eleven days prior to hearing, claimant's attorney telephoned both opposing counsel and the Referee and read to them proposed exhibit 13 which claimant's counsel had just received from a physician. Claimant's attorney thereafter mailed the exhibit which was received by opposing counsel and the Referee prior to the hearing in this matter. A second exhibit, proposed exhibit 14, was generated in response to exhibit 13. It was submitted within ten days prior to hearing. The Referee excluded both exhibits saying:

> "Without any cogent explanation for the lateness of the reports, the objections to Exhibits 13 and 14 are sustained."

After reviewing the record, we conclude that the Referee abused his

discretion in declining to consider exhibits 13 and 14. Claimant did not receive exhibit 13 until eleven days prior to hearing. He immediately telephoned opposing counsel and the Refereee and attempted to put them on notice that he intended to rely on that report. He then sent copies. In addition he solicited a report from another physician in response to exhibit 13. While that report was not even in existence ten days prior to hearing, it was submitted prior to the actual date of hearing. It is apparent that claimant's attorney was not playing litigation games. Rather, he was attempting to comply with the spirit of the ten day rule by making sure that both opposing counsel and the Referee had notice of exhibits upon which he intended to rely. Balancing this agency's fact finding mandate against its policy of minimizing game playing designed to obscure the search for truth, we conclude that the Referee abused his discretion in declining to admit exhibits 13 and 14. Accordingly, we consider those exhibits in our review of the case.

On the merits, we reverse the Referee's order.

Claimant began working as a potato inspector on February 1, 1982. Within two weeks of that date, claimant began to experience numbness and tingling in her right hand. She had never before experienced such symptoms. She was diagnosed as having bilateral carpal tunnel syndrome, right worse than left. Her treating physician related the onset of carpal tunnel symptoms to her work activity. The SAIF Corporation referred claimant to Dr. Peter Nathan for an evaluation. Dr. Nathan opined:

> "She noted the onset of her symptoms within a few days of commencement of employment at Lamb Weston in her capacity of a Utility III worker. It does not seem reasonable that this work activity is either the cause of the underlying disease nor significantly responsible for the symptoms."

Based on the medical evidence, the Referee found that claimant's work activity was the major contributing cause of her symptoms. We agree with that finding and adopt it.

The Referee held, however, that the carpal tunnel syndrome was not compensable because claimant had failed to prove a worsening of the underlying condition as he believed the Supreme Court required in Weller v. Union Carbide, 288 Or 27 (1980). Since the Referee's order, the Court of Appeals has made it clear that the Weller requirement that a claimant prove a worsening of an underlying condition does not apply when the claimant has not previously sought medical attention for the underlying condition. Wheeler v. Boise Cascade, 66 Or App 620 (1984). Because we find that claimant was asymptomatic prior to her work exposure, we conclude that claimant does not have to prove a worsening of her underlying condition.

Because Weller does not apply to this case, and because we find that claimant has proven by a preponderance of the evidence that her work activities were the major contributing cause of her symptoms, we reverse the Referee. SAIF's denial should be set aside.

ORDER

The Referee's order dated May 20, 1983 as amended by his order on reconsideration dated July 8, 1983 is reversed. The denial dated July 6, 1982 set aside and this claim is remanded to the SAIF Corporation for acceptance and processing according to law. Claimant's attorney is awarded $2000 for services on Board review, to be paid by the SAIF Corporation.

WILLIAM B. JOHNSON, Claimant
Ringo, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-11060
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Quillinan's order which modified the November 16, 1981 Determination Order by increasing claimant's permanent disability award from 96° for 30% permanent partial disability to permanent total disability benefits for claimant's brain injury.

SAIF contends that claimant is not entitled to an award of permanent total disability because his impairment is only of a moderate degree and precludes him only from jobs involving dangerous machinery or complex tasks. Second, SAIF contends that claimant has not met the requirements of ORS 656.206(3) in that he has voluntarily retired and has not made any real effort to find work. Claimant has cross-appealed the Referee's order contending that the effective date of his permanent disability award should be July 14, 1981, the date when his treating physician, Dr. Knox, determined that claimant was medically stationary.

On April 29, 1980, claimant was in a compensable motorcycle accident in which he sustained a skull fracture and cerebral contusions among other injuries. He was left with severe memory defects, severe headaches, emotional distress and depression. At the time of hearing claimant was 55 years old. Although attending school only to the sixth grade, claimant has obtained a GED and a community college degree in engineering technology. At the time of his injury, he had been employed for eighteen years as a laboratory technician at Oregon State University where he assisted chemical engineering students with their research projects. His background includes other job skills of watch repair, jewelry store owner, baker and restaurant and hotel management.

Prior to the injury, claimant suffered from dyslexia, a condition which interferes with reading and writing. Claimant compensated for this problem by developing an excellent verbal and visual memory. He also suffered from rare incidents of syncope with associated left-sided blindness. His employer at OSU had a cot nearby that claimant could use if he felt he was going to black out. Claimant also has a defective heart valve which was not limiting.

In August and September 1980, Dr. Ackerman, psychologist, examined claimant during three separate appointments. His report states claimant's complaints:

"Mr. Johnson experiences throbbing,

bihemispheric, headaches which bring tears to his eyes, sweating, and intense feelings of frustration. He believes these headaches are brought on by 'thinking.' He recognizes that events about which he becomes emotionally distressed usually result in intense headaches . . . Mr. Johnson experiences disruptions in his sense of flow of time, sequence of events, and whether he's done something, heard about it, and cannot recall whether this was something from the distant past, recent past, or even a fantasy. He states that people tell him that he's said or done things recently and he cannot believe, for, 'that's just not like me.' He experiences a lot of difficulties with expressive language functioning, frequently being unable to name people or common objects . . . He complains of being more depressed these days, states that when he's aware he feels motivation, often feels well enough, but cannot persist in directed activity because of lapses of concentration, and the frequent fatigue and headaches. At times, 'I find myself sitting in front of the t.v. I wonder what the hell I'm doing here? I tell myself, get busy.' 'Or I'll take the calf out and tie her up, thought I fed her and turned her loose, then go out the next day and she's still tied up and she has no food. I forget to feed the chickens. I sit at home and think about my job, and I'm sure I can do it. I check in at the lab twice a week, and then I meet students I've known for a couple of years and I can't think of their names. I try to remember the project we've been working on, and I can't remember the basis for their study. I knew all this before. I'm afraid if I go back to work I won't be able to do the work and I might hurt someone.' Associated with the headaches is a lot of dizziness and periodic nausea. His stomach often feels upset. And the man frequently feels fatigued."

Dr. Ackerman's Neuropsychological Evaluation contains the following statement:

"On the Rey Auditory-Verbal Learning Test the patient produced a flattened learning curve that reached an asymptote at 50% the level we would expect with an undamaged brain. Long-term recall was extremely poor, with prompted recognition was at 50% of the level we would expect. These results indicate serious auditory learning and recall difficulties, but with accessing and retrieval problems even more serious than memory

problems . . .Immediate and medium term visual memory recall shows moderate impairment, while interposing visual distractions results in moderately severe loss of access to stored material . . . Tasks requiring sequential mental operations, especially those involving double tracking, like reversing months, doing serial subtraction, are very difficult for this man. He required 25 seconds to subtract 7 from 100, and after 90 seconds had done three serial subtractions. Simple, over-learned sums and differences at times are inaccessable to him; '9-7.. What? (counts on his fingers) I'm blank.'

"Again Mr. Johnson asserts that he always was very good at mental calculations and seemed genuinely perplexed at the amount of difficulty he now has doing specific, sequential mental operations.

"Fine visual analyses are slowed and impaired. Embedded fingers, shadow shapes, are slowly and incorrectly perceived. The cortical visual analyses of complex figures seem moderately impaired at this time . . . At times he has aphasic lapses in understanding of words or concepts, and at other times forgets important data, but when he can momentarily understand and remember the components, he can do the processes. I'd conclude that higher order abstract reasoning is quite intact, though he shows significant problems with momentary concentration and recall, indicating a variable acoustic-mnestic aphasia, as well as momentary visual agnosias, and other accessing difficulties to both visual and auditory information . . . In testing visual-positional sense, I note a strong tendency towards echopraxia. About a third of the time he cannot suppress the immediately, echopraxia response, though he tends to self-correct immediately thereafter. He avoids echopraxic imitation with difficulty."

Regarding claimant's emotional status, Dr. Ackerman reported:

"I think some of his dramatic frustration and hopelessness as well as the intensity and mode of onset of his headaches reflect a psychophysiological reaction to stress and frustration. But I think the core problem is one of the head injury which limits his ability to cope cognitively as well as physically."

Dr. Ackerman concluded:

> "I find significant attention and concentration problems in this man that are consistent with a head injury causing generalized cerebral dysfunction, but affecting more significantly temporal-parietal occipital cooperation. There are some mild pre-motor signs though the most significant problems are with visual and auditory attention, learning, recall, and sequential mental operations . . . I would attribute at least 75 percent of his difficulties to brain dysfunction and no more than a quarter of his difficulties to functional, psychological factors. I have no doubt that stress increases his fatigue, distractability, and psychosomatic reactions."

In June 1981, claimant was evaluated at the Callahan Center. Testing revealed marginal reading ability with dull or low normal verbal aptitude, low borderline numerical reading, low average perceptual abilities, motor coordination and finger dexterity, and borderline ability and manual dexterity. Claimant qualifies for only one occupational pattern. Claimant's overall intellectually efficiency as measured by the Wechsler IQ scale was average, but claimant had difficulty with tasks requiring attention, concentration and recall.

Dr. Johnson, Callahan Center psychologist, summed up claimant's job status in this way:

> "Conversation with Mr. Johnson indicates that he would likely be willing to consider and explore the possibility of re-employment, although to a large extent, in his own words, he had resigned himself to retirement. Given his problems and circumstances, his resignment is not difficult to understand. In view of the patient's impaired memory, and his inability to attend and concentrate, plus the possibility of petit mal seizures, it is questionable that Mr. Johnson would be able to perform in most job settings. As he points out, he would need a job where he doesn't have to think . . . As to the question of return-to-work, the patient's subtle combination of problems would appear to make return to work planning difficult if not impractical. Although he apparently has a number of skills to draw from, each would appear to depend upon ability to maintain a mental set, attend and concentrate. In the final analysis, vocational plans would have to involve non-intellectually demanding activities and be assessed on the job."

After receiving the Callahan Center reports, a Field Services

Division representative determined ". . . that it is not feasible to provide you with our services at this time. If, at a later date, improvement in your condition occurs, I will be happy to provide you with assistance." A few days later, claimant decided not to pursue vocational assistance at that time with the Field Services Division.

In July 1981, Dr. Knox, claimant's treating neurologist, stated that claimant could not return to his job at Oregon State University because of his memory impairment.

Dr. Ackerman re-evaluated claimant in September and October of 1981. Dr. Ackerman noted claimant's complaints:

> "The core of Mr. Johnson's complaints seems a profound impairment of memory where he constantly loses his focus of attention and point in conversation, can't keep the order of events straight so that an hour seems like a week ago, or a month ago seems like a few minutes ago. He asserts that he continues to mislay things, gets confused on projects, lose his order sequence, and live in a time-disrupted, disjointed world of great memory defect. He even expressed the idea that he can't remember his present wife prior to his hospitalization, although he's told by friends that he's known her for years.
>
> "I'd summarize Mr. Johnson's memory complaints by saying that he seems to live in a little sliver of time around the present where each new memory seems to displace the previous memories, and all previous memories seem equally recent and probably as he retrieves them in a jumbled, time-disrupted order.
>
> I talked to Mrs. Johnson alone, and she reports about the same problems with Mr. Johnson's memory as he describes . . . Regarding his daily behaviors, she reports that on old, highly practiced, manual tasks he does adequately. But given a project that he's attempting to organize and complete, he seems to be unable to plan and execute the whole sequence. The decision-making, remembering, sequencing, and follow up seems more than he can handle and he doesn't get his action plan going. She notes that if he's told more than two things at a time he gets mixed up or forgets."

On his neuropsychological evaluation, Dr. Ackerman reported:

> "Some improvement in claimant's overall condition while noting the continuing problems with memory, expressive language and comprehension. All of which demonstrated

> an overall level of moderate impairment of intellectual functioning. Mr. Johnson has significant defects of memory in respect to learning, retention, and retrieving. Immediate recall is impaired, but with any intervening, distracting task the client appears to suffer a severe inability to retrieve information and a lot of contamination of material presented early and material presented later. Overall, it appears that his memory has deteriorated significantly over the past year . . . I believe he suffers a moderate defect of memory due to organic factors, but his severe to profound apparent defects of memory are due to emotional factors . . . Emotionally, Mr. Johnson has shown a gradual increase in elevation of his MMPIs over repeated testings, and the profile looks more chronically psychoneurotic with a gradual increase in signs of discomfort in the form of mild-moderate level of chronic anxiety, depression, and multiple somatic and cognitive complaints."

Dr. Ackerman concluded claimant was retrainable and employable on an organic basis, but when considering his psychological status, Dr. Ackerman thought the probability of claimant's successful return to work or becoming rehabilitated was poor. Due to memory lapses and inability to concentrate, claimant was potentially dangerous to himself and others if distracted while operating or using certain types of dangerous machinery. "His organic brain status renders him employable; emotionally and practically speaking I doubt that he'll work again."

In December 1981, Dr. Knox indicated his agreement with Dr. Ackerman's assessment.

Claimant was referred to Dr. Holland, psychiatrist, by the insurer. Dr. Holland referred claimant to Dr. Lewinsohn, psychologist, for testing. In Dr. Lewinsohn's opinion, claimant could be expected to experience difficulties in every day situations requiring short and long term memory, and the amount of information claimant could simultaneously grasp was limited. Claimant also experienced significant difficulties with mastering sequences of events. Dr. Lewinsohn concluded claimant had a "very serious and generalized memory disorder extending to all modalities and involving attentional, short-term and long-term memory processes." "One might expect," he stated, "this man will find it very difficult to perform in occupational situations which do not involve highly over-learned routines in very familiar surroundings."

Upon receiving Dr. Lewinsohn's report, Dr. Holland agreed that neuropsychological testing documented significant impairment of the central nervous system functioning on an organic basis. He noted Dr. Lewinsohn's comment that "it would be most difficult for Mr. Johnson to perform in an occupational setting which was not extremely familiar and repetitious in its nature." Dr. Holland did

not agree with Dr. Lewinsohn that claimant's depression was in need of treatment. Dr. Holland felt claimant experienced moderate impairment of the central nervous system functioning, but believed that he was capable of performing some vocational activity where "he would not be required to perform complex and varied tasks which require the retrieval of a great deal of short-term memory . . . I do not see him returning to vocational activity for the simple reason that he is very contented with the situation in which he finds himself."

In December 1982, Dr. Knox reported that claimant continued to complain of recurrent intermittent episodes of dizziness as well as continuing problems with recent memory. "It is my opinion that the patient is totally and permanently disabled because of his condition and is unable to return to gainful employment, primarily due to his severe recent memory defect well-documented by repeated psychological testing."

Our review of the medical evidence shows that, with the exception of Dr. Holland, all the doctors consider claimant's mental capacity to be severely impaired by a combination of organic factors, as well as by emotional, psychoneurotic reaction. Claimant did make only one attempt to return to work when he contacted his former employer at OSU, but there were no openings.

ORS 656.206(3) requires workers to make reasonable efforts to seek work. Given claimant's age at 55, his inability to return to any of his previous employment, his preexisting condition of black out episodes which apparently have become more frequent in recent years, his greatly reduced writing and mathematical ability, his preexisting dyslexia, and his severe loss of mental capacity in the form of impairment of memory and attention span along with resulting emotional problems, such as depression, frustration and disorientation, precluding employment in all but the very simplest activities, we cannot say, given claimant's mental difficulties and emotional status, that claimant is not motivated or that it would be anything but futile for claimant to seek work. As the Referee noted, all the doctors, with the exception of Dr. Holland, found claimant to be motivated, but also to be realistic in assessing his probabilities of re-employment. Field Services Division determined that it would be useless to provide job services to the claimant.

Based on the above, we find that the Referee's thorough and well-reasoned order granting claimant permanent and total disability benefits should be affirmed.

The Referee did not indicate in her order a specific date that claimant's award of permanent total disability benefits should commence. Our review of the record indicates that Dr. Knox, claimant's treating neurologist, found claimant permanently and totally disabled when he was last seen on October 21, 1982. We find that claimant's permanent total disability benefits should be effective from that date and modify the Referee's order accordingly.

ORDER

The Referee's order dated May 20, 1983 is modified in part. The Referee's award of permanent and total disability shall be effective October 21, 1982. The remainder of the order is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the SAIF Corporation.

JULIE R. JONES, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-02680
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Menashe's order which set aside its March 5, 1982 denial. The issue for review is compensability.

Claimant, who was 32 years of age at the time of the hearing, suffered a compensable injury on January 29, 1976 while working as a licensed practical nurse. Claimant was adjusting a patient in bed when she suffered a strain of her right shoulder and upper arm. Dr. Corbett diagnosed a rotator cuff and axillary nerve sprain. Dr. Corbett found no neurological deficits and treated claimant conservatively. On June 17, 1976 a Determination Order issued awarding claimant approximately two weeks of temporary total disability benefits.

Claimant sought no further medical treatment from March 1976 until December 1977 when she returned to Dr. Corbett complaining of pain. Claimant suffered intermittent exacerbations of pain throughout 1978, for which she continued to treat with Dr. Corbett. Dr. Corbett referred claimant to Dr. Silver, a neurosurgeon. Claimant was examined by Dr. Silver on May 12, 1978, at which time he diagnosed claimant as suffering from a chronic muscle strain of her right shoulder and a chronic cervical strain.

Claimant was thereafter referred by Dr. Corbett to Dr. Hendricks. Dr. Hendricks reported on June 29, 1978 that upon EMG testing, he could find no objective evidence of any problem, and that he had no suggestions to offer claimant in the way of treatment.

Nothing further from a medical standpoint was heard from claimant until December 8, 1980 when claimant returned to Dr. Corbett complaining of right shoulder pain. Dr. Corbett reported that he could find no objective evidence of any pathology and that he had prescribed pain medication. On December 23, 1980 Dr. Corbett reported that he believed that a Minnesota Multiphasic Personality Inventory test should be administered to claimant and that:

> "The MMPI would be of considerable value if one were to entertain further treatment of the patient. At present, the patient's complaints continue to be unsupportable and I would anticipate that if an MMPI were suggested or ordered for her that she would cease her visits to this office as she did in 1978. I have no evidence to indicate an ongoing pathologic process related to her injury of 29 January 1976. The patient, however, apparently does."

Claimant continued to complain of pain and continued to treat with Dr. Corbett. Dr. Corbett continued reporting that there was nothing objective to support claimant's complaints. Nevertheless,

a second EMG was performed on claimant by Dr. Hendricks in February 1981. Dr. Hendricks reported on February 23, 1981 that the EMG results were entirely normal and that claimant had no positive neurological findings whatsoever.

Claimant was thereafter examined by Dr. Eisler, a neurologist. Dr. Corbett reported on June 26, 1981 that Dr. Eisler's examination of claimant was essentially noncontributory. Dr. Corbett referred claimant to Dr. Camp, a neurosurgeon at the Whitman Institute of Neuroscience in Walla Walla, Washington.

Dr. Camp reported on November 30, 1981 that claimant was suffering from a rhomboid and levator scapulae spasm. Dr. Camp expressed some skepticism that claimant should be suffering from subjective symptoms from a minor injury which occurred nearly six years previous. Dr. Camp indicated that the perpetuation of claimant's symptoms was more likely related to claimant's emotional and social circumstances rather than her 1976 injury.

On March 5, 1982 SAIF issued a partial denial alleging that claimant's current medical treatment was not related to the January 1976 injury.

Claimant thereafter sought further treatment from Drs. Eisler and Gillespie. Dr. Eisler reported he could find no objective reasons for claimant's continued discomfort. Dr. Gillespie similarly reported that he was at a loss to explain claimant's complaints of pain, and that he did not believe claimant was suffering from residuals of the 1976 injury.

On March 31, 1983 Dr. Eisler performed nerve conduction studies on claimant. As expected, the results of those studies failed to establish any reason for claimant's subjective complaints, which by this time involved claimant's entire right arm and migrated to her left arm as well.

Since November 1978 claimant has worked 16 hours per week at Eastern Oregon Hospital and Training Center. Claimant has a young daughter and her hobbies involved quilt making, tole painting and refinishing furniture.

The Referee concluded that because there was no apparent nonindustrial cause of claimant's pain that it must, therefore, be related to the 1976 injury. We disagree.

As noted by SAIF, claimant has been examined and tested for a period of over seven years by numerous physicians in various specialties. In those seven years, no physician has been able to make a specific diagnosis in relation to claimant's current problem nor find any objective evidence of residuals related to claimant's 1976 injury. All of the physicians involved in this case have reached that same basic conclusion. Dr. Corbett, who has been claimant's primary physician throughout this entire period of time, has consistently stated that he could find absolutely nothing to indicate that any pathologic problem was present. Although this fact is certainly not conclusive, it must be remembered that claimant has the burden of proof, and as a practical matter, that burden is almost always going to be more difficult to carry in the absence of any specific findings or diagnosis. See Lorrie A. Minton, 34 Van Natta 162 (1982); John R. Hart, 35 Van Natta 665 (1983).

In this case, claimant's injury was initially diagnosed as a strain. She received some conservative care for a period of time, and sought no medical treatment from March 1976 until December 1976. Following a period of treatment for further complaints in 1978, claimant sought no medical treatment from June 1978 until December 1980, a hiatus of two-and-one-half years. When claimant returned to Dr. Corbett in December 1980 he reported that he had no evidence which would indicate claimant was suffering from residuals of her 1976 injury. The most that Dr. Corbett has been able to say is that claimant appears to have pain in the area of the 1976 injury. Dr. Camp reported that it was unlikely that claimant's symptoms were related to the 1976 injury. Although Dr. Eisler did report that claimant's complaints were probably related to the 1976 injury by her history, in view of the above, we do not find this to be sufficient.

Unlike the Referee, we do not find the fact that there is no apparent nonindustrial explanation for claimant's condition to be particularly persuasive evidence. Although this may create an inference, it is insufficient to satisfy claimant's burden of proof. Brad L. Loren, 35 Van Natta 303 (1983); William Strebendt, 35 Van Natta 314 (1983), aff'd without opinion, ___ Or App ___ (1984).

In summary, we have a claimant who experienced a minor shoulder strain in 1976 necessitating two weeks of time loss, followed by an eight month hiatus in treatment, followed by 6 months of additional conservative treatment, followed by another hiatus of two-and-one-half years, followed by additional examinations and tests thereafter with no injury-related residuals having been noted, no objective findings having been revealed and no specific diagnosis having been rendered. All things considered, we cannot say that we are convinced by a preponderance of the evidence that claimant's current medical treatment is related to her 1976 strain injury.

ORDER

The Referee's order dated July 20, 1983 is reversed. The March 5, 1982 denial is reinstated and affirmed.

PATRICIA M. KNUPP, Claimant
SAIF Corp Legal, Defense Attorney

WCB 82-05092
January 31, 1984
Order on Review (Remanding)

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Seymour's order which found that claimant's aggravation claim was not compensable. In addition to contending that her aggravation claim is compensable, claimant contends that the SAIF Corporation, after initially accepting her claim for aggravation and after the expiration of 60 days, should not have been allowed to deny her claim.

The question raised by claimant is certainly a valid one in light of the Supreme Court's recent decision in Bauman v. SAIF, 295 Or 788 (1983). In Bauman, the court held that an insurer may not deny compensability of a claim after it has accepted the claim and

after 60 days have elapsed, unless fraud, misrepresentation or other illegal activity is shown. The record shows that SAIF paid claimant temporary total disability benefits and the medical bills related to her aggravation claim, but the record does not indicate when SAIF received notice of the aggravation claim. Without knowing the date of notice of the claim, we cannot determine whether SAIF denied the claim within 60 days of that notice. Inasmuch as the facts bearing on this issue were incompletely developed at hearing, we deem a remand to be appropriate. ORS 656.295(5).

Therefore, we remand this case to the Referee for further taking of evidence and a determination of whether SAIF's back-up denial is barred by the holding in Bauman.

ORDER

The Referee's order dated June 3, 1983 is vacated and this case is remanded to the Hearings Division for further proceedings in accordance with this order.

LEWIS A. LETTS, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-06742 & 82-03720
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Seifert's order which: (1) Affirmed the March 24, 1982 Determination Order which awarded claimant no permanent disability for his right wrist carpal tunnel syndrome; (2) affirmed the July 12, 1982 Determination Order which awarded 7.5° or 5% for claimant's left wrist carpal tunnel syndrome; and (3) found claimant had not proven that his left wrist condition had worsened in October 1982, therefore, refusing to reopen claimant's claim as of that time.

Claimant contends that he is entitled to an award of permanent disability for his right wrist and a greater award of permanent disability for his left wrist. Claimant additionally contends that he is entitled to claim reopening for his left wrist on the basis of Dr. Korn's November 18, 1982 report. We affirm that portion of the Referee's order which denied reopening of claimant's left wrist claim in October 1982. We reverse those portions of the Referee's order which affirmed the March 24, 1982 and July 12, 1982 Determination Orders, and we award claimant additional scheduled permanent disability for injury to both upper extremities.

On November 8, 1977 claimant, a sawmill worker, suffered injury to his right hand when a piece of wood he was cutting fell on his arm. To compensate for soreness in his right hand and forearm, he relied more on his left hand and developed problems with his left wrist in the form of moderately severe carpal tunnel syndrome. As a result, he underwent left carpal tunnel surgery in January 1978. After four months of recuperation, claimant was able to return to his regular job as resawyer. At that time claimant had some weakness, but no significant residuals, due to his left wrist carpal tunnel syndrome. Therefore, a Determination Order dated June 22, 1978 awarded temporary disability compensation, but no permanent disability compensation.

On April 20, 1979 claimant was changing a saw blade and strained the tendons in his right hand. This new injury was treated as an injury separate from the 1977 incident and was assigned a separate claim number. As a result of the April 1979 strain claimant underwent right carpal tunnel release on June 14, 1979. Claimant had some complaints of soreness in the palm of his right hand and aching and burning with use, but both Dr. Button and Dr. Bond did not anticipate any permanent impairment of function at that time. As a result the Determination Order dated November 16, 1979 awarded four more months of temporary total disability benefits, but no permanent disability benefits for the 1979 right wrist strain.

Claimant had been able to return to work in October 1979, but in February 1980 claimant again strained his right wrist which eventually resulted in surgical re-exploration of claimant's right wrist in October 1980. By May 1981 Dr. Bond released claimant to regular work stating he thought there was no apparent impairment in the right wrist, but that a recurrence of the problem in the future was possible and conceivable. Claimant did return to regular work at that time, but in October 1981 he again strained his left wrist. This resulted in a second carpal tunnel release of his left wrist in February 1982. In March 1982 Dr. Button gave his closing exam of claimant's right wrist stating that claimant had no permanent impairment of function in that wrist. A Determination Order followed on March 24, 1982 which awarded 14 more months of temporary disability benefits, but no permanent disability benefits for the right wrist.

At this time, however, claimant was still off work due to his left wrist surgery. Dr. Button gave a closing exam for claimant's left wrist in May of 1982 indicating complaints of pain and demonstrated weakness of power grip, but a full range of motion and a normal sensory examination. He concluded that these findings resulted in minimal permanent disability to the left wrist. As a result, a Determination Order issued on July 12, 1982 which awarded claimant seven more months of temporary disability benefits, but only 7.5° or 5% left wrist permanent disability benefits.

Meanwhile, claimant had again returned to regular work in July 1982. Thereafter, he only worked off and on due to the mill's sporadic operation. During this time his wrist symptoms of pain and numbness and loss of grip recurred. Claimant began seeing Dr. Korn and in a November 18, 1982 report Dr. Korn repeated the long history of claimant's right and left carpal tunnel conditions. He noted:

> "The patient has complaints mainly referrable to his left upper extremity where he complains that his hand 'goes to sleep a lot' and 'aches like a toothache.' "He has difficulty in lifting, grabbing and pulling heavy things which is commonly required in his demanding job. He has noted improvement in the symptomatology over weekends and, in fact, between the two office evaluations, he was laid-off and has had improvement in his symptomatology."

On examination Dr. Korn noted that claimant had full range of motion and normal sensation in both wrists. He stated that claimant's complaints of pain, tightness and weakness were entirely consistent with his previous injuries and requirement of prolonged healing periods. Dr. Korn measured claimant's bilateral grip strength and concluded that his strength is "approximately 15 to 20% less than one would expect of someone with his occupation and physical activity."

At hearing, claimant testified that he now has pain and numbness in both of his wrists that is increased by activity; that his left wrist is worse than his right because he has occasional, severe, shooting, shock-like pain in his left wrist which causes him to drop things.

Based on Dr. Button's and Dr. Bond's predictions that claimant would suffer recurrence of his wrist disability if he continued in his regular work, and claimant's four wrist surgeries, the most recent medical report of Dr. Korn and claimant's testimony as to his problems upon returning to work, we find that claimant has suffered some disability in both wrists due to grip loss caused by pain and numbness. Therefore, we modify the March 24, 1982 Determination Order to award claimant 10% or 15° and modify the July 12, 1982 Determination Order by increasing claimant's award for permanent disability benefits for his left wrist from 5% or 7.5° to 15% or 22.5°.

ORDER

The Referee's order is reversed in part and affirmed in part. Those portions which affirmed the March 24, 1982 and July 12, 1982 Determination Orders are reversed. The March 24, 1982 Determination Order, which awarded no compensation for permanent disability, is modified to award claimant 15° of scheduled permanent disability for a 10% loss of the right forearm (wrist). The July 12, 1982 Determination Order is modified to award claimant an additional 15° or 10% scheduled disability for injury to her left forearm (wrist), for a total award of 22.5° of scheduled permanent disability for a 15% loss of the left forearm (wrist). The remainder of the Referee's order is affirmed. Claimant's attorney is allowed 25% of the additional compensation awarded herein as a reasonable attorney's fee, not to exceed $2,000, payable out of claimant's compensation and not in addition thereto.

LINDA L. LOGAN, Claimant
Morrison & Reynolds, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 82-09972 & 82-04865
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

EBI Companies requests review of that portion of Referee Quillinan's order which set aside its denial of claimant's aggravation claim for her low back injury, approved the SAIF Corporation's denial of claimant's new injury claim and assessed EBI a penalty for an unreasonable denial. On review the issues are responsibility and whether the penalty was justified.

The Board affirms the order of the Referee as it pertains to

the responsibility issue. We reverse that portion of the order which found the denial to be unreasonable.

Claimant initially compensably injured her back in October 1974. Her condition was diagnosed as right dorsolumbar strain. She was off work approximately five days. Treatment was conservative and there was no permanent impairment.

Claimant sustained another compensable injury to her back on January 5, 1981. At the time she was employed as a fry cook for EBI's insured. Her condition was diagnosed as low back strain, right-sided sciatic pain and a possible herniated disc. All treatment was conservative. On July 21, 1981 she was found medically stationary by Orthopaedic Consultants, who rated her impairment related to the industrial injury as minimal. Her treating chiropractor, Dr. Rasmussen, concurred with their findings, recommended retraining and restricted claimant to a 25 pound weight limitation. Her claim was closed on September 15, 1981 by a Determination Order which awarded only temporary total disability benefits. There was no evidence that this order was appealed.

From November 1981 through March 1982 claimant worked as a janitor. She did very little lifting or moving furniture. Her back pain continued with more left leg involvement. Although she sought treatment intermittently, she experienced no serious complaints and continued to work. Claimant left this work to obtain further education training through a CETA program.

In July 1982 claimant became employed as a recreational aide at a nursing home, SAIF's insured. On August 17, 1982 claimant injured her back while lifting, sliding and moving a six to eight foot long table. She experienced an immediate onset of lower back pain and an inability to stand erect. Claimant saw Dr. Rasmussen that day. He prescribed exercises, rest, heat and ice.

On September 21, 1982 claimant saw Dr. Karmy, an orthopedist. Dr. Karmy reported the following impressions of claimant's condition:

> "1. Status post lumbosacral strain.
>
> "2. L5-S1 degenerative disc disease, mild.
>
> "3. Aggravation of prior lumbosacral strain and pre-existing degenerative disc disease."

Dr. Karmy compared claimant's condition with that reported by Orthopaedic Consultants prior to this latest incident. He opined that claimant did not suffer a material worsening of her condition due to the August 1982 injury.

Claimant continued to receive conservative treatment. Although she never returned to work, she did enroll in a secretarial program at a local community college.

Dr. Pettee, an orthopedist who had treated claimant throughout the relevant periods in question, diagnosed claimant's condition as chronic lumbar disc syndrome. By report dated December 29, 1982 he felt that the August 1982 episode was a mild transient aggravation

of a long standing previous back problem. According to his notes, claimant had not made any significant mention of the episode at the nursing home, except to say she did hurt her back.

By letter dated October 20, 1982 Dr. Rasmussen agreed with both Drs. Karmy and Pettee.

Claimant was hospitalized in December 1982 and January 1983 for exacerbations. On January 2, 1983 claimant was examined by Dr. Weeks, an orthopedist. He reported on January 13 that claimant's complaints regarding her low back and left lower extremity have persisted and always have been the same. To complicate matters, the doctor noted, a recent CT scan and consultation indicated claimant had degenerative disc disease at L5-S1, but more significantly a herniated disc at L3-4. On January 27, 1983 Dr. Weeks reported to EBI that claimant's symptoms were persisting and that he was awaiting authorization and review from "Insurance Carriers" regarding back surgery.

By letter dated February 3, 1983 EBI denied claimant's request for reopening. EBI stated that following their investigation and a review of the medical information it had received, it was denying any future benefits because claimant's current condition was not related to her January 5, 1981 injury.

Under these circumstances, we do not agree with the Referee that EBI's denial was unreasonable. The insurer is entitled to find medical evidence and opinions unpersuasive. This is especially true in a confusing case such as this. Claimant's original compensable injury resulted in no permanent disability. Since that time there have been repeated episodes of off-the-job exacerbations, some requiring hospitalization. More importantly, these off-the-job exacerbations of December 1982 and January 1983 followed a distinct incident in August 1982. Given the facts of the incident (lifting, sliding and moving a six to eight foot long table) and the immediate onset of back pain, there was a legitimate doubt whether claimant's current condition was attributable to an aggravation or to a new injury.

Based on the evidence available to it at the time the denial was issued, EBI had a reasonable belief that claimant's current condition was not related to claimant's January 1981 injury. Neither at hearing or during Board Review has EBI waivered from its argument that it is not responsible for claimant's current condition. Although we are persuaded that claimant did suffer an aggravation and that EBI is the responsible party, we cannot say that it was unreasonable for EBI to deny the claim.

ORDER

The Referee's order dated June 20, 1983 is affirmed in part and reversed in part. Those portions of the order which set aside EBI's denial and remanded the claim to it for further processing are affirmed. Those portions of the order imposing a penalty for an unreasonable denial and awarding an attorney's fee on the basis of the penalty are reversed. Claimant's attorney is awarded $300 for services on Board review, to be paid by EBI Companies.

DONALD G. MOORE, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-09680
January 31, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Thye's order which set aside SAIF's denial of claimant's aggravation claim. SAIF argues that the parties' September 1982 stipulation, which resolved the issues in a prior proceeding, should be considered the last award or arrangement of compensation, and that claimant has not shown a worsening of his condition since the date of that stipulation.

Relying on Syphers v. K-W Logging, Inc., 51 Or App 769 (1981), the Referee's initial order concluded that the September 1982 stipulation could not have effectively disposed of claimant's then-pending and prior aggravation claim because that claim was not then in denied status. This line of reasoning would no longer appear to be viable in light of the court's subsequent refinement of Syphers in Thomas v. SAIF, 64 Or App 193 (1983).

In an order denying reconsideration, the Referee also concluded that the September 1982 stipulation was not an award or arrangement of compensation within the meaning of ORS 656.273. We agree with this conclusion for the reasons stated in Lewis Twist, 34 Van Natta 52, 34 Van Natta 290 (1982), aff'd 62 Or App 602 (1983).

Since the primary issue involves identification of the "last award or arrangement of compensation," we state the relevant facts chronologically:

November 1980: Claimant sustained a compensable upper back and neck injury.

May 1981: Claimant's claim was closed by Determination Order which awarded time loss only.

October 1981: SAIF's denial of claimant's first aggravation claim was upheld by a Referee's order in a prior proceeding.

July 1982: Claimant requested another hearing, again contending, among other things, that he was entitled to claim reopening on the basis of aggravation.

September 1982: The July 1982 hearing was resolved by a stipulation of the parties. That stipulation provided that SAIF would pay claimant for some travel expenses in connection with medical treatment and would pay claimant's attorney a fee. Nothing was specifically said about claimant's aggravation claim, but the stipulation states that claimant's "Request for Hearing (and all issues raised thereby, or which could have been raised thereby) be, and the same hereby is, dismissed with prejudice." The net effect would appear to be that claimant was then agreeing that his mid-1982 aggravation claim could and would be deemed to be denied. See Thomas v. SAIF, supra.

September/October 1982: Very shortly after the approval of

the stipulation, claimant consulted Dr. Melson who suggested that claimant's claim "should be reopened for further medical treatment." Claimant's attorney followed up Dr. Melson's report with a letter requesting that SAIF "promptly authorize the treatment requested by Dr. Melson."

November 1982: SAIF denied the aggravation claim represented by Dr. Melson's report and claimant's attorney's letter. That denial led to this proceeding.

In Lewis Twist, supra, we concluded that a prior litigation order upholding a denial of an earlier aggravation claim was not the last award or arrangement of compensation within the meaning of ORS 656.273 when a claimant asserts a later aggravation claim. That reasoning is directly applicable in this case in the sense that the October 1981 Referee's order, which upheld a prior denial of a prior aggravation claim, is not the last award for present purposes. We also here conclude that Twist is applicable to the September 1982 stipulation in the sense that, even if that stipulation had expressly said that claimant's mid-1982 aggravation claim could and would properly be deemed denied, the stipulation can have no greater force or effect than a litigation order. Stated differently, if a prior litigation order that upholds an aggravation denial is not the last award of compensation, we think it follows that a prior stipulation that has the effect of upholding an aggravation denial likewise is not the last award of compensation.

For all of these reasons, the last award or arrangement of compensation for present purposes is the May 7, 1981 Determination Order which first closed claimant's November 1980 injury claim. From this conclusion, we further find that it follows rather easily that claimant has proven a worsening of his compensable condition since May 1981.

ORDER

The Referee's orders dated May 19, 1983 and June 1, 1983 are affirmed. Claimant's attorney is awarded $500 for services rendered on Board review, to be paid by the SAIF Corporation.

JOYCE A. MORGAN, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-01415
January 31, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Danner's order which found that claimant sustained a compensable aggravation of her December 1978 injury; ordered SAIF to pay claimant benefits for temporary total disability from November 13, 1981 through January 6, 1982; and ordered SAIF to pay claimant a penalty in the amount of 10% of the compensation due for that same period of time for unreasonable delay in denying the aggravation claim. The issues are the compensability of claimant's November 1981 aggravation claim and the propriety of the Referee's imposition of a penalty.

Claimant, a then 36 year old custodian for Tri City Elementary School, sustained a compensable lumbosacral strain while moving desks in a classroom on December 29, 1978. Claimant was treated

conservatively by Dr. Streitz, returned to work on May 9, 1979 and continued working until approximately August 1979. A Determination Order issued on September 13, 1979 awarding claimant benefits for temporary total disability only. Claimant did not request a hearing regarding that Determination Order and it became final by operation of law.

In September 1979 claimant began being treated by a chiropractor, Dr. Resner, for low back pain. In a series of reports, Dr. Resner indicated that it was unlikely claimant would be able to return to her previous employment, that she could expect periodic exacerbations and that he was providing treatment on a "maintenance" basis. SAIF apparently paid for claimant's treatments with Dr. Resner pursuant to ORS 656.245.

Claimant was examined by Dr. Streitz on November 17, 1980. Dr. Streitz reported that claimant's condition was basically no different than it had been in August 1979. He felt that claimant's excessive weight was a factor in her continued symptomatology. X-rays of claimant's back were interpreted as being normal. Dr. Streitz felt that claimant's continued chiropractic care was palliative in nature. On December 5, 1980 Dr. Resner reported that he concurred with Dr. Streitz.

In a letter to SAIF dated December 7, 1981 (received by SAIF on December 9, 1981) claimant's attorney wrote:

> ". . . this is a claim for aggravation pursuant to ORS 656.273. We are enclosing medical records which support the claim for aggravation. Please review the file and submit the claim through the Evaluation Division for a second Determination Order."

In a letter to SAIF dated December 10, 1981 (received by SAIF on December 15, 1981) Dr. Resner reported:

> "On November 13, 1981 [claimant] coughed and immediately had acute low back pain with radiculations down both legs. All lower reflexes were depressed. She was placed in complete bed rest and acute symptoms subsided . . . .
>
> "Symptoms are suggestive of a posterior protrusion of a lumbar disk. * * * "

Dr. Resner requested an orthopedic evaluation.

On January 6, 1982 claimant was examined by Dr. Bert, an orthopedist. Dr. Bert diagnosed osteitis condensans ilia, a progressive and degenerative condition characterized by dense sclerosis on the iliac side of the sacroiliac joint. Dr. Bert felt that claimant was stationary.

Claimant was again examined by Dr. Streitz on January 12, 1982. Although Dr. Streitz noted the November 1981 coughing episode, and indicated that claimant appeared to have had some exacerbation of her symptoms at that time, he offered no opinion

about the relationship between claimant's 1978 compensable injury and the 1981 coughing episode.

By letter dated February 10, 1982 claimant filed a request for hearing alleging as the issue: "De facto denial of aggravation claim filed by the claimant 12/7/81." At the time of the November 1982 hearing, SAIF still had not issued a formal denial of the December 1981 aggravation claim.

On February 26, 1982 Dr. Resner reported that in his opinic claimant was suffering from a degenerative disc condition in the lumbar area which was related to her 1978 industrial injury. However, a subsequent myelogram was interpreted as entirely normal.

The Referee concluded: "Claimant has carried her necessary burden, to show that her condition had worsened since the original closing." We disagree.

We are unable to determine just what evidence the Referee relied upon in finding the claimed aggravation of November 1981 to be compensable. There are no medical reports whatsoever that address the question of the relationship between claimant's current condition and her prior compensable injury, let alone answer it.

The only medical report in the record which could even remotely be construed as addressing the question of the causal relationship between the 1978 industrial injury and claimant's November 1981 condition is Dr. Resner's brief report of February 26, 1982. Dr. Resner notes that claimant had several exacerbations of back pain since the original injury and that: "At present she is in a period of exacerbation. . ." Dr. Bert at first suggested the possibility of a degenerative disc related to the industrial injury; however, as noted above, this was ruled out by a subsequent myelogram. Dr. Bert also diagnosed claimant as suffering from the degenerative condition osteitis condensans ilia; there is nothing in the record relating this condition of unknown etiology to the industrial injury. There is also some indication that claimant's 1981 back difficulties are due to obesity rather than to the 1978 industrial injury. On this record we are not even sure what is the nature of claimant's 1981 back condition, but we are sure there is no persuasive evidence linking claimant's 1981 back condition to her compensable back strain which occurred almost three years earlier.

The next question concerns penalties. The Referee concluded that the December 7, 1981 letter from claimant's attorney to SAIF constituted a valid claim for aggravation. We agree. The fact that the letter is not sufficient to establish an aggravation is irrelevant to the question of an employer or insurer's duty to respond to the claim. SAIF was, therefore, obliged to accept or deny the claim within 60 days. It failed to do so. Accordingly, the Referee penalized SAIF for unreasonable delay in accepting or denying the claim.

We conclude that penalties are not warranted in this situation, even though SAIF failed to issue a formal acceptance or denial of the claim.

On several occasions, we have dealt with the issue of what consitutes a sufficient denial. In Terry Dorsey, 31 Van Natta 14 (1981), the insurer issued timely denial, but failed to include a

notice of appeal rights in that denial. The Referee concluded that this was not an effective denial and assessed penalties against the insurer for failure to pay interim compensation from the date of the denial to the date of the hearing. We reversed, reasoning that since claimant had requested a hearing on the denial despite the absence of appeal rights, there was no prejudice and the denial was, therefore, effective. See also Delbert Greening, 34 Van Natta 1982 (1982).

In Angela V. Clow, 34 Van Natta 1632 (1982), the Referee assessed a penalty against the insurer for failure to formally accept or deny an aggravation claim within 60 days. We reversed. Relying on Stroh v. SAIF, 261 Or 117 (1972), we concluded that in a situation where claimant was represented by an attorney, where the insurer's position was informally made known to claimant's attorney and where the attorney requested a hearing after being so notified, any deviation from the statutory requirements by failing to issue a formal denial was harmless error. 34 Van Natta at 1635. See also Patricia M. Dees, 35 Van Natta 120 (1983).

More recently, in Martha A. Baustian, 35 Van Natta 1287 (1983), we addressed a similar issue. In Baustian, the insurer failed to issue a formal acceptance or denial of a claim for aggravation and failed to pay interim compensation after receipt of a medically verified inability to work. The Referee ordered the insurer to pay a penalty on the amount of interim compensation due from the date of the verification (October 1982), to the date of the hearing (March 1983), even though a request for hearing was filed by claimant in November 1982 and the employer filed a response to that request in December 1982, which alleged that claimant had not sustained a compensable aggravation. Relying on the cases cited above, we stated:

> "We thus conclude that the insurer's December 10, 1982 response to claimant's hearing request, which was served on claimant's attorney, was adequate notice to claimant that his aggravation claim was being denied." 35 Van Natta at 1288.

Accordingly, we found the insurer liable for interim compensation and penalties only up to the date of the insurer's response to the request for hearing.

We conclude that, despite the fact that SAIF failed to issue a formal denial in this case, the appropriate period for determining whether a penalty will be assessed and the amount thereof is the period between the filing of the claim for aggravation and the request for hearing on the "de facto" denial. The only apparent difference between the current case and those cited above is that in all of the prior cases there was some form of notification received by the claimant or the claimant's attorney which was understood to be, or reasonably should have been understood to be, the equivalent of a denial. In this case, there was no similar notification. However, claimant's attorney was familiar with the de facto denial concept and filed a request for hearing on that basis almost immediately after expiration of the 60 day period. If a "de facto" denial is sufficient to invoke the jurisdiction of this agency, cf Syphers v. K-W Logging, Inc., 51 Or App 769 (1981), we think that a claimant who elects to request a hearing on a "de facto" denial must be deemed to have received at least some form of

notification of the position of the employer/insurer. We think it follows that requiring an employer/insurer to issue a formal denial with notice of hearing rights or face penalties even after a request for hearing on a de facto denial has been filed would be, as we stated in Clow, 34 Van Natta at 1635, an elevation of form over substance.

We do not think that this conclusion is a license for employers and insurers to disregard their statutory duty to accept or deny claims within 60 days. Unless and until an employer/insurer complies with that statutory duty, the time limit within which a claimant can request a hearing will not begin to run. Thus, every day that a formal denial is delayed adds a day to the limitation period within which a claimant must request a hearing or forfeit that right.

But a claimant may request a hearing even before a formal denial by invoking the de facto denial concept. Syphers v. K-W Logging, Inc., supra. When a claimant elects to do so -- and we think this is entirely a matter of the claimant's election, there being no limitation period applicable to hearing requests on de facto denials -- then the date that the claimant's hearing request is filed should be used for determining whether a penalty for delayed denial will be imposed and the amount thereof.

In this case claimant filed a claim for aggravation on December 7, 1981. A request for hearing based on a de facto denial was filed 65 days later on February 10, 1982. Based on the standards set forth in Zelda M. Bahler, 33 Van Natta 478 (1981), we conclude that a penalty can not be justified for such a minimal delay.

ORDER

The Referee's order dated March 17, 1983 is reversed. The SAIF Corporation's denial of claimant's aggravation claim is affirmed.

SHERYL A. SHEPERD, Claimant
Ferris & Hunter, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-00661
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Brown's order which affirmed the SAIF Corporation's denial of claimant's claim for costs for her right foot surgery.

Claimant contends that the evidence established the existence of a causal connection between her industrial injury, a bone cyst, and the need for surgery. We agree. Consequently, we reverse.

In December 1981 claimant, a waitress, injured her right foot when a five pound tray jack fell on it. She completed her shift, but the next day sought emergency room treatment. X-rays were normal. The diagnosis was a contusion, with a notation that claimant had mentioned she had a previous ganglion in the area of the injury.

The claim was accepted as nondisabling and claimant continued

working. However, the pain increased and a lump continued to grow to the point that she eventually sought treatment. In October 1982 she consulted Dr. Hoyal, a podiatrist. Dr. Hoyal testified that a point on the lateral side of claimant's foot was exquisitely tender. An x-ray revealed a possible ganglion and a bone cyst over the cuboid region. Because of the possibility of sarcoma, surgery was performed.

During surgery Dr. Hoyal excised what he initially thought was a ganglion (later proved to be fibro-fatty tissue) at the base of the fifth metatarsal bone following the peroneous longus tendon beneath the cuboid bone. He also excised some calcified tendon adjacent to and beneath the cuboid bone. Finally, Dr. Hoyal excised a benign cyst (two centimeters long, two centimeters wide and one centimeter deep) which was located one millimeter inside the calcaneal cuboid joint. The incision was just over one inch in length. The depth of the exploration was not reported.

Dr. Hoyal opined that the bone cyst was causing claimant's pain. Claimant testified that the pain and swelling she experienced before the surgery was not like her prior ganglion problem. When her foot was palpated prior to surgery, the pain was described as deep and nonradiating. Dr. Hoyal reasoned that if the ganglion-like material or the tendon had been responsible for the pain, it would have been radiating.

Dr. Hoyal testified that bone cysts are usually associated with trauma, but can occur idiopathically. Based on claimant's history, Dr. Hoyal opined that within a reasonable medical probability, claimant's surgery was related to her injury which occurred in claimant's employment. He agreed his opinion would be different if the tray jack did not land at the site of the bone cyst. However, he testified that the location of the bone cyst was where claimant described the tray jack had landed.

Claimant suffered no intervening injuries and was asymptomatic post-surgery except for an episode of ganglion pain. The pain, which occurred approximately two to three months after surgery, was located proximal and dorsal from the area of the cyst. Dr. Hoyal felt this was a recurrence of the pain claimant had experienced before the injury and was likely from the same ganglion. The pain was resolved by injection.

Claimant testified she could not state exactly where the tray jack hit her foot. She mentioned the ganglion to the emergency room doctor because she thought the tray jack incident might have exacerbated it.

The Referee found Dr. Hoyal's opinion to be succinct and detailed in explaining how claimant's pain complaints were caused by the bone cyst, and based on her history, how the bone cyst was caused by the falling tray jack. However, the Referee concluded the causal connection did not exist because claimant's testimony did not indicate the tray jack dropped where the bone cyst was located. The Referee believed the tray jack dropped on the location of the prior ganglion in the same place as the one treated post-surgery.

We disagree. We find the medical, lay and circumstantial evidence persuasive in establishing a causal connection between claimant's injury, the bone cyst and the need for surgery.

Claimant did sustain a traumatic injury to her foot. X-rays taken at the time were normal. Dr. Hoyal testified it takes 21 to 30 days, sometimes as long as 5 weeks, for changes in the bone to be detected on x-rays. Subsequently, without incurring any intervening injuries, her pain increased and a lump developed on her foot and grew larger. This pain was not like her previous ganglion pain. New x-rays revealed a possible ganglion and a bone cyst. Based on her complaints of deep nonradiating pain and her description of the tray jack incident, her treating podiatrist related her pain to the bone cyst. Bone cysts are usually associated with a traumatic injury. After the surgery, claimant's pain was relieved, except for a recurrent ganglion flare-up located in a site other than that of the bone cyst.

We believe the reasonable conclusion to be drawn from this recitation of the evidence is that there was a causal connection between claimant's industrial injury and her foot surgery.

We do not consider claimant's statements concerning the location of where the tray jack hit her foot to be fatal to her claim. It is understandable that she would mention prior complaints pertaining to her foot when giving a history. Besides, claimant is quoted in the emergency room report as stating the tray jack hit in the same area of the foot as the previous ganglion. Further, she testified that the previous ganglion was on the same side of the foot as where the tray jack landed. It is a broad leap to conclude from these statements, as the Referee did, that the previous ganglion specifically establishes the site of the tray jack injury.

Although Dr. Hoyal describes the ganglion's and the bone cyst's location as being not closely related in terms of location, we must keep in mind the context in which he is utilizing these phrases. Dr. Hoyal is focusing upon an extremely compact and intimate area. He is speaking in terms of millimeters and centimeters, not inches and feet. When analyzed in this context and considering his overall opinion, we are not dissuaded by these comments from agreeing with Dr. Hoyal's opinion concerning compensability.

For the foregoing reasons we find that claimant has established a causal connection between her industrial injury and the need for her right foot surgery.

ORDER

The Referee's order dated June 20, 1983 is reversed. SAIF's denial of December 17, 1982 is set aside. Claimant's attorney is awarded $1,500 for services on Board review and before the Referee, to be paid by the SAIF Corporation.

LLOYD S. THORNTON, Claimant
Moomaw, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-06122
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer requests review of Referee Galton's order which set aside its June 9, 1982 denial. The issue for review is compensability.

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

The employer argues that the Referee incorrectly concluded that this claim is properly viewed as an industrial injury rather than an occupational disease and that when the rule of Weller v. Union Carbide, 288 Or 27 (1979), is applied, the claim must fail. We disagree. For the same reasons as noted in his order, we conclude that the Referee properly characterized this claim as one for industrial injury rather than occupational disease. We also conclude that based on the evidence in this record, the Referee properly set aside the employer's denial.

In addition to finding that claimant sustained a compensable industrial injury, the Referee made an alternative finding that even if Weller was applicable, claimant's evidence met the necessary criteria. We disagree with this alternative finding. There is nothing in the record which indicates that claimant's employment activities had any effect whatsoever on his preexisting congenital prespondylolisthesis condition. As claimant points out in his brief:

> ". . . the injury in this case has been diagnosed as a back strain which began in the upper part of the back and eventually moved to the lower back. It has nothing to do whatsoever with any congenital defect."

We agree with that statement. The evidence indicates that claimant suffers from a compensable back strain and nothing else. With that proviso, we affirm the Referee's order.

ORDER

The Referee's order dated July 22, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the employer.

JOHN R. TURNER, Claimant
Evohl Malagon, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 83-05570
January 31, 1984
Order of Remand

The self-insured employer requested review of the Referee's order herein and thereafter notified the Board of its intent to withdraw its request for Board review and instead request that the Referee reconsider portions of his order. The Referee's order was entered on January 13, 1984. The Board received the employer's Request for Review on January 19, 1984. On January 23, 1984, counsel for the employer notified the Board of its intent to withdraw its request for review and, on that same date, petitioned the Referee for reconsideration.

The employer's request for review divested the Referee of jurisdiction to reconsider his order. OAR 436-83-480; Eduardo E. Ybarra, 35 Van Natta 1192 (1983). The employer's notice of intent to withdraw its request for Board review does not automatically revest the Referee with jurisdiction in the absence of Board action terminating the proceeding on review. See Eduardo E. Ybarra, supra.

Counsel for the employer was out of the office when the Referee's order was mailed. Apparently another individual in the office assumed responsibility for the file and mailed a request for Board review. Counsel seeks to petition the Referee for reconsideration in order to identify and perhaps correct allegedly mistaken factual findings. In addition, one of the Referee's conclusions may be inconsistent with a pre-hearing informal agreement entered into between counsel for claimant and the employer, of which the Referee apparently was not aware.

Based upon the peculiar facts and circumstances presented herein, we deem it appropriate to allow the employer to petition the Referee for reconsideration of his order. This case is remanded to the Referee, who may reconsider his order as requested by the employer. If, after the Referee has had an opportunity to reconsider his order, either party is aggrieved, a new request for Board review may be filed pursuant to ORS 656.295.

ORDER

This case is remanded to the Referee for further proceedings.

JOYCE K. WALLIS, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07707
January 31, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Foster's order which awarded claimant benefits for permanent total disability. Claimant had previously received a total of 192° for 60% unscheduled permanent partial disability. The issue for review is the extent of claimant's disability.

Claimant, who was 54 years of age at the time of the hearing, suffered a compensable back injury in 1974 while employed as a licensed practical nurse. Claimant underwent a laminectomy and foraminotomy at L4-5 and L5-S1 in 1975. The claim was closed by a June 1975 Determination Order which awarded claimant 15% unscheduled permanent partial disability. The claim was subsequently reopened and claimant underwent a refusion of the lumbar spine for pseudoarthrosis in 1977.

In 1978 claimant entered the Callahan Center. The physicians at the Callahan Center were of the opinion that despite her exaggerated pain behavior, claimant could be gainfully employed in an occupation requiring no repetitive bending, stooping or twisting movements of the low back. Claimant was found to be exhibiting moderate depression, tension, nervousness and anxiety plus multiple somatic complaints. Hysteroid features were noted with the possi-

bility of secondary gain being present.

A second Determination Order issued in September 1978 and awarded claimant an additional 45% permanent disability for a total of 60% unscheduled permanent partial disability.

Claimant thereafter entered an approved program of vocational rehabilitation with the apparent goal of becoming a registered nurse. Claimant did not complete the program and a third Determination Order issued in September 1979 awarding additional time loss benefits only.

In December 1979 claimant was examined by Dr. Radmore, a psychiatrist. Dr. Radmore was of the opinion that claimant was suffering from psychological difficulties which were a result of the 1974 industrial injury.

In May 1980, after a comprehensive review of her medical history, Dr. Holland performed a psychiatric examination of claimant. Dr. Holland noted that claimant had a long history of psychological and emotional difficulties which preceded her industrial injury. Dr. Holland stated:

> "This lady's behavior during the interview significantly attested to the fact that she is comfortably settled in to a disability way of life, and that she has been able to marshall a considerable number of people in her life who obviously provide her with all sorts of dependency gratification."

Dr. Holland believed that although claimant's injury did play a role in her condition, the major factor which explained her condition was her dependent personality disorder, which predated the industrial injury. Dr. Holland felt that claimant exhibited elements of secondary gain.

Claimant was thereafter referred to Crawford Rehabilitation Services. Testing indicated that claimant had an I.Q. in the bright-normal range with above average verbal skills and superior comprehension. The vocational consultant concluded that claimant appeared to be employable from all standpoints.

A new vocational program was thereafter implemented. Claimant attended Umpqua Community College on a part-time basis for training in the medical/secretarial field. However, in March 1981 claimant dropped out of school. Dr. Radmore reported that claimant's difficulties with her daughter and the suicide of a very close friend had a negative impact on claimant. Claimant returned to school for a short period of time, but the vocational program was eventually terminated in July 1981 due to emotional and personal difficulties which claimant was experiencing.

In January 1982 claimant was admitted to the Northwest Pain Center. The Pain Center physicians were initially pessimistic about the prospects for successful treatment of claimant. The examiners found claimant to have a tendency to use somatic foci as a means of avoiding dealing with underlying emotional difficulties. Secondary gain elements were felt to be operative in the areas of relief from work pressures and potential for continued financial compensation. The physicians at the Pain Center felt that claimant had neither any interest in nor any intention of returning to

gainful employment. Nevertheless, improvement was noted at the time of claimant's discharge from the Pain Center. Claimant had dropped much of her pain behavior and appeared to be in generally good spirits at the conclusion of the program.

On July 6, 1982 Dr. Quan performed a pscyhiatric examination of claimant. Dr. Quan reported that in a normal day, claimant prepared her breakfast after arising in the morning, exercised for one-half of an hour two or three times per day on an exercise bicycle and did her housework. On Mondays, Wednesdays and Fridays claimant did volunteer work at a family planning clinic for four hours per day. After this work, claimant would swim for approximately one hour. Additional activities included visiting friends and working in her 10' by 15' greenhouse. Although he was of the opinion that psychological factors contributed to claimant's physical condition, Dr. Quan believed that continued psychiatric treatment was palliative in nature, and that there was no reason from a psychological standpoint why claimant could not return to work. Dr. Radmore concurred.

Prior to being examined by Dr. Quan, claimant had taken a five-and-one-half week vacation to England to visit relatives. After this vacation, claimant did not return to her volunteer work at the family planning clinic. It was later determined that the clinic was not interested in claimant's return.

A Determination Order issued on August 18, 1982 awarding claimant additional benefits for temporary total disability.

Claimant thereafter received additional vocational rehabilitation assistance. On December 21, 1982 the vocational organization closed claimant's file on the basis of claimant's increased emotional difficulties, which Dr. Radmore believed to be due to claimant's inability to find work, her continued physical and emotional problems and the loss of financial security as a result of her claim being closed. Dr. Radmore reported that claimant had been forced to move from her residence and give up her greenhouse, and that claimant reacted to this with a recurrence of depression and a worsening of her psychophysiological complaints. Dr. Radmore felt that further attempts to rehabilitate claimant were useless.

On February 7, 1983 Dr. Holland reexamined claimant and prepared a thirteen page report summarizing his findings and conclusions. Dr. Holland stated:

> "This claimant has the most exaggerated, bizarre, repertoire of pain and illness behaviors this examiner has seen. This statement comes from the context of a general medical practice of some seven years, and a psychiatric practice of fourteen years. During my psychiatric practice, I have evaluated approximately 350 injured workers. [Claimant] assumes postures and manifests behaviors which have no organic explanation in terms of being pain-relieving."

The report contains the following questions and answers.

"1. Is the claimant's present need for psychiatric treatment related to the February 11, 1974 industrial injury or to other factors?

"In my opinion, her current need for psychiatric treatment relates causally to factors which have nothing to do with her injury. She has merely used her injury to explain all of the stress in her life and the inadequacies in her personal performance.

"2. You questioned what, in my opinion, was the cause of the re-occurence of the claimant's depression?

"I believe the causes of the recurrence of this claimant's depression are primarily related to her coping style of capitulation and seeing her illness as a valued process.

"3. Is [claimant] motivated to return to work?

"* * * Conclusions are made about motivation on the basis of behavior. I invite anyone to inspect this lady's behavior and find much to suggest she has ever intended to return to work.

"4. From a psychiatric viewpoint, would the claimant benefit from obtaining and performing gainful employment?

"In my opinion, yes.

"5. Do [claimant's] psychiatric problems preclude her from returning to work?

"In my opinion, it is her desire to assume the role of an invalid which is precluding her returning to work. I do not view this as a psychiatric problem. I view it as an attitudinal problem.

"6. Does [claimant] have a conscious goal of obtaining permanent total disability status?

"In my opinion, yes."

The Referee stated that although he did not believe claimant was permanently and totally disabled from a physical standpoint, when her physical disability was combined with her mental disorder a finding of permanent total disability resulted. The Referee appeared to base his conclusion primarily on certain statements made by Dr. Holland when he testified at the hearing.

We agree with the Referee and SAIF that from a physical standpoint, claimant is clearly not totally disabled. There is not a

single medical report among the 51 exhibits in this case which so states. Dr. Thompson, the Orthopaedic Consultants, the physicians at the Northwest Pain Center, Dr. Jansch and Dr. Radmore agreed that claimant's impairment was in the range of moderate and that she was physically capable of light or sedentary work.

Even when social/vocational considerations are factored into the equation, the sum still does not equal total disability. Claimant was 54 years of age at the time of the hearing and had received her GED and completed enough additional schooling to become a licensed practical nurse. Claimant has completed additional coursework through various vocational rehabilitation programs she participated in throughout the course of this claim. As previously noted, claimant's I.Q. has been rated in the bright-normal range, and she exhibited above average verbal skills and superior comprehension. Although claimant is not able to return directly to nursing, a vocational counselor testified that claimant has many skills which are transferable to related areas in the medical field.

The real difficulty in determining the extent of claimant's compensable disability involves claimant's psychological condition. Unlike the Referee, we interpret the evidence as indicating that even when claimant's psychological difficulties are taken into consideration, she is capable of returning to work if she has a true desire to do so. Although claimant did have an initial psychological reaction to her industrial injury, the great preponderance of the evidence indicates that what is currently interfering with claimant's return to gainful employment is not psychological residuals from her industrial injury, but, rather, claimant's lack of true desire to do so.

Other than a few months of volunteer work and some caring for an elderly invalid for a short time, claimant has made no sincere attempts to return to work and appears to have intentionally interfered with vocational efforts instituted on her behalf. The record is replete with medical reports which refer to claimant's unwillingness to return to work and the fact that claimant sees her continued illness and pain behavior as a valued process because it results in disability benefits and continued relief from work pressures. Claimant is not entitled to an award of permanent total disability solely because she prefers not to work. For a remarkably similar factual situation where we also refused to award permanent total disability, see Lena Hunter, 35 Van Natta 301 (1983), aff'd without opinion, 65 Or App 814 (1983).

It appears from a reading of his order that the Referee believed that Dr. Holland's testimony at the hearing was inconsistent with some of the reports he authored. Although not a model of clarity, we do not read Dr. Holland's testimony as being inconsistent with his reports. For example, Dr. Holland did testify that claimant's mental condition prevented her from working, but he elaborated: "I can't conceive of anybody employing her with the behavior that we've seen in the room today." Dr. Holland also testified that claimant's injury was a significant psychological stressor; however, this does not detract from his previous testimony that it was claimant's attitudinal problems, rather than psychological residuals from the injury which were interfering with her return to work.

Based on the above, we find that claimant has not established entitlement to an award of permanent total disability. We conclude that claimant's previous awards totalling 192° (60%) of unscheduled permanent partial disability have adequately compensated her for her injury.

ORDER

The Referee's order dated May 16, 1983 is reversed. The Determination Order dated August 18, 1982 is affirmed.

Board Member Lewis Dissenting:

I agree with the Referee's finding that claimant is permanently totally disabled. The majority states that claimant's psychological problems do not prevent her from returning to work and that claimant would be capable of returning to work is she had a true desire to do so. Although the record contains some support for the majority's position, I find Dr. Radmore's contrary opinion to be more persuasive. Dr. Radmore has been claimant's treating psychiatrist since October 1979 and has treated claimant on a regular basis during this time. Dr. Radmore's medical opinions are well-explained and her reasoning is consistent throughout the record.

During the time Dr. Radmore has treated claimant's psychological problems, claimant has had emotional ups and downs as reflected by the medical reports. For example, Dr. Radmore's and Dr. Quan's reports reflect a euphoria experienced by claimant immediately before and after claimant's trip to England. In August 1982 Dr. Radmore agreed with Dr. Quan that claimant's psychiatric problems did not preclude her from returning to work. Dr. Radmore indicated, however, her concern that claimant was not as stable as she presented herself and that she may regress after the holiday euphoria was eroded by the grimness of her unemployability. Later, in December 1982, Dr. Radmore reported that since August 1982 claimant had suffered considerable regression in her ability to function.

Dr. Radmore's reports of December 1982 and January 1983 discuss claimant's condition during the time closest to the hearing. Dr. Radmore states that she has not doubted claimant's motivation to return to work. The vocational reports also indicate that claimant was cooperative and followed up on the employment leads found by her vocational counselor. Dr. Radmore notes that claimant tried to work as a volunteer at a family planning clinic, but that her attempt was unsuccessful. Vocational reports indicate that the clinic was not interested in having claimant resume working at the clinic because she was too slow and tearful to assist any of their clients. Dr. Radmore opines that claimant is being realistic in fearing she cannot expect to be paid for her work when her performance was considered too unsatisfactory to qualify her for volunteer work. Dr. Radmore recommended:

> "With full recognition that removal of the potential option of ever being a working (and therefore 'useful') member of society again will be an extremely threatening

message to [claimant], it is nevertheless my recommendation that further attempts to rehabilitate her be considered to be of insufficient value to continue, and that she be recognized as permanently disabled, both from the standpoint of her emotional debilitation and the resultant aggravation of the physical problems which have followed her industrial injury. Her present state of insecurity, in which her survival is threatened, leaves her in a state of personal torment which is emotionally painful and almost intolerable, but additionally interferes with her efforts to become physically rehabilitated and to become involved in a job search program. Considering the amount of time and effort which have been spent over the period of time I have known [claimant], it seems reasonable to assume that she will not recover sufficiently to find employment, with whatever external support can be provided, unless the job market changes abruptly, and her limited abilities are once again in demand."

Although Dr. Holland disagrees with some of Dr. Radmore's opinions, Dr. Holland agrees that claimant is very ill psychiatrically and that he cannot conceive of anyone hiring her with her pain behavior.

The Referee found that claimant has a serious physical disability which, in itself, may not completely incapacitate her from useful and gainful employment. Combining her physical impairment with her mental disorder, however, the Referee found claimant to be permanently and totally disabled and incapable of performing gainful work. I agree with the Referee and would affirm his order and, therefore, respectfully dissent.

THEODORE P. BROWN, Claimant
Tamblyn & Bush, Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 82-00672 & 82-06820
February 3, 1984
Corrected Order on Review

EBI Companies requests "clarification" of a portion of our Order on Review dated January 25, 1984. The questioned portion of our order reads:

"Since no party to this review has challenged the Referee's referral of the extent of disability question to the Evaluation Division, we affirm that portion of his order."

As EBI correctly points out, although it is true that no party challenged the Referee's decision to refer the case for evaluation, that referral became irrelevant when we affirmed all denials issued by both insurers in this case, and the October 1981 Determination Order is final. For the sake of clarity, we delete the above-quoted portion of our order and substitute the following in its stead:

"No party to this review has challenged the Referee's referral of the extent of disability question to the Evaluation Division. However, our finding on the compensability issues renders that referral a nullity."

It is also necessary for us to modify a sentence in the "Order" portion of our Order on Review. That sentence currently reads:

"Those portions of the Referee's order which affirmed the July 6, 1982 denial issued by Fred S. James and Company on behalf of Pepsi and which referred the question of the extent of claimant's disability to the Evaluation Division are affirmed."

That sentence is hereby amended to read as follows:

"Those portions of the Referee's order which affirmed the July 6, 1982 denial issued by Fred S. James and Company on behalf of Pepsi are affirmed."

ORDER

As modified herein, the Board's Order on Review dated January 25, 1984 is readopted and republished.

JOE COGDILL, Claimant
Rolf Olson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-11562
February 3, 1984
Order on Review

Reviewed by the Board Members en banc.

The insurer requests review of that portion of Referee Danner's order which set aside its denial of claimant's claim for depression, remanded the claim to the insurer for acceptance as a compensable occupational disease and assessed a penalty against the insurer for failure to pay interim compensation. On review the issues are compensability and the assessment of a penalty.

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

Claimant dates the onset of his compensable occupational disease as November 4, 1982, claimant's last day of work for the employer. His 801 form gives the date of diagnosis as November 5, 1982, the date his treating physician had claimant hospitalized. The form was filed on November 10, 1982. Claimant's employer acknowledges on the 801 form that it first knew of claimant's problem on November 5, 1982. The employer denied the claim on January 4, 1983, never having paid interim compensation benefits.

The Referee held that the insurer was obligated under ORS 656.262(4) to commence temporary total disability payments within 14 days after November 10, 1982, until the denial was published. The Referee, pursuant to ORS 656.262(9) (now ORS

656.262(10)), awarded an attorney fee and a 25% penalty was assessed for the amount due claimant for the period commencing November 5, 1982 through January 4, 1983.

The insurer submits that if a penalty is assessed, it should be payable from November 24, 1982, the date on which it became obligated to pay temporary total disability benefits under ORS 656.262(4) (14 days after the date of the claim), rather than November 5, 1982 as ordered by the Referee. The insurer cites no authority for this contention, with which we disagree.

ORS 656.262(4) states that the first installment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. Here, claimant's claim was filed with the employer on November 10th. On the 801 claim form, the employer acknowledges that it first knew of claimant's problem on November 5th. November 5th is also the date claimant was hospitalized "and became temporarily, totally disabled."

Since claimant was an inpatient in a hospital, his temporary disability payments would be recoverable beginning November 5th, without the normal first three calendar day exemption. See ORS 656.210(3). Clearly, compensation time began to accrue from November 5th, the date claimant first missed work, his condition was diagnosed and, most importantly, he was hospitalized. However, payment for this compensation was not required until 14 days from November 10th, the date of the employer's notice of the claim, which was November 24, 1982.

ORS 656.262(9), now ORS 656.262(10), states the insurer "shall be liable for an additional amount up to 25 percent of the amounts then due." In the present case, the insurer's unreasonable action began on the date the employer had notice that claimant filed his claim, November 10, 1982, until the date of the claim's denial, January 4, 1983.

ORDER

The Referee's order dated March 29, 1983 is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the insurer.

Board Member Barnes Concurring in Part:

I am not sure I understand what the majority is saying about whether interim compensation should be paid from the date of disability, here November 5, 1982, or from the date of notice of the claim, here November 10, 1982. The Referee apparently assumed that interim compensation was due from disability date, since he imposed a 25% penalty for nonpayment of interim compensation starting November 5, 1982.

The Referee was incorrect. We have previously ruled that interim compensation is due from the date of the claim; only if and when the claim is accepted must the employer/insurer then pay temporary total disability benefits for the interval between date of disability and date of claim. Donald Wischnofske, 32 Van Natta 136 (1981), 34 Van Natta 664 (1982); Janet S. Robb, 34 Van Natta 1086 (1982). The Court of Appeals has reached the same

conclusion. Stone v. SAIF, 57 Or App 808 (1982).

If the Board majority's discussion of the penalty issue in this case is intended to overrule what the Board and court have previously said about interim compensable payable only from date of claim, I disagree and would adhere to Wischnofske. Stated differently, if the insurer had argued in this case that the penalty for nonpayment of interim compensation should apply only to interim compensation payable after November 10, 1982, I would agree with that position and vote to modify the Referee's order accordingly. I concur, however, solely because I do not understand the insurer to have raised the Wischnofske issue.

I express no view on the merits of the compensability of this claim.

DANNY J. JONES, Claimant
Welch, Bruun & Green, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 84-0016M
February 3, 1984
Own Motion Order Allowing Attorney's Fees

In April 1983 claimant requested that the Board exercise its own motion authority and reopen his October 21, 1970 injury claim for a worsened condition related to his original injury. In accordance with the Board's standard practice and procedure, claimant's request for own motion relief was forwarded to the insurer, SAIF Corporation, for a decision regarding voluntary claim reopening. ORS 656.278(4). On December 23, 1983, the Board was advised by SAIF that it would be voluntarily reopening the claim.

Claimant's attorney has petitioned the Board for allowance of an attorney's fee for services rendered in effecting voluntary claim reopening. Counsel alleges 20 to 30 hours were expended in obtaining claim reopening.

> "If a proceeding is initiated on the Board's own motion because of a request from a claimant and an increase in compensation is awarded, the Board shall approve for claimant's attorney a reasonable fee payable out of any increase awarded by the Board." OAR 438-47-070(2).

This rule governing attorney fees in own motion proceedings has been in existence since January of 1974, and was not altered by the amendments to OAR Chapter 438, Division 47 promulgated by the Board in early 1979 (WCB Admin. Order 1-1979, effective February 1, 1979). Although the rule appears to allow a fee in own motion proceedings payable only "out of [an] increase awarded by the Board," the literal terms of the rule must be read in light of subsequent developments in own motion practice, as well as the general principles and policies underlying the Workers' Compensation Act. ORS 656.012(2).

ORS 656.278 was amended by Oregon Laws 1981, chapter 535 § 32, by which subsection (4) was added. The legislature expressly provided that employers/insurers have authority to pay compensation and reopen a claim without an order of the Board

after expiration of a claimant's aggravation rights. See also ORS 656.018(4). The 1981 amendment, to a certain extent, was a codification of existing practice inasmuch as some claims were "reopened" by some insurers after expiration of the five years for payment of additional benefits without an own motion order of the Board As part of the same enactment, the legislature also clarified that medical services pursuant to ORS 656.245 are compensation granted as a matter of right for the life of an injured worker, denied claims for which are to be contested pursuant to ORS 656.283. Oregon Laws 1981, chapter 535 § 31.

ORS 656.278(4) is in furtherance of one of the express objectives of the Act:

> "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).

Although attorney involvement, by definition, tends to enhance the adversary nature of a proceeding, as opposed to reducing or eliminating it, it is also certain that there are many instances in which counsel can be effective in persuading an employer or insurer that voluntary reopening is in order, thereby obviating the need for Board intervention and entry of an order pursuant to ORS 656.278.

It is common in worker's compensation practice for an attorney to be instrumental in obtaining acceptance of a claim or payment of additional compensation without the need for a hearing, in which case, the administrative rules provide for allowance or approval of a reasonable attorney's fee by a Referee in a "summary proceeding." OAR 438-47-015. The general principles set forth in the Board's rules governing attorney fees, including fees in proceedings pursuant to ORS 656.278, provide that an attorney's fee will be allowed when the attorney is instrumental, with or without proceedings before a Referee, the Board or a court: "(a) In obtaining acceptance of a denied claim; or (b) in obtaining compensation or an increase to the claimant; or (c) in successfully defending an award of benefits to claimant against reduction." OAR 438-47-010(1).

We conclude that existing administrative rules allow the Board to provide for payment of a reasonable attorney's fee to claimant's attorney when counsel has been instrumental in obtaining voluntary claim reopening pursuant to ORS 656.278. The alternative is to construe the rules as allowing the Board to provide for payment of an attorney's fee only upon closure of the claim. This manner of proceeding has proven to be unsatisfactory in the past. Fred Gascon, 34 Van Natta 1551A (1982). If an attorney is instrumental in obtaining voluntary claim reopening, he or she should inform the Board of the efforts expended in claimant's behalf, preferably in affidavit form. Any fee allowed by the Board is to be paid out of claimant's compensation as paid. The fee is not payable in addition to compensation. OAR 438-47-070(2); Bernie Hinzman, 35 Van Natta 1374 (1983). See also ORS 656.386(2).

ORDER

Claimant's application to the Board for allowance of a reasonable attorney's fee is granted. Claimant's attorney is allowed 25% of the temporary disability compensation paid to claimant in connection with the SAIF Corporation's voluntary claim reopening pursuant to ORS 656.278(4). The attorney's fee payable under the terms of this order shall not exceed $500 and is payable out of claimant's compensation, not in addition thereto. Counsel's entitlement to an additional fee will be considered at the time of claim closure.

LARRY FUNKHOUSER, Claimant
Roll & Westmoreland, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 81-08931
February 7, 1984
Order of Dismissal

Claimant requested review of Referee Howell's order which affirmed a Determination Order dated February 18, 1983, which awarded claimant 25% for 80° of unscheduled permanent partial disability for injury to claimant's low back. The self-insured employer has moved to dismiss claimant's request for review on the grounds that it was not timely filed.

The Referee's order was entered on December 6, 1983. Claimant's request for review is dated January 6, 1984, and was mailed by certified mail on that same date. The 30th day after the Referee's order, not including the date on which the order was entered, was January 5, 1984; therefore, claimant's request for review, which was mailed on the 31st day after the Referee's order, is untimely. ORS 656.289(3); OAR 436-83-700(2).

In response to the employer's motion to dismiss, claimant contends that the 30-day period for requesting Board review did not expire until January 9, 1984 by operation of Rule 10C of the Oregon Rules of Civil Procedure. ORCP 10C provides:

> "Except for service of summons, whenever a party has the right or is required to do some act or take some proceedings within a prescribed period after the service of a notice or other paper upon such party and the notice or paper is served by mail, 3 days shall be added to the prescribed period."

The scope of the Oregon Rules of Civil Procedure is stated in Rule 1A:

> "These rules govern procedure and practice in all circuit and district courts of this state, except in the small claims department of district courts, for all civil actions and special proceedings whether cognizable as cases at law, in equity, or of statutory origin except where a different procedure is specified by statute or rule. These rules shall also govern practice and procedure in all civil actions and special proceedings, whether cognizable as cases at law, in equity, or of statutory origin, for the

small claims department of district courts and for all other courts of this state to the extent they are made applicable to such courts by rule or statute. Reference in these rules to actions shall include all civil actions and special proceedings whether cognizable as cases at law, in equity or of statutory origin."

In the exercise of its rulemaking authority, ORS 656.726(5), the Board could adopt the Oregon Rules of Civil Procedure, or portions thereof, for proceedings in contested cases before this agency; however, this has not been accomplished as of this date. Existing statutory and regulatory provisions, as previously interpreted by the Board and the court, are controlling. ORS 656.289(3); ORS 174.120; OAR 436-83-700(1), (2); Rodney V. Calvin, 35 Van Natta 1293 (1983); Matthew Sampson, 34 Van Natta 1145 (1982); Ray Williams, 20 Van Natta 89 (1977); Donna Bassford, 18 Van Natta 141 (1976); Norman L. Cobb, 11 Van Natta 224 (1974); Robert Wright, 11 Van Natta 40 (1973); Gerald McElroy, 10 Van Natta 184 (1973); Pauline Mabe, 6 Van Natta 98 (1971); Stephen A. Johnson, 5 Van Natta 105 (1970); Page William Medford and Gordon Dee Medford, 1 Van Natta 46 (1967); Phillip E. Lowe, 1 Van Natta 23 (1967). See also Argonaut Insurance Co. v. King, 63 Or App 847 (1983); Albiar v. Silvercrest Industries, 30 Or App 281 (1977).

Perhaps some consideration should be given to the possibility of excluding legal holidays in the computation of the thirty-day limitations period since many offices frequently are closed during certain periods of the year or operate with only a skeleton staff, see ORCP Rule 10A; presently, however, such days are included in the computation of a limitations period unless the last day of the period falls thereon. See ORS 174.120. Under existing law, the thirty-day period for requesting Board review of the Referee's order in this case expired the day before claimant perfected his request. Accordingly, we lack jurisdiction, and the claimant's request for review must be dismissed.

ORDER

Claimant's request for review of the Referee's order dated December 6, 1983 is dismissed as not timely filed.

PATRICK A. SHIELDS, Claimant
Frye, Hanna, & Veralrud, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-5953 & 83-5954
February 7, 1984
Order of Dismissal

The insurer has requested review of Referee's order dated December 22, 1984. The request for review was filed with the Board on February 3, 1984 , more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

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

WILLI ARNDT, Claimant
Joseph Post, Claimant's Attorney
Cheney & Kelley, Defense Attorneys

WCB 81-08483
February 9, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer requests review of Referee Pferdner's order which found claimant to be permanently totally disabled. The sole issue is extent of disability, including permanent total disability.

Claimant was born in Poland, raised in Poland and Germany, and came to the United States in 1957. In Europe, he spoke both Polish and German. Since coming to the United States, claimant has learned to speak and understand English, he believes, well. However, an interpreter was used at the hearing. Claimant can read English to a limited extent, e.g., he can understand the sports section of the newspaper without assistance, but most other written materials require his wife's assistance. He cannot write English. Claimant received the equivalent of about six grades of education in Poland and Germany, and no additional education in the United States. His intelligence has been determined to be in the low average range.

Other than the employment which gave rise to this claim, claimant's work history includes training guard dogs, laying railroad ties, hoisting rolls of paper in a paper mill, working as a janitor and farm work. Claimant lives on a 48 acre farm and, prior to his injuries involved here, was able to ride a tractor, move irrigation pipes, handle bales of hay, maintain a garden and otherwise carry out farming operations.

Claimant has been employed by the employer involved in this proceeding since 1958 or 1959 as a sheet metal worker and welder. In February 1975 claimant sustained a ruptured disc in the course of his employment. X-rays taken at that time also revealed the existence of spondylolysis. A laminectomy and discectomy at L5-S1 were carried out in March 1975 and the claim was closed in January 1976 with an award of 5% permanent disability. An aggravation claim was filed which led to back surgery again in September 1976. Bone fragments and scar tissue from the first surgery were removed. Another laminectomy and removal of disc material were performed. Claimant's back was fused at L5-S1. Subsequently claimant developed an infection at the hip donor site which resolved with hospitalization. In March 1977 claimant was released to and returned to work with the same employer.

A September 1977 medical report from claimant's treating physician for the first time mentioned that claimant "showed a significant amount of emotional problems...suggesting that strong functional component may be prolonging and increasing his disability state." There does not appear to have been any follow up on this suggestion at that time. Closing evaluations found the extent of orthopedic impairment to be in the moderate range, and the aggravation claim was eventually closed in February 1978 with an award of an additional 15% permanent disability. There is no indication whether claimant's psychological problems were factored into that award of permanent disability.

Claimant's work thereafter included lifting 125 pound incuba-

tors onto a work bench. Claimant experienced periodic incidents of back pain but continued working. In June 1979 claimant experienced pain when he lifted a 200 pound compressor. He quit work the following day. Claimant's back pain did not respond to at-home care. He was hospitalized for therapy and evaluation, diagnosed as having a lumbar strain and status post laminectomy and fusion, and discharged in an improved condition. Claimant received psychological therapy (primarily biofeedback training, it appears) from Joan Kelley, Ph.D., at that time and for a period of time thereafter.

Claimant's back pain continued and he developed neck pain. A myelogram performed in December 1979 revealed degenerative changes in the cervical portion of the spine. With respect to the lumbar spine, a comparison of the 1979 myelogram and a myelogram that had been performed in 1976 revealed "no essential difference in the configuration of the pantopaque column in the last two myelograms." Claimant's physicians determined that further surgery was not indicated and that claimant's neck condition and symptoms were not related to either the 1976 or the 1979 industrial incidents.

Between the 1975 and 1979 incidents, the employer had changed insurers. There was a hearing on the issue of whether the 1979 incident constituted an aggravation or a new injury. The outcome of that proceeding was a finding that claimant had sustained a new injury. See Willi Arndt, 32 Van Natta 286 (1981).

A closing examination by Orthopaedic Consultants resulted in a report wherein claimant was diagnosed as having "status post lumbar laminectomy, times two, and post lumbosacral fusion, and chronic recurrent lumbar strain." Interference from functional disturbance was considered moderate. Permanent impairment attributable to the 1979 injury was judged to be mildly moderate and overall permanent impairment at moderate.

A psychiatric evaluation of claimant was done by Dr. Colbach who noted that claimant was a man of limited intelligence and limited education who had always worked hard, that he was anxious and frightened about having back problems which rendered him unable to do physical work, that in many ways claimant had given in to his dependency needs, that he was exaggerating his symptoms to some degree, "probably unconsciously," that claimant's fear and anxiety make his physical limitations worse, and that the amount of impairment due to psychiatric problems was mild to moderate.

The 1979 claim was closed in November 1981 with an award of 35% unscheduled disability which, according to the Evaluation Division's worksheet, took into consideration claimant's psychological impairment as well as his orthopedic impairment. This award was in addition to the previous awards of 20%, for a total of 55% unscheduled disability. This case stems from an appeal by claimant from that Determination Order, claimant contending that his extent of permanent disability is greater, including permanent total disability.

In summary, claimant has numerous forms of impairment. The most serious impairment arises from claimant's 1975 industrial injury which resulted in two laminectomies and a fusion. That 1975 claim is not here directly in issue; the present issue is claimant's disability following his 1979 injury and claim. However, the residuals of the 1975 injury would be "preexisting disability" that

could be considered for purposes of an award of permanent total disability under ORS 656.206(1)(a). The only other preexisting disability that might be of significance under ORS 656.206(1)(a) would be claimant's loss of his little finger and part of the fourth finger of his left hand in a previous industrial accident. Claimant also has liver disease, gall bladder disease and intestinal disorders; however, it does not appear that these conditions are contributing to his disability. Claimant also has degenerative disc disease in the cervical portion of his spine; however, that condition is unrelated to any industrial injury and its disabling effects began after the 1979 injury here in question. We thus do not consider that condition in evaluating the extent of disability.

Frank Mason, 34 Van Natta 568, aff'd 60 Or App 786 (1982); Emmons v. SAIF, 34 Or App 603 (1978). In short, claimant has several forms of impairment that are not properly part of the disability calculus now before us.

That fact makes evaluation of the lay testimony more difficult. Claimant testified that he has difficulty sleeping for any prolonged period; that his daily activities are restricted to feeding pressed pellet foot to his pigeons, chickens and rabbits; that these activities take him about an hour and a half; that after doing these activities he must rest for 30 minutes to an hour. Claimant's son received an early discharge from the Navy to take care of the farm because claimant is no longer able to handle most farming operations. Claimant feels he is unable to drive a car. When he sits, he can only sit on his left buttock.

We infer that the majority (but not all) of claimant's limitations and difficulties are probably due to his 1975 and/or 1979 industrial injuries. On the other hand, it is safe to assume that some of claimant's limitations are due to noncompensable conditions, like his cervical disc disease. The main reason to link a majority of claimant's problems to his industrial injuries is the fact that claimant's most pronounced symptoms, according to both the medical evidence and lay testimony, are low back pain and numbness radiating into his right leg. These symptoms would appear to be most consistent with claimant's 1975 low back ruptured disc, two laminectomies and fusion. Yet, strange as it may seem, claimant was able to and did return to fairly heavy work for more that two years after recovering from his 1975 injury.

Claimant's 1979 injury appears to have been much less serious, diagnosed as only a lumbar strain. A myelogram performed after the 1975 injury revealed "no essential difference" from a prior myelogram. It is very difficult to understand -- and the record does not explain -- how claimant could have had such a successful recovery from his more serious 1975 injury and be as disabled as he claims after his more minor 1979 injury.

Claimant has not been employed (other than what might be regarded as de minimus self-employment in farming) or sought employment since his 1979 injury. The employer thus argues that claimant has not satisfied the seek-work requirement of ORS 656.206(3) and thus cannot be found to be totally disabled. Claimant, of course, responds that he comes within the "futility exception" to ORS 656.206(3) created by Butcher v. SAIF, 45 Or App 313 (1980), and its progeny.

As indicated above, we think it is clear that claimant has various forms of physical impairment that were neither caused by his 1979 injury nor are preexisting disability that we can consider under ORS 656.206(1)(a). We are frankly unsure how the futility exception should be applied in this kind of situation; we assume that we should focus only on whether claimant's compensable impairment (i.e., cognizable impairment under ORS 656.206(1)(a)) makes seeking work futile, not whether claimant's total impairment makes seeking work futile. Just before claimant's 1979 injury, his compensable impairment did not prevent him from working at a fairly strenuous job. We do not think the incremental impairment caused by the 1979 strain-type injury, although difficult to understand on this record, is of a magnitude that would make seeking work futile. We conclude that ORS 656.206(3) precludes an award of total disability.

Turning to the question of the extent of claimant's partial disability, we first note that Exhibit 71 indicates that the Evaluation Division rated claimant's orthopedic and psychological impairment at 15%. This seems significantly low. Orthopaedic Consultants rated claimant's orthopedic impairment attributable to the 1979 injury as mildly moderate, i.e., 20% to 40%. Dr. Colbach rated claimant's psychological impairment as mild to moderate, i.e., 10% to 60%. There is an obvious overlap between these two forms of impairment, i.e., the principal form of orthopedic impairment is disabling pain and the principal form of psychiatric impairment is enhancement of subjective pain. We conclude that an impairment rating of about 40% is indicated.

The social/vocational factors all increase the extent of claimant's disability. His age, 54 or 55, justify an impact factor of +8. His lack of education justifies an impact factor of +15. Before the 1979 injury he was capable of heavy work; now, apparently, he is only capable of sedentary work; adaptability from heavy to sedentary yields a +20 rating. Claimant's dull-normal mental capacity justifies an impact factor of at least +5, if not more because of his language problem. We find the labor market considerations to yield an impact of +15. Combining all these values and resolving all doubt in claimant's favor leads to a disability rating of 75%.

We do not understand the employer to argue that we should take into account claimant's previous awards totalling 20% disability pursuant to ORS 656.222. In any event, because of lack of clarity in the record about many aspects of this case, we think it would be inappropriate to do so.

ORDER

The Referee's order dated July 20, 1982 is reversed. Claimant is awarded 240° for 75% unscheduled low back and psychiatric disability; this award is in lieu of all prior awards. Claimant's attorney's fee should be adjusted accordingly.

SIMON ZINGANI, Claimant
Pozzi, et al., Claimant's Attorneys
Richard C. Pearce, Defense Attorney

WCB 81-06993
February 9, 1984
Order Denying Request to Dismiss

The Board has received respondent's request to dismiss the claimant's request for Board review on the grounds claimant has not filed an appellant's brief nor received permission for extension of filing of its brief.

The Board allowed appellant an extension of time for brief submittal dated February 1, 1984. There is no requirement in the workers' compensation law or the Board rules which indicates that a brief must be filed by appellant or respondent before the Board will review the case. ORS 656.295(5). While briefs are a significant aid in the review process, the failure to file a brief is not grounds for dismissal of a request for review. The request for dismissal hereby is denied.

IT IS SO ORDERED.

DEWAYNE D. DUNLAP, Claimant
Richard O. Nesting, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 83-00653
February 13, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Fink's order which awarded claimant 128° for 40% unscheduled permanent partial disability on review of the July 23, 1982 Determination Order which awarded no permanent disability. Claimant cross-requests review contending that his award should be increased. The issues are extent of disability and the application of ORS 656.222.

We agree with the insurer's contention that the award is excessive. Therefore, we modify the Referee's order.

Claimant is a 33 year old warehouseman for a grain and wheat mill who compensably injured his neck/cervical spine in December 1981 while shoveling wheat from under a conveyor belt. He is a high school graduate and has completed two years of general college courses. His work experience consists of primarily heavy labor employment.

Claimant previously suffered an industrial injury to his neck in January 1973, for which he received an award of 15% permanent disability. Although the exact amount of this previous award was not known at hearing, we have chosen to take notice of this prior order. See Dennis Fraser, 35 Van Natta 271, 274 (1983). Since this action was not requested by either party, we have given the parties an opportunity to comment. Fraser, supra, 35 Van Natta at 274.

Claimant also suffered an industrial injury to his neck in September 1978, for which he received a stipulated award of 20% in December 1980. Thus, prior to his present claim, claimant had received a total of 35% permanent disability for his neck/cervical spine injuries.

All treatment for claimant's injuries has been conservative. Following the 1973 and 1978 injuries claimant eventually returned to work without restrictions.

After the December 1981 injury claimant's treating neurologist, Dr. Isaacs, diagnosed claimant's condition as mild-moderate chronic cervical strain syndrome. Although claimant's condition was suggestive of mild sensory neuropathy, the doctor found no evidence of radiculopathy or any neurologic deficit.

Dr. Isaacs has placed a 15 pound weight restriction for claimant's lifting and has recommended that claimant avoid activities which involve twisting his neck. There is an indication in a chart note of an examining physician that Dr. Isaacs had modified this weight restriction to a 25 pound limitation. However, there is no report from Dr. Isaacs that this 15 pound limitation has been modified.

These work restrictions have prevented claimant from returning to his warehouse job which involved lifting weights of 50 to 130 pounds. Dr. Isaacs indicates that should claimant manifest a good response to treatment, these restrictions could be modified to some degree over many months. However, the doctor remained doubtful that claimant's neck condition would resolve and felt that it would continue to be aggravated by moderate activity.

Claimant credibly testified that although he was experiencing a more intense pain, his present neck problems were basically the same as he had experienced over the past ten years. Claimant experienced numbness in the shoulders and arms, a constant sometimes jabbing pain, which resulted in a severe loss of motion to his neck. He sometimes wore a neck brace and often awoke ten times a night due to the pain and discomfort. Formerly very athletic, claimant had been forced to severely restrict his physical activities. There is no suggestion in any report that claimant's symptoms and impairment are contrived or that claimant is malingering.

The insurer argues that an award of 40% permanent disability, in addition to the previous awards for the same area of claimant's body, is excessive. The insurer cites ORS 656.222, which states that an award of compensation for a further accident shall be made with regard to the combined effect of the injuries and the worker's past receipt of money for such disabilities.

Claimant argues that nothing in ORS 656.222 requires that a strict arithmetic offset be made between compensation for the first injury and subsequent injuries. He cites Cascade Steel Rolling Mills v. Madril, 57 Or App 398, 402 (1982), as support for his argument. Claimant argues that a strict offset is particularly inappropriate here where he has substantially improved from prior injuries and where this latest injury has diminished his future earning capacity.

The Board has found that sometimes an arithmetic computation is appropriate when no other rational method can be seen to measure the difference in disability. William Still, 34 Van Natta 1543 (1982). Pursuant to reason and ORS 656.222, we shall consider the

previous determinations of extent of disability arising from previous injuries. However, while we consider the previous determinations, we do not necessarily engage in a strict mathematical computation. Cascade Steel Rolling Mills v. Madril, supra; R. L. Matthews, 35 Van Natta 52, 53 (1983). Cf American Bldg. Maint. v. McLees, 64 Or App 602 (1983).

Here we find it unnecessary to apply a strict mathematical computation. See also James W. Thomason, WCB Case No. 79-05982, 36 Van Natta 143 (decided this date). The record contains sufficient evidence with which to determine claimant's disability attributable to his 1981 injury. The objective findings from the medical reports, particularly those of Dr. Isaacs, claimant's work restrictions and his testimony provide us with a sufficient basis from which to evaluate claimant's disability. In arriving at our determination, we are aware that the award should compensate claimant for his new or additional disability that has resulted from this latest injury and that was not compensated for by the prior awards. See Cascade Steel Rolling Mills v. Madril, supra, 57 Or App at 601. We also take note that the prior awards contemplate fluctuations of symptoms. Harmon v. SAIF, 50 Or App 121, 126 (1981); Jo Wanda Orman, 35 Van Natta 650 (1983).

We have applied the guidelines in OAR 436-65-600 et seq. and considered claimant's age, education, work experience, mental capacity, adaptability, physical impairment, disabling pain, work restrictions and labor market findings. In comparing the facts of this case to similar cases and considering his prior disability awards, we conclude that claimant is entitled to 10% unscheduled permanent partial disability.

ORDER

The Referee's order dated May 10, 1983 is modified. Claimant is awarded 32° for 10% unscheduled permanent disability. This award is in lieu of the 128° for 40% permanent disability awarded by the Referee. Claimant's attorney is allowed 25% of the compensation awarded herein as an attorney's fee, not to exceed $2000, payable out of claimant's compensation and not in addition thereto.

DARLENE J. EMERSON, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-08692
February 13, 1984
Order on Review

Reviewed by the Board en banc.

Claimant requests review and the SAIF Corporation cross-requests review of Referee McCullough's order which affirmed SAIF's denial of claimant's back problems and which set aside the Determination Orders of November 1 and November 19, 1982 as being premature. Claimant contends her back condition is compensable. SAIF contends that the Determination Orders should be affirmed inasmuch as claimant's psychiatric condition is medically stationary.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated April 12, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

Board Member Barnes Dissenting in Part:

On SAIF's cross-request for review, I would reverse that portion of the Referee's order which set aside the November 1 and November 19, 1982 Determination Orders as premature.

Admittedly, the reports of claimant's treating psychiatrist, Dr. Rinier, use all the correct "magic words" -- opining that claimant was not medically stationary (in a psychological sense) when the challenged Determination Orders were issued. However, I understand our statutory duty and obligation as factfinders to be to weigh and to assess the evidence and to determine whether we can truly say that we find any expert opinion offered by the party with the burden of proof to be persuasive. And I believe an important aspect of assessing persuasiveness of any expert opinion is to consider the expert's reasons for that opinion. E.g. Samuel v. Vanderheiden, 277 Or 239 (1977).

Dr. Rinier explained the reasons for his opinion in a deposition, Exhibit 92. As I read that deposition, Dr. Rinier is using "medically stationary" in some sense other than the statutory definition of that term. For example, Dr. Rinier is apparently not going to regard claimant as medically stationary (in a psychological sense) until "she's productively, gainfully employed." (Ex. 92, p. 11.) When asked whether claimant could return to her pre-injury job, Dr. Rinier elaborated on his concerns about the quality of claimant's work experience:

> "Well, she can, if she's treated like you would treat any human being. In other words, she can't always be afraid that she's going to be fired. She can't always feel that they're giving her shit work to do. She can't feel that she's being discriminated against and harrassed or whatever. She has to be given productive work . . ." (Ex. 92, p. 9.)

Dr. Rinier's holistic approach to claimant's health care is interesting, but I know of no provision of the workers' compensation law that even suggests that claimant should be paid time loss until she obtains stimulating employment. Because I do not think the reasons Dr. Rinier stated for his opinion are legally sufficient, I do not find that opinion persuasive. It follows, I believe, that claimant has not proven that the November 1982 Determination Orders were other than proper closures of her industrial injury claim.

For these reasons, I respectfully dissent from the majority's contrary conclusion on the issue raised by SAIF.

DOUGLAS E. STEVENSON, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-7767
February 13, 1984
Order of Dismissal

The insurer has requested review of Referee's order dated January 9, 1984. The request for review was filed with the Board on February 9, 1984 , more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

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

JAMES W. THOMASON, Claimant
Cramer, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 79-05982
February 13, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Johnson's order which awarded claimant 192° for 60% unscheduled permanent disability in lieu of the 48° for 15% permanent disability awarded by Determination Order dated July 14, 1978. SAIF contends the permanent disability award is excessive. We agree with SAIF and modify the Referee's order.

Claimant is a 50-year-old cable television lineman who compensably suffered a cervical/dorsal strain in a November 1977 fall. Claimant previously suffered an industrial injury to his cervical/dorsal spine in January 1970, for which he received an award of 20% permanent disability. Claimant returned to his lineman job after the 1970 injury. After the November 1977 injury, a panel of doctors at the Orthopaedic Consultants recommended that claimant not return to work as a lineman, that he should limit himself to light work and that his impairment rating was mildly moderate or 20-40%. When the Orthopedic Consultants examined claimant in May 1976, they found his disability related to his 1970 injury to be mild.

Claimant testified that he has not returned to work as a lineman since his 1977 injury, although he has attempted several other jobs such as a ranch hand and truck driver which caused him problems with his back, neck and arms. For the two years before the hearing, however, claimant has been employed by the United States Forest Service as a warehouseman and compound manager. This job requires claimant to work nine months out of the year. Claimant must bid on the job annually and has no guarantee that the job will be his each coming year. The job duties involve lifting up to 45 pounds, pushing and pulling movements, prolonged walking, standing, bending and use of arms, hands and legs. Claimant testified that he performs no substantially heavy labor, but that he does some lifting and operates a Hyster. Claimant also testified that he continues to have pain in his back, neck and arms for which he takes pain medication. Further, claimant testified he has discontinued or reduced hunting, woodworking and horseback riding.

SAIF argues that an award of 60% permanent disability, in addition to the 20% permanent disability previously awarded for the

same area of claimant's body, is excessive. SAIF argues that claimant's disability should be determined by applying the guidelines in OAR 436-65-600 et seq. using claimant's total impairment, which yields a rating of 55%. SAIF then asks us to subtract from that rating the 20% disability award claimant received for his 1970 injury, resulting in a disability rating of 35% for claimant's 1977 injury. The Court of Appeals, however, has held that such a strict mathematical computation is not required by ORS 656.222, and in some cases may be inappropriate. Compare Cascade Steel Rolling Mills v. Madril, 57 Or App 398 (1982) with American Bldg. Maint. v. McLees, 64 Or App 602 (1983). See Roy J. Fenton, 34 Van Natta's 1686 (1982). Accordingly, we decline to make such strict mathematical computations here where we have sufficient evidence to determine the increased impairment to claimant's cervical/dorsal spine as a result of his 1977 injury. Cf William Still, 34 Van Natta 1543 (1982) (mathematical computation used where no other rational method seen to measure difference in disability); DeWayne D. Dunlap, WCB Case No. 83-00653, 36 Van Natta 139 (decided this date).

Based on the Orthopedic Consultants' finding that claimant's impairment related to his 1970 injury was mild, we find that claimant's impairment relating to his neck was 15% prior to his 1977 injury. We further find that claimant's total impairment following his 1977 injury is 30%. Therefore, we find that claimant's impairment resulting from the 1977 injury is 15%.

Applying the guidelines in OAR 436-65-600 et seq., considering claimant's age, education, work experience, adaptability, and labor market findings, results in a disability rating of 40%. Comparing that rating with other similar cases, we find that an award of 40% adequately compensates claimant for the permanent disability related to his 1977 injury.

ORDER

The Referee's order dated May 27, 1983 is modified. Claimant is awarded 128° for 40% unscheduled permanent disability. This award is in lieu of the 192° for 60% permanent disability awarded by the Referee and in lieu of the 48° for 15% unscheduled permanent disability awarded by Determination Order dated July 14, 1978. Claimant's attorney is allowed 25% of the additional compensation awarded herein (80°) as an attorney's fee, not to exceed $2,000, payable out of claimant's compensation and not in addition thereto.

MICHAEL D. COPLEY, Claimant
Zafiratos & Roman, Claimant's Attorneys
Robert Olson, Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Asst. A.G.

WCB 83-00158
February 15, 1984
Order on Reconsideration

Claimant has moved for and award of attorney fees in connection with our Order on Review dated January 19, 1984. We regard this as a motion to reconsider. On reconsideration, we decline to award claimant's a fee and adhere to our Order on Review.

The SAIF Corporation requested review of a Referee's order setting aside its denial. No briefs were filed and the Board affirmed the Referee's order. Thus, claimant prevailed on Board

review. In our order we stated: "No attorney fee will be awarded to claimant's attorney as no brief was filed." Claimant's attorney now argues:

> "I don't feel that you have the authority to prevent me from receiving fees and if you do, please cite me the proper authority."

OAR 438-47-010 which sets forth the general principles for awarding attorney fees states:

> "(1) Attorney fees for claimant's attorney will be allowed only when the attorney is instrumental, with or without proceedings before a referee, the Board or a court:
>
> * * *
>
> "(c) In successfully defending an award of benefits to claimant against reduction.
>
> "(2) The amount of a reasonable attorney fee when authorized under 47-000 to 47-095 including cases involving extraordinary services shall be based on the efforts of the attorney and the results obtained...."

While it is true that the Referee's order setting aside the denial was affirmed, claimant's attorney was not instrumental in defending the Referee's order. Accordingly, under the general principles set forth in OAR 436-47-010, the Board declines to award claimant's attorney a fee on Board review.

ORDER

On reconsideration, the Board's Order on Review dated January 19, 1984 is hereby reaffirmed and republished.

MICHAEL G. CRAGUN, Claimant
Flaxel, et al., Claimant's Attorneys
Atherly, et al., Defense Attorneys

WCB 82-08199
February 15, 1984
Order on Reconsideration

Claimant has requested reconsideration of our January 31, 1984 Order on Review which reduced the attorney fee awarded by the Referee from $1,200 to $700.

Claimant first argues that he is entititled to a full attorney fee as he requested a hearing prior to the issuance of the .307 order. This is correct. However, that request for hearing was filed in relation to the August 16, 1982 denial, and that denial was affirmed by the Referee. Therefore, no fee can be awarded on this basis.

Claimant next argues that our reliance on cases such as Hanna v. McGrew Bros. Sawmill, 45 Or App 757 (1980), and National Farmers' Union Insurance v. Scofield, 56 Or App 130 (1982) is inappropriate as those cases involved single employers with two

insurance carriers, whereas the current case involves two employers who happen to have the same insurance carrier. That, in our opinion, is a distinction without a difference.

Claimant also argues that more than just responsibility was in issue at the hearing as the attorney representing SAIF on behalf of Wardrobe Cleaners indicated compensability was also being contested. What was actually stated was as follows:

> "Mr. Butler: In behalf of Wardrobe Cleaners, it is our position that compensability is an issue with respect to the claim 12-23-82 incident to the extent that we take the position if anything happened on that day it was not related to his work with Wardrobe Cleaners, but it was soley related to the June of 1980 accident. . . ." (Emphasis added.)

Although Mr. Butler may have used the word "compensability," it is clear that he was speaking only in context of responsibility. The remainder of the transcript supports this.

Claimant's arguments have failed to convince us to change our conclusion in this case. We, therefore, adhere to our original order.

ORDER

On reconsideration, the Board adheres to its Order on Review dated January 31, 1984, which hereby is reaffirmed and republished.

DANIEL D. GRIGGS, Claimant
Cash Perrine, Claimant's Attorney
Minturn, et al., Defense Attorneys

WCB 82-11195
February 15, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Seifert's order which affirmed the SAIF Corporation's November 29, 1982 denial, by which SAIF refused to reopen claimant's claim for low back surgery on the grounds that the proposed surgery was not reasonable and necessary.

In June 1978 claimant, a then 51 year old former heavy equipment operator, filed a claim for occupational disease for a low back condition. Claimant had experienced chronic back symptoms for many years prior to the filing of his claim and in December 1977 he underwent a complete lumbar laminectomy with removal of a protruding disc at L4-5. At that time claimant was employed as a field representative for the Operating Engineers Local #701.

Claimant returned to work following his surgery, but had to give up his job due to severe back pain which occurred as a result of the long distance driving which his job required. Claimant was examined by Orthopaedic Consultants on September 13, 1978. The Consultants were of the opinion that claimant should undergo no further surgical treatment as he had already undergone a discectomy between L-4 and L-5 with a wide laminectomy between L-3 and L-5, and a complete laminectomy between L-4 and L-5.

Claimant was again hospitalized in November 1978. A myelogram demonstrated a large extradural defect to the right at the L4-5 interspace. Spondylotic changes were present at L3-4 and L4-5. On November 24, 1978 claimant underwent another laminectomy. An extruded disc at L4-5 was excised and a foraminotomy at the L-5 nerve root was performed. The discharge diagnosis was degenerative lumbar disc disease.

Claimant thereafter received continuous conservative treatment for low back and leg pain. Dr. Miller, claimant's then treating physician, was of the opinion that claimant was permanently and totally disabled. Dr. Corrigan was of the opinion that claimant's discomfort was a result of surgical collapse of the L4-5 disc space with resultant mechanical instability, and felt that claimant was restricted to very sedentary activity.

Claimant underwent a repeat examination by Orthopaedic Consultants on December 30, 1980. The Consultants concluded that claimant was medically stationary and noted in their report that claimant stated he was not enthusiastic about undergoing a third surgery. The Consultants felt that a spinal fusion would not decrease claimant's impairment. Dr. Miller agreed with the Consultants.

On January 16, 1981 Dr. Norton, a medical consultant for SAIF, reviewed claimant's medical records. Dr. Norton reported that although there was "some reasonable chance" that a successful fusion might increase claimant's prospects for gainful employment, the long term prognosis from the standpoint of substantial permanent relief of pain was thought to be poor. Dr. Norton noted that claimant was probably suffering further anatomic changes in his spine due to the prior surgeries. He concluded:

> "In this particular claimant I find it somewhat difficult to make strong recommendations in either direction on the basis of the medical record. In this particular clinical situation I would not oppose surgical management of the claimant's instability."

Claimant thereafter began treating with Dr. Kendrick, a neurosurgeon. As he was reluctant to recommend surgery, Dr. Kendrick utilized various conservative measures in an attempt to treat claimant. On April 23, 1981 Dr. Kendrick reported that he did not feel a surgical fusion was indicated at that time.

On the basis of Dr. Kendrick's report, a Determination Order issued on May 28, 1981. Claimant was awarded benefits for temporary total disability from June 12, 1978 through April 23, 1981, and 55% unscheduled permanent partial disability.

Claimant was referred by Dr. Kendrick to Dr. Sulkosky. Dr. Sulkosky reported on November 24, 1981 that he did not feel that claimant had too much to lose by an attempt at a fusion.

Claimant was also examined by Dr. Altrocchi. Dr. Altrocchi reported that he doubted anything short of a fusion would be of much benefit to claimant, but that he would defer to Drs. Kendrick and Sulkosky on that question.

Claimant requested a hearing in relation to the May 1981 Determination Order. In an order dated May 18, 1982 Referee Howell increased claimant's permanent disability to 80%. Referee Howell's order was affirmed by the Board. Daniel D. Griggs, 35 Van Natta 154 (1983).

On May 21, 1982 Dr. Kendrick reported that if claimant underwent a foramenotomy, that the prospect for relief of the majority of his leg pain was good. Claimant informed Dr. Kendrick that he really did not wish to undergo any further surgery at that time, and that he was able to function so long as he limited his physical activity.

On July 23, 1982 Dr. Kendrick reported that claimant should have a foraminal decompression at L4-5, and that if marked instability was found during the surgery, he would perform an interbody fusion at L4-5. Dr. Kendrick formally requested authorization from SAIF to proceed with the surgery.

In apparent response to Dr. Kendrick's request, SAIF arranged for claimant to be examined by Dr. Raaf for a second opinion. Dr. Raaf reported on October 4, 1982 that further surgery would not be effective in returning claimant to gainful employment, and that it was highly questionable whether reexploration of the nerve roots would even make claimant more comfortable. Dr. Raaf concluded further surgery would be "fruitless," and that claimant indicated he was not anxious to have any more surgery in any event. Dr. Raaf further stated that if claimant did undergo surgery, he assumed it would be SAIF's responsibility.

SAIF thereafter requested another opinion from Dr. Norton. Dr. Norton reported that claimant's clinical picture presented multiple difficult decisions. Dr. Norton stated that he could not recommend surgical treatment, but that:

> "In this circumstance, if the attending physician has elected to treat the claimant surgically, and the patient is in agreement, I do not have any formidable medical argument to oppose a third surgical operation in this clinical situation other than the poor success rate statistically."

On November 29, 1982 SAIF denied the request to reopen the claim for low back surgery.

On December 17, 1982 Dr. Kendrick reported that he strongly disagreed with Dr. Raaf's conclusions. Dr. Kendrick's interpretation of claimant's diagnostic tests and clinical symptoms differed from that of Dr. Raaf. Additionally, Dr. Kendrick indicated that claimant did not tell him that he did not wish to proceed with surgery. Dr. Kendrick stated that he could not promise that claimant would have complete relief of his symptoms following surgery, but that there was an excellent chance that he could be improved over his unsatisfactory condition at the present time. He also noted that in his experience the success rate for the proposed surgery was better than Dr. Raaf believed it to be.

Claimant requested a hearing in relation to SAIF's November 1982 denial. The apparent issues were the propriety of the denial,

penalties and attorney fees for failure to accept or deny that claim in a timely manner. The Referee concluded that claimant's condition was a result of a natural degenerative process which had taken place over the years, and that as such, his current condition was not the result of his "industrial injury." Consequently, the Referee affirmed the denial.

As the issues in this case have become somewhat vague, we proceed on the basis of our understanding of what the issues are.

We understand the first issue to be the relationship between claimant's current condition and his accepted occupational disease. We disagree with the Referee's conclusion that claimant's current back condition is not compensable. Claimant's back condition was accepted by SAIF as a compensable occupational disease, not as an injury, and claimant has undergone approximately four years of continuous conservative and surgical treatment for that condition. All of claimant's treatment included treatment for his degenerative condition, all of that treatment has been paid for by SAIF and claimant has received an award of 80% unscheduled disability in recognition of his compensable condition. Additionally, Dr. Kendrick specifically stated in his report of December 2, 1981 that claimant's degenerative condition was aggravated by his work activities, and Dr. Raaf stated on October 6, 1982 that if claimant was going to proceed with surgery, the surgery would be the responsibility of SAIF.

We understand the second issue in this case to be whether the surgery proposed by Dr. Kendrick is reasonable and necessary. We answer that question in the affirmative. It is apparent that Dr. Kendrick has given considerable thought to the question of whether claimant should undergo another surgical assault on his low back. It is also apparent that Dr. Kendrick has made a valiant attempt to avoid surgery by use of conservative methods of treatment, and that it is only with reluctance that he has concluded claimant should undergo a third low back surgery. Dr. Kendrick has the agreement of Dr. Sulkosky as well as Dr. Altrocchi. Even Dr. Norton, SAIF's medical consultant, stated that he would defer to claimant's treating physician on the question of the necessity of a third surgical procedure. The only disagreement comes from Dr. Raaf, with whose conclusions Dr. Kendrick strongly disagreed. Considering Dr. Kendrick's familiarity with claimant's medical condition, we feel that his opinion is entitled to more weight than that of Dr. Raaf. Lucine Schaffer, 33 Van Natta 511 (1981). Even without that consideration, the preponderance of the evidence is in claimant's favor. We conclude that claimant has established the proposed surgery is reasonable and necessary.

The third issue in this case involves the question of when this claim should be reopened. SAIF argues that claimant is requesting reopening of his claim but is not willing to undergo the proposed surgery. SAIF contends that the claim should not be opened for an indefinite period of time while claimant attempts to make up his mind whether to proceed with surgery or not. As we find the evidence does not warrant a conclusion that the claim should be reopened prior to the time claimant submits to surgery, we agree with SAIF's position.

Claimant has indicated to various examiners on several occasions that he was reluctant to undergo any further surgery. As late as May 21, 1982 claimant related to Dr. Kendrick that he was not willing to proceed with the proposed surgery. Claimant reiterated this position when he was examined by Dr. Raaf. Claimant testified at the hearing as follows:

> "A. After two surgeries I don't want to have another one unless I have to. But if I get to where I can't walk like I have on several occasions then there's no way I can get around it.
>
> * * *
>
> "Q. It sounds to me like you're saying that if the Referee says yes you can have the operation you're not going to have it unless you have one of these incidences and it doesn't resolve itself right away.
>
> "A. It depends on the doctor too, I have to let somebody decide if it's going to help me. Sure, I'll have an operation but if your doctor tells me I can't work now here I go again, I shouldn't. But, anyway he's not for it. He doesn't think an operation will help me. And my doctor is saying it as well. So, what are you going to do?"

Although we have concluded that SAIF's denial must be set aside, in view of the fact that it is uncertain whether claimant will ever decide to undergo the proposed surgery, we find that SAIF need not reopen this claim until claimant actually submits to surgery. Cf. Charles A. Murray, 34 Van Natta 249 (1982).

The last issue for our determination concerns penalties and attorney fees. Claimant contends that penalties and attorney fees are appropriate, as SAIF failed to issue a denial within 60 days of Dr. Kendrick's July 23, 1982 request for authorization for surgery. It appears that claimant was paid interim compensation pending denial of the claim; therefore, there are no amounts due on which a penalty can be assessed. Ray A. Whitman, WCB Case Nos. 83-00043, 83-00726, 36 Van Natta 160 (decided this date); EBI Companies v. Thomas, 66 Or App 105 (1983).

ORDER

The Referee's order dated July 25, 1983 is reversed. SAIF's November 29, 1982 denial is set aside, and the matter is remanded to SAIF for reopening when claimant submits to surgery as proposed by Dr. Kendrick. Claimant's attorney is awarded $1,700 for services performed at the hearing and on Board review, to be paid by the SAIF Corporation.

BARBARA G. MARQUIS, Claimant
Rolf Olson, Claimant's Attorney
Gilah Tenenbaum, Defense Attorney

WCB 82-07973
February 15, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review of Referee Peterson's order which set aside its denial of claimant's claim, which is apparently primarily in the nature of an occupational disease claim, for her low back condition.

The medical evidence generally relates claimant's back condition to her employment, but solely based on the history the doctors obtained from claimant. Credibility is thus crucial.

We find numerous conflicts in the testimony. As claimant described her work, the lifting required was frequent and heavy; claimant mentioned often lifting boxes that weighed more than 100 pounds. Claimant's supervisor and several co-workers testified that all the workers rotated through different jobs, many of which did not involve any lifting; and that the heaviest of the relatively infrequent lifting would have been about 55 pounds, which would have been lifted by two people.

Claimant testified that about the summer and fall of 1981 she was experiencing back pain at work, that later in the fall the pain began radiating into her leg, that her co-workers were aware of her pain and that she often had to work with her leg propped up because of pain. Claimant's supervisor and several co-workers testified that they never heard claimant complain during this period, never saw her leg propped up even when working right next to her and never saw claimant sitting or moving in any way that suggested back or leg pain.

Claimant was laid off from December 3, 1981 to March 1, 1982, not having made any formal claim for her back/leg condition before the lay off. It was during this lay off that claimant first sought medical treatment on February 1, 1982. Claimant testified that during the lay off she did housework, yardwork and went jogging. After returning to work in March 1982, claimant still did not relate her continuing back/leg problems to her work. It was not until June 1982, when Dr. Buza asked if she could remember a specific work incident, that claimant first suggested a causal link between her work and her disability.

The Referee found all the witnesses to be credible. We find the conflicts in the testimony to be so significant that it seems impossible for all testimony to be credible. Claimant described frequent, heavy lifting; all other witnesses described less frequent, lighter lifting. Claimant described complaints of co-workers and behavior at work that would have clearly manifested her problem; all co-workers swore they did not hear any complaints or see any manifestations of pain. And hardest of all to believe is claimant's statement that, after she had been experiencing back/leg pain so severe that it was interfering with her ability to do her work, she attempted to go jogging.

Perhaps the Referee's point was that all witnesses were equally credible, that is, that there was no demeanor, etc., basis for accepting any one version of the matters in conflict as more

likely true. That would be our own finding. We think it follows that, with the critical credibility issue in equal balance, claimant has not sustained her burden of proving the compensability of her claim.

ORDER

The Referee's order dated April 11, 1983 is reversed. The insurer's denial dated July 15, 1982 is reinstated and affirmed.

LORETTA G. McGEE, Claimant
Fishman & Smith, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10247
February 15, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Mongrain's order which upheld the SAIF Corporation's denial of claimant's claim, apparently in the nature of an occupational disease claim, for her right shoulder condition variously diagnosed as inflammation and/or calcific tendinitis and/or osteoarthritis. Claimant contends her right shoulder condition is compensable and that SAIF's denial was unreasonable.

On February 21, 1982, approximately 11 days before hearing, claimant was examined for the first time by Dr. Peterson. At the hearing Dr. Peterson's report, dated February 21, was admitted into evidence. Following the hearing, in reply to interrogatories from claimant's attorney, Dr. Peterson answered some questions concerning the cause of claimant's condition. Claimant has attached the interrogatories and Dr. Peterson's answers to her brief. We regard the submission of this document as being in the nature of a motion for remand for consideration of additional evidence. The motion is denied for the reasons stated in Ora M. Conley, 34 Van Natta 1698 (1982), aff'd 65 Or App 232 (1983). We have not considered the additional evidence submitted by claimant. ORS 656.295(5).

On the merits, we affirm and adopt the Referee's order.

ORDER

The Referee's order dated April 4, 1983 is affirmed.

LELAND M. SPORE, Claimant
Michael Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-03426
February 15, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Quillinan's order which set aside its denial of claimant's occupational disease claim for psychological problems. SAIF argues that claimant has failed to prove that job stress was the major cause of his psychological problems.

We first note some possible procedural confusion. Claimant initially filed a claim for severe anxiety on January 27, 1982. Claimant then signed a SAIF form withdrawing this claim on March 9, 1982. SAIF then denied the claim on March 24, 1982. On April 16, 1982 claimant filed a request for hearing challenging the March 24, 1982 denial which had been issued, in effect, at claimant's request. On June 24, 1982 claimant filed a second claim, this time alleging: "Stress pressure & anxiety -- previous claim withdrawn on 3-9-82 -- due to continued stress, pressure & anxiety claim is being refilled [sic]." On August 4, 1982 SAIF denied the second claim. Claimant requested a hearing to protest that denial on August 20, 1982. SAIF does not contest claimant's right to withdraw his first claim and then to challenge the denial of that claim. We thus proceed on the understanding that this case now involves both stress claims and both denials which, in effect, have been "merged" into a single claim.

Turning to the merits, all parties seem to agree that there have been both employment and nonemployment sources of stress in claimant's life that contributed to his psychiatric illness. The issue is joined on whether the employment stress or the nonemployment stress was the major cause of that illness.

Claimant testified that during the summer and fall of 1981 he began to experience mild chest pain and felt nauseated in the mornings. Nonemployment stress during this period includes the following. During the summer of 1981 claimant's twin sons were having personality problems. At the suggestion of a counselor at their school, claimant contracted to have an addition built onto his home so that each boy could have his own bedroom. Various problems plagued the construction project and the contractor filed a lien on claimant's home in approximately October 1981. During September 1981 claimant was the defendant in a personal injury action involving an earlier automobile accident. The limit of his liability insurance policy was $50,000. A judgment against him for $84,000 was entered in September 1981.

Employment stress during this same period includes the following. Claimant was working as a veterans' representative with the Employment Division. During the summer of 1981 he was reprimanded for allegedly refusing to refer a client to a potential employer. In October 1981 budget cuts eliminated clerical support so that claimant was forced to do paper work and computer logging which previously had been done by clerical staff. Claimant testified that about this time his attempts to place veterans in jobs became more difficult because of the economy; more veterans began seeking assistance, but fewer jobs were available. He testified

that he typically interviewed 24 to 28 veterans per day and had to process paper work on all his clients. He testified that under federal quotas he was supposed to place 24% of his clients in jobs, but that he was unable to meet this requirement because of the economic situation.

Also, in October 1981, a woman became claimant's supervisor. Claimant testified that the new supervisor talked down to the men in the office. Claimant felt the supervisor was waiting for an opportunity to "get him." He said he felt the supervisor singled him out to be "dumped on."

During the fall of 1981 claimant was twice accused of sexual harrassment of other employes. In one incident an assistant manager accused him of having his hand on a fellow employe's leg. Claimant testified that he was called into the supervisor's office and questioned about the incident. The fellow employe was then questioned and claimant was vindicated. In the other incident, claimant testified that he was "clowning around" with another employe in the lunchroom before work one morning. A third employe took offense to the "clowning around" and reported the incident to the supervisor. Again, claimant was called into the supervisor's office. Claimant testified that no formal action was taken against him because of these incidents:

> "But it made me think that they was trying to make me feel like a real low life scum bag, which I didn't appreciate. I never considered myself a low life scum bag....The least that could have been done was an apology."

What was probably the single most significant source of stress falls into a gray area between employment-related and nonemployment-related. To claimant's surprise, on December 31, 1981 his paycheck was garnished because of the judgment against him in excess of his liability insurance coverage that had been entered the prior September. Claimant testified that he began to experience severe chest pains after learning of the garnishment. In early January claimant went to see Dr. Craven who hospitalized him for three days. The final diagnosis was "angina secondary to stress" and "extreme anxiety and depression."

Claimant testified that by late January or early February 1982 he was convinced that his legal difficulties would be resolved in his favor. He testified that he withdrew his first claim because by March 1982 he felt that his anxiety was not related to his job. He said that it was only later, after the nonemployment stressors had abated and he continued to feel depressed that he concluded that it was his job which had caused the problem.

In April 1982 claimant was officially reprimanded for having inadvertently referred a client to an Amway dealer who charged the client a fee for a consultation. This type of referral was specifically against the employer's rules. Claimant's salary was reduced for six months because of the reprimand. Sometime after the reprimand, claimant was named veterans counselor of the year. His salary was also returned to its previous level because he received a good performance evaluation. Claimant also testified that his desk was moved to another part of the building away from the supervisor with whom he had problems. Nonetheless, he

testified that his depression remained about the same as it was following the garnishment incident.

The only other stressful incident reported in this record apparently occurred shortly before the hearing. Claimant was verbally reprimanded by the supervisor for smoking in a non-smoking area. That same evening claimant and another employe almost came to blows in an alley outside their office over the smoking incident. A supervisor observed that altercation and told both employes that had they actually fought, both of them would have been terminated.

Only two physicians offer opinions on causation. Not surprisingly, their opinions are at odds.

Claimant began seeing Dr. Jens on April 23, 1982. He again saw her on May 3 and 4, 1982. Following those visits Dr. Jens opined:

> "In summary [claimant] is a 55 year old, married father of five children who has been having escalating depression, also chest and abdominal pain. His office situation has been stressful to the degree that Mr. Spore's depression probably initiated from it and has continued to grow."

Dr. Jens made no mention of any nonemployment sources of stress.

In July 1982 Dr. Holland evaluated claimant for SAIF. Dr. Holland saw claimant twice and then wrote a comprehensive report. He recited claimant's history in great detail and then evaluated claimant's stressors in terms of the Diagnostic and Statistical Manual of the American Psychiatric Association III's (DSM III) categories. He reported and opined:

> "[Claimant] presents as a poised, well dressed, well groomed, soft-spoken male. His predominant ideation is that his problem is all due to [his woman supervisor] and his job. He relates a localization of depressive symptomatology to the work place which is quite unusual. He is cooperative and volunteers information, but is quite defensive and non-communicative regarding non-vocational stressors.
>
> * * *
>
> "He accomplished a Minnesota Multiphasic Personality Inventory and his response to this test was so guarded and defensive as to invalidate the test protocol. The type of defensiveness he manifested is not unusual in educated, higher socio-economic groups, and it could reflect self-confidence and optimism about dealing with life problems. However, at this level of defensiveness, and

> even for such higher socio-economic educational groups, the likelihood of psychological distortion is substantial. When I discussed these results with [claimant], he stated that he did not feel as if he had any psychological problems, except when he was around the work place. This explanation is not a tenable one, since the items on the M.M.P.I. are not variable with the environment. It is significant to note his score on Scale II, the depression scale of the M.M.P.I., is not significantly elevated, while his scores on Scale I and III are above seventy. If this profile was valid, it would document a conversion disorder.
>
> * * *
>
> "I do not believe the work source is necessarily the major factor in current psychological problems. My reason for stating this is that the relative assignment of codes of severity for psychosocial stressors, as outlined in DSM-III, gives more weighting to such stressors as major financial loss and automobile accidents than it would to vocational stressors such as change in work hours or conflict in the work place. There appear to be a number of factors in [claimant's] life, all of which could be either causally related or merely concomitants of his psychological distress."

SAIF sent a copy of Dr. Holland's report to Dr. Jens who then responded:

> "In summary, the historical facts that Dr. Holland says he used in arriving at his conclusions are, in the main, known to me. From [claimant's] course during treatment, I continue to hold the opinion that work related stress is the major contributing cause of his physical-psychiatric difficulties."

Dr. Jens did not offer any explanation of the basis of this opinion.

Dr. Holland elaborated on the analysis in his report in his testimony at hearing:

> "This claim is not terribly authentic from a psychiatric standpoint, and the reason I say that it's not authentic is that I think the diagnosis of depression can be questioned on the basis of lack of documentation by psychological testing. I think it can be questioned on the basis that the diagnosis is made on [claimant's] self-reporting. His

> self-reporting relates and reveals that he's having depression only in the work place. That's not the way depressions act. Depressions are pervasive and global, and the symptoms aren't localized to a work place.
>
> * * *
>
> "Q: Do you have any reason to believe that [claimant's] retrospective reporting of his problems and symptoms is questionable in this case?
>
> "A: Yes, sir. I do.
>
> "Q: What makes you say that?
>
> "A: Well, his whole history features reversals and admissions on his part that he was engaging in certain behavior for certain reasons and then changed his mind that he wasn't going to engage in that behavior anymore, and I think when he does that, it's hard to know which story you should credit."

In order to establish that his occupational disease claim is compensable, claimant must prove by a preponderance of the evidence that employment conditions, when compared to nonemployment conditions, are the major cause of his disease. SAIF v. Gygi, 55 Or App 570 (1982). We do not find the evidence persuasive in this regard.

If the only issue involved weighing the unexplained opinion of Dr. Jens against the comprehensively-explained opinion of Dr. Holland, it would simply be impossible to find Dr. Jens' opinion to be the more persuasive. There is, however, another wrinkle to this case. In finding this claim compensable, the Referee reasoned that the nonemployment stress in claimant's life was decreasing in 1981-82 while employment stress was increasing:

> "The significant [nonemployment] stressors of financial loss to which Dr. Holland attributes claimant's problems were largely resolved by July 1982 and were resolving as early as February 1982. The symptoms, therefore, should have disappeared. They failed to do so and, in fact, became somewhat worse following claimant's April 1982 on-the-job reprimand and pay cut. * * * The symptoms have continued to date even though the off-work problems have been removed."

While this analysis is plausible, we are not convinced that it is supported by the present record. Dr. Holland specifically disagreed with the idea that claimant's nonemployment stress factors "were largely resolved by July 1982": "I don't think that people can really put things like that out of their mind and not worry about them at one level or another, whether it be conscious, preconscious or unconscious." This observation, combined with Dr.

Holland's expressed doubt about the accuracy of claimant's reported symptoms, leaves little basis in this record for concluding that "the off-work problems have been removed."

Even if the stress from nonemployment sources was declining, we find little support for the Referee's implicit assumption about temporal relationships: That a source of stress will cause fairly immediate psychological symptoms that will end fairly promptly after the source of stress is removed. Dr. Holland testified that the relationship between stress and psychological symptoms "is not at all clear." We think one area that lacks clarity is the temporal relationship between the former and the latter. For example, both combat veterans and injured workers have asserted claims for post-traumatic stress syndrome, i.e., for psychological symptoms, arising long after the allegedly precipating events.

Finally, even if it were proven that a closer temporal relationship was the norm, the closest temporal relationship established in this record is between the garnishment of claimant's paycheck in late December and his hospitalization in early January. While garnishment of pay has some connection with work, the underlying problem of an unsatisfied judgment has no connection with claimant's work. We conclude that this source of stress did not arise out of and in the course of claimant's employment.

ORDER

The Referee's order dated February 28, 1983 is reversed. The SAIF Corporation's denials dated March 24, 1982 and August 4, 1982 are reinstated and affirmed.

JOHN R. THOMAS, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-10051
February 15, 1984
Order Denying Reconsideration

The Board previously has issued its Order on Remand herein, affirming the Referee's order dated February 23, 1981. 36 Van Natta 13 (January 13, 1984). We reserved ruling on an award of a reasonable attorney's fee pursuant to ORS 656.388(1), in view of claimant's attorney's request for an opportunity to submit written argument on the issue.

The SAIF Corporation has requested reconsideration of our Order on Remand affirming the Referee's order on the issue of compensability of claimant's "second aggravation claim." SAIF contends that in our Order on Remand we neglected to address the specific questions presented by SAIF's request for review:

> "First, was claimant foreclosed from using the same medical condition and need for treatment, fully and finally denied by SAIF's August 12, 1980 denial, to assert a second aggravation claim for a later time.
>
> "Second, did claimant prove by the necessary preponderance of evidence that the industrial injury of January 20, 1979 was a material contributing cause of

claimant's disability and need for treatment beginning in early 1981."

We understand the Referee's order to indicate that the Referee understood, considered and addressed these issues. In re-reviewing the record and the parties' arguments, we agreed with the result reached by the Referee and so stated in our Order on Remand. SAIF's request for reconsideration raises no new argument in support of a conclusion to the contrary; therefore, we decline to reconsider our prior order.

The Board is in receipt of claimant's written submission in support of his claim for a reasonable attorney's fee. SAIF is allowed five (5) days from receipt of this order within which to respond. Upon receipt of SAIF's submission or upon the expiration of the stated period, the Board will proceed to enter a Supplemental Order on Remand, awarding claimant's attorney a reasonable attorney's fee pursuant to ORS 656.388(1).

IT IS SO ORDERED.

ROY WHEATLEY, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 83-0389M
February 15, 1984
Own Motion Determination

The insurer voluntarily reopened claimant's claim for a worsened condition related to his industrial injury of March 29, 1968.

The claim has now been submitted for closure. Claimant's attorney has requested that a penalty and attorney fee be assessed against SAIF Corporation for its delay in the processing of claimant's claim. In declining to assess a penalty aainst SAIF, we refer to Bernie Hinzman, Own Motion Order on Further Reconsideration, September 26, 1983. Although in Hinzman the insurer declined to pay benefits, whereas in the instant case SAIF merely delayed the payment of benefits, we find the principle to be the same.

> ". . . The fact that employers/insurers have authority to voluntarily pay own motion benefits, when deemed appropriate, does not change the fact that own motion relief is discretionary in nature and not compensation to which the claimant is entitled as a matter of right. It is highly questionable, therefore, whether the employer/insurer can be subject to a penalty/attorney fee for declining to grant this discretionary remedy, where there is no right which has been violated. . . . . The exception might be an instance in which the employer/insurer fails or refuses to comply with the terms of an order issued by the Board pursuant to ORS 656.278."

Claimant is hereby granted compensation for temporary total disability from May 9, 1983 through September 18, 1983. No additional award for permanent partial disability is due. Claimant's attorney is allowed a fee equal to 25% of the increased compensation granted by this order, payable out of said compensation as paid, not to exceed $600.

IT IS SO ORDERED.

RAY A. WHITMAN, Claimant
Richardson, et al., Claimant's Attorneys
Cheney & Kelley, Attorneys
Roberts, et al., Defense Attorneys

WCB 83-00043 & 83-00726
February 15, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Industrial Indemnity (the new injury insurer, hereinafter "Industrial") requests review of those portions of Referee Podnar's order which, in relevant part: (1) Assigned responsibility to Industrial for claimant's current low back condition; (2) assessed a 25% penalty against Industrial for its failure to pay a hospital bill; (3) assessed an additional penalty of 25% of temporary total disability benefits whether previously paid or not; and (4) awarded claimant's attorney an insurer-paid fee of $1,500. Industrial alleges that the Referee erred in each of these rulings, and, in addition, argues that the Referee erred in refusing to grant a continuance or to hold the record open for cross-examination of Dr. Grewe. Industrial requests that we remand to the Referee for this purpose.

We consider the remand issue first. This case basically involves a question of whether claimant sustained an aggravation or a new injury. Dr. Grewe, the treating physician, consistently maintained that claimant had sustained a new injury. Drs. Raaf and McKillop were of the opinion that claimant had sustained an aggravation. Industrial was aware of all these opinions well in advance of the hearing. A few days before the hearing, counsel for Industrial received the claims file and decided to see whether Dr. Grewe would change his opinion upon being confronted with the contrary opinions of Drs. Raaf and McKillop. The attorney was apparently frustrated in this attempt because Dr. Grewe had been instructed by claimant's attorney not to talk to other attorneys about the case. At hearing the Referee declined to continue the hearing or to leave the record open for cross-examination of Dr. Grewe because he felt that Industrial had sufficient opportunity to obtain the information it sought from Dr. Grewe. Had Industrial forwarded the file to their attorney earlier, counsel could have reached some accommodation with claimant's attorney concerning his desire to talk to Dr. Grewe, or he could have subpoenaed Dr. Grewe if claimant's attorney had refused to cooperate. We believe that under these circumstances the Referee did not abuse his discretion in declining to continue the hearing or to leave the record open for cross-examination of Dr. Grewe. Therefore, we decline to remand this case for further proceedings.

On the responsibility issue, we affirm and adopt those

portions of the Referee's order which assigned responsibility to Industrial.

On the penalty issues, the Referee found, and we agree, that Industrial received notice or knowledge of this claim on January 20, 1982. We find that Industrial immediately began paying temporary total disability compensation and continued payment until the Compliance Division entered an order designating EBI as paying agent on January 19, 1983. See generally ORS 656.307. Industrial had formally denied the claim by denial letter of December 30, 1982, at which time it also requested that the Compliance Division enter an order pursuant to ORS 656.307.

The Referee found that Industrial's manner of processing this claim had caused claimant to be denied medical treatment by his treating physician, "left him in limbo for some 11 months and caused him to be dunned by credit agencies for non-payment of hospital bills." The Referee assessed a penalty against Industrial in the amount of 25% of all compensation due claimant from the sixtieth day after Industrial had notice or knowledge of the claim until the date of the request for the .307 order (December 30, 1982), and that this penalty was to be calculated based upon all compensation due claimant, "even if he has in fact received it." We understand the Referee's order to require payment of a penalty based upon temporary disability compensation paid by Industrial prior to issuance of its denial.

Industrial failed to accept or deny claimant's claim until December 30, 1982, well beyond the sixty-day requirement of ORS 656.262(6). We held in Norman J. Gibson, 34 Van Natta 1583 (1982), and Eugene Thomas, 35 Van Natta 16 (1983), that in situations involving an unreasonably delayed denial the insurer would be penalized for violation of this statutory duty regardless of its payment of interim compensation. We interpreted the "then due" language of ORS 656.262(10)(formerly ORS 656.262(9)) to mean that when a denial was unreasonably late a penalty would be imposed and calculated upon the interim compensation paid between the sixtieth day and the date of the denial. Norman J. Gibson, supra, 34 Van Natta at 1584; Eugene Thomas, supra, 35 Van Natta at 18. In apparent reliance upon these decisions, the Referee imposed a penalty based upon all compensation due claimant until December 30, 1982, regardless of payment.

The Court of Appeals recently reversed that portion of our order in Thomas which imposed a penalty and attorney's fee, and in so doing, cast considerable doubt upon our interpretation of the "then due" language in ORS 656.262(10) as expressed in Gibson. EBI Companies v. Thomas, 66 Or App 105 (1983). Although the court's statements appear to be dicta, the clear message is that in situations such as this, where the insurer unreasonably delays acceptance or denial of a claim but nevertheless complies with its separate and distinct duty to pay interim compensation during the period of delay, the insurer is not subject to a penalty for unreasonably delaying acceptance or denial pursuant to ORS 656.262(6), because there are no amounts "then due" upon which a penalty can be assessed within the meaning of ORS 656.262(10). 66 Or App at 111. See also Darrell W. Carr, 36 Van Natta 16 (January 19, 1984). But see Hewes v. SAIF, 36 Or App 91, 96 (1978). To the extent that our holding in Norman J. Gibson, supra, is to the contrary, it is overruled.

Because Industrial paid all interim temporary disability compensation due during the period in question, any penalty to which it might be subject cannot be calculated upon this compensation. Other compensation in the form of medical services was claimed during this same period, and Industrial ultimately has been found responsible for payment of this compensation. Whether these claimed medical services can form the basis for imposition of a penalty, i.e. whether these medical services can be considered compensation "then due" within the meaning of ORS 656.262(10), requires separate analysis.

There is some doubt concerning Industrial's receipt of the bill for claimant's hospitalization. Although it is not necessary to resolve this factual issue, as will be seen from the legal conclusion we reach regarding Industrial's possible liability for a penalty, we are persuaded by the testimony of claimant's wife that she forwarded this bill for hospitalization to Industrial together with other bills for medical services; and we expressly find as a matter of fact that Industrial did receive the hospital bill in question sometime during the eleven months that claimant's new injury claim was in deferred status and Industrial was paying claimant compensation for temporary total disability. We also find and conclude that Industrial unreasonably delayed acceptance or denial of claimant's new injury claim. Nevertheless, we conclude that Industrial cannot be penalized for its unreasonable claims processing in this case.

> "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 of 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. * * * " ORS 656.262(6) (Emphasis added.).

The underscored sentence was added to ORS 656.262(6) by Oregon Laws 1981, chapter 874, §4, with an effective date of July 1, 1981 (Oregon Laws 1981, chapter 874, §23). For injuries occurring on and after the effective date of this enactment, the insurer is not obligated to pay medical bills on an interim basis pursuant to ORS 656.262(4). ORS 656.202(2); SAIF v. Mathews, 55 Or App 608 (1982). Because there is no obligation to pay medical services on an interim basis, such medical services cannot constitute compensation "then due" within the meaning of the penalty provision of ORS 656.262(10).

Industrial has been found responsible for claimant's September 15, 1981 new injury. ORS 656.262(6) was in effect in its present form on that date. Accordingly, claimant was not entitled to be paid compensation in the form of medical services pending acceptance or denial of his new injury claim by Industrial. It follows, therefore, that no penalty can be imposed.

The penalty issue presented in this case is analogous to, but

significantly different from, the penalty issues considered in Billy J. Eubanks, 35 Van Natta 131 (1983), and Gary L. Clark, 35 Van Natta 117 (1983). See also Richard Kirkwood, 35 Van Natta 140 (1983). In those cases we considered the claims processing obligations of employers/insurers upon receipt of a claim for medical services pursuant to ORS 656.245 after the claimant's initial claim has been accepted. For the reasons stated in Eubanks the employer/insurer is subject to being penalized for failure to properly process such claims for medical services. See Madden v. SAIF, 64 Or App 820 (1983); Adams v. SAIF, 63 Or App 550 (1983).

We hold that when an employer/insurer unreasonably delays acceptance or denial of an original claim, bills for medical services which are submitted to and received by the employer/insurer while the original claim is in deferred status, and for which the employer/insurer ultimately is found responsible, do not provide the basis for imposition and calculation of a penalty because such bills do not constitute compensation "then due" within the meaning of ORS 656.262(10), in claims for injuries occurring on and after July 1, 1981. Our holding in Billy J. Eubanks, supra, is not to the contrary and is not altered by our holding in this case.

We realize that the practical effect of our conclusion on the penalty issues in this case is that the Board and its Referees are divested of authority to enforce the 60-day provision of ORS 656.262(6) in the majority of claims filed by injured workers. But see Bono v. SAIF, 66 Or App 138 (1983), requiring payment of interim compensation in non-disabling injury claims. We believe that there is a serious gap in the penalty provision of ORS 656.262(10), one which may not have been intended by the legislature; however, correction of this apparent problem is a legislative matter and cannot be remedied by the Board. Cf. Gary L. Clark, supra, 35 Van Natta at 119.

Industrial also raises an issue concerning the reasonableness of the attorney's fee awarded by the Referee. The Referee awarded claimant's attorney $1,500 for "efforts in representing his client on all issues in this matter." A portion of the fee awarded by the Referee, therefore, included a penalty-associated fee pursuant to ORS 656.382(1). Since we have eliminated the penalty, this gives rise to the possibility that the attorney's fee also should be reduced or eliminated. Based on our conclusion that Industrial is not subject to a penalty pursuant to ORS 656.262(10), it necessarily follows that claimant's attorney is not entitled to any fee pursuant to ORS 656.382(1). Darrel W. Carr, supra. See also Richard Davies, 35 Van Natta 25 (1983).

In determining an appropriate fee to be awarded based on counsel's services at hearing in connection with Industrial's denial, we must consider the fact that the two insurers entered into an order pursuant to ORS 656.307. The only issue, therefore, aside from the claims processing issues raised by claimant, was insurer responsibility for an otherwise compensable claim. OAR 438-47-090(1) provides for payment of an attorney's fee at a hearing convened after issuance of an order pursuant to ORS 656.307, when claimant's attorney " . . . actively and meaningfully participates at the hearing in behalf and in defense of claimant's rights." See generally Wilfred Pultz, 35 Van Natta 684 (1983); Brent Bennett, 34 Van Natta 1563 (1982). Most, if not all, of

counsel's efforts were directed toward establishing the insurer's (primarily Industrial's) liability for payment of penalties. Claimant did not take a position on the issue of insurer responsibility, and we are hard-pressed to find evidence of counsel's "active and meaningful" participation on this issue at hearing. Accordingly, no fee can be awarded for counsel's services at hearing. Present Board rules governing attorney fees do not provide for "an appearance fee" in cases involving only issues of insurer responsibility. Wilfred Pultz, supra, 35 Van Natta at 686. Although responsibility was not the only issue at hearing, in view of our holding eliminating the penalties imposed by the Referee, it is the only issue which could provide the basis for an award of an attorney's fee at the hearing level.

For similar reasons, we find claimant's attorney is only entitled to a nominal fee for services on Board review. Robert Heilman, 34 Van Natta 1487 (1982).

ORDER

The Referee's order dated March 11, 1983 is reversed in part. Those portions of the order which directed Industrial Indemnity to pay claimant a penalty for unreasonably delaying acceptance or denial and which awarded claimant's attorney a $1,500 fee are reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $200 for services on Board review.

DARREL W. CARR, Claimant
David C. Force, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 82-00911 & 82-00912
February 17, 1984
Order on Reconsideration

Claimant requests that we reconsider our Order on Review in this case contending: (1) That his attorney is entitled to an attorney fee on Board review pursuant to ORS 656.382(2) for prevailing on an employer-initiated appeal regarding the extent of claimant's disability; and (2) that the $500 attorney fee awarded by the Referee for the insurer's failure to process the claim should be reinstated.

We agree it was error not to award claimant's attorney a fee for prevailing on the issue of extent on Board review and, therefore, award claimant's attorney $500 pursuant to ORS 656.382(2). Regarding claimant's second contention, we affirm our Order on Review finding no statutory authority to affirm the Referee's $500 attorney fee award.

ORDER

Claimant's motion for reconsideration is granted. Our Order on Review dated January 19, 1984 is modified. Claimant's attorney is awarded $500 for Board review, payable by the insurer pursuant to ORS 656.382(2). The remainder of that order is affirmed.

TERRY R. ATKINSON, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-02637
February 21, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of that portion of Referee Neal's order and order on reconsideration which failed to provide an award of attorney fees.

The issue before the Referee in this case was the propriety of the SAIF Corporation's March 14, 1983 aggravation claim denial. The denial stated in part:

> "The reason for this denial is the medical information in our file indicates that your current condition is a result of your pre-existing degenerative disc disease, which has also been affected by your overweight condition."

Although the Referee affirmed the denial, she did so on the basis that claimant had not established a worsening of his condition since the last award or arrangement of compensation. The Referee specifically rejected SAIF's argument that claimant's current condition was not related to his previous industrial injury.

Claimant thereafter requested the Referee to reconsider that portion of her order which failed to award an attorney fee. It was claimant's position that the March 14, 1983 denial was a denial of the entire claim, including a denial of medical benefits pursuant to ORS 656.245. Since the Referee disapproved the denial to the extent that it stated claimant's current condition was unrelated to his industrial injury, claimant argued that he was entitled to an attorney's fee for securing continued medical benefits pursuant to ORS 656.245.

The Referee thereafter abated her order to allow time for reconsideration.

SAIF responded in a letter dated July 26, 1983. SAIF argued that claimant's attorney was entitled to no fee because:

> "SAIF Corporation never denied claimant's rights to ORS 656.245 treatments. That issue was not raised by claimant and not addressed at hearing."

On reconsideration, the Referee stated that:

> "I have now reconsidered my Order in light of the pleadings, exhibits and arguments by both parties on the reconsideration request. I do not interpret the March 14, 1983 Denial as a denial of claimant's claim in its entirety, but view it as a denial of an aggravation. I therefore decline to change my June 30, 1983, Opinion and Order."

On review, claimant has basically renewed the argument made

before the Referee that he is entitled to an attorney's fee. Alternatively, claimant requests the matter be remanded to the Referee for receipt of additional evidence concerning SAIF's alleged post-hearing failure to pay claimant's current medical expenses. SAIF argues that although the Referee was correct in concluding that claimant's condition had not worsened, she erred when she stated claimant's condition was, nevertheless, still related to his compensable injury.

Addressing SAIF's argument first, we conclude that the Referee was correct in finding that claimant's condition, although not worse, was still related to his industrial injury. As we agree with the Referee's reasoning, we see no need to restate the evidence concerning this issue.

With regard to the issue concerning attorney fees, we are in complete agreement with the Referee. Although it is true that there is an inherent ambiguity between ORS 656.273 and ORS 656.245, and that questions concerning ORS 656.273 often necessarily involve questions concerning ORS 656.245, that does not appear to have been the case here. There was no specific contention at the hearing that medical benefits were an issue, and there was no indication at that time that SAIF had failed to pay for any medical benefits. In its July 26, 1983 letter to the Referee, SAIF specifically stated that it had never denied claimant's right to medical benefits.

If it is true, as claimant alleges, that SAIF is now refusing to pay claimant's injury related medical expenses, we perceive this to be a new and distinct issue. As such, it is a matter for a new hearing. If we were to grant claimant the relief he requests, the effect of such an order would be to short-circuit the hearings procedure. This we decline to do. Cf. Carlton A. Spooner, 34 Van Natta 1594 (1982), Charles L. Thornton, 35 Van Natta 690 (1983). Claimant's request for attorney fees and alternative request for remand are, therefore, denied.

ORDER

The Referee's orders dated June 30, 1983 and August 3, 1983 are affirmed.

JEFFREY D. GANIEANY, Claimant
John Svoboda, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-06355
February 21, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Browne's order which awarded claimant 67.5° for 50% scheduled permanent disability for loss of the right foot (ankle), in lieu of the 20.25° for 15% scheduled permanent disability awarded by Determination Order dated May 17, 1982. The insurer contends that the Referee's award is excessive. We agree with the insurer and reverse the Referee.

The Referee found that claimant is entitled to an award of 50% scheduled permanent disability after considering claimant's education, work experience, mental capacity, adaptability and the fact that his injury will restrict his ability to find

employment. The Referee erred in applying the unscheduled injury analysis, ORS 656.214(5), to a scheduled injury case, ORS 656.214(2)(d). The criteria for rating permanent disability for a scheduled injury is loss of use or function of the injured member. ORS 656.214(2). Application of the loss of earning capacity criteria is limited to unscheduled injuries. ORS 656.214(5).

We evaluate claimant's permanent disability in light of OAR 436-65-545 and 548. The medical reports do not indicate that claimant has any loss of range of motion in his ankle joint. Furthermore, claimant's treating doctor's most recent report states that no significant evidence of laxity in the ankle is shown clinically or by x-ray. Considering claimant's complaints of occasional twisting of his ankle and of pain and swelling after prolonged standing, we find that claimant has been adequately compensated by the 15% permanent disability awarded by the Determination Order.

ORDER

The Referee's order dated July 18, 1983 is reversed. The Determination Order dated May 17, 1982, which awarded claimant 20.25° for 15% scheduled permanent disability, is affirmed.

DADE LEE PAGE, Claimant
Dept. of Justice

WCB CV-83014
February 21, 1984
Order of Remand

Reviewed by Board Members Lewis and Ferris.

On November 10, 1983 the applicant, Dade Lee Page, requested Board review of a Department of Justice Order affirming the Department's previous order denying the applicant compensation under the Crime Victims' Compensation Act, ORS 147.005 et seq. Attached to the request for review was a letter written by Dr. Richard Heitsch, M.D., who had treated claimant on the night of his alleged assault. The letter purports to be an explanation as to why claimant may not have cooperated with the police on the night of his alleged assault. In the Board's letter acknowledging claimant's request for review, we noted:

> "In deciding your case, the Board can consider only such documentary evidence as has been considered by the Department of Justice. Only those persons whose statements were considered by the Department of Justice will be permitted to testify at the hearing."

The applicant has now submitted another copy of Dr. Heitsch's letter along with another letter from Dr. Heitsch's office. He asks the Board whether Dr. Heitsch will be required to testify or whether the Board will accept the letters in lieu of testimony. The Act is quite clear on the issue of whether the Board may consider new evidence. It states:

"[N]o evidence is admissible at a hearing that has not previously been considered by the department." ORS 247.155(5).

It has been the Board's practice, however, to allow witnesses who have made statements contained in the Department's file to explain the meaning of those statements. Dr. Heitsch's letter purports to explain a statement contained in his hospital reports from the night of the alleged assault. However, the letter goes far beyond any explanation. In essence, it offers a new theory as to why applicant may not have cooperated with the police. Nothing in the record from Dr. Heitsch even concerns applicant's cooperation with the police. Accordingly, we consider Dr. Heitsch's letters new evidence which we are not empowered by the Act to consider.

The Act, however, also gives the Board broad powers to achieve "substantial justice." ORS 147.155(5). We find that the reports from Dr. Heitsch are relevant to the issue of applicant's cooperation with the police. In the interest of determining the truth and achieving substantial justice, we regard applicant's submission of these reports to us as a motion to remand, which we grant. We believe the search for truth and substantial justice will be best served by remanding this case to the Department.

ORDER

This case is remanded to the Department of Justice for consideration of the letters from Dr. Heitsch.

PATRICIA M. KNUPP, Claimant
SAIF Corp Legal, Defense Attorney

WCB 82-05092
February 22, 1984
Order on Reconsideration

The SAIF Corporation has requested reconsideration of the Board's Order on Review dated January 31, 1984.

The request is granted. On reconsideration, the Board amends the third paragraph of said order by deleting the words "back-up denial" and reading as follows: Therefore, we remand this case to the Referee for further taking of evidence and a determination of whether SAIF's denial is barred by the holding in Bauman.

ORDER

On reconsideration, the Board amends its Order on Review dated January 31, 1984, as stated above, which hereby is reaffirmed as amended and republished.

EVELYN M. WOLFE, Claimant
Carney, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-09920
February 22, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Pferdner's orders which set aside its denial of claimant's back injury claim. The issue for review is compensability.

The compensability of this claim turns entirely on the issue of credibility. Considering some of the credibility findings made by the Referee, it is difficult to understand why he set aside SAIF's denial. For the reasons set forth in SAIF's brief, we find the testimony of claimant and her witnesses to be totally incredible.

ORDER

The Referee's orders dated July 29, 1983 and August 1, 1983 are reversed. SAIF's denial dated October 26, 1982 is reinstated and affirmed.

WILMA FORNEY, Claimant
Evohl F. Malagon, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 80-07538
February 24, 1984
Order on Remand

On review of the Board's order dated August 23, 1982, the Court of Appeals reversed and remanded with instructions to order the employer to repay claimant that amount of compensation which the employer deducted from claimant's temporary total disability benefits.

Now, therefore, the above-noted Board order is vacated, and this matter is remanded to the employer with instructions to repay claimant the amounts deducted from claimant's temporary total disability compensation.

IT IS SO ORDERED.

ARLISS D. INGRAM, Claimant
Kenneth Peterson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-06472
February 24, 1984
Order on Reconsideration

The Board issued its Order on Review herein on January 31, 1984. 36 Van Natta 96 (1984). Claimant has requested reconsideration of that portion of our order which awards claimant's attorney $2,000 "for services on Board review." Claimant also has directed our attention to erroneous references in the order, which are in the nature of clerical errors. On reconsideration we deem it appropriate to award claimant's attorney an additional fee and, in order to correct the referenced clerical errors, we withdraw our Order on Review and substitute this order therefor.

Claimant requests review of Referee Menashe's order which upheld the employer's denial of claimant's carpal tunnel syndrome. Claimant argues that the Referee erred in upholding the denial. She also argues that the Referee erred in excluding certain documents pursuant to OAR 436-83-400(3) and (4), the ten day rule.

On the evidentiary issue, we reverse. Eleven days prior to hearing, claimant's attorney telephoned both opposing counsel and the Referee and read to them proposed exhibit 13 which claimant's counsel had just received from a physician. Claimant's attorney thereafter mailed the exhibit, which was received by opposing counsel and the Referee prior to the hearing in this matter. A second exhibit, proposed exhibit 14, was generated in response to exhibit 13. It was submitted within ten days prior to hearing.

The Referee excluded both exhibits saying: "Without any cogent explanation for the lateness of the reports, the objections to Exhibits 13 and 14 are sustained."

After reviewing the record, we conclude that the Referee abused his discretion in declining to consider exhibits 13 and 14. Claimant did not receive exhibit 13 until eleven days prior to hearing. He immediately telephoned opposing counsel and the Referee and attempted to put them on notice that he intended to rely on that report. He then sent copies. In addition he solicited a report from another physician in response to exhibit 13. While that report was not even in existence ten days prior to hearing, it was submitted prior to the actual date of hearing. It is apparent that claimant's attorney was not playing litigation games. Rather, he was attempting to comply with the spirit of the ten day rule by making sure that opposing counsel and the Referee had notice of exhibits upon which he intended to rely. Balancing this agency's fact finding mandate against its policy of minimizing game playing designed to obscure the search for truth, we conclude that the Referee abused his discretion in declining to admit exhibits 13 and 14. Accordingly, we consider those exhibits in our review of the case.

On the merits, we reverse the Referee's order.

Claimant began working as a potato inspector on February 1, 1982. Within two weeks of that date, claimant began to experience numbness and tingling in her right hand. She had never before experienced such symptoms. She was disagnosed as having bilateral carpal tunnel syndrome, right worse than left. Her treating physician related the onset of carpal tunnel symptoms to her work activity. The employer referred claimant to Dr. Peter Nathan for an evaluation. Dr. Nathan opined:

> "She noted the onset of her symptoms within a few days of commencement of employment at Lamb Weston in her capacity of a Utility III worker. It does not seem reasonable that this work activity is either the cause of the underlying disease nor significantly responsible for the symptoms."

Based on the medical evidence, the Referee found that claimant's work activity was the major contributing cause of her symptoms. We agree with that finding and adopt it.

The Referee held, however, that the carpal tunnel syndrome was not compensable because claimant had failed to prove a worsening of the underlying condition, as he believed the Supreme Court required in Weller v. Union Carbide, 288 Or 27 (1980). Since the Referee's order, the Court of Appeals has indicated that Weller, which requires proof of a worsened underlying condition, does not apply when the claimant has not previously sought medical attention for the underlying condition. Wheeler v. Boise Cascade, 66 Or App 620 (1984). Because we find that claimant was asymptomatic prior to her work exposure, we conclude that claimant does not have to prove a worsening of her underlying condition.

Because Weller does not apply to this case, and because we find that claimant has proven by a preponderance that her work activities were the major contributing cause of her symptoms, we reverse the Referee. The employer's denial should be set aside.

Claimant's attorney has submitted an affidavit detailing the time and effort expended in connection with this denied claim. Counsel for the employer has responded to claimant's submission. We have taken this information into consideration in determining a reasonable attorney's fee for services rendered before the Referee and the Board. OAR 438-47-040(2).

ORDER

The Referee's order dated May 20, 1983, as amended by his order on reconsideration dated July 8, 1983, is reversed. The employer's denial dated July 6, 1982 is set aside, and this claim is remanded to the employer for acceptance and processing according to law. Claimant's attorney is awarded $1,750 for services before the Referee and $650 for services before the Board, for a total fee of $2,400, to be paid by the employer.

WALTER P. SORENSON, Claimant
Bottini & Bottini, Attorneys
Breathouwer & Gilman, Attorneys

Own Motion 82-0194M
February 24, 1984
Own Motion Order

Claimant has submitted an ostensible request for own motion relief, requesting that the Board set aside a stipulation entered into between claimant, who is not represented by an attorney, and the employer/insurer. The document is titled "Disputed Claim Settlement, Stipulation and Order of Own Motion Claim (ORS 656.278) and Medical Expenses and Payments (ORS 656.245)," was signed by claimant and counsel for the employer/insurer and approved by the Board, by signature of two Board members, on April 15, 1983. The stipulation disposes of issues raised by claimant's petition for own motion relief pursuant to ORS 656.278, as well as related issues concerning medical expenses arising under ORS 656.245.

The employer/insurer has been notified of claimant's request that the stipulation be set aside and has indicated its opposition to claimant's request.

Rather than consider claimant's request in the exercise of our discretionary own motion authority pursuant to ORS 656.278, we deem it more appropriate to regard claimant's request that the stipulation be set aside as a request for hearing pursuant to ORS 656.283. Cf. George T. David, 35 Van Natta 1703 (1983); Timothy D. Martinez, 35 Van Natta 1315 (1983); Lawrence Woods, 34 Van Natta 1671 (1982). See also ORS 656.278(5)(b).

Accordingly, claimant's ostensible request for own motion relief is denied, and this matter is referred to the Hearings Division for processing pursuant to ORS 656.283. This order does not constitute a referral of an own motion matter pursuant to OAR 436-83-820. The Hearings Division shall assign a regular WCB number to claimant's request for hearing, which shall be acknowledged in the ordinary course, and the Referee shall conduct

a hearing and issue an order with appeal rights pursuant to ORS 656.289. Any further consideration of this matter by the Board shall be in the performance of the Board's review function pursuant to ORS 656.295.

IT IS SO ORDERED.

SAMUEL WALLACE, Claimant
Willner, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-02577
February 24, 1984
Order on Remand

On review of the Board's order dated March 23, 1982, the Court of Appeals reversed and remanded with instructions that this claim be accepted. The Supreme Court affirmed.

Now, therefore, the above-noted Board order is vacated, and this claim is remanded to the employer/insurer for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

SHIRLEY A. REIJONEN, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10703
February 27, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Braverman's order which affirmed that portion of the April 21, 1983 Determination Order which found claimant medically stationary as of March 2, 1983; awarded claimant 128° for 40% unscheduled permanent partial disability, that being an increase of 64° for 20% over claimant's previous awards of unscheduled disability; and authorized the SAIF Corporation to offset against the award of permanent partial disability an overpayment of temporary total disability benefits in the amount of $1,268.68. Claimant contends that the Referee erred on all counts.

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

We agree completely with the Referee's conclusion that claimant was medically stationary as of March 2, 1983. This claim originally arose out of an injury claimant sustained to her clavicle in 1977. Although complications did arise, it appears that by the time claimant was finally declared medically stationary by Dr. Borman on March 2, 1983, claimant had received the gamut of possible medical treatment for her injury. On March 3, 1983, the day following Dr. Borman's conclusion that claimant was medically stationary, claimant requested permission to change treating physicians. Thereafter Dr. Burke became her tenth treating physician.

Dr. Borman reported on April 25, 1983 that he had read Dr. Burke's report of April 11, 1983. Dr. Borman stated that the findings indicated by Dr. Burke appeared to be "substantially the same as noted at the time of my examination." Dr. Burke reported on April 28, 1983 that claimant was making "objective and subjective improvement." However, the only treatment instituted by Dr. Burke was osteopathic manipulation and home exercises and, as the

Referee noted, Dr. Burke's testimony was not convincing that his treatment was effecting any material improvement in claimant's condition. ORS 656.005(17). There is no reason why claimant cannot continue to receive conservative treatment from Dr. Burke pursuant to ORS 656.245, but there is no need for her claim to continue to remain open indefinitely for her to do so.

With regard to the issues concerning extent of disability and the offset allowed for overpayment of temporary total disability benefits, we affirm the order of the Referee.

ORDER

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

ERVIN M. STRICKLAND, Claimant
Pozzi, et al., Claimant's Attorneys
Edward C. Olson, Defense Attorney

WCB 83-03097
February 27, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Menashe's order which upheld the insurer's denial of claimant's claim for bilateral carpal tunnel syndrome, which was apparently premised on an occupational disease theory. Should the claim be found compensable on the present record, the insurer requests that this matter be remanded for the taking of additional evidence.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated August 12, 1983 is affirmed.

Board Member Barnes Concurring:

I agree that our decision on the merits makes it unnecessary to reach the remand issue as it is presented, but I nevertheless write separately to briefly comment on that issue.

While claimant was adamantly ambiguous on whether his claim for carpal tunnel syndrome was premised on an injury or a disease theory, the thrust of claimant's present position invokes the law applicable to occupational diseases. Appellate court decisions in this area generally contemplate comparison of work and nonwork causation and determining which is the predominate causation.

Undoubtedly with such a comparison in mind, claimant testified about his work as a hod carrier and the various stresses and strains that it produced in his wrist area; and claimant also testified in essence and in very general terms, that none of his activity other than as a hod carrier involved comparable stress and strain in the wrist area. The evidence which the insurer would offer on remand consists of evidence that claimant had been self-employed as a ferrier for many years prior to working as a hod carrier for this employer and apparently continued doing some shoeing of horses while also working as a hod carrier; the insurer would also offer evidence that shoeing horses involves stress and

strain in the wrist area which, presumably, could be as much or more a cause of carpal tunnel syndrome as working as a hod carrier.

In opposition to remanding for introduction of this additional evidence, claimant argues that the insurer's "request to remand this claim is nothing less than an attempt to have the results of its post-hearing investigation admitted into the record." I wish that the law governing remands were as simple as claimant's argument assumes. However, the Court of Appeals remanded for introduction of the results of a post-hearing investigation in Egge v. Nu-Steel, 57 Or App 327 (1982); and a majority of this Board remanded for introduction of the results of a post-hearing investigation in Casimer Witkowski, 35 Van Natta 1661 (1983); and in the most recent and most surrealistic decision of all, Bailey v. SAIF, 296 Or 41 (1983), the Supreme Court seemingly encouraged remands for introduction of the results of post-hearing investigations.

Therefore, proceeding on the understanding that in some situations we are supposed to remand for introduction of the results of post-hearing investigations, my main purpose is to here state that I think that any situation in which there is a colorable showing of possible false testimony by any party presents a compelling reason for remand. For this reason, I would grant the insurer's motion to remand in this case if it were necessary to reach that issue.

MARVIN C. YAGER, Claimant
Burt, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys
Schwenn, et al., Defense Attorneys

WCB 83-00187, 82-08609 & 82-09187
February 27, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Allianz Insurance Company requests review of Referee Daron's order which: (1) Found that claimant sustained an aggravation of his 1979 industrial injury, and thus set aside Allianz's December 28, 1982 aggravation denial; (2) upheld the August 30, 1982 aggravation claim denial issued by Argonaut Insurance Company; and (3) upheld the September 29, 1982 new injury/disease denial issued by Planet Insurance Company. Allianz argues that claimant sustained either an aggravation of his 1981 industrial injury, for which Argonaut would be responsible, or that he sustained a new injury or disease in 1982, for which Planet would be responsible.

Although we do not necessarily agree with all of his analysis, we find that the Referee reached the correct result and thus affirm his order.

ORDER

The Referee's order dated July 29, 1983 is affirmed.

Board Member Barnes Concurring:

Oregon's two appellate courts have recently been quite active in defining and redefining the law governing employer/insurer responsibility. The Referee described these appellate decisions as "increasingly confusing." I agree.

In this case, for example, the Referee found that claimant's hearing testimony was not credible. The only medical opinions in

the record are based on claimant's history and thus can hardly be regarded as persuasive in light of the Referee's credibility finding. Without credible lay testimony and without persuasive medical opinions, exactly how do the appellate courts expect us to decide the insurer responsibility issue? I really to not know, and the result we reach in this case is only my best guess.

GLORIA J. BAS, Claimant
Doblie & Francesconi, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10089
February 29, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Galton's order which found that claimant was entitled to temporary total disability compensation, rather than temporary partial disability compensation, from October 2, 1982 until claim closure pursuant to ORS 656.268. SAIF contends that the Referee improperly made a finding concerning claimant's termination from employment, specifically, whether claimant's termination was reasonable and just. SAIF further contends that the Referee erroneously applied OAR 436-54-222(5) and (6), rather than OAR 436-54-222(4), and, as a result, improperly increased claimant's temporary partial disability payments to temporary total disability payments even though there was evidence that claimant could perform work four hours a day. We affirm.

Claimant sustained a compensable injury to her low back on March 18, 1982. Before she was medically stationary she was released to return to her employment on a half-time basis. At that time her temporary total disability payments were reduced to temporary partial disability payments to reflect her ability to work half-time and her receipt of wages. See ORS 656.212; OAR 436-54-222(1).

In August 1982 claimant secured permission from one of her supervisors, Mrs. Ryan, to take vacation time from October 2 through 6, 1982. On October 1, 1982 one of claimant's other supervisors, Donald Ryan, told claimant that she could not take the time off because they were opening a new store at that time and they needed her help. Feeling that Mrs. Ryan's approval of her vacation was still effective, claimant left for vacation October 2 through October 6, despite Donald Ryan's direction to the contrary. When claimant returned to work on October 7, Donald Ryan told her she was terminated and that she had been replaced by a full-time employe.

The dispute in this case centers on the proper application of OAR 436-52-222 to the facts presented. That rule provides:

> "(1) The rate of temporary partial disability compensation due a worker shall be determined by:
>
> "(a) Subtracting the post-injury wage earnings available from any kind of work; from
>
> "(b) the wage earnings from the employment

at the time of, and giving rise to, the injury; then

"(c) dividing the difference by the wage earnings in (b) to arrive at the percentage of loss of earning power; then

"(d) multiplying the current temporary total disability compensation rate by the percentage of loss of earning power.

"(2) If the post-injury wage earnings are equal to or greater than the wage earnings at the time of injury, no temporary disability compensation is due.

"(3) An insurer or self-insured employer shall cease paying temporary total disability compensation and commence making payment of such temporary partial disability compensation as is due from the date an injured worker accepts and commences any kind of wage earning employment prior to claim determination.

"(4) Temporary partial disability compensation payable pursuant to subsection (3) shall continue to be paid until:

"(a) The attending physician verifies that the worker cannot continue working and is again temporarily totally disabled;

"(b) the compensation is terminated by order of the Department or by claim closure by the insurer or self-insured employer pursuant to ORS 656.268; or

"(c) compensation has been paid for two years.

"(5) An insurer or self-insured employer shall cease paying temporary total disability compensation and start making payment of such temporary partial disability compensation as would be due in subsection (1) when an injured worker refuses wage earning employment prior to claim determination under the following conditions:

"(a) The attending physician has been notified by the employer or insurer of the specific duties to be performed by the injured worker and the physical requirements thereof;

"(b) the attending physician agrees that the offered employment appears to be within the worker's capabilities; and

"(c) the employer has provided the injured worker with a written offer of the employment which states the beginning time, date and place; the duration of the job; the wage rate payable; an accurate description of the job duties and that the attending physician has said the offered employment appears to be within the worker's capabilities.

"(6) Temporary partial disability compensation payable pursuant to subsection (5) shall continue to be paid until:

"(a) The attending physician verifies that the worker's condition is such that he could no longer perform such work and is again temporarily totally disabled;

"(b) the duration of the offered job has expired or that the offer of such employment is withdrawn (the employer discharging the worker because of violation of normal employment standards shall not be considered a withdrawal of offered employment);

"(c) the compensation is terminated by order of the Department or by claim closure of the insurer or self-insured employer pursuant to ORS 656.268; or

"(d) the compensation has been paid for two years.

" * * * "

Subsections (1), (2) and (3) were promulgated by the Workers' Compensation Department in order to provide insurers with a method for determining when a claimant is entitled to receive compensation for temporary partial disability, rather than temporary total disability, and for calculating the rate at which such benefits are to be paid. These subsections implement the general provisions of ORS 656.212, which provides:

"When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years, that proportion of the payments provided for temporary total disability which his loss of earning power at any kind of work bears to his earning power existing at the time of the occurrence of the injury."

Subsection (4) clarifies the insurers' claims processing obligations vis-a-vis termination of temporary partial disability and resumption of temporary total disability on the one hand; and termination of all temporary disability benefits on the other, under the provisions of ORS 656.212 and 656.268.

Subsections (5) and (6) implement ORS 656.325, which, in part, addresses the claimant's duty to reduce his or her disability, and the measures which may be taken by the insurer and the Department where the claimant, for example, refuses to take reasonable steps toward reducing his or her disability. Subsection (5) of this statute provides:

> "Notwithstanding ORS 656.268, an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 [temporary total disability] and shall commence making payment of such amounts as are due pursuant to ORS 656.212 [temporary partial disability] when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered."

SAIF contends that the proper determination of claimant's entitlement to temporary partial disability versus temporary total disability is arrived at by application of subsections (3) and (4) of OAR 436-54-222; and that applying those subsections results in the conclusion that SAIF correctly paid temporary partial disability only. This is so, argues SAIF, because upon claimant's return to part-time work, her temporary total disability was properly reduced to temporary partial disability pursuant to subsection (3); that SAIF was obligated to continue paying temporary partial disability for a maximum period of two years, or until the claim was closed, under subsections (4)(b) and (c); and that the obligation to resume payment of temporary total disability did not arise in the absence of claimant's attending physician's verification of claimant's inability to continue working, pursuant to subsection (4)(a). SAIF contends that subsections (5) and (6) are inapposite because subsection (5) is premised upon the claimant's refusal to accept suitable wage earning employment. SAIF objects to the Referee's consideration of the employer's motive for terminating claimant, stating that such considerations are not a material factor in determining claimant's entitlement to temporary total disability, and that: "Investigation and determination of possible bad faith terminations are the sole responsibility of the Employment Division of the State Department of Labor."

The argument posed by SAIF is appealing in its simplicity; however, we are not persuaded that it provides a reasonable application of the administrative rule to factual situations presented by disputes of the nature involved herein. In fact, we already have considered the application of this administrative rule to cases of this nature, where the issue is the claimant's entitlement to temporary disability compensation when the claimant is capable of performing modified employment before attaining a medically stationary status, the worker has returned to modified employment and is subsequently terminated for reasons unrelated to the compensable injury. Thomas C. Harrell, 34 Van Natta 589 (1982).

In Harrell claimant sustained an injury to his knee and, in order to return him to work promptly, the employer offered him a light-duty job performing receptionist and bookkeeping duties. After taking time off for additional surgery, claimant returned to the light-duty job. He then had an argument with his supervisor and was fired. Claimant contended that he was entitled to temporary total disability benefits between the date on which he was fired and the date that he was released for regular work by his attending physician. We evaluated the case in light of ORS 656.325(5), 656.212 and OAR 436-54-222 and concluded that claimant was not entitled to temporary total disability compensation for the period in question: "Claimant's inability to continue working in his modified job situation was not the result of his compensable injury. It was the result of his own actions, independent of his injury." 35 Van Natta at 591.

The Referee in Harrell had awarded claimant compensation for temporary total disability for the period in question. We reversed that award without discussing claimant's possible entitlement to temporary partial disability. Because claimant had returned to modified work at his regular wage and, therefore, was earning full wages at the time of his discharge, the insurer was not paying any temporary partial disability. Therefore, the issue in Harrell was an either-all: Neither party contended that claimant was entitled to temporary partial disability. In this case, unlike Harrell, claimant was in receipt of partial wages and temporary partial disability benefits; therefore, the question is whether claimant is entitled to receive only temporary partial disability or full temporary total disability benefits.

One of the reasons that SAIF's proposed application of the administrative rule is appealing is that it avoids the necessity of making a case-by-case evaluation of the circumstances surrounding an individual worker's termination and the reasons therefor. It is implicit in ORS 656.325, however, as well as other portions of the workers' compensation law, that a claimant's entitlement to workers' compensation benefits will be determined on the basis of this agency's judgment concerning the relative reasonableness of a claimant's actions. See, for example, ORS 656.206(3). See also Nelson v. EBI Companies, 296 Or 246 (1984) (reasonableness of failure to follow necessary medical advice); Reef v. Willamette Industries, 65 Or App 366 (1983) (reasonableness of claimant's refusal to undergo a myelogram); Carr v. SAIF, 65 Or App 110 (1983) (reasonableness of claimant's failure to attend medical examination); Dean Planque, 34 Van Natta 1116 (1982) (reasonableness of post-injury leisure activity, found to attenuate causal connection between original injury and worsened condition).

Consistent with our holding in Thomas C. Harrell, supra, we hold that subsections (5) and (6) of OAR 436-54-222 are applicable in determining a claimant's entitlement to temporary disability compensation when the claimant returns to gainful employment during the period that the worker is not medically stationary and, for reasons not related to the claimant's compensable injury, the employment is terminated. We interpret subsections (5) and (6) as applying not only to those situations in which the claimant refuses to accept wage earning employment prior to claim determination, but also those situations in which the claimant, once having accepted the employment, refuses to continue in that employment. Having resolved the issue of the proper application of OAR 436-54-222 to

the facts of this case, we now address the factual dispute concerning the circumstances of claimant's termination.

Two witnesses testified at hearing: Claimant and one of the principals of the employer, Donald Ryan. The testimony is consistent with regard to the relationship between claimant, Mr. Ryan and Mrs. Ryan, Mr. Ryan's sister-in-law. Donald Ryan, Mrs. Ryan and her husband (Donald Ryan's brother) are the three owners of Union Furniture, the employer. Mrs. Ryan was claimant's immediate supervisor and, according to claimant's testimony, gave claimant her permission to take a vacation during a period of time that all employes had been requested to refrain from taking vacation because the employer recently had built a new store and, in effect, found itself running two stores with the staffing for only one. As stated above, Mrs. Ryan granted claimant permission to take this vacation in August 1982. It was not until the day before this scheduled vacation that claimant was informed by Mr. Ryan that she would not be permitted to take the vacation in issue. Mrs. Ryan did not testify.

The Referee found claimant a credible and reliable witness, and he found Mr. Ryan "credible and reliable only in part." We find no comfortable basis for disagreeing with the Referee's conclusions concerning witness credibility; therefore, any discrepancies arising from different factual accounts given by these two witnesses necessarily have been resolved in claimant's favor.

We find that claimant's action in taking her scheduled vacation notwithstanding Mr. Ryan's instruction to the contrary was not unreasonable under the facts and circumstances presented herein. We, therefore, conclude that the employer did not discharge claimant because of her "violation of normal employment standards." OAR 436-54-222(6)(b). We find that claimant did not refuse to continue her part-time employment and that, in effect, the duration of this employment expired, or the offer of the part-time employment was withdrawn, within the meaning of OAR 436-54-222(6)(b). Therefore, claimant was entitled to reinstatement of her temporary total disability benefits for the period in question, rather than temporary partial disability as paid by SAIF.

In her respondent's brief, claimant has requested that we reverse that portion of the Referee's order which failed to impose a penalty and attorney's fee for SAIF's failure to resume payment of temporary total disability benefits. Claimant contends that in light of our decision in Thomas C. Harrell, supra, in which SAIF was the insurer, SAIF's refusal to reinstate claimant's temporary total disability benefits was unreasonable. We agree with the Referee's characterization of this dispute concerning claimant's entitlement to temporary total, as opposed to temporary partial, disability benefits as a "good faith dispute [in the] interpretation of administrative rules." Therefore, we affirm and adopt that portion of the Referee's order which declined to impose a penalty and associated attorney's fee.

ORDER

The Referee's order dated November 30, 1982 is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the SAIF Corporation.

ROBERT R. BURNS, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-09783 & 82-08352
February 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Industrial Indemnity Insurance Company requests review of Referee Brown's order which assigned responsibility to it for claimant's current back condition on the basis of aggravation of a December 1980 injury. This case was heard pursuant to an order issued under ORS 656.307. Responsibility is the only issue on review.

Claimant compensably injured his low back on December 10, 1980 while working for Industrial Indemnity's insured. The claim was accepted as non-disabling. Claimant had some symptoms, but no significant problems until he began working for the SAIF Corporation's insured in June 1982. Within two weeks of beginning work for SAIF's insured, claimant began to develop increased back pain. The work claimant performed for SAIF's insured was heavier work than he had performed for Industrial Indemnity's insured.

We find that if claimant's condition is SAIF's responsibility, it arose out of an occupational exposure rather than an industrial injury. We also find, based on the deposition of Dr. Woolpert, the treating physician, that claimant's occupational exposure at SAIF's insured was a material contributing cause of claimant's worsened condition.

The Referee's findings of fact are in accord with our own. However, in assigning responsibility to Industrial Indemnity, he relied on the Court of Appeals' case of Boise Cascade v. Starbuck, 61 Or App 631 (1983). He interpreted that case as follows:

> "I interpret Starbuck as standing for nothing more than the proposition that the rule in Smith v. Ed's Pancake House, 27 Or App 361 (1976) does not apply when there is no injury [at the second employer]."

Since the Referee issued his order, Starbuck has been reviewed by the Supreme Court. Boise Cascade v. Starbuck, 296 Or 238 (1984). The Supreme Court's opinion casts doubt on the accuracy of the Referee's analysis.

The facts of Starbuck are similar to those in this case. In Starbuck, the claimant suffered a compensable injury at one employment. That injury contributed to a disability occurring during a later employment which involved work conditions capable of causing the disability, but which did not actually contribute to the disability. The court held that the first employer was liable and that responsibility would not shift to the second employer unless the later employment contributed to the disability, as opposed to only being capable of contributing to the disability.

Applying that holding to the present case, we find that claimant's second employment with SAIF's insured actually and materially contributed to claimant's disability, and therefore, SAIF's insured is responsible for claimant's disability.

ORDER

The Referee's order dated February 28, 1983 is reversed. Industrial Indemnity's denial dated September 2, 1982 is reinstated and affirmed. The SAIF Corporation's denial dated October 22, 1982 is set aside and this claim is remanded to SAIF for acceptance and processing. No attorney's fee will be awarded claimant's attorney as claimant did not participate on Board review.

VICTOR DERKACHT, Claimant
Roll & Westmoreland, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-03804 & 82-02990
February 29, 1984
Order on Review

Reviewed by the Board en banc.

The insurer requests review of those portions of Referee Menashe's order which found claimant entitled to compensation for permanent total disability. Claimant cross-requests review of those portions of the Referee's order which affirmed the insurer's June 24, 1982 denial of claimant's low back condition. The insurer has additionally made alternative motions to abate the Referee's order and remand the matter for a new hearing on the question of the extent of claimant's disability, or, to remand the matter for the taking of additional evidence relevant to the issue of the extent of claimant's disability.

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

On review, the insurer has basically renewed the motion it made before the Referee. The insurer, citing Gary Freier, 34 Van Natta 543 (1982), argues that it is not proper for a Referee to rate the extent of a claimant's permanent disabilty when there is a pending request for curative treatment. We disagree. Freier dealt only with situations involving the question of whether it was appropriate to determine the extent of a claimant's disability while his claim was in open status. We answered that question in the negative. 34 Van Natta 545, 546. We have never held that a claimant has no right to a determination of the extent of his disability simply because his claim might be reopened at some future date. Although it might make sense in certain situations (and as a practical matter, it probably would have in this case), if that were the law, it would be questionable whether any claimant would ever have a right to a hearing on the issue of the extent of his disability.

Although the dissent makes a valid point in noting that it seems counter-productive to make a decision on the extent of disability issue when claimant has potentially curative surgery pending, it must be remembered that:

> [W]hether this claimant is permanently totally disabled must be decided upon conditions existing at the time of decision, and his award of compensation . . . can be reduced only upon a specific finding that the claimant presently is able to perform a gainful and suitable occupation. (Emphasis added.) Gettman v. SAIF, 289 Or 609, 614 (1980).

In addition, it is also to be noted that:

> "The legislative provision on ORS 656.206(5) for periodic reexamination of each permanent total disability award further indicates that a permanent total disability award is based upon existing occupational abilities. That award can be adjusted if the claimant is no longer permanently incapacitated from regularly performing work at a gainful and suitable occupation. Gettman v. SAIF, supra, 289 Or at 614, 615.

Thus, if claimant does undergo surgery, and if the surgery does prove beneficial, ORS 656.206(5) provides a method whereby claimant's award of permanent total disability may be reexamined, and if appropriate, reduced.

In addition to the above, it appears to us that the insurer is being somewhat disingenuous in requesting remand. The insurer argues that it is inappropriate to consider the question of the extent of claimant's disability as the claim may be reopened for surgery. However, at the same time that it makes this argument, the insurer has denied claimant's request for surgery. See Victor Derkacht, WCB Case No. 83-00508, 36 Van Natta 184 (decided this date). This being the case, it seems somewhat unreasonable to us, to say the least, for the insurer to argue that claimant has no right to a determination of the extent of his disability until after recovery from surgery. Had the insurer authorized claimant's surgery, its position would be defensible; however, at the time of the hearing, and at the time the insurer renewed its motion before the Board, the question whether claimant would ever have surgery was speculative at best. The insurer's motions are denied.

With regard to the questions of the extent of claimant's disability, and the compensability of his low back condition, we affirm and adopt the order of the Referee.

ORDER

The Referee's order dated October 29, 1982 is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the insurer.

Board Member Barnes Dissenting:

This date the Board decides two separate cases involving this same claimant. This case primarily involves the question of extent of disability. The other case, WCB Case No. 83-00508, involves the question of claimant's entitlement to surgery.

In my opinion, the Board should first consolidate these two obviously interrelated cases on its own initiative because it seems irrational to me to simultaneously determine, as the Board has, that claimant is totally disabled and that claimant is entitled to potentially curative surgery.

After consolidation of these two cases, we should then address the question of entitlement to surgery before considering the question of extent of disability. For the reasons stated in the separate order issued this date in WCB Case No. 83-00508, I agree that claimant has established entitlement to the surgery in question.

Having made that determination, and still proceeding on the belief that the two cases before us should be consolidated, I would then conclude that the record before us on the extent issue is insufficiently developed within the meaning of Bailey v. SAIF, 296 Or 41 (1983), and thus grant the insurer's motion to remand. "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, 296 Or at 46. I do not believe that an extent-of-disability decision rendered in this case on the present record, in the face of our knowledge that claimant will receive potentially curative surgery, is based on accurate facts or reaches a just conclusion.

Therefore, although I agree with the decision that claimant is entitled to surgery, I dissent from the Board's failure to consolidate these two pending, interrelated cases and failure to remand on the question of extent of disability in view of our decision on the surgery question.

VICTOR P. DERKACHT, Claimant
Roll & Westmoreland, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-00508
February 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Williams' order which affirmed the insurer's January 3, 1983 partial denial, by which the insurer denied Dr. Nash's request for authorization to perform cervical surgery on claimant. The sole issue for review is whether the surgery proposed by Dr. Nash is reasonable and necessary.

A partial rendition of the factual background relevant to this case is contained in Victor P. Derkacht, WCB Case Nos. 82-03804 and 82-02990, 36 Van Natta 182 (decided this date). We see no need to reiterate those facts here, and for purposes of review of this case we hereby adopt the statement of facts set forth therein. Additional facts are as follows.

Dr. Nash reported on July 9, 1982 that diagnostic testing revealed that claimant had bilateral extradural defects at the C6-7 level, and that there was direct evidence of nerve compression at this point which was compatible with claimant's neurological findings. On July 29, 1982 Dr. Nash requested the insurer's authorization to perform a cervical laminotomy.

On August 19, 1982 Dr Nash reported that surgery at C6-7 would relieve the compression on the nerve roots existing at that level and would relieve some of claimant's complaints. Dr. Nash stated that this would "certainly lessen [claimant's] suffering," that it might aid claimant's employment prospects, and that even if it did not relieve all of claimant's symptoms, the surgery was justified on a "humanitarian basis."

Claimant was examined by Dr. Rosenbaum, a neurosurgeon, on August 24, 1982. Dr. Rosenbaum was of the opinion that claimant had reached maximum improvement as a result of his July 1981 injury, and that no further medical or surgical treatment would be beneficial. Dr. Rosenbaum felt that there was minimal correlation between claimant's cervical symptoms and his myelographic findings, and that considering claimant's "marked functional overlay," claimant would be a poor candidate for surgery.

On September 22, 1982 the insurer requested that Dr. Nash select a physician to render a third opinion with regard to the question of the proposed cervical surgery. Dr. Nash selected Dr. Raaf, a neurosurgeon.

Claimant was examined by Dr. Raaf on November 17, 1982. After examining claimant and thoroughly reviewing his medical history, Dr. Raaf stated that he did not believe claimant's condition would be improved as a result of cervical surgery. Dr. Raaf, similar to Dr. Rosenbaum, felt that claimant did not show objective signs of cervical nerve root pressure.

On January 3, 1983 the insurer denied authorization for cervical surgery.

Claimant was thereafter referred by Dr. Nash to Dr. Berkeley, a neurosurgeon. After examining claimant and reviewing his medical records, Dr. Berkeley reported that, although he could find no specific focal neurological abnormalities apart from some changes in claimant's reflexes, claimant did have severe mechanical problems in his neck, and that claimant's myelographic findings were strongly positive for a significant lesion at C6-7. Dr. Berkeley felt this would account for claimant's right shoulder-arm pain, neckaches and headaches. It was Dr. Berkeley's opinion that claimant should be given the option of surgical treatment for his cervical condition. (Note: Dr. Berkeley felt that lumbar surgery was also indicated; however, in WCB Case Nos. 82-03804 and 82-02990 we upheld the insurer's denial of claimant's lumbar condition.)

Claimant was thereafter examined by Dr. Reiter, a psychologist. Dr. Reiter found claimant to be depressed and abnormally concerned with bodily complaints. Dr. Reiter felt that claimant was exhibiting some cognitive deficits, but was uncertain whether this was due to claimant's injury or his heightened emotional condition. Dr. Reiter was of the opinion that if claimant's surgery was to take place, claimant should undergo some individual or group psychotherapy.

The insurer thereafter sent copies of all of the exhibits contained in the record of this case to Dr. Larson, a neurologist, who had examined claimant shortly after his July 1981 injury. In a "check-the-boxes" type report, Dr. Larson gave a negative response to the question of whether the proposed surgery for claimant was reasonable. See Joyce Adair, 34 Van Natta 203 (1982).

The Referee found that there was an aura surrounding this case which suggested that claimant had an unrealistic expectation concerning the certainty of the value of Dr. Nash's proposed surgery. The Referee concluded that the evidence did not preponderate in favor of surgery and affirmed the insurer's partial denial.

Although we certainly agree with the Referee that the evidence in this case tends to indicate that claimant may have unrealistic expectations concerning the value of the proposed cervical surgery, and, although we find it to be a close question, we conclude that claimant should be given the option of undergoing the proposed cervical surgery.

In Glenn R. Pettey, WCB Case No. 80-02562 (July 8, 1981), we stated that:

> "On questions of the need for medical treatment, the Board will always defer to the treating doctor absent some compelling reason not to do so."

Accord Lucine Schaffer, 33 Van Natta 511 (1981); Charles A. Murray, 34 Van Natta 249 (1982); Earl Freeman, 34 Van Natta 1284 (1982); Thomas Huddleston, 34 Van Natta 1616 (1982); Stephen R. Goode, 35 Van Natta 1338 (1983).

For reasons that are obvious, this agency is not in the best of positions to resolve disputes which are basically medical in nature and about which experienced physicians disagree, although we have jurisdiction to do so. See Lloyd C. Dykstra, 36 Van Natta 26 (1983). It is for this reason that we have adopted the policy expressed in Pettey. Were the question of reasonableness and necessity of surgery merely a question of counting medical opinions pro and con, cases such as this would be easy to resolve. It is not that we find the opinions of the physicians who recommended against surgery unpersuasive. In fact, Drs. Rosenbaum and Raaf are both experienced physicians who set forth the reasons for their opinions in detail. The reason we find in claimant's favor is that it is our general policy to defer to a claimant's treating physician on the question of the reasonableness and necessity of medical treatment unless, as noted above, there are compelling reasons to do otherwise.

Comparing the opinions of Drs. Raaf and Rosenbaum (and giving some weight to Dr. Larson's "check-the-boxes" report), we cannot say that the reasons given against surgery are so compelling that we would feel secure in rejecting Dr. Nash's recommendation.

Although Drs. Raaf and Rosenbaum are of the opinion that claimant's symptoms do not correlate sufficiently with his objective findings to warrant surgery, Dr. Nash feels otherwise. Unlike Drs. Raaf and Rosenbaum, Dr. Nash has had the opportunity to examine claimant on numerous occasions, and has thoroughly explained his reasons for believing that surgery will be beneficial to claimant. Additionally, Dr. Nash does have the concurrence of another neurosurgeon.

The fact that Drs. Rosenbaum and Reiter felt that claimant was not psychologically prepared for surgery is not a reason to deny him the benefit of surgery. If psychological counseling is necessary to prepare claimant for his ordeal, such counseling should be provided prior to surgery. That fact alone, however, is an insufficient basis on which to affirm the denial.

In summary, we conclude that although there are good reasons set forth by competent physicians who recommend against surgery, we cannot conclude that they are so compelling as to overcome claimant's treating doctor's recommendation in favor of surgery. The insurer's partial denial is, therefore, set aside, and claimant is entitled to have his claim reopened at the time he submits to cervical surgery.

ORDER

The Referee's order dated August 2, 1983 is reversed. The insurer's January 3, 1983 partial denial is set aside. Claimant's attorney is awarded $1,200 for services before the Referee and $450 for services before the Board, for a total fee of $1,650, to be paid by the insurer.

WILLIAM J. FRAME, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 80-07617
February 29, 1984
Order on Remand

On review of the Board's order dated March 5, 1982, the court reversed that portion of the Board's order which held that claimant is not eligible for an authorized training program and remanded to the Board with instructions "to admit claimant to an authorized training program."

Now, therefore, that portion of the above-noted Board order holding that claimant is not eligible for an authorized training program is vacated, and this matter is remanded to the Field Services Division of the Workers' Compensation Department with instructions to provide claimant vocational assistance in a manner consistent with the order of the court.

IT IS SO ORDERED.

NORMA J. GERARDO, Claimant
Cash Perrine, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 79-01506
February 29, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Seifert's order which affirmed the August 4, 1982 Determination Order which awarded claimant an additional 16° for 5% unscheduled disability for a total of 48° for 15% unscheduled permanent partial disability for injury to the low back. The issue for review is the extent of claimant's disability.

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

The Referee's apparent basis for concluding that claimant was not entitled to an increased award of unscheduled disability was as follows:

> "The most recent examination by Dr. Bernson in May 1983 indicated that the etiology of claimant's muscle spasm was probably in the facets and the history was not suggestive of a typical herniated disc problem. Claimant

has a long history of back problems. The medical evidence indicates that her pain symptoms are primarily from degenerative joint disease. Consequently, I find the evidence insufficient to establish that she has suffered any greater permanent partial disability from her industrial injury than awarded."

It is certainly true, as the Referee noted, that claimant had a history of back problems before the industrial injury here in issue. It is also true that the evidence suggests that certain aspects of her current difficulty are not directly related to her industrial injury. We disagree with the Referee, however, that claimant's degenerative joint disease is unrelated to her industrial injury.

Claimant underwent a lumbar laminectomy and L4-5 diskectomy as a result of her industrial injury. There is ample medical evidence that claimant is experiencing a progressive narrowing at L4-5 as a result of that surgery. Dr. Kendrick reported on February 2, 1981 that claimant was experiencing degenerative joint disease in the facets, and that this had been precipitated by changes resulting from progressive narrowing at L4-5 as a result of her disc rupture and subsequent surgery. A CT scan performed in December 1982 revealed degenerative changes at L4-5. Dr. Newby reported on August 23, 1982 that claimant was suffering from residuals of her herniated disc manifested by loss of ranges of motion of the lumbar spine, positive straight leg raising, etc. We are satisfied that the majority of claimant's current symptoms are the result of her March 1978 industrial injury and subsequent surgery.

With regard to the specific question of the extent of claimant's disability, we conclude that claimant is entitled to an additional award of unscheduled permanent disability. Claimant was employed as an off bearer for a cut-stock plant at the time of her injury -- work that was heavy in nature. Although claimant has been retrained, she is limited to light duty work, and claimant is experiencing continued difficulties as a result of residuals from her injury. The Orthopaedic Consultants concluded in their report of June 15, 1979 that claimant's total loss of function as a result of her injury was in the range of mildly moderate.

Although claimant's impairment is significant, other factors relative to the rating of unscheduled disability are not particularly unfavorable. Claimant was only 41 years of age at the time of the hearing. Claimant's performance in her vocational program indicates that she has average to above average intelligence. Although the medical reports indicate that there may be a mild amount of functional disturbance present, claimant appears to have no psychological or emotional impediments. Claimant has a high school education and apparently attended beauty school. As a result of her vocational program, claimant obtained a degree in business technology at Central Oregon Community College.

Considering all of the above, we conclude that claimant is entitled to an increase in her award of permanent partial disability.

ORDER

The Referee's order dated July 12, 1982 is modified. Claimant is awarded 25% (80°) unscheduled permanent partial disability, in lieu of all previous awards, that being an increase of 10% (32°) over all previous awards. Claimant's attorney is allowed 25% of the additional compensation granted by this order as a reasonable attorney's fee.

KENNETH J. HOLSTON, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-06453
February 29, 1984
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of that portion of Referee Foster's order which set aside SAIF's denial of claimant's aggravation claim and ordered SAIF to pay claimant's travel expenses from Jasper, Oregon, to Eugene, Oregon for medical treatment. The issues on review are whether claimant's condition has aggravated and whether claimant is entitled to travel expenses for claimant's trips for treatment.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated December 13, 1982 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

Board Member Barnes Dissenting:

I respectfully disagree with the Referee and the Board majority; I would find that claimant has not established a compensable aggravation claim and is not entitled to all of the reimbursement for travel expense that he here seeks.

I

Before getting into the details of the aggravation claim, by way of an overture I note a pattern that is obvious to me in this record. Since claimant's January 1979 industrial injury, virtually all of the numerous doctors who have treated or examined claimant have opined or implied that claimant's reported subjective symptoms are out of all proportion to any objective medical findings. And since all treating doctors have sooner or later come to the conclusion that no further treatment is indicated, claimant keeps changing doctors. I suggest that this aggravation claim should be evaluated with this pattern of "doctor shopping" and unverified subjective symptoms in mind.

The last award of compensation is an October 1981 stipulation by which claimant was awarded 15% unscheduled disability. Shortly thereafter Dr. Campagna, who apparently had been claimant's primary treating physician during most of 1981, advised claimant that he had nothing further to offer him.

Claimant then began treating with Dr. Golden, who also referred claimant for consultation to Dr. Becker. In March 1982 Dr. Golden reported: "I think that on the basis of [claimant's] present condition his claim should be reopened and I would plan to do a myelogram with prior authorization." Dr. Golden did not elaborate at that time on claimant's "present condition." In May 1982 Dr. Becker echoed Dr. Golden's request for claim reopening.

Also in May claimant was hospitalized for a myelogram -- which was the third myelogram performed in the three years since claimant's industrial injury. After receiving the myelogram results, which were essentially normal, Dr. Golden opined:

> "[Claimant's] condition has not worsened but has been persistent as a chronic pain problem.
>
> ". . .he should be treated conservatively with weight loss, medications as needed . . . and attempt to get him back to work with a job change."

Also based on the diagnostic results, Dr. Becker opined: "It is my feeling that [claimant's] condition was essentially the same from January 31, 1982 through May 28, 1982." I am not sure of the relevance of these dates to Dr. Becker, but his opinion hardly supports a finding of a worsening of claimant's condition after the last award of compensation in October 1981.

In short, claimant changed doctors after the last award, the new doctors requested claim reopening so that they could perform the same diagnostic procedures, e.g., a myelogram, that claimant's prior doctors had performed, the myelogram was normal and there were no other objective findings to the contrary, and claimant's new doctors then opined that claimant's condition "has not worsened" (Dr. Golden) and "was essentially the same" (Dr. Becker). What is the basis of finding a compensable aggravation?

Perhaps the majority finds evidence of a worsening of claimant's condition in the report of Orthopaedic Consultants, who examined claimant in July 1982. I do not so interpret that report, which states in part:

> "It is to be noted that the degree of interference from a functional disturbance is considered to be severe. This is manifested by refusals and inconsistencies.
>
> * * *
>
> "It is my opinion that this patient's condition is not stationary, and his treatment should be continued at the pain clinic in Eugene.
>
> * * *
>
> "I feel that the functional overlay is so profound at this time that physical impairment cannot readily be evaluated.

* * *

> "I do not feel that this patient has necessarily worsened, and as indicated above, psychiatric evaluation should be obtained prior to determining any possible residuals from this injury."

In some situations a doctor's opinion that a worker's condition "is not stationary" can reasonably be interpreted to support a finding that the worker's condition has worsened within the meaning of ORS 656.273. But I do not think any such interpretation would be reasonable in this situation. Here claimant's treating doctors had already concluded that claimant's condition has not worsened and they have only conservative treatment to offer before Orthopaedic Consultants offered a "not medically stationary" opinion coupled with comments about "severe functional disturbance" and "not necessarily worsened." Whatever all this means, it is not sufficient to persuade me that claimant's condition worsened after the last award of compensation.

In reaching the contrary conclusion, the Referee noted that claimant had been hospitalized for nine days in May 1982 by Dr. Golden and reasoned: "That in itself indicates an aggravation of claimant's condition, at least on a temporary basis." I disagree. As I understand the record, claimant was hospitalized for diagnostic procedures, not for any form of treatment. And, as previously noted, those diagnostic procedures revealed no change in claimant's condition or objective basis for his chronic pain complaints. It is one of the chronic ambiguities in Oregon's workers compensation law whether workers hospitalized for a diagnostic work-up are entitled to time loss on the basis of aggravation when the results are no worsening, no change of condition, no objective findings, etc. Without trying to tackle that ambiguity, I submit that, at the most, claimant should be paid time loss for the actual period that he was hospitalized pursuant to OAR 436-83-525; but that is a far cry from ordering claim reopening and "payment of compensation until closure pursuant to ORS 656.268," which is what the Referee ordered.

Nor am I persuaded by claimant's argument that he established an aggravation because Orthopaedic Consultants' July 1982 range-of-motion findings are worse than other range-of-motion findings from before the last award of compensation. Range-of-motion tests are subjective and can vary from one day to the next and from one examiner to the next. See Leonard Wonslyd, 34 Van Natta 230 (1982). Moreover, those general problems are here compounded by Orthopaedic Consultants' general comments about claimant's functional interference and specific comment about their range-of-motion test: "how much effort he is putting into them remains questionable."

Finally, I am not persuaded by claimant's final fall-back argument: That he established an aggravation by proving that his functional overlay worsened after the last award of compensation. Although we do not agree at this Board on what "functional overlay" means, see Phillip J. Barrett, 35 Van Natta 789 (1983), whatever it means it has been consistent in this case. Claimant had functional problems before the last award of compensation as indicated by the series of doctors who could find no objective basis for claimant's

chronic pain complaints, and those same problems continue today. No doctor opines that claimant's functional problem has worsened.

In summary, we should judge this aggravation claim by the standards stated in Oakley v. SAIF, 63 Or App 433, 436 (1983):

> "An aggravation claim based solely on a claimant's statement that his condition has deteriorated is statutorily insufficient. Likewise, a medical report which only sets forth claimant's statement that his condition has deteriorated is insufficient. At the very least, an expression of opinion by the doctor that he believes the claimant or that he finds objective evidence from a medical standpoint to substantiate claimant's history, is necessary."

Judged by these standards, the present aggravation claim is clearly insufficient, and I am at a loss to even guess what in the record the Board majority might be relying on in finding to the contrary.

II

The travel expense issue arises on the following facts. Claimant lives in Jasper, Oregon and during the periods here in issue was receiving medical care in Eugene, Oregon. It is about a 50-mile round trip from Jasper to Eugene and back. On a single day claimant made three round trips between Jasper and Eugene: The first for an 8 a.m. appointment in connection with his weight-loss program; the second for a 3 p.m. appointment with a physical therapist; and the third for a 7 p.m. appointment with his psychiatrist. SAIF advised claimant that it was willing to reimburse him for travel expenses for one round trip per day. The Referee and the Board majority conclude that SAIF must reimburse claimant for all three round trips per day.

The first question should be whether there is any reasonableness limitation on travel expenses in connection with compensable medical care. In a prior proceeding involving this same claimant, we interpreted the prior decisions of the Court of Appeals to have rejected any reasonableness limitation on travel expenses. Kenneth L. Holston, 34 Van Natta 952 (1982). On review of that decision, the Court of Appeals strongly implied that we had misinterpreted its prior decisions which "did not specifically address the question whether, under the circumstances, it was reasonable or necessary for claimant to travel for treatment." SAIF v. Holston, 63 Or App 348, 352 n. 2 (1983).

I understand the court's decision in the prior Holston proceeding to conclude that it is an open question whether and to what extent there is a reasonableness limitation on travel expenses in connection with compensable medical treatment. Assuming it is an open question, I submit the better answer is in the affirmative.

Proceeding on that basis, the ultimate issue then becomes whether it was reasonable for claimant to make three separate 50-mile round trips for medical appointments in a single day. I think not.

Claimant, not the industrial insurer, had some control over the times of his various appointments in Eugene. Claimant testified that he was unable to schedule the three appointments closer together, but I find that testimony incredible. If insurance reimbursement for travel were not available, I strongly believe claimant would have found a way to schedule his affairs so as to require only one trip to Eugene.

But even accepting claimant's testimony at face value, consider the surrounding circumstances. We have a claimant (1) whose back is so severely injured that, according to the Board majority, he is unable to work and who (2) insists on driving an additional 100 miles per day (so long as he is paid for it). We have a claimant who (1) according to some documents in the record, is supposedly interested in a retraining program in bookkeeping but who, (2) according to his testimony, would have nothing to do in Eugene during the hours between his various medical appointments. I suggest that, rather than subjecting his injured back to an additional 100 miles of driving, claimant should have welcomed the opportunity to investigate the bookkeeping reference materials in the public library.

Of course, it was claimant's prerogative to choose to embark on three 50-mile round trips in one day because of his own beliefs about ultimate personal convenience. However, I think it is unfair and unreasonable to expect the workers compensation system to pay for each and every one of these personal voyages. On this record, I would limit SAIF's duty to reimburse transportation costs to one round trip per day between claimant's home and Eugene.

For all of these reasons, I would reverse the Referee's order on both issues presented on review and thus respectfully dissent.

GORDAN J. JUEDES, Claimant
Doblie & Francesconi, Claimant's Attorneys
Lindsay, Hart, et al., Defense Attorneys

WCB 83-03464
February 29, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Podnar's order which upheld the insurer's backup denial of claimant's industrial injury claim.

Claimant filed an 801 form on October 19, 1982, alleging he injured his shoulders while pushing cabbage leaves with a rake. The claim was accepted and benefits paid until April 7, 1983 when the insurer issued its denial here in issue, which states in part:

> "As medical records have been received, however, it has become obvious that you are simply using the claim as a means to obtain drugs. You have visited an extraordinary number of physicians and hospitals simply seeking narcotic medication."

The denial letter went on to allege that claimant had provided "at least five materially inconsistent descriptions of the alleged injury and have at different times alleged that you injured eight different parts of your body, and these descriptions of the areas injured have been materially inconsistent."

The Referee found that claimant was not a credible witness, and concluded that he failed to carry his burden of proving he sustained a compensable injury.

Subsequent to the hearing in this matter, the Supreme Court issued its decision in Bauman v. SAIF, 295 Or 788 (1983), where it concluded that once an insurer notifies a claimant that it has accepted his or her claim, the insurer may not deny the compensability of the claim after the statutory 60 days have elapsed, except on grounds of fraud, misrepresentation or other illegal activity. 295 Or at 794. Claimant contends that Bauman requires a reversal of the Referee's order in this case because the insurer had accepted his claim and more than 60 days elapsed prior to the issuance of the insurer's backup denial. The insurer contends that its backup denial was permissible under Bauman because the denial was based on fraud.

The Supreme Court's decision in Bauman has been further interpreted by the Court of Appeals in Wilkins v. SAIF, 66 Or App 420 (1984), and Skinner v. SAIF, 66 Or App 467 (1984). In Benjamin G. Parker, 36 Van Natta 69 (1984), we set forth our understanding of the effect of these appellate decisions:

> "[T]he burden of going forward with some evidence of fraud, misrepresentation or other illegal activity lies with the insurer. Once this burden of going forward is met, it is the claimant's ultimate burden to prove the compensability of the claim." 36 Van Natta at 70 .

We here conclude that the insurer more than satisfied its burden of going forward with some evidence of fraud, etc. Without setting forth the particulars of each one, we note that the record contains numerous and varying versions of the manner in which claimant alleges to have injured himself. There are also numerous inconsistencies in relation to what body part or parts claimant supposedly injured. During a six month period, claimant visited eight hospitals and eleven physicians. There are a number of medical reports which imply, as the insurer alleges, that claimant was using his claim as a means to obtain drugs, and that he probably never sustained an industrial injury at all. Claimant indicated on the 801 form that there were no witnesses to his alleged injury. At the hearing, claimant testified that there were 20 or 30 employes who witnessed his injury. No such witnesses were produced at the hearing. Additionally, the Referee found claimant to be not credible.

As we noted in Parker, once the insurer produces evidence of fraud, etc., the ultimate burden of establishing compensability is the claimant's. There is no basis in the record for concluding that claimant sustained this ultimate burden.

ORDER

The Referee's order dated July 15, 1983 is affirmed.

BARBARA KESSLER, Claimant
Thomas C. Carler, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-10440
February 29, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer requests review of Referee Neal's order which awarded claimant 40% (128°) unscheduled permanent partial disability for injury to her low back and left hip, that being an increase of 20% (64°) over the Determination Order of October 22, 1982. The only issue is the extent of claimant's disability.

Claimant, who was 42 years of age at the time of the hearing, was a department supervisor for Pendleton Woolen Mills. Claimant developed low back and left hip pain following work activities performed in late July and early August 1980. Lumbar strain was diagnosed. An April 2, 1981 Determination Order awarded claimant benefits for temporary total disability from August 7 through December 31, 1980.

Claimant returned to work in January 1981, but was off work again from May through August 1981 with a recurrent lumbar strain. Electromyographic testing by Dr. Long indicated a left radiculopathy. Claimant again returned to work and the claim was closed by a second Determination Order on January 26, 1982 which awarded additional time loss benefits.

Following treatment for some unrelated (and noncompensable) problems, claimant returned to work in January 1982. Claimant quit her job in February 1982 due to a recurrence of back pain. Claimant underwent a myelogram, CAT scan and bone scan. All test results were normal. Dr. Bald found claimant medically stationary on September 24, 1982. Dr. Bald reported that claimant continued to have complaints related to pain in her left hip area. Claimant exhibited no lumbar tenderness and her ranges of back motions were quite good. No neurological deficits were found. Dr. Bald stated: "[Claimant] does have some permanent disability from this injury related primarily to pain and limitations in function related to the pain."

Claimant thereafter received vocational assistance and obtained a position in a government funded project, teaching vocationally disadvantaged Asian students how to operate sewing machinery in order to help them obtain jobs in the garment industry. Claimant continued in this capacity from January to June 1983, and reported to Dr. Bald that the increased activity was beneficial.

The Referee stated:

> "At the time of the hearing claimant was 42, with [an] eleventh grade education, a GED and courses at a community college in management. She presented a good appearance at the hearing and appeared to be a credible witness."

Apparently on that basis, the Referee awarded claimant a total of 40% unscheduled permanent disability.

We conclude that the Referee's award was excessive. We see no

need in this case to depart from the guidelines for the rating of unscheduled permanent disability. The Referee pointed to no factors which are not considered in the guidelines, and our review of the record reveals none.

All of claimant's treatment for her back injury has been conservative. Although it was originally thought that claimant demonstrated a positive radiculopathy, nerve root involvement was later ruled out. Objective physical findings have generally been minimal, and claimant's main restrictions are on the basis of pain only. Claimant's testimony concerning her condition generally indicates that her restrictions are not particularly significant and appears consistent with Dr. Bald's report of September 24, 1982. In fact, Dr. Bald's chart note of February 10, 1983 indicates that claimant's condition actually improved somewhat over previous examinations.

The Evaluation Division assigned claimant an impairment value of +14. That value appears to be based mainly on claimant's pain and pain related restrictions. Based on our above findings, we conclude that this impairment value is quite adequate.

With regard to other factors considered in rating claimant's disability, we find that the values assigned by the Evaluation Division pursuant to OAR 436-65-600 et seq. were also correct. Claimant's age, 42, yields a value of +1. Her education, mental capacity, emotional and psychological status all yield values of zero. Claimant's work at the time of her injury was classified as light, and she is currently restricted to light work. This also yields a value of zero. The Dictionary of Occupational Titles reveals that the specific vocational preparation value for claimant's employment is 6, which results in a value of +8. Claimant still has 37% of the labor market available to her, and this yields a value of -9. The combined positive values equal a +22. Multiplying the negative percentage value by the positive value and then substracting it from the positive value results in a final value of +20.02. Rounded to the nearest 5%, this results in an award of 20% permanent partial disability, exactly what was awarded by the Determination Order comparing this case to others involving similar situated injured workers, we find 20% (64°) unscheduled disability to be an appropriate award.

ORDER

The Referee's order dated August 2, 1983 is reversed. The Determination Order dated October 22, 1982 is reinstated and affirmed.

PETER S. McCABE, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01704
February 29, 1984
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Galton's order which set aside its denial of claimant's claim for industrial injury or occupational disease.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated November 2, 1982 is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the SAIF Corporation.

Board Chairman Ferris Dissenting:

I respectfully dissent from the majority opinion. I would reverse the Referee's order in its entirety and affirm the SAIF Corporation's February 10, 1982 denial.

I.

The facts of this case are relatively simple.

Claimant, who was 32 years of age at the time of the hearing, was elected Chief Executive Officer of Local 757 of the Amalgamated Transit Workers Union in Portland, in May 1979. Claimant had no previous experience as a union official and received no assistance from the union's Executive Board. In fact, the Executive Board was generally hostile to claimant.

Claimant worked six and sometimes seven days per week, sometimes for as many as 16 hours per day. Claimant's work entailed substantial amounts of overnight travel. In the fall of 1980 claimant became heavily involved with potential financial irregularities involving union funds. The situation became so serious that claimant was considering filing a lawsuit against the members of the Executive Board.

It is clear from the record that the stress to which claimant was subject was severe. Claimant began to drink heavily, and his cigarette usage increased from one pack a day to almost two-and-one-half packs per day. Claimant also began to experience memory difficulties, headaches and uncharacteristic outbursts of anger.

On the evening of September 24, 1981 claimant was in Eugene for a union meeting. Claimant was notably upset due to a telephone conversation he apparently had with the managing director of the Eugene Transit District. Claimant was admitted to Sacred Heart Hospital in Eugene at 3:46 a.m. the next morning. He was found to have sustained an anterior cerebral aneurysm while engaging in sexual intercourse early that morning. There is general agreement from a medical standpoint that it was this activity which precipitated the rupture of the aneurysm.

II.

The Referee stated, and I agree, that it is difficult to determine whether this claim should be viewed as being based on industrial injury or occupational disease. The Referee went on to state:

> "I conclude the result is the same regardless of whether the claim is classified as involving an industrial injury or an occupational disease."

I agree with that also, except that I would conclude that the claim is not compensable as an industrial injury or an occupational disease. Moreover, unlike the Referee and the majority, I believe that there is a substantial analytical difference depending on how this claim is classified.

If this claim is viewed as a claim based on industrial injury, virtually the only question that need be asked and answered, is whether claimant's ruptured aneurysm arose out of and in the course of his employment with the Amalgamated Transit Workers Union.

Any case dealing with questions concerning "course and scope of employment" would be incomplete without a citation to Rogers v. SAIF, 289 Or 633 (1979). In Rogers the court synthesized the arising out of employment and the course of employment prongs of compensability questions, and stated the ultimate inquiry in course and scope cases to be:

> ". . . is the relationship between the injury and the employment sufficient that the injury should be compensable?" 289 Or at 642.

The court also stated, however, that existing law concerning proximity, causation, risk, economic benefits and other concepts useful in determining work relationship remains applicable. 289 Or at 643. When considering such factors as proximity, causation, risk, etc., can it be said that there is a sufficient relationship between claimant's injury and his employment that the injury should be compensable? The answer in this case is an unequivocal "no."

In Simons v. SWF Plywood Co., 26 Or App 137, 143 (1976), as reaffirmed in Hackney v. Tillamook Growers, 39 Or App 644 (1979), the court adopted the following from 1A Larson, Workmen's Compensation Law 5-200, §25.00 (1980):

> "Employees whose work entails travel away from the employer's premises are held in a majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. * * *" (Emphasis added.)

I would agree with claimant that for purposes of this case, he can be considered a traveling employe. I find, however, that the activity he was engaging in at the time his aneurysm ruptured was certainly a "distinct departure on a personal errand," thus consti-

tuting a deviation from his employment.

There is a rich vein of case law dealing with the question of deviations. The general rule that can be extracted from all of these cases is that for workers who have well-defined duties, times and places of employment, even minor deviations will take the worker outside the limits of employment connectedness. Seidl v. Dick Niles, Inc., 18 Or App 332 (1974). Conversely, workers with positions involving wider latitude are allowed to engage in more substantial deviations before the work connectedness requirement will be broken. Boyd v. Francis Ford Inc., 12 Or App 26 (1973); Fowers v. SAIF, 17 Or App 189 (1974); Simons v. SWF Plywood Co., supra. Nevertheless, even in the case of traveling employes who have positions involving few restrictions on their time, movement and duties, distinct departures can still occur which will take the employe outside the ambit of coverage.

And they have. Hackney v. Tillamook Growers, supra; O'Connell v. SAIF, 19 Or App 735 (1974).

The claimant in Hackney was a long-haul truck driver who injured his arm while arm-wrestling with a co-worker while drinking beer and watching television during a 5 1/2 hour delay in work activities. The court affirmed the denial of coverage, finding that a distinct departure on a personal errand occurred.

In O'Connell, claimant left on a business trip from St. Helens to Seaside. Claimant took along a female companion and completed the business portion of his trip at noon. Claimant and his companion spent the remainder of the afternoon eating, shopping and walking on the beach. In the evening, claimant and his companion had dinner with friends, at which time a considerable amount of alcoholic beverage was consumed. Claimant was injured that evening in a car accident while returning to St. Helens. Finding that a departure had occurred, the court affirmed the denial of coverage.

The most recent case dealing with traveling employes appears to be Slaughter v. SAIF, 60 Or App 610 (1982). The claimant in Slaughter was a long-haul truck driver who had unloaded a cargo at Las Vegas and proceeded to Indio, California where he had another load to pick up. Upon arriving in Indio, claimant telephoned his employer who directed him to stay overnight and to telephone for further instructions in the morning. With nothing to do, claimant went to a nearby tavern and was seriously injured in an altercation. The court stated that in the case of traveling employes, injuries sustained are compensable when they result from activities "reasonably related" to the worker's travel status. 60 Or App at 615, 616. Since claimant was forced to layover for the evening and his need to kill time arose out of necessity, at the instruction of his employer, claimant's action in passing the time in a tavern was found not unreasonable. Hackney was distinguished on the basis that the claimant in that case disregarded his dispatch instructions and proceeded on a personal errand. 60 Or App at 614.

Although the court in Slaughter found the claim compensable, it cautioned that coverage was not infinite. It stated:

> "The broader coverage is not, however, unlimited. Although a traveling employe will remain covered while engaged in some

> personal activities such as eating or sleeping, he will not be covered while engaging in other personal activities that are a 'distinct departure on a personal errand.'" (Citations ommitted.) 60 Or App at 610.

See also Wallace v. Green thumb, Inc., 296 Or 79 (1983), where the court stated:

> "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)." 296 Or at 83.

I would conclude that claimant's activities at the time he sustained a ruptured aneurysm were a clear and distinct departure of the most personal nature. I can see no business connection whatsoever between claimant's injury producing activity and his employment. Additionally, I do not believe that the injury producing activity in this case was of the type which the Slaughter court would have contemplated as compensable, even for a traveling employe.

Claimant argues that given situations such as Boyd, where a .37 blood alcohol content was not considered a deviation, claimant's injury producing activity in the current case can hardly be considered a deviation. The difficulty with this argument is that cases such as Boyd, Simons and Slaughter are easily distinguishable as there was at least some relation between employment and the injuries, even considering the deviation. Conversely in O'Connell, a case with some factual similarities to Boyd and Simons, coverage was appropriately denied as there was no employment relation present whatsoever. Nor am I persuaded by claimant's citation to several California cases allowing coverage in situations which would appear to involve even more substantial deviations than that in the current case. I do not believe those cases would be compensable under Oregon law, and they are probably questionable even under California law.

I find Hackney, O'Connell and the relevant language from Slaughter to be controlling in this case. I would affirm SAIF's denial on the basis that claimant had left his employment and was involved in a personal errand at the time he ruptured his aneurysm.

III.

If this claim is viewed as a claim based on occupational disease rather than industrial injury, claimant must satisfy the requirements of James v. SAIF, 290 Or 343 (1981) and Dethlefs v. Hyster Company, 295 Or 298 (1983). In occupational disease cases involving issues of compensability, it is not so much a question of where the disability occurs, as it is one of the relative amount of work contribution. I will concede that the evidence establishes that claimant experienced a significant amount of stress which was related to his employment. I will also concede that claimant experienced minimal non-employment related stress. However, the fact that claimant experienced substantial amounts of work-related stress does not necessarily establish, ipso facto, that this stress was the major cause of his condition. In other words, medical causation is still a factor to consider.

The question of medical causation in this case boils down to a determination of whose opinion is more convincing, Dr. Uhland's or Dr. Raaf's. It should be noted at this time that neither Dr. Uhland nor Dr. Raaf treated or examined claimant.

Dr. Uhland testified to the effect that claimant's work-related stress was the major cause of his ruptured aneurysm. He stated that claimant was probably born with a weak spot in his blood vessel, and that the stresses claimant was experiencing at work resulted in high blood pressure, which caused a thinning of the wall of the aneurysm. Dr. Uhland stated that this thinning resulted in "micro-bleedings" which he believed were explanatory of claimant's behavioral changes and memory difficulties, and that this entire process culminated on the night of September 25, 1981. Dr. Uhland agreed that the aneurysm ruptured during sexual intercourse, but he felt that the aneurysm would not have ruptured as soon as it did in the absence of claimant's work stress.

Dr. Raaf testified that an aneurysm generally expands with age, and that as it expands the walls undergo a thinning process. He stated that as the walls get thinner, a rise in blood pressure can precipitate a rupture of the aneurysm. Dr. Raaf stated that a high percentage of aneurysms rupture during sexual activities, and he was of the opinion that a rise in claimant's blood pressure as a result of these activities on the morning of September 25, 1981 was the cause of the aneurysm rupture. Dr. Raaf stated that he was unaware of any scientific evidence which would support the proposition that intermittent elevations in blood pressure were responsible for the thinning process of the aneurysm wall, as opposed to age.

The Referee rejected Dr. Raaf's testimony. I assume the majority does also. The ostensible reasons the Referee gave for doing so were that Dr. Raaf did not have a complete and accurate medical history concerning claimant's personality changes which occurred before the aneurysm ruptured, and that Dr. Raaf "simply did not know if an aneurysm expands at all upon blood pressure increasing and that if the aneurysm does so expand, whether it would return to its prior size when the blood pressure decreases to 'normal.'"

Unlike the Referee, I would reject the testimony of Dr. Uhland

and find that of Dr. Raaf to be persuasive. I disagree completely with the Referee's characterization of Dr. Raaf's testimony. Dr. Raaf did not testify that he "simply" did not know if an aneurysm underwent intermittent expansion and contraction with intermittent elevations in blood pressure. Dr. Raaf testified that he was aware of no scientific information which would support such a theory. It is interesting that Dr. Uhland pointed to no such supportive information during his testimony.

Additionally, if there is any scientific support for the micro-bleeding theory, considering his background and credentials, I would expect Dr. Raaf would certainly have been aware of it. Dr. Raaf is a board certified specialist in neurosurgery. He received his M.D. from Stanford, was with the Mayo Clinic for five years, received a Ph.D. in neurological surgery from the University of Minnesota and has been in private neurosurgical practice since 1941. From his testimony, it is clear that Dr. Raaf's practice includes treatment of patients with ruptured aneurysms. Dr. Uhland is board certified in internal medicine. He described his speciality as the non-surgical care of adults. Although he practiced internal medicine privately for nine years, he has basically been employed in a hospital administrative position for many years prior to the hearing. At the time of the hearing, Dr. Uhland had left this position due to a "difference in philosophy." Based on the record, it is unclear whether Dr. Uhland has even treated anyone with a cerebral aneurysm. I understand cerebral aneurysms to be a neurological and/or neurosurgical problem. Expertise is a consideration in a case such as this, and I find Dr. Raaf to be the heavy favorite indeed in this regard.

I also disagree with the Referee's statement that Dr. Raaf's opinions were based on an incomplete history. It is true that Dr. Raaf testified that he had not read Exhibit 33 prior to the hearing. However, nearly all of the facts contained in that exhibit are generally contained in the remainder of the exhibits with the possible exception of the indication of a personality change in claimant just prior to the rupture of the aneurysm. In addition, Dr. Raaf did hear a portion of the testimony concerning these personality changes and was presented with a hypothetical question which took these factors into account. Dr. Raaf answered that these facts would not change his opinion.

One additional factor, which is not mentioned in the Referee's order, concerns the opinion of Dr. Mundall. It appears from the record that Dr. Mundall was the head of the team of physicians who treated claimant at Sacred Heart Hospital following the rupture of his aneurysm. On January 28, 1982 Dr. Mundall reported:

> "In my opinion, [claimant's] condition was not likely to be due to the work he was performing for the Amalgamated Transit Union but was rather a natural progression of a weakening in the wall of his blood vessel that he was probably born with and then precipitated by physical exertion."

This appears to be virtually identical to the opinion of Dr. Raaf. The Referee does not explain why he did not find Dr. Mundall's opinion of any relevance. Although this is not necessarily a case where a treating physician is in any better position to render a cogent opinion than a medical consultant, Hammons v. Perini Corp., 43 Or App 299 (1979), I consider Dr. Mundall's opinion to lend

further support to the opinion of Dr. Raaf.

To summarize, I find Dr. Raaf's expertise in this area of medicine to be substantially superior to that of Dr. Uhland. Dr. Uhland's theory concerning micro-bleedings is novel, but it appears to be little more than unsupported speculation for which Dr. Raaf indicated there is no objective scientific support. It was Dr. Raaf's opinion (and apparently Dr. Mundall's) that the ruptured aneurysm was due to a congenital condition which worsened with age, and that the rise in blood pressure coincident with claimant's activities on the morning of September 25, 1981 caused the aneurysm to rupture, not claimant's work stresses. I find Dr. Raaf's opinion cogent and persuasive, and I accept it over that of Dr. Uhland. Claimant's occupational disease claim, therefore, fails due to a lack of convincing medical evidence.

Based on the above, I would conclude that claimant failed to establish the compensability of his claim as an industrial injury, and additionally failed to establish the compensability of his claim as an occupational disease. I would reverse the Referee's order in its entirety and reinstate SAIF's denial.

ROY G. McCONNELL, Claimant
Emmons, et al., Claimant's Attorneys
Lindsay, Hart, et al., Defense Attorneys

WCB 82-04764
February 29, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The insurer requests review of Referee Johnson's order which found claimant's left upper arm, shoulder and neck condition compensable. The insurer contends that these disputed conditions are not related to claimant's compensable lower arm injury in November 1978.

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

Claimant contends that his left upper arm, shoulder and neck problems in 1982 are related to his 1978 injury and that he has had left shoulder symptoms since the 1978 incident. The insurer argues that claimant's 1978 injury only involved his elbow and forearm and points to the lack of shoulder complaints in Dr. Martin's 1978 and 1979 chart notes or in Dr. Fitchett's report.

In assessing these respective positions, we find Dr. Martin's May 20, 1982 chart note most illuminating. It states:

> "I talked also with [claimant] about his own personal reluctance to speak up when he should, such as when he was told by the supervisor to do some work that he wasn't capable of doing. Also, about talking with his doctors, [claimant] seems to be rather reluctant and passive about making complaints to his physicians of the degree of discomfort that he is in."

This entry and the record as a whole persuade us that claimant is a relatively stoic individual who was reluctant to complain to doctors about the extent of his arm and shoulder problems until

they became severe. This assesment, combined with the Referee's credibility finding, leads us to agree with the result reached by the Referee.

ORDER

The Referee's order dated July 28, 1983 is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the insurer.

TRAVIS N. McMILLEN, Claimant
Roll & Westmoreland, Claimant's Attorneys
Macdonald, et al., Defense Attorneys

WCB 82-11143
February 29, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Williams' order which upheld the SAIF Corporation's December 3, 1982 denial of claimant's alleged left leg and back conditions. The issue for review is compensability.

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

Claimant argues that the Referee failed to consider the uncontradicted opinions of Dr. Nash which are generally supportive of compensability. It is true that the Referee's order does not discuss the opinions of Dr. Nash. However, our reading of the Referee's order satisfies us that his ultimate conclusion must have been based on a conclusion that claimant's testimony was not completely credible, claimant's arguments to the contrary notwithstanding. We cannot say that such a finding is unsupported on this record.

It would appear that Dr. Nash's opinions concerning causation are based almost entirely on claimant's history. Both the court and this Board have previously stated that a physician's conclusions are only valid to the extent that the patient's history is complete, accurate and truthful. Miller v. Granite Construction Co., 28 Or App 473 (1977); Melodie A. Gage, 34 Van Natta 1245 (1982). Additionally, Dr. Nash's opinions appear to be little more than a recitation of claimant's own conclusions and offer little in the way of medical explanation. Such "medical opinions" are generally not persuasive. Moe v. Ceiling Systems, 44 Or App 429 (1980). For example, Dr. Nash reports that claimant's current back problem involves the L3-4 area, that claimant has spinal canal stenosis at that level and that there are filling defects associated with posterior intrusion of bone into the lumbar canal narrowing the interspace at L3-4. Dr. Nash fails to explain how the driving activities claimant did in performing his work for a relatively short period of time could have caused bone intrusion and stenosis.

For the reasons recited above, we find that the Referee reached the proper conclusion, and we affirm his order.

ORDER

The Referee's order dated August 19, 1982 is affirmed.

DONALD G. SANDBERG, Claimant
Pozzi, et al., Claimant's Attorneys
Lindsay, Hart, et al., Defense Attorneys

WCB 82-10128
February 29, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The employer requests review of Referee Fink's order which granted claimant an award of 64° for 20% unscheduled disability to his back. The employer does not contest the extent of claimant's disability, but rather argues that the Referee erred in sua sponte determining that claimant's disability was the result of a May 1982 new injury rather than a result of an aggravation of a May 1981 compensable injury. We agree and thus modify the Referee's order.

Claimant compensably injured his low back on May 1, 1981. The claim was accepted and closed by a Determination Order which granted time loss but no award for permanent disability. Claimant returned to work for this employer as a truck driver. In May 1982 claimant drove his truck to Vancouver, British Columbia. Claimant began to experience mid back pain, allegedly because of the bouncing involved in that trip. The employer accepted and processed the 1982 pain complaints as an aggravation of the 1981 injury. A Determination Order issued on October 15, 1982, closing the 1982 aggravation claim, which awarded claimant time loss but no award for permanent disability. This second Determination Order listed the date of injury as May 1, 1981. Claimant requested a hearing contesting this second Determination Order.

At hearing no party raised the issue of whether the May 1982 incident was an aggravation of the May 1981 injury or was a new injury. However, in his order, the Referee sua sponte held that the May 1982 incident was a new injury. We conclude that the Referee erred in unilaterally recasting this claim without that issue being raised. As we said in Michael R. Petkovich, 34 Van Natta 98 (1982):

> "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."

ORDER

The Referee's order dated July 12, 1983 is modified. Claimant is awarded 64° for 20% unscheduled disability as a result of his May 1, 1981 compensable injury.

MARY STONE, Claimant
Galton, et al., Claimant's Attorneys
Moscato & Meyers, Defense Attorneys

WCB 82-03564
February 29, 1984
Order on Review

Reviewed by the Board en banc.

Fred Meyer, Inc., the employer herein, requests review of Referee Williams' order which: (1) Reversed the employer's denial of claimant's psychological condition claim; (2) ordered the employer to provide treatment at the Northwest Pain Center and to otherwise process the claim in accordance with law; (3) set aside the Determination Order previously closing the claim as being premature; and (4) awarded an employer-paid attorney's fee of $1300.

The employer contends that: (1) Claimant's psychological condition is not compensable; (2) the treatment at the Northwest Pain Center is for the psychological condition, and therefore, is not related to a compensable condition; (3) even if the condition is compensable, the Northwest Pain Center treatment is not necessary; (4) even if the psychological condition is compensable, the Determination Order should not have been set aside, but rather the claim should have been reopened effective the date of claimant's entry into the Center's program; and (5) in any event, since the Referee's order set aside a Determination Order and reversed a denial, thereby resulting in payment of additional temporary total disability, the attorney's fee should be apportioned between an employer-paid fee and a percentage of the time loss resulting from the Referee's order, as provided in Charles A. Murray, 34 Van Natta 249 (1982).

In addition, on review claimant has submitted a request for remand for consideration of new evidence. The evidence in question is the discharge report following claimant's participation in the Northwest Pain Center's program pursuant to the Referee's order. Based upon this and other evidence, claimant contends that even if the psychological condition is not compensable, the treatment at the Northwest Pain Center was reasonable and necessary treatment for the physical aspect of claimant's injury.

Thus, the issues are: (1) Whether the psychological component of claimant's condition is a compensable consequence of the accepted injury; (2) if not, whether to remand for consideration of new evidence; (3) whether the treatment at the Northwest Pain Center is reasonable and necessary treatment for a compensable condition; (4) whether the Referee erred in setting aside the Determination Order as premature; and (5) whether the attorney's fee awarded by the Referee should be apportioned between an employer-paid fee and a percentage of the resulting time loss.

As far as they go, we adopt the Referee's findings of fact as follows:

> "Claimant is now a 51-year-old female worker who on February 20, 1979 suffered an accepted disabling injury involving her low back. She was treated conservatively with some success but her symptoms persisted and have been disproportionate to her physiological condition. As early as February, 1981 an orthopedic surgeon to whom her

> treating physician had referred her felt that her complaints were intensified by tension and depression. In March of 1981 at the request of the employer the claimant was examined by Doctors Kloos, Halferty and Marble of Orthopaedic Consultants who strongly recommended that claimant be referred to a pain center for both psychological evaluation and possible treatment. Since that time similar recommendations have been received by claimant's treating physician, Dr. Ronald Rohlfing; her registered physical therapist, Carol Conrades; Dr. Duff, an orthopedic surgeon; and Rogers J. Smith, psychiatrist. Dr. Smith opined that claimant suffered psychiatric disorder and drug overuse directly related to her accepted disabling compensable injury and indicated that she would need active psychiatric and medical therapy for her depression and pain for a period of at least six to twelve months."

In addition, the record indicates that a psychiatrist, Dr. Stolzberg, examined claimant and opined that claimant's psychological condition was medically stationary, that claimant's personality profile was in no way related to or aggravated by the industrial injury, but that claimant's personality profile made her "vulnerable to exaggerated somatic complaints out of proportion to findings."

After closure of the record following hearing before the Referee, the Referee reopened the record and ordered that claimant be evaluated by the Northwest Pain Center. After receipt of the Pain Center's evaluation report, the Referee reclosed the record and issued his order.

I.

With respect to the compensability of the alleged psychological condition, we are satisfied that the psychological component of claimant's condition is a compensable consequence of the accepted injury. We are not entirely persuaded that claimant has a separate, identifiable psychological condition. However, we are certain that as a result of the interaction between claimant's injury and her personality, or claimant's psychological reaction to the residuals of the injury, she experiences pain disproportionate to objective findings. We also are certain that the injury itself is a material factor in the pain that claimant experiences; therefore, the pain is compensable and treatment reasonably intended to resolve that pain is compensable.

In finding that claimant experiences what could be termed as functional overlay, see Barrett v. Coast Range Plywood, 294 Or 641 (1983), and that it is compensably related to her industrial injury, we are most persuaded by the initial report of the Orthopaedic Consultants, as well as the reports of claimant's treating physician and Dr. Dennis, Dr. Duff and the physical therapists who have treated claimant. For the reasons outlined in the employer's brief, Dr. Smith's report is not a model of persuasiveness, but it does tend to confirm what the rest of the record,

exclusive of Dr. Stolzberg's report, indicates concerning whether claimant has a compensable psychological component of her accepted injury.

It follows from our conclusion concerning the compensability issue that the treatment at the Northwest Pain Center is compensable in that it is causally related to the accepted injury. There is some suggestion in the record that the treatment may be unnecessary because similar treatment modalities had been tried on claimant and found unsuccessful. However, given the unique multidisciplinary and "on-campus" treatment approach of the Pain Center, we cannot say the treatment was unreasonable or unnecessary.

Having found that claimant's psychological condition is compensable, we do not reach claimant's motion to remand for consideration of new evidence.

II.

Citing Charles A. Murray, 34 Van Natta 249 (1982), the employer contends that even if we find the psychological condition compensable and the treatment at the Northwest Pain Center appropriate, nevertheless, the Determination Order should be affirmed and the claim merely reopened effective the day claimant began participation in the Center's program. While the facts of Murray and this case are remarkably similar, they are different in one significant area: Apparently in Murray, the first real indication that the claimant was affected by functional overlay came after the claim had been initally closed and while the claimant was engaged in vocational rehabilitation. Here, claimant's depression and suggestions for treatment with mood altering medication were mentioned as early as February 1979. Similar references to the role of claimant's psychological makeup and need for treatment for that aspect of her condition were reiterated by virtually every physician who examined claimant thereafter (except Dr. Stolzberg). The Orthopaedic Consultants "strongly recommended" a referral to the Pain Center in March 1981 for psychological evaluation as well as weaning from drugs. There is a plethora of other evidence that could be cited, but it is sufficient to state that the preponderance of the evidence establishes that the psychological component of claimant's condition was not medically stationary when the April 1982 Determination Order issued. In view of our finding that claimant's psychological condition is compensable, it follows that the Referee correctly set aside the Determination Order.

III.

The last issue is whether the Referee erred in failing to apportion the award of attorney fees between an employer-paid fee, related to claimant prevailing on a partial denial, and a percentage of the increased time loss claimant presumably will receive because the Determination Order was set aside.

There is dicta in Charles A. Murray that supports the employer's position here. 34 Van Natta at 251. However, that dicta has to be understood in light of the facts of the Murray case. In Murray the insurer had never denied a psychological claim; indeed, the claimant did not claim that he had one. The only issue in Murray was the compensability of proposed treatment at the Northwest Pain Center. Here, by contrast, it is clear that claimant is alleging a psychological condition, or at least a

psychological component to her condition, as well as extended psychological treatment. Also, the employer has denied liability for any psychological condition or disability or treatment related to a psychological condition. Moreover, the Determination Order was set aside by the Referee not because he found that claimant was not medically stationary orthopedically but because claimant was not stationary with respect to the psychological component of her condition. It was a mere fortuity that the Determination Order issued prior to the hearing on the partial denial. Had the Referee decided the partial denial question prior to the Determination Order issuing, there would be no question but that claimant would be entitled to an employer-paid attorney's fee without reference to time loss that might result in the reversal of the denial. In short, there is no reason to treat this case any differently than other cases where the only issue presented is the propriety of a partial denial. When such denials are set aside we do not apportion the resulting award of attorney fees between the employer/insurer and the claimant by deduction of a percentage from time loss resulting from the reversal.

Here, it does not readily appear that claimant will have any additional time loss other than during the period of time she was participating in the Pain Center's program. While claimant may have been experiencing more pain than that justified by objective findings, she appears to have been released to return to work. We assume that this is the reason that claimant has not taken issue with the Referee's action in allowing the employer to take an offset arising from the claim in April 1982 and at the same time setting aside the April 1982 Determination Order.

Under the facts of this case the Referee properly awarded a wholly employer-paid attorney's fee.

ORDER

The Referee's order dated November 10, 1982 is affirmed. Claimant's attorney is awarded $850 on Board review, to be paid by the employer.

Board Member Barnes Dissenting in Part:

I respectfully disagree with that portion of the majority's order which concludes that all of claimant's attorney's fees must be paid by the self-insured employer; I express no view on the other issues raised on review.

In Charles A. Murray, 34 Van Natta 249 (1984), we stated:

> "When a partial denial and a Determination Order are both set aside, resulting in payment of greater temporary total disability benefits, then a total attorney fee should be apportioned between that amount to be carrier-paid because claimant prevailed on the partial denial and that amount to be claimant-paid out of the increased time loss benefits."

The Board majority calls this "dicta" and apparently also regards

Murray as factually distinguishable. Of course, if what we said in Murray is not binding -- either because it is "dicta" or because of a lack of commitment to stare decisis -- then there is no need to "distinguish" Murray; and the Board majority's effort to do so will probably create the impression that apportionment of fees is proper in some cases but not in other cases, albeit without any comprehensible guidance about when to apportion fees.

I would adhere to what we said in Murray, apply Murray in this case and, based on Murray, modify the Referee's order to apportion claimant's attorney's fees between the self-insured employer and claimant.

RAYMOND F. WALTON, Claimant
Evohl Malagon, Claimant's Attorney
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11734 & 82-11733
February 29, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Johnson's order which affirmed the December 10, 1982 aggravation claim denial issued by the SAIF Corporation; affirmed the January 18, 1983 aggravation claim denial issued by EBI Companies; and denied claimant's request for penalties and attorney fees against both insurers. The issues for review are the compensability of claimant's aggravation claims and entitlement to penalties and attorney fees against both insurers. Additionally, claimant requests that this matter be remanded for the admission of additional evidence.

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

The Referee concluded that, although claimant had established a worsening of his back condition since his last award of compensation, he had not established any causal connection between his worsened condition and his October 2, 1981 or March 21, 1982 industrial injuries. We agree with the Referee that claimant has failed to establish that his current condition is related to either one of his prior compensable injuries. None of the medical reports relevant to claimant's aggravation claim make even the slightest attempt to relate claimant's condition to either injury.

In addition, we conclude that claimant has also failed to establish that he has actually suffered a worsening. The circumstances and medical evidence surrounding claimant's alleged back difficulties beginning in September 1982 generally indicate that claimant's actual problem at that time was due to an unrelated viral problem. There are certain inconsistencies in the record in this regard, and the Referee stated that he questioned whether claimant was an entirely credible witness. In any event, the physicians who examined claimant appear to have been more concerned with claimant's viral problems, and there are virtually no objective findings concerning claimant's back.

Claimant's request for remand is denied. The evidence proffered does not convince us that this case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). See Myrtle E. York, 36 Van Natta 23 (1984). In fact,

the evidence claimant would have admitted on remand appears more adverse than favorable to his position.

ORDER

The Referee's order dated May 25, 1983 is affirmed.

MATHILDA D. WILLIAMSON, Claimant
Rolf Olson, Claimant's Attorney
Miller, et al., Defense Attorneys

WCB 82-08506
February 29, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

The insurer has requested Board review contending that the case should be remanded to the Referee for the admission of further evidence or, in the alternative, that Referee Quillinan's order setting aside its September 2, 1982 denial of claimant's bilateral carpal tunnel disease, right wrist ganglion, and right index finger condition should be reversed.

The issue at hearing was compensability. Claimant contended that her work activity had caused the conditions, while the insurer contended that the cause of claimant's conditions was not work-related. There was some evidence of a prior right-hand injury that claimant sustained in June 1981 when she fell from a mechanical bull. Her testimony regarding that incident was that it had involved her right index finger and thumb only, and that she had made a full recovery. There was no medical evidence from her treating physician, Dr. Teal, alluding to the June 1981 injury and its location or severity. In fact, Dr. Teal indicated in one report that there was no evidence of trauma outside of claimant's work activities that could be a source of her problems. Later, however, after the insurer began to process the claim pursuant to the Referee's order, it received chart notes from Dr. Teal indicating that claimant had sustained a severe sprain in her right wrist along with torn tendons in the web of her thumb as a result of the June 1981 mechanical bull fall. One chart note indicates that the injury caused some impairment.

It is significant in this case that this off-the-job injury occurred only six months prior to the time claimant states that her right index finger, thumb, and wrist began hurting due to work activity. We find that the absence of any medical documentation as to claimant's June 1981 right-hand injury, Dr. Teal's failure to mention the location, significance and severity of that injury, and the consulting doctors' ignorance of such an injury when rendering their opinions about causation of claimant's condition indicate that the record in this case has been incompletely developed. It is not known why the chart notes were not supplied to the parties earlier, but it does not appear that their absence was the fault of the insurer. Therefore, we order this case remanded to the Hearings Division for the taking of additional evidence regarding claimant's June 1981 fall from the mechanical bull and the effect this accident had on the conditions denied by the insurer.

ORDER

This case is remanded to the Hearings Division for additional evidence taking in accordance with this order.

RONALD J. GAZELY, Claimant
Carney, et al., Claimant's Attorneys
Howard Cliff, Defense Attorney
David Horne, Defense Attorney

WCB 82-07310 & 82-10541
March 2, 1984
Order on Review (Remanding)

Reviewed by the Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Knapp's order which: (1) Affirmed Industrial Indemnity's August 5, 1982 denial of a new low back injury which allegedly occurred on June 21, 1982; (2) affirmed Wausau's November 9, 1982 denial of an aggravation of a compensable December 4, 1975 low back injury; and (3) awarded no penalties or attorney fees for Wausau's failure to provide complete discovery to claimant pursuant to OAR 436-83-460.

Further, claimant requests that this case be remanded to the Referee for consideration of: (1) Evidence that would have been before the Referee had complete discovery been made; and (2) new evidence of claimant's condition that was generated after the hearing.

We affirm the Referee's approval of Industrial Indemnity's denial of a new injury for the reasons set out in his order. We affirm on the issue of penalties and attorney fees for Wausau's failure to provide complete discovery to claimant.

Claimant has requested that we remand this case for additional medical evidence of an objective finding of disc herniation in claimant's lower back. The primary reason for the Referee's holding affirming Wausau's denial of claimant's low back aggravation claim was that there was insuffient objective evidence of a worsening to substantiate claimant's subjective complaints. Prior to the hearing in this case, X-rays of claimant's lower spine had failed to show any specific cause for the claimant's complaints of pain. However, within days of the hearing claimant visited a new physician, Dr. Thomas, who ordered that a CT scan be performed on claimant. He had not received a CT scan previously. That test revealed a central herniated disc at L4-L5. Claimant was then referred to a new neurologist, Dr. Misko, who ordered a myelogram to ascertain the presence of lumbar stenosis and disc protrusion. The myelogram confirmed the presence of an anterior and anterio-lateral herniated nucleus pulposus at L5-S1. Dr. Misko noticed that this is the identical location of the previous herniated disc caused by the compensable 1975 injury. Dr. Misko's opinion is that the claimant is suffering from a recurrent protruded disc, and that this condition is related to his industrial injury of December 4, 1975 and his subsequent lumbar laminectomy.

We find remand appropriate in this case because the facts are similar to those in Egge v. Nu-steel, 57 Or App 327 (1982), in which remand was granted. Like the claimant in Egge, this claimant had not had the medical tests performed that would reveal an objective cause for his worsening until immediately after the hearing. In another case regarding remand, Bailey v. SAIF, 296 Or 41 (1983), the court has stated that as an administrative board we should be flexible in our search for accurate facts and just conclusions when determining whether it is appropriate to remand in a particular case. See also Edith Grimshaw, 36 Van Natta 63 (January 26, 1984).

In this case, the Referee was unaware of any objective evidence of claimant's condition and, in large part, he based his approval of Wausau's denial of aggravation on the absence of objective evidence. We find, therefore, that the case has been incompletely developed and heard by the Referee and remand to the Hearings Division for further evidence taking regarding the newly developed evidence concerning the condition of claimant's lower back. ORS 656.295(5).

ORDER

We affirm that portion of the Referee's orders dated February 1, 1983 and March 13, 1983 which approved Industrial Indemnity's August 5, 1982 denial of new injury. We affirm that portion of the orders which denied penalties and attorney fees for Wausau's failure to provide discovery to claimant. We vacate that portion of the Referee's orders which approved Wausau Insurance Company's November 9, 1982 denial of aggravation of claimant's low back condition and remand this case to the Hearings Division for further evidence taking on that issue. If the claimant prevails on the issue of compensability of his aggravation claim before the Referee, the Referee shall award an attorney's fee taking into consideration the services rendered by claimant's attorney at the original January 3, 1983 hearing, before this Board and at hearing on remand. ORS 656.388(1).

HOWARD DEAN, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05128
March 7, 1984
Order on Review (Remanding)

Reviewed by the Board en banc.

The SAIF Corporation requests review of those portions of Referee Baker's order which set aside the Determination Order dated August 18, 1982 as premature and set aside SAIF's denial to the effect that claimant's diabetes was not worsened by his November 1979 industrial injury.

Claimant suffered a compensable injury to his neck, left shoulder and left arm on November 15, 1979. On November 29, 1979 a cervical laminectomy and discectomy was performed. About the time of the surgery, a mass was detected near claimant's left collarbone. This mass has continued without a clear diagnosis, and apparently is the major cause of claimant's continuing problems.

Through numerous examinations, diagnostic tests and further disc surgery, the pain in the area of claimant's left shoulder has persisted. Except for some initial physical therapy, claimant has resisted psychological evaluation, physical therapy or pain therapy.

In August 1981 Dr. Jefferson, claimant's treating physician, reported that he was still not convinced that an adequate diagnosis had been made.

In October 1981 Dr. Smith, the neurosurgeon who had performed claimant's last disc surgery, reported that he had advised claimant

that he had nothing further to offer him. At that time he pronounced claimant medically stationary.

In November 1981 claimant was evaluated by Orthopaedic Consultants. They concluded that claimant's condition was not medically stationary and that further evaluation and treatment was indicated. They found some fullness in the supraclavicular area. The doctors agreed that the diagnosis was still inadequate. They did note that claimant had not cooperated in the psychological phase of the examination.

Subsequently, a Doppler venous examination, a thoracic aortogram and a left arm venogram were performed. The results were normal. The mass in claimant's shoulder area remained undiagnosed.

Claimant was reexamined by Orthopaedic Consultants on June 30, 1982. The Consultants reported that they had no other medical treatment to recommend, except that the claim be considered stationary and closed. The doctors recommended that claimant decrease his drug intake; if the medication could not be reduced by other means, they recommended pain center treatment, which claimant had previously refused. Finally, they reported that the supraclavicular mass was not apparent at the time of their examination.

A Determination Order issued August 18, 1982 terminating time loss compensation as of June 30, 1982, the date of claimant's reexamination by Orthopaedic Consultants, and a date that was about 32 months post-injury.

By letter dated August 20, 1982, Dr. Jefferson reported that it was clear from the beginning that claimant was experiencing true pain and was not malingering. He noted that he had asked SAIF to refer claimant for another diagnostic evaluation in the Portland area. Although no one had yet been able to diagnose claimant's condition, the doctor felt that claimant's condition could be diagnosed.

In October 1982 Dr. Butters, an orthopedist, reviewed claimant's medical records and consulted with Dr. Jefferson. Dr. Butters opined that claimant suffered from an upper extremity pain syndrome started by brachial plexus scarring or stretching in the supraclavicular area. Dr. Butters concluded that claimant's condition demanded a multidisciplinary pain center approach. He felt that if any exploratory surgery was performed it must be preceded by cooperative pain center approach with claimant actively participating.

In November 1982 Dr. Jefferson reported that claimant was afraid to go to the pain center because claimant was convinced that any therapy on his shoulder would merely aggravate his condition. He further reported that claimant merely wanted a diagnosis of his condition and would, if need be, submit to exploratory surgery just to obtain a diagnosis. The doctor advised that claimant was prepared to live with the pain if the doctor told him nothing could be done.

Dr. Jefferson suggested that exploratory surgery be performed

without the pain center approach. The doctor concluded that without further treatment claimant was 100% disabled from the injury and its resulting pain.

The Referee found that the claim was closed prematurely and that claimant should not be considered medically stationary. The Referee noted that this conclusion was supported by claimant's primary treating physician as well as specific recommendations for further evaluation and treatment (exploratory surgery).

SAIF contends that claimant has not met his burden of proof in establishing that his claim was prematurely closed. We agree.

The possibility of exploratory surgery was first broached by Dr. Butters. However, Dr. Butters made it clear that he would not recommend (and, we infer, would not perform) surgery until claimant had participated and cooperated in a pain center approach. We cannot infer from this record that claimant is willing to submit to further treatment or exploratory surgery on Dr. Butters' terms. Thus, the irresistable force meets the immovable object: A doctor who will not provide treatment on the patient's terms and a patient who will not accept treatment on the doctor's terms. Both doctor and patient undoubtedly have the right to assert their respective positions, but this kind of doctor-patient disagreement hardly establishes premature claim closure.

Dr. Jefferson also suggested pain center intervention at an earlier point in claimant's treatment. Subsequently, Dr. Jefferson endorsed proceeding with exploratory surgery without first exhausting the pain center alternatives. The fact remains that, at least as reflected in this record, no surgeon is willing to proceed on that basis. We do not think that this claim should remain open indefinitely to await the emergence of an unnamed doctor who will immediately perform diagnostic surgery without first requiring claimant to participate in conservative pain therapy.

Furthermore, we are not convinced that the exploratory surgery is likely to improve claimant's condition. The record indicates that, at most, claimant's adjustment to his condition would possibly be improved.

In the approximately three-year period since claimant's injury, he has undergone surgeries, x-rays, CT scans, arteriographs, venographs and other diagnostic tests which have been conducted by medical specialists in a variety of areas. Every medical procedure suggested by any doctor and agreeable to claimant has been performed, with the one exception of exploratory surgery. Despite these thorough examinations, consultations and diagnostic procedures, claimant's condition has remained undiagnosed and his symptoms basically unaltered. No physician has come forth with any curative treatment for this undiagnosed condition. It appears claimant's only continuing treatment has been pain medication.

We find that claimant has failed to satisfy his burden of proving that his claim was prematurely closed. We feel that the evidence indicates that claimant is medically stationary because no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Although we appreciate the genuine desires of claimant and his treating physician for answers to claimant's complaints of pain, we find that claim closure was warranted.

The Board affirms and adopts that portion of the Referee's order that pertains to the compensability of claimant's diabetic condition.

Since the Referee found a premature closure, he did not reach the issue of the extent of claimant's permanent disability. We remand for further proceedings on that issue.

ORDER

The Referee's order dated January 25, 1983 is affirmed in part and reversed in part. Those portions of the order which set aside SAIF's denial of responsibility for the effect of claimant's injury on his diabetes condition are affirmed. Those portions of the order which set aside the Determination Order dated August 18, 1982 as premature are reversed. The Determination Order dated August 18, 1982 is reinstated and affirmed as a proper closure of claimant's claim. This case is remanded to the Referee for further proceedings consistent with this order.

Board Member Lewis Dissenting:

I would affirm the Referee's order which set aside the August 18, 1982 Determination Order as premature.

In finding that claimant's claim was prematurely closed, I rely on the November 17, 1982 report of claimant's treating doctor, Dr. Jefferson, which indicated that claimant was willing to proceed with exploratory surgery. Regarding claimant's fear of a pain center approach, Dr. Jefferson seemed to sympathize with claimant's past experiences with physical therapy which had increased his shoulder pain. Dr. Jefferson's final recommendation was that claimant proceed with surgical exploration and abandon the pain center approach. This recommendation was made about a month before the hearing and the record does not contain any follow-up to Dr. Jefferson's recommendation.

ORS 656.005(17) defines "medically stationary" as "no further material improvement would reasonably be expected from medical treatment, or the passage of time." I cannot say that claimant is medically stationary inasmuch as claimant's treating doctor and others have been unable to diagnose claimant's condition and claimant's treating doctor indicates that further diagnostic approaches should be pursued. Without a diagnosis, claimant's doctor is unable to determine whether further medical treatment would result in material improvement in claimant's condition.

Claimant is genuinely interested in finding a diagnosis and possible treatment of his shoulder problem. If a doctor eventually tells him that nothing can be done for his shoulder, claimant is willing to live with the pain. Claimant's determination to find an answer to his shoulder problem does not seem unreasonable.

The majority states that it cannot infer from the record that claimant is willing to submit to further treatment or exploratory surgery on Dr. Butters' terms. I disagree that claimant has to be willing to submit to surgery on Dr. Butters' terms. Dr. Butters is not claimant's treating doctor and, in fact, has neither treated

nor examined claimant. Claimant's treating doctor recommended exploratory surgery without first going to the pain center, and claimant seems agreeable to this course of action.

I would find that claimant's claim was prematurely closed and would remand the claim to SAIF for referral to a surgeon for surgical exploration of claimant's shoulder. I would affirm the Referee and, therefore, I respectfully dissent.

SAM WILLARD, Claimant
Stan Bunn, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-06802
March 7, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Wilson's order which set aside its denial of claimant's back injury claim. SAIF contends that the claim should be found noncompensable because greater weight should be given to the opinion of claimant's treating orthopedist and surgeon than to the opinion of his treating family physician. We agree and thus reverse the Referee's order.

In early April of 1982 claimant suffered low back and leg pain after teaching tennis classes in connection with his work as a college basketball coach. Claimant went to his family physician, Dr. Kern, who suspected a herniated disc at L4-5. Dr. Kern referred claimant to Dr. Struckman, orthopedist, who performed exploratory surgery. Dr. Kern assisted in the surgery.

Dr. Struckman's reports indicate basically that no significant problem was found at the L4-5 level, but that degenerative changes were found at the L3-4 level. Specifically, no true disc herniation was found at L4-5, and the L4-5 disc space was found to be normal. There is some reference to mild bulging of the L4-5 disc, apparently without nerve root irritation. At the L3-4 level, Dr. Struckman found that the lamina and medial pedicle had overgrown, causing tight entrapment of the nerve root, and apparently producing extreme scarring of the L3-4 nerve root which Dr. Struckman observed. Dr. Struckman relieved this nerve entrapment at the L3-4 level.

Dr. Struckman later reported that the small bulging disc found at the L4-5 level was not the cause of claimant's symptoms. Rather, Dr. Struckman stated that claimant's back and leg symptoms were caused by the significant degenerative changes at the L3-4 level which he found (and corrected) at surgery. In Dr. Struckman's opinion, the tennis teaching incident made claimant become symptomatic but did not cause or worsen his degenerative spinal condition.

Dr. Kern, on the other hand, has expressed a variety of positions. He opined that claimant had an acute strain injury when teaching tennis which caused a disc herniation at L3-4. Dr. Kern further stated that a portion of bone was causing pressure on a nerve root because of the protruded herniated disc below the nerve root. Dr. Kern's assessment is directly contrary to Dr. Struckman's surgical findings that claimant did not have a

herniated intervertebral disc and that claimant's pain was due to the degenerative changes at L3-4.

Given Dr. Struckman's greater expertise as the orthopedic surgeon and given his opportunity to actually see claimant's spinal condition at surgery, we are not persuaded by any of Dr. Kern's various opinions. We therefore conclude that claimant has not established by a preponderance of the evidence that an industrial injury was a material contributing cause of his disability. Harris v. Albertson's Inc., 65 Or App 254 (1983). Although claimant may have been able to establish a compensable injury separate from his noncompensable surgery for an idiopathic condition, see Brooks v. D & R Timber, 55 Or App 688 (1982), neither party asserted such a theory, and we decline to consider it.

ORDER

The Referee's order dated July 8, 1983 is reversed. The SAIF Corporation's denial dated June 1, 1982 is reinstated and affirmed.

RICHARD F. ERZEN, Claimant
Winfree & Noonan, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-01698
March 8, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

EBI Companies, as insurer of Homecraft Construction Company, requests review, and claimant cross-requests review of Referee Mulder's order which found that claimant was a subject worker of Homecraft by operation of ORS 656.029 at the time of his injury and, thus, set aside EBI's denial of claimant's claim for benefits. The insurer contends that claimant was not a subject worker of Homecraft. Claimant raises an issue concerning the Referee's failure to impose a penalty for the insurer's allegedly unreasonable denial.

Claimant formed a partnership with his brother and another individual in January 1981. This partnership was registered with the Corporation Division, Department of Commerce, under the assumed business name of E & M Construction and was engaged primarily in the business of framing new houses. In October 1981 E & M submitted a bid form for the framing of one house to Homecraft. This document, titled "Subcontract Agreement", is a preprinted form containing several recitations, one of which states: "Although the contractor [Homecraft] has control over the quality of all work relating to this project, the subcontractor [E & M] is an independent contractor in all respects; the subcontractor is responsible for his employes, his subcontractors, materials, equipment and all applicable taxes, benefits and insurances."

Homecraft verbally accepted E & M's bid and E & M began performance, but the bid form was not actually signed until January 1982, after the date of claimant's injury. The bid form was one apparently used by E & M for submitting bids to contractors. Another form, apparently supplied by Homecraft to subcontractors in order to obtain information, is signed by claimant's brother and their other partner and is dated August 3, 1981. This form contains the following language directly above the spaces for signature by the subcontractor providing the requested information:

> "To the best of my knowledge, I am a legal subcontractor in the State of Oregon. I am recognized by the Department of Revenue as an employer, as is evidenced above, and agree to pay the required unemployment tax and worker's compensation insurance. As an independently established business, I have either a business location separate from my personal residence or it is in a portion of my home used for the business. I have a separate business telephone and business cards (please attach a card)."

The information provided by the E & M partners indicates that they were doing business as a partnership. In the space for insertion of a workers' compensation insurance policy number, the word "none" is written. "R. W. Fullerton Co." is identified as the workers' compensation insurance company as well as the general liability insurance company. An insurance agent's name and telephone are also provided.

E & M commenced framing the house in November 1981. E & M had no employes, and all of the work was performed by the three partners. On December 19, 1981, while working in accordance with the terms of the parties' contract, claimant fell and sustained the injuries for which he now seeks compensation. By letter dated February 19, 1982, the insurer denied the claim on behalf of Homecraft, stating the following reasons:

> "1. You were not nor ever have been an employe of Homecraft Construction.
>
> "2. You are not a subject worker as defined in ORS 656.027.
>
> "3. You are listed as a partner in the firm of E & M Construction. You did not elect workers' compensation coverage pursuant to ORS 656.128."

The Referee found that claimant was a partner in E & M and thus not a subject worker under ORS 656.027(7); but that claimant was a subject worker of Homecraft by operation of ORS 656.029. The Referee declined to impose a penalty, finding that the insurer's denial was not unreasonable. We agree with the Referee's conclusions with regard to all issues raised on review and, therefore, affirm.

There is a conflict in the evidence concerning E & M's intent to obtain workers' compensation insurance prior to claimant's injury. However, we do not think this conflict is of any relevance. The material facts are that claimant was injured while performing the E & M/Homecraft contract and that E & M did not have workers' compensation insurance at the time of that injury.

All statutory references are to the law in effect at the time of claimant's injury. ORS 656.202(1). ORS 656.029 provides:

> "(1) If any person engaged in a business and subject to this chapter as an employer

> lets a contract involving the performance of labor and such labor is performed by the person to whom the contract was let, with assistance of others, all persons engaged in the performance of the contract are deemed subject workers of the person letting the contract unless the person to whom the contract is let has qualified either as a carrier-insured employer or a self-insured employer.
>
> "(2) If the person to whom the contract is let performs the work without the assistance of others, that person is subject to this chapter as a subject worker of the person letting the contract unless that person and the person letting the contract jointly file with the insurer or self-insured employer a declaration stating that the services rendered under the contract are rendered as those of an independent contractor.
>
> "(3) A person who files the declaration of status as an independent contractor is not eligible to receive benefits under this chapter unless the individual has obtained coverage for such benefits pursuant to ORS 656.128.
>
> "(4) The filing of a declaration of status pursuant to this section creates a rebuttable presumption that the person is an independent contractor."

Most of this statute was enacted by Oregon Laws 1979, Chapter 864, Section 2 (SB 476), which contained what is currently subsections (1), (2) and (3) of ORS 656.029. In 1981 what is currently subsection (4) was added by Oregon Laws 1981, Chapter 725, Section 1 (SB 649), which also made minor editorial changes in the first three subsections. It appears that the only substantive change in 1981 was the addition of subsection (4).

Other relevant statutory provisions are those defining who are "subject employers," ORS 656.023; who are "subject workers," ORS 656.027; the definitions of "employer," "person" and "worker" in ORS 656.005; and the provision for elective coverage by sole proprietors and partners in ORS 656.128.

An employer is defined as: "[A]ny person . . . who contracts to pay a remuneration for and secures the right to direct and control the services of any person." ORS 656.005(14). A "subject employer" is an employer who is subject to the Workers' Compensation Act. ORS 656.023; ORS 656.005(25).

A "worker" is: "[A]ny person, including a minor whether lawfully or unlawfully employed, who is engaged to furnish services for a remuneration, subject to the direction and control of an employer. . . ." ORS 656.005(28). "Subject worker" means a worker who is subject to the Act. ORS 656.027; ORS 656.005(26). There

are numerous subsections exempting various workers from the classification of "subject worker." ORS 656.027(7) (prior to amendment by Oregon Laws 1983, Chapter 579, Section 3) exempts all "sole proprietors and partners" from the classification of subject worker. Partners, therefore, are not subject workers for whom workers' compensation coverage must be provided pursuant to ORS 656.017; however, partners may elect to obtain workers' compensation coverage and thereby obtain the benefits provided by the Act. ORS 656.128.

The insurer in this case argues that the evidence conclusively establishes that claimant was a partner in E & M Construction at the time of his injury, and that the partnership had not elected to provide workers' compensation coverage for the partners pursuant to ORS 656.128. The Referee so found, and we agree. Claimant was, therefore, not a "subject worker," nor was he insured for purposes of workers' compensation coverage under the elective provisions of ORS 656.128.

Given these findings, the insurer argues the Referee erred, having acknowledged claimant's status as a non-subject worker, in setting aside its denial of claimant's claim. The insurer contends that an absurd result was reached by the Referee in construing ORS 656.029 to require the insurer to provide benefits to claimant; that by reading ORS 656.029 as bringing a partnership within the ambit of workers' compensation coverage, the effects of ORS 656.027(7) are vitiated; and that nothing in ORS 656.029 or its legislative history indicates that the provision was intended to have such an effect.

We conclude that the effect of ORS 656.029 is to create a limited exception to ORS 656.027(7).

A review of the 1979 legislative history of SB 476 indicates that there were at least two goals addressed by the bill: Elimination of "phony partnerships" in the construction industry; and elimination of the confusion in workers' compensation law concerning who is an independent contractor as opposed to an employe. "Phony partnerships" were composed of individuals who would form a partnership organization in order to avoid certain costs of doing business, including the cost of workers' compensation insurance, which would enable such partnerships to underbid other business entities that were required to pay such costs and whose bid amount reflected passing such business costs onto those with whom they did business. Minutes, Senate Committee on Labor, Consumer and Business Affairs, April 24, 1979, p. 5. This problem of formation of a particular business organization for the purpose of avoiding certain costs of doing business has not been limited to the building industry. The legislative record of SB 476 indicates that this problem was also a concern in reforestation contracts. See generally Associated Reforestation Contractors, Inc. v. State Workers' Comp Bd. et al, 59 Or App 348, rev den 294 Or 295 (1982).

It apparently was anticipated by the members of the two legislative committees that conducted hearings on SB 476 that a "registration requirement" such as that presently contained in ORS 656.029(3) would serve two purposes. First, and possibly foremost, it would provide a simple test for determining who was an independent contractor and who was a subject worker. If the "independent

contractor" without workers' compensation insurance and the other contracting party filed the declaration contemplated by ORS 656.029(2) and (3), there would be no question concerning the status of the "independent contractor" as actually being that of an independent contractor, one for whom the other contracting party would have no liability for workers' compensation coverage, either in terms of paying a premium or paying for a work-related loss. In the absence of this filing of a declaration of status as an independent contractor, both parties would understand that, although the "independent contractor" might indeed be independent for some purposes, for purposes of workers' compensation coverage the "independent contractor" would be deemed to be the subject worker of the other contracting party.

This contemplated registration procedure was expected to produce a second desired result: Encouraging the purchase of workers' compensation insurance by "independent contractors," including "phony partnerships" who held themselves out as independent contractors. This would be accomplished indirectly by essentially forcing the "employer" to require the "independent contractor" to have or obtain workers' compensation insurance in its own right. It was expected the "employer" would so require in order to avoid the cost of paying a premium for the "independent contractor" in the absence of a declaration filed in accordance with the statute. In other words, the "employer" would avoid having another subject worker by requiring the "independent contractor" to do one of two things: Either obtain its own workers' compensation insurance or file a declaration of status as an independent contractor.

There was a concern expressed about "forcing" someone who would otherwise be considered a subject worker of the "employer" to waive the right to receive benefits under the Act by filing the declaration contemplated by ORS 656.029. Minutes, Senate Committee on Labor, Consumer and Business Affairs, February 27, 1979, p. 3. This concern may explain part of the reason for enactment of what is currently subsection (4) of ORS 656.029, by Oregon Laws 1981, Chapter 725, Section 1, discussed more fully below. See Minutes, Senate Committee on Labor, June 3, 1981, p. 2.

Another apparent concern addressed by the filing procedure of ORS 656.029 was the filing and processing of claims against non-complying employers. ORS 656.052; ORS 656.054. We remain uncertain of the exact nature of the concern raised by certain members of the Senate Committee, and how the committee may have anticipated the ORS 656.029 filing procedure would impact the processing of non-complying employer claims. We are fairly certain, however, that this portion of the legislative record, and whatever legislative intent it may reflect, does not assist in a resolution of the issue presently before us.

SB 476 was not enacted in 1979 in the form in which it was originally introduced. It was substantially amended in the Senate Committee, and it is apparent from the minutes that the amended version of the bill that was enacted was modeled after an earlier version which had been part of the Workers' Compensation Law prior to the comprehensive 1965 revision. Minutes, Senate Committee on Labor, Consumer and Business Affairs, February 27, 1979, p. 7; April 24, 1979, p. 6. Prior to enactment of the 1965 Act, former ORS 656.124 provided:

"(1) If any person engaged in a business and subject to ORS 656.002 to 656.590 as an employer, in the course of such business, lets a contract involving the performance of labor, and such labor is performed by the person to whom the contract was let with the assistance of others, all persons engaged in the performance of the contract are deemed workmen of the person letting the contract for the purposes of this section unless the person to whom the contract is let is regularly engaged in a business involving the occupation covered by the contract and has currently on file and in effect with the commission a statement or notice made under ORS 656.024, 656.034, 656.052 or subsection (2) of this section. Any person having currently on file and in effect with the commission such a notice or statement may qualify as a workman only in accordance with the provisions of ORS 656.128.

"(2) If the person to whom the contract is let performs the work without the assistance of others, he is subject to ORS 656.002 to 656.590 as a workman of the person letting the contract unless he and the person letting the contract jointly file with the commission a notice stating that the services rendered under the contract are rendered as those of an independent contractor.

"(3) The provisions of this section apply only if the occupation covered by the contract is a hazardous occupation as defined in ORS 656.082 to 656.086."

This provision was repealed by Oregon Laws 1965, Chapter 285, Section 95. However, it is apparent that the pre-1965 version of former ORS 656.124 is substantially the same as the post-1979 version of ORS 656.029.

There are two Supreme Court decisions that we have found construing former ORS 656.124: Berry v. SIAC, 238 Or 39 (1964), decided before enactment of the 1965 Workers Compensation Act and repeal of former ORS 656.124; and Didier v. SIAC, 243 Or 460 (1966), decided after the 1965 repeal of ORS 656.124. The 1979 history indicates that the Senate Committee was aware of the court's construction of the former statute in Berry, but apparently unaware of the court's subsequent decision in Didier. Minutes, Senate Committee on Labor, Consumer and Business Affairs, April 24, 1979, p. 6.

Berry involved a surviving spouse's claim for death benefits. The case was submitted to the trial court upon stipulated facts. Berry was engaged by Van Osten whereby Van Osten let a contract to Berry involving the performance of labor, which was performed by Berry without the assistance of others. Berry and Van Osten did

not comply with the then-existing provisions of ORS 656.124(2) by jointly filing a notice stating that Berry's services were rendered under the contract as an independent contractor. The stipulation further recited that: "The incidents of employment between Berry and Van Osten were such that Berry would be considered subject to the benefits of the SIAC as an employe, unless ORS 656.124(1) bars him, or his heirs, from recovery herein."

The court held:

> "It appears that the legislative intent by the 1957 amendments to ORS 656.124 was to eliminate the problem of deciding the independent contractor versus employe status as in Butts v. SIAC, 1951, 193 Or 417, 239 P2d 238. See Survey of Oregon Legislation Enacted in 1957, 37 Ore L Rev 67, 86. The facts in the Butts case appear to have been similar to those in the instant case. The Butts decision sustained a finding that the workman had been an independent contractor and that his widow could not receive benefits. We agree with the commentators in the cited Ore L Rev that: 'The principal effect of the [1957] amendment is to extend the benefits of the Act to persons who have heretofore been regarded as independent contractors, as in the Butts case.'
>
> "The primary test of the statute now is, as the trial court concluded, to first determine if the workman was laboring with or without the assistance of others. It is no longer necessary to decide the bothersome independent contractor versus employe question. If the contractor does not have assistance he is covered, unless the notice provided by ORS 656.124(2) has been served on the commission. The notice is the secondary determination. If the workman does have assistance other portions of the statute, we are not now concerned with, would apply. In this instance the stipulated facts establish that '* * * Berry performed this work without the assistance of others.' He was covered." 238 Or at 42-43. (Emphasis added.)

The subsequent case of Didier v. SIAC, supra, also involved a surviving spouse's claim for benefits. The decedent worked full-time for the federal government and occasionally performed welding or mechanical work for remuneration in a shop at his residence. LaRue, a wholesale gasoline and fuel oil distributor, brought a portable gasoline tank to the decedent's home and engaged his services to repair the gasoline tank. LaRue and decedent had transacted business in the past, and it was contemplated that decedent would make the necessary repairs and bill LaRue for payment.

An accident in the course of making the repairs caused fatal injuries. At the time of this incident, LaRue was a covered employer under the Workers' Compensation Law and he had employes for whom he provided workers' compensation. Decedent had no coverage as a self-employed person.

The trial court had found that the decedent was an independent contractor, but that under Berry v. SIAC, supra, the decedent was a "covered workman" because the notice referred to in subsection (2) of former ORS 656.124 had not been filed. The Supreme Court agreed that decedent was an independent contractor, but did not agree, "that merely because the decedent was engaged to perform services for the covered employer the decedent became a covered workman under the covered employer's account." 243 Or at 463.

In distinguishing the Berry case from the case before it, the court in Didier stated that the briefs filed in the Berry case disclosed that Berry was not operating a repair shop for the accommodation of the general public. The stipulated facts in the Berry case included the statement that "'Berry was engaged by Van Osten, in the course of * * * [Van Osten's logging] business, whereby Van Osten let a contract to Berry involving the performance of labor, and such labor was performed by Berry to whom the contract was let, and Berry performed this work without the assistance of others * * *.'" 243 Or at 464. (Emphasis in original.) The Didier court stated that the significant words in the stipulation in the Berry case were the words dealing with the "letting" of the contracts:

> "In common parlance, one who leaves an implement with a repairman is not said to have 'let a contract.' It is also clear from the Berry case that the covered employer was letting a contract for the part of the work he was doing as his principal business. In such cases the legislature understandably would intend that the covered employer bring his contractors and their workmen under his own compensation coverage. This interpretation of the statute avoids a compensation hiatus that otherwise might occur in a number of hazardous industries in which the use of 'independent' contractors is a common practice.
>
> "The trial court in effect applied the Berry case to bring under the compensation law the operator of any public repair shop whenever one of his customers might be a covered employer in the principal business in which the customer was engaged. While a strictly mechanistic reading of the Berry case might tend to support such a result, there is nothing in the history or stated purposes of the Workmen's Compensation Law which would justify the inference that the legislative assembly intended such a result. No such haphazard type of coverage is afforded casual beneficiaries elsewhere in the compensation law.

> "When possible, legislation is to be construed so that it will carry out its revealed legislative purpose. If the legislative purpose is unclear from the language of the section under examination, courts are required to give to the section a meaning that comports with common sense and with the statutory scheme as a whole. * * *
>
> "Construction should avoid inconsistent and unconscionable results. We believe that if the legislature had intended to bring repair-shop operators under the automatic coverage of the compensation law while they were working on equipment left by some of their customers but not while working on equipment left by their other customers, the legislature would have directed this remarkable expansion of the state compensation system by means of language conveying such an intention." 243 Or at 464-65. (Emphasis added.)

The Didier court apparently was impressed with the "haphazard type of coverage" that would result from the extension of workers' compensation benefits if the literal provisions of the former statute were applied to the facts of that case. One of the circumstances they found distinguishable from the circumstances in Berry was that the covered employer in Berry "was letting a contract for a part of the work he was doing as his principal business." The court in Didier somehow found this to be different from LaRue, who was engaged in the business of selling gasoline and fuel oil, bringing a portable gasoline tank for repairs to decedent's home repair shop.

We need not here attempt to reconcile all facets of Didier and Berry, however, because it is sufficiently clear from the language of the existing statutory provision, when read in light of the legislative history from 1979 and 1981, that the legislature in fact intended the result we reach: That claimant is to be considered the subject worker of Homecraft for purposes of this industrial injury.

The portion of ORS 656.029 that applies to the facts of this case is subsection (2), which operates to make a "person" to whom a contract is let and who performs the work without assistance of others the subject worker of the person letting the contract unless both parties to the contract have jointly filed with the insurer or self-insured employer a declaration stating that the person to whom the contract is let is performing services as an independent contractor. For an example of how subsection (1) of the statute operates, where the person to whom the contract is let performs work "with the assistance of others," see Richard O. Hampton, WCB Case Nos. 82-05869 and 82-05870, 36 Van Natta 230 (decided this date).

The "person" under the facts of this case is the partnership E & M Construction. It was anticipated by the legislature that a partnership would constitute a "person" under ORS 656.029 by virtue of the definition of person in ORS 656.005(21), which included a

partnership at the time SB 476 was enacted, as it did at the time of claimant's injury. Minutes, Senate Committee on Labor, Consumer and Business Affairs, April 24, 1979, p. 7. It follows, therefore, that each partner is considered a subject worker once ORS 656.029 is brought into operation. Cf. Ex. "A" to the Senate Committee Minutes, February 27, 1979, Oregon AFL-CIO Testimony on SB 476, p. 3.

The legislative record also indicates that ORS 656.029 was not intended to have the effect of abrogating ORS 656.027(7), the general exemption of sole proprietors and partners as subject workers; but that it was intended that ORS 656.029 would operate to make such "persons" subject workers of the person letting the contract in the absence of filing the declaration contemplated by subsection (2). The underlying purpose of the 1979 enactment may not have been to extend the benefits of the Workers' Compensation Act to persons previously regarded as independent contractors, however, in order to accomplish the goals that were trageted by th 1979 enactment, we think this result necessarily follows in this case.

There is a point not raised by the insurer that does give us pause -- the effect to be given subsection (4) of ORS 656.029, which provides a "rebuttable presumption" that a person is an independent contractor once the filing of a declaration of status as such has been made. Prior to the enactment of this additional subsection in 1981, it apparently would have been conclusively presumed that a person filing the declaration of status as an independent contractor was in fact an independent contractor ineligible to receive benefits under the Workers' Compensation Act. ORS 656.029(3). Similarly, in the absence of the filing, it was apparently intended by the legislature that the person to whom the contract was let would be conclusively presumed to be a subject worker of the person letting the contract, at least in those situations arising under subsection (2) of the statute. This is the obvious purpose and intent of the Senate Committee's amendments to the bill in 1979, as evidenced by Senator Kulongoski's statements before the House Committee on Labor to the effect that it was inappropriate to expect or allow the judiciary to define or decide who is and who is not an independent contractor. Minutes, House Committee on Labor, June 6, 1979, p. 1.

The confusion we face with regard to the 1981 addition of subsection (4) is: Considering the apparent intent of the 1979 legislature to establish a litmus-paper type of test to govern the determination of who is an independent contractor and who is a subject worker, what was the purpose of the 1981 Act, and thus, what is the effect to be given this "rebuttable presumption" that a person is an independent contractor? In other words, if it is to be rebuttably presumed that a person is an independent contractor when the declaration of status as such has been filed, is it also to be rebuttably presumed -- or is it to be conclusively presumed -- that, in the absence of such filing, the person to whom the contract is let is a subject worker? If the status as a subject worker is conclusively presumed in the absence of the filing under ORS 656.029(2), the Referee's analysis and conclusion are absolutely correct; if, however, the presumption of the person's status as a subject worker is merely rebuttable, then the apparent purpose of the 1979 Lesislative Assembly, in seeking to avoid the

proliferation of litigation to determine one's status as an independent contractor or subject worker, has been frustrated by the subsequent enactment of subsection (4) of ORS 656.029.

We are assisted in resolving this question by reference to the sparse legislative history of Oregon Laws 1981, Chapter 725 (SB 649). The tape recordings of the 1981 hearings on SB 649 before the Senate and House Labor Committees disclose that during the interim following the 1979 legislative session problems arose in the administration of the new Act, particularly regarding the procedure of filing a declaration of status as an independent contractor. Senator Kulongoski advised the Senate Labor Committee that what was expected to be a simple administrative procedure, i.e. that of filing with an insurer or self-insured employer a declaration stating that the services of the person performing the contract were performed as an independent contractor, had not been accepted by the insurance industry. The insurers were apparently resistant to accepting such a declaration as a satisfactory indication that the party in question was in fact an independent contractor as claimed. When a declaration of independent contractor status was filed with a subject employer's insurer, the insurer would nevertheless demand payment of an additional premium from the subject employer. This apparently had become a serious problem in the real estate industry, where real estate brokers were being forced to pay premiums for real estate salespeople in their office, who were traditionally considered to be independent contractors. The insurers apparently felt that the declaration was insufficient to establish the salesperson as an independent contractor if there were other indicia of an employer-employe relationship between the broker and salesperson.

In response to this practical problem with the administration of the 1979 Act, Senator Kulongoski introduced SB 649 in 1981, providing for the rebuttable presumption of a person's status as an independent contractor when the declaration of status as such had been filed. There was discussion concerning the alternatives of making the presumption rebuttable or conclusive. The reasoning and purpose for making the presumption rebuttable is not entirely clear from the legislative history; however, we understand the apparent intent to have been that some party, either the Director of the Workers' Compensation Department or an insurer, would be permitted to establish that, although the declaration of status as an independent contractor had been filed, there was evidence indicating that the "independent contractor" was in reality a subject worker of the person letting the contract. In order to establish this as fact, the party contending that the "person" performing the services <u>was not</u> an independent contractor would be required to overcome the presumption that the "person" <u>was</u> an independent contractor.

The one fact that is fairly clear from the legislative record of the 1981 hearings is that, by amending ORS 656.029 to include the rebuttable presumption provision of subsection (4), there was no intent to change the operative effect of the 1979 legislation, which makes a person performing work without the assistance of others the subject worker of the person letting the contract in the absence of the joint filing of the declaration of status as an independent contractor. The 1981 amendment was enacted in an attempt to cure an administrative problem that had arisen in

accomplishing the purposes of the original Act, problems existing between employers subject to the Workers' Compensation Act and their insurers vis-a-vis persons performing services for the subject employers; the purposes of the 1979 legislation, which we have previously discussed, remained unchanged.

We conclude that in enacting SB 649 in 1981 the legislature did not intend to create a rebuttable presumption of any nature other than that expressed in the explicit terms of ORS 656.029(4): Where the declaration of status as an independent contractor has been filed it is rebuttably presumed that the person is an independent contractor. Where there has been no filing of the joint declaration there is no presumption, either rebuttable or conclusive, that arises. The statute simply operates to make the person performing the work without the assistance of others the subject worker of the person letting the contract.

Addressing the facts of this case, there is no issue concerning the fact that the "person" performing the services pursuant to the contract in question, i.e. the partnership of E & M Construction, was performing the contract without the assistance of others; there is no question concerning the fact that the contract involved the performance of labor; nor is there an issue concerning the fact that Homecraft Construction Company was a person engaged in business and subject to the Workers' Compensation Act as an employer. In consideration of Didier v. SIAC, supra, we also find that Homecraft and E & M clearly "let a contract", even in "common parlance"; and that Homecraft was letting a contract for a part of the work Homecraft was engaged in as its principal business. We, therefore, find that extending coverage to the claimant in this case is not "haphazard," and that claimant is not a "casual beneficiary" of the Workers' Compensation Act. But even if this is a haphazard extension of the Act, and even if claimant is a casual beneficiary, we think the legislature intended the result we reach today.

Addressing the issue raised by claimant's cross-request for review, concerning the Referee's failure to impose a penalty for the insurer's allegedly unreasonable denial of the claim for benefits filed by claimant, we can only state that if the insurer had read Berry v. SIAC, supra, as the claimant argues it should have, the denial may have been unreasonable; but if the insurer had read Didier v. SIAC, supra, then the denial certainly could not be considered unreasonable. Having probably read only the provisions of ORS 656.029, the employer and insurer most likely believed, as did the court in Didier, that if the legislature intended "this remarkable expansion of the state compensation system" it would have accomplished this purpose "by means of language conveying such an intention." 243 Or at 465. We agree with the Referee's finding that the insurer's denial was not unreasonable. Robert Bellesle, 34 Van Natta 1227, 1231 (1982); Mayes v. Boise Cascade Corp., 46 Or App 333, 345 (1980); Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977).

ORDER

The Referee's order dated June 7, 1982 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

RICHARD O. HAMPTON, Claimant
THOMAS C. RYDER dba R & R SHEETMETAL, Employer
Robert N. Ehmann, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Ass't A.G.

WCB 82-05869 & 82-05870
March 8, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation, as insurer of Lowell and Richard Spiess, dba The Cinema, requests review of that portion of Referee Howell's order which found that claimant was a subject worker of The Cinema at the time of his November 1981 injury by operation of ORS 656.029(1) and thus set aside SAIF's denial of claimant's claim against The Cinema. SAIF contends that ORS 656.029(1) does not operate to make claimant a subject worker of The Cinema.

The pertinent facts are as follows. Thomas C. Ryder, dba R&R Sheetmetal, entered into a contract with Lowell and Richard Speiss, dba The Cinema. The Cinema had recently purchased a warehouse which it planned to convert to a three screen movie theater and amusement center. The contract provided that R&R was to furnish and install a heating and ventilation system for a total price of $19,461. Apparently Thomas Ryder performed most of R&R's contracts either alone or with just the assistance of his son, but the nature of R&R's usual operations and the nature of the business relationship between father and son are not really explained in this record. In any event, The Cinema contract was an unusually large one for R&R and Thomas Ryder found it necessary to employ claimant as a sheetmetal worker in order to perform that contract.

Claimant began working for R&R on September 15, 1981. On November 4, 1981 he cut two fingers on his left hand on a piece of sheetmetal. R&R paid for claimant's initial emergency room visit, but was not able to pay for the extensor tendon repair operation on claimant's small finger which was necessitated by the injury.

An investigation was conducted by the Workers' Compensation Department. It was determined that R&R Sheetmetal was a subject, but noncomplying, employer from September 15, 1982 through March 26, 1982. The investigation also revealed that The Cinema did have workers' compensation coverage in effect at the time of claimant's injury, which was being provided by SAIF. Apparently as a result of the Department's investigation, two workers' compensation claims were ultimately filed. One was filed against R&R as a noncomplying employer; this claim was forwarded to SAIF as the statutory processing agent for claims against noncomplying employers pursuant to ORS 656.054. The other claim was filed against The Cinema; this claim was forwarded to SAIF as the insurer for The Cinema.

In a letter dated April 23, 1982, the Workers' Compensation Department advised SAIF to deny the claim against R & R and to accept the claim against The Cinema because the latter had workers' compensation insurance in effect and because, pursuant to ORS 656.029, claimant should be considered an employe of The Cinema, rather than an employe of R&R, at the time of the injury. Apparently not finding the Department's advice to be cogent, SAIF denied both claims. It denied the claim against The Cinema in its role as insurer for The Cinema. It denied the claim against R&R in its role as processing agent for claims against noncomplying employers.

At the request of SAIF, an order designating a paying agent was issued pursuant to ORS 656.307 on June 30, 1982. SAIF was ordered to process the claim as insurer for The Cinema, and the responsibility issue was referred for hearing. Claimant retained an attorney who appeared at the hearing but took no position on the responsibility issue; claimant's attorney only raised issues concerning penalties and attorney fees.

The Referee concluded that, at the time of his injury, claimant was a subject worker of The Cinema by operation of ORS 656.029(1). The Referee thus set aside SAIF's denial of the claim against The Cinema and upheld SAIF's denial of the claim against R&R. The Referee also concluded that penalties were not appropriate as SAIF could have had a legitimate doubt as to the responsibility of both R&R and The Cinema. Additionally, he refused to award an attorney fee to claimant based on National Farmers Union Insurance v. Scofield, 56 Or App 130 (1982). The Referee found that the claimant was a "nominal party" on the issue of responsibility, that none of claimant's right were in jeopardy and that, if new issues had arisen that jeopardized claimant's interests, claimant necessarily would have been given appropriate notice and then could have obtained an attorney.

References to ORS 656.029 are to the law in effect at the time of claimant's injury. ORS 656.202(1). In Richard F. Erzen, WCB Case No. 82-01698, 36 Van Natta 218 (decided this date), we discussed at length various interpretation problems that arise in the application of ORS 656.029, which is a relatively new statute. The threshhold problem is whether a given case arises under subsection (1) or subsection (2), the differences being: Whether the contract in question is performed by a person/business entity with the assistance of others (a subsection (1) case) or without the assistance of others (a subsection (2) case); with any filed certification of status as an independent contractor being relevant in subsection (2) cases, but irrelevant in subsection (1) cases.

This is a subsection (1) case because the "person" to whom the contract was let, R&R Sheetmetal, performed that contract with the assistance of others, specifically claimant. ORS 656.029(1) provides:

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

SAIF argues that the Referee erred in holding The Cinema responsible for claimant's injury under the provisions of that statute. SAIF contends that the statute was never intended to have such a broad sweep, and that such a literal interpretation makes any business which happens to contract with a noncomplying employer liable, regardless of whether or not the contract was unrelated or

only remotely related to the "prime" contractor's business. It argues that the statute was meant to apply only to contractors who seek to escape their responsibility of purchasing workers' compensation coverage by sub-contracting work out to smaller employers who might not have workers' compensation coverage. SAIF also argues that the Referee's interpretation of ORS 656.029 allows the noncomplying employer to completely escape his statutory obligations and serves to make contracting employers, such as The Cinema, policing agents for the workers' compensation system.

We considered and rejected some of these same arguments in Erzen. However, we think that certain points raised by SAIF merit additional consideration in the factual context of this case.

ORS 656.029(1) applies to "any person engaged in a business . . . [that] lets a contract involving the performance of labor." (Emphasis added.) SAIF argues that the phrase, "engaged in a business," should be interpreted as a limitation, and perhaps a significant limitation, on the scope of ORS 656.029(1). In this case, for example, SAIF suggests that the principal business activity of The Cinema was operating movie theaters and showing movies, not remodeling or construction work; and that the heating and ventilation contract between The Cinema and R&R was, from The Cinema's point of view, clearly secondary, collateral and incidental to the "business" in which The Cinema was "engaged."

This is a troublesome contention for several reasons, the first of which arises from the 1979 legislative history of ORS 656.029. As discussed in Erzen, the 1979 enactment of ORS 656.029 was based in part on an earlier statute that had been repealed in 1965, former ORS 656.124. That former statute contained exactly the same wording as ORS 656.029, with an additional modifying phrase: "If any person engaged in a business . . . in the course of such business, lets a contract involving the performance of labor . . . ." (Emphasis added.) This same modifying language was in some of the versions of the bill that was eventually enacted in 1979 and became ORS 656.029. However, this modifying language was eliminated in the House committee amendments with the somewhat perplexing observation that the presence or absence of this modifying language did not make any substantive difference. House Labor Committee, Staff Measure Analysis; House Labor Committee Minutes, June 22, 1979, page 2; see House Amendments to printed A-Engrossed SB 476 (1979).

We think the presence or absence of modifying language such as that in the pre-1965 statute can make a difference, as illustrated by the facts of this case. Certainly, at the very least, SAIF's argument here that a remodeling contract was incidental to the business of operating movie theaters would be on a much stronger foundation under the pre-1965 statute than is possible under the literal wording of ORS 656.029.

Considering the statutory language in effect at the time of claimant's injury, we think the more likely legislative intent was that in virtually all, if not literally all, situations in which a business entity (corporation, partnership, etc.) enters into a contract as a business entity, that contract is subject to ORS 656.029. It might be possible that in some case we would find the purpose of the contract to be so totally unrelated to the business of the "prime" contractor that application of ORS 656.029 would

stretch that statute to the breaking point. This, however, is not such a case. The contract here in question involved the remodeling of premises in which the "prime" contractor, The Cinema, intended to engage in business. In our opinion, the purpose of this contract is not totally unrelated to the business of The Cinema.

A second point raised by SAIF merits only brief comment, but only because it is a point that goes far beyond the jurisdiction of this Board. SAIF repeatedly asserts or assumes that, by virtue of the Referee's order, SAIF, for the account of The Cinema, must assume the costs of this claim without any possible recourse against R&R Sheetmetal. We only note that we do not necessarily share SAIF's assumption. We find it quite conceivable in this type of case that the "prime" contractor or its industrial insurer (as a third party beneficiary or based on subordination rights) would have a contractual or quasi-contractual cause of action against the noncomplying subcontractor. That question will ultimately be determined in some forum other than this agency; we only note that, in answering the questions that are now properly before us, we are not willing to join SAIF in the assumption that there is no possible recourse against a noncomplying subcontractor in this kind of situation.

We find and hold that, at the time of the claimant's injury, The Cinema was a person engaged in a business and subject to ORS Chapter 656 as an employer; that The Cinema let a contract involving the performance of labor to R&R Sheetmetal; that the labor which was the subject of the contract was performed by R&R Sheetmetal, the person to whom the contract was let, with the assistance of others, specifically claimant; that R&R Sheetmetal failed to qualify under ORS 656.017 by obtaining a policy of workers' compensation insurance; and that, therefore, by operation of ORS 656.029(1), claimant is deemed to be a subject worker of The Cinema for purposes of paying workers' compensation benefits associated with claimant's November 4, 1981 injury.

With regard to claimant's request that we award penalties against SAIF for its unreasonable denial of both claims, we decline to do so. We agree with the Referee that the denial which SAIF issued on behalf of R&R was done on the Department's advice. We also conclude that SAIF's doubts concerning its responsibility pursuant to ORS 656.029 were not so unreasonable at that time as to warrant imposition of a penalty. See Richard F. Erzen, supra.

Finally, we agree with the Referee's decision not to award attorney fees to claimant's attorney for services rendered at the hearing. As we recently noted in Wilfred Pultz, 35 Van Natta 684 (1983), the controlling administrative rule is OAR 436-47-090. That rule provides that when the issue of employer/insurer responsiblity goes to hearing pursuant to a 307 order, as in this case, "then the [claimant's] attorney will receive no fee unless he/she actively and meaningfully participates at the hearing in behalf and in defense of claimant's rights." In Pultz, and earlier in Robert Heilman, 34 Van Natta 1487 (1982), we interpreted active and meaningful participation to mean at least taking a position adverse to one of the potentially responsible employers/insurers. Since claimant's attorney in the current case took no position on the responsibility issue, he is not entitled to a fee for his appearance at the hearing. See also Brent Bennett, 34 Van Natta 1563 (1982).

Although claimant's attorney is entitled to no fee for services at the hearing, he did prepare and file a brief before the Board, defending the Referee's determination that SAIF/The Cinema was responsible for claimant's industrial injury. Since claimant's attorney did meaningfully participate and successfully defend the Referee's determination, we conclude that he is entitled to a fee for services before the Board. Robert Heilman, supra.

ORDER

The Referee's order dated January 21, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation as insurer for The Cinema.

Board Member Lewis Dissenting:

I would reverse the Referee's order which found that claimant was a subject worker of The Cinema under ORS 656.029 and, therefore, I respectfully dissent.

I agree with the arguments made and the conclusions advocated by SAIF in its appellant's brief to the Board on review. Legislative intent is not clear from the language of ORS 656.029. Also, when the plain meaning of ORS 656.029 is literally applied, the absurd result occurs of placing liability on any businessperson who contracts with a noncomplying employer, for injury suffered by that noncomplying employer's employee, regardless of whether the businessperson is in the business of letting such contracts. Consequently, legislative history must be consulted in order to determine legislative intent. Johnson v. Star Machinery Co., 270 Or 694, 704 (1974).

The legislative history shows an intent by the legislature to place liability on the person letting the contract only when the that person does so in the course of their business of letting contracts. As discussed by SAIF, the legislative history contains repeated references to the intent that the statute be applied to contractors who let contracts to subcontractors, and not to consumers who initially contract with the contractor and who happen to be engaged in business. Furthermore, the legislative purpose of the statute was to prevent evasion of liability by those who subdivide their regular operations in order to escape direct employment relationships with those performing the work.

In the present case, The Cinema was not in the business of letting contracts for the performance of labor. Rather, The Cinema was in the business of a movie theater and amusement center. Had The Cinema attempted to subdivide its regular operations by entering into a contract with a noncomplying employer for the performance of labor related to the movie or amusement business, such as running film projectors, and the person performing that labor was injured, The Cinema would be deemed the employer under ORS 656.029. In the present case, however, The Cinema was converting a building for its needs and entered a contract for performance of sheet metal work. The Cinema was not in the business of remodeling buildings and the contract for that work was incidental to its regular operations. Therefore, under ORS 656.029, as interpreted in light of the legislative intent, The Cinema would not be deemed the employer of claimant.

This interpretation of the statute is not diminished by the legislative amendment to the bill which deleted the phrase, "in the course of such business." As discussed by the majority, some versions of the legislative bill that eventually became ORS 656.029 contained the following language: "If any person engaged in a business ... in the course of such business, lets a contract involving the performance of labor ...." (Emphasis added.) The emphasized phrase was deleted in the House Committee amendments with the observation that the phrase had no substantive effect on the meaning of the statute. I agree with the majority that the deleted phrase affects the meaning of the statute. I disagree, however, with the majority's conclusion that SAIF's position is weakened by the deletion of this phrase. I am reluctant to interpret the deletion of the phrase to mean that the legislature intended to extend liability to any businessperson who contracts with a noncomplying employer, particularly in the face of the legislative belief that such deletion made no substantive difference.

ORS 656.029 was not intended to be applied to every businessperson who contracts for the performance of labor with a noncomplying employer. Furthermore, ORS 656.029 was not intended to protect a noncomplying employer by placing liability on the businessperson who contracts for the performance of labor with that employer. I would limit the application of ORS 656.029 to place liability only on persons who contract for the performance of labor as a part of their regular business operations, as in the usual contractor-subcontractor relationship in the building industry, as illustrated by Richard F. Erzen, WCB Case No. 82-01698, 36 Van Natta 218 (decided this date).

Therefore, I would find that ORS 656.029 does not place liability on The Cinema in this case and I would find Thomas C. Ryder, dba R&R Sheetmetal, to be claimant's employer for the purposes of workers' compensation law and to be a noncomplying employer. I respectfully dissent.

DALIA MESA, Claimant
Pozzi, et al., Claimant's Attorneys
Frank Moscato, Defense Attorney

WCB 81-00393
March 8, 1984
Order on Remand

On review of the Board's order dated July 30, 1982, the court reversed that portion of the order which held that the insurer was permitted to unilaterally withhold amounts due for temporary total disability compensation in order to recover previously overpaid temporary total disability benefits. The court remanded for entry of an order directing repayment of the amounts withheld by the insurer.

Now, therefore, that portion of the above-noted Board order which held that the insurer properly recovered overpaid temporary total disability benefits from claimant's compensation is vacated, and this matter is remanded to the insurer with instructions to repay claimant those amounts previously deducted from her temporary total disability compensation.

IT IS SO ORDERED.

JOHN R. THOMAS, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-10051
March 8, 1984
Supplemental Order on Remand

This matter is presently before the Board on claimant's attorney's application for a reasonable attorney's fee pursuant to ORS 656.388(1), for services rendered before the Referee, the Board, the Court of Appeals and the Board on remand. See John R. Thomas, 34 Van Natta 1207 (1982), 36 Van Natta 13 (January 13, 1984), 36 Van Natta 158 (February 15, 1984); Thomas v. SAIF, 64 Or App 193 (1983). In awarding a reasonable fee, we have taken into consideration efforts expended and results obtained by claimant's attorney in claimant's behalf, as reflected, in part, by claimant's written submissions to the Board and the court, as well as counsel's affidavit, previously submitted to the court. Preliminarily we note SAIF's suggestion that any fee awarded counsel for services rendered before the court should be paid out of the Administrative Fund for the reason that the jurisdictional issue which formed the basis of the claimant's petition for review and the court's order was raised sua sponte by the Board. In response to SAIF's suggestion we quote from a portion of the court's opinion: "SAIF argues the Board should be affirmed . . . ." 64 Or App at 196.

Considering the nature and the amount of compensation in controversy, and the complexity of the factual and legal issues involved in this litigation, we find that $3,900 is a reasonable attorney's fee for services rendered before the Referee, the Board and the Court of Appeals.

ORDER

Claimant's attorney is awarded $3,900 as a reasonable attorney's fee, to be paid by the SAIF Corporation.

SUSAN E. DODGE, Claimant
Doblie & Francesconi, Claimant's Attorneys
John Snarskis, Defense Attorney

WCB 83-06005
March 9, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Podnar's order which set aside its June 9, 1983 denial. The issue for review is the compensability of a back injury which claimant alleges took place on April 6, 1983.

The insurer urges us to reverse the Referee's order on the basis that claimant is not credible. The Referee's order found claimant's testimony regarding the injury credible. We normally defer to a Referee's findings concerning credibility unless there is a strong basis to do otherwise. Donald W. Hardiman, 35 Van Natta 664 (1983).

ORDER

The Referee's order dated August 22, 1983 is affirmed. Claimant's attorney is awarded $350 for services on Board review, to be paid by the insurer.

MERCEDES A. EVANS, Claimant
Garrett, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Schwenn, et al., Defense Attorneys

WCB 82-04068 & 82-10141
March 9, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The self-insured employer, Fred Meyer, Inc., requests review of Referee Galton's order which set aside its March 9, 1982 partial denial and found claimant's temporarily exacerbated condition of June and July 1981 to be the responsibility of Fred Meyer, as an aggravation; the Referee also affirmed the October 29, 1982 denial entered by United Pacific Insurance Company on behalf of Benjamin Franklin Savings and Loan of claimant's alternative new injury claim. The only issue for review is employer/insurer responsibility.

We agree with the Referee's conclusion that claimant's condition constitutes an occupational disease. There is much to be said for Fred Meyer's contention that Benjamin Franklin is responsible for the temporary exacerbation of claimant's condition which occurred in June and July 1981. However, Fred Meyer originally accepted responsibility for claimant's condition, and although claimant's subsequent employment activities at Benjamin Franklin did cause her condition to become symptomatic, the medical evidence is convincing that the underlying condition itself did not worsen. As we understand the state of the law, responsibility remains with the initial employer or insurer in such situations. SAIF v. Baer, 60 Or App 133 (1982); Bracke v. Baza'r, 293 Or 239, 250 (1982).

ORDER

The Referee's order dated May 10, 1983 is affirmed. Claimant's attorney is awarded $300 for services on Board review, to be paid by Fred Meyer, Inc.

WARREN R. FARWELL, Claimant
Walter Hogan, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-11311
March 9, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Johnson's order which set aside its denial of claimant's claim for injuries sustained in a motor vehicle accident. The issue is whether claimant was acting in the course of his employment when he was injured.

Claimant is the sales manager for two radio stations in Coos Bay. Claimant's duties included directing the sales staff in selling advertising and organizing promotional events for the radio stations. Claimant also sold advertising himself. He spent approximately 80% of his work hours away from the stations' office. His normal working hours were 8 a.m. to 5 p.m., Monday through Friday, but he often worked other hours as required to attend promotional events. He was required by his employer to provide an automobile for his job. The gas for the automobile was provided by service stations in the area in exchange for advertising on the radio stations.

On Sunday, September 19, 1982, claimant was working on a promotion in North Bend. During the course of the day claimant drove back and forth between North Bend and the stations' office to pick up and deliver trophies and banners. At about 3 p.m. his duties at the promotion were complete. Claimant left the promotion and began driving toward his home in Myrtle Point. He was involved in a motor vehicle accident on his trip home. The Referee found that claimant's trip home was within the course of his employment. We agree, but for reasons somewhat different than those stated by the Referee.

Larson states:

> "If the employee as a part of his job is required to bring with him his own car... for use during his working day, the trip to and from work is by that fact alone embraced within the course of employment." 1 Larson, Workmen's Compensation Law, §17.50 (1982).

The Court of Appeals adopted this section of Larson in Giltner v. Commodore Contract Carriers, 14 Or App 340, 347 (1973).

The uncontroverted evidence in this case is that claimant was required as part of his job to bring his car to the work site on the day in question and use his car for work-related activity on that day. Accordingly, we find that claimant was acting within the course of his employment when the motor vehicle accident occurred.

ORDER

The Referee's order dated September 8, 1983 is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the SAIF Corporation.

JAMES R. KUNST, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-10956
March 9, 1984
Order on Review (Remanding)

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Galton's order which set aside the insurer's denial on the ground that res judicata barred the insurer from issuing the denial. The insurer contends that it was not barred from denying the claim. We agree with the insurer and reverse and remand.

In April 1982 claimant allegedly suffered an on-the-job injury. The claim was accepted and time loss benefits were paid until May 1982, when the insurer discontinued payment of those benefits. In August 1982 a hearing was held on the insurer's unilateral termination of time loss benefits. Subsequently, the insurer denied compensability of the claim based on claimant's testimony at the August 1982 hearing, which the insurer contended cast doubt on the validity of the claim. Claimant requested a hearing on that denial, which led to the hearing in the present case. The Referee set aside the denial, stating that the insurer had to raise compensability at the August 1982 hearing on time loss benefits, and that, not having done so, the insurer was now barred by res judicata from denying compensability.

The Referee cited Mavis v. SAIF, 45 Or App 1059 (1980), and Million v. SAIF, 45 Or App 1097 (1980), in support of his conclusion. We find that neither case is dispositive. Instead, we rely on Bauman v. SAIF, 295 Or 788 (1983), which held that an insurer may subsequently deny a claim after previously accepting it, but only on the basis of fraud, misrepresentation or other illegal activity. The insurer's backup denial here in issue is based on fraud. We find that, under these circumstances, the insurer is not barred from denying compensability of the claim. Bauman does not place a time limit on denials precipitated by the insurer's belief that a claimant has not been truthful.

ORDER

The Referee's order dated August 10, 1983 is reversed. This case is remanded to the Hearings Division for a hearing on the merits of the insurer's denial.

JOHN LOSINGER, Claimant
Elliott Lynn, Claimant's Attorney
Tooze, Kerr, et al., Defense Attorneys

WCB 82-10633
March 9, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Knapp's order which found that claimant was "estopped to litigate" the insurer's denials of claimant's hand surgery and right shoulder condition. Claimant contends he is not barred from raising these issues and requests that we remand this case to the Referee for a hearing on the merits of these issues. We agree with claimant and reverse and remand to the Referee.

We make the following findings of fact.

In September 1980 claimant suffered a severe compensable injury when his right hand was caught in a cotton shredding machine. His treating doctor, Dr. Jewett, performed extensive surgery to repair claimant's hand and forearm.

In August 1981 when claimant was seen at the Callahan Center, his complaints included right arm, shoulder and neck pain. At that time, claimant indicated he had wrenched his shoulder and neck trying to pull his hand out of the cotton shredding machine. Claimant received treatment for his shoulder condition at the Callahan Center. The insurer received reports referring to claimant's right shoulder problem and treatment in August 1981. No denial of claimant's shoulder condition was issued by the insurer at that time.

On September 1, 1981 a Determination Order issued which awarded claimant 55% scheduled permanent disability for loss of use of his right forearm. Claimant requested a hearing raising the issue of extent of disability.

On September 11, 1981 claimant saw Dr. Button for an opinion regarding his right hand problems. Dr. Button recommended a surgical tendon transfer and release of scar contractures. In response, Dr. Jewett advised against the surgery recommended by Dr. Button.

Claimant did not pursue surgical treatment and continued in his vocational rehabilitation and job search efforts. Surgery was neither requested nor denied at that time.

At the August 19, 1982 hearing requested by claimant on extent, the parties reached an agreement and entered their stipulation on the record. Claimant's attorney indicated on the record that although this injury involved the shoulder too, the medical evidence had not been developed for establishment of an unscheduled permanent disability. The stipulation provided for an increased award for scheduled disability only.

On August 30, 1982 Dr. Button reported that since his examination of claimant in September 1981, claimant had returned to Dr. Jewett who recommended against further surgery. Subsequently, reported Dr. Button, claimant went to work in electronic components assembly, where he was required to repetitively use pliers. This work caused claimant pain and swelling in the base of his thumb and rapid fatigability of the right arm. Dr. Button recommended the same surgery on claimant's hand that he previously recommended and requested that the claim be reopened for that surgery.

On September 22, 1982 the insurer issued a denial of the requested surgery. Claimant requested a hearing on the insurer's denial.

Thereafter, claimant had additional examination and diagnostic testing of his right shoulder and arm problems and other right sided symptoms. On December 30, 1982 the insurer issued a second denial, which denied that claimant's shoulder problems were related to his industrial hand and forearm injury.

The hearing requested by claimant with regard to the insurer's September 22, 1982 denial of surgery was held on January 10, 1983. After much discussion at the hearing, the Referee decided to postpone the hearing and to make a decision first on whether claimant was "estopped to go forward" on the hand surgery and shoulder claims.

In his order the Referee found that claimant was "estopped to litigate" both issues. The Referee found that at the last hearing on extent, claimant could have but did not raise the issue of his need for hand surgery even though it was "a viable question" and would have affected the issue of extent. Similarly, the Referee found that compensability of the right shoulder claim was "a claim within the operative facts" of the August 1982 hearing, was a question that would have affected the outcome of that hearing and, therefore, was an issue that had to be raised at the time of that hearing. The Referee applied the doctrine of res judicata and dismissed claimant's request for hearing with regard to the denied hand surgery and the denied shoulder condition.

We disagree with the Referee on both issues.

In Million v. SAIF, 45 Or App 1097 (1980), the court held that res judicata applies to every claim which could have been alleged under the same set of operative facts in existence at the time of the prior proceeding. In Million, the claimant had requested a hearing in 1975, alleging that her condition was related to a prior

compensable injury. After failing on the injury aggravation claim, claimant claimed her condition in 1975 was caused by occupational exposure. The court held that the claimant was barred from asserting the occupational disease claim because at the time of filing the injury aggravation claim in 1975, claimant was aware that her condition was at least in part the product of an occupational disease. Under the circumstances, the Million court held that a claim on the occupational theory could have been raised at the prior hearing and claimant's failure to do so barred raising it later.

In Syphers v. K-W Logging, Inc., 51 Or App 769 (1981), the court addressed the question of when an issue is ripe for determination. In Syphers, the claimant requested a hearing and, at the same time, made an aggravation claim. Consequently, the request for hearing was made prior to the insurer's denial of the aggravation claim and prior to the expiration of the time within which the insurer had to accept or deny the claim. The claimant did not renew the request for hearing after the claim was denied. The court held that the Referee correctly dismissed the case for lack of timely filing the request for hearing within 60 days after the denial as required by ORS 656.319. The court stated:

> "The statutory scheme does not reasonably permit a hearing on compensability of the claim prior to a timely acceptance or denial or prior to the expiration of the time in which the carrier may investigate and consider the claim without risking penalties. Until one of those events occurs, it is not known whether a hearing will be necessary or, if so, what issue or issues will be presented at the hearing. Claimant's request for a hearing on the sole question of whether the claim should be accepted was premature and therefore ineffective." 51 Or App at 771.

The Board has long objected to a proliferation of hearings and appeals. In Elfreda Puckett, 8 Van Natta 158 (1972), the Board stated:

> "It is contemplated that a request for hearing will resolve all matters at one time, and the conclusion of an order extends not only to matters actually determined, but also to other matters which could properly have been determined." 8 Van Natta at 159.

The latter doctrine referred to by the Board in Puckett was res judicata. The question of whether to apply the res judicata doctrine usually arises where a hearing has been held on particular issues and, thereafter, one party requests another hearing. At the second hearing, the opposing party contends that the first party is barred from litigating the issue raised in the latter request for hearing because that issue "could have been raised" at the prior hearing. If the issue raised in the second proceeding in fact could have been raised at the first, the party raising the issue is barred by res judicata from litigating the issue.

For the party to be barred by res judicata, however, the issue that the party attempts to litigate in the second proceeding must have been one that properly could have been determined in the first proceeding. Accordingly, in Kevin McAllister, 34 Van Natta 158 (1982), the Board refused to bar the claimant from litigating new injury/aggravation claims in a second proceeding where those issues were not at issue in the first hearing on extent of disability. The Board held that the new injury/aggravation issues could not be at issue until the employers denied the claims, which they did not do until after the first hearing. Moreover, the Board held that litigating the new injury/aggravation issues at the first hearing, in the absence of any denials, would have been premature, citing Syphers v. K-W Logging, Inc., supra. See also Hettie M. Eagle, 33 Van Natta 671 (1981).

Applying the holdings and reasoning of these cases to the present case, first we note that the doctrine in question here is res judicata and not collateral estoppel as implied in the Referee's order. Million v. SAIF, supra. We hold that the issue of the hand surgery was not one that properly could have been determined at the time of the August 1982 hearing on extent. Claimant had not requested and the insurer had not denied the surgery. The surgery, having neither been requested nor denied, cannot be deemed to have been an issue that could have been determined at that time. Million v. SAIF, supra; Elfreda Puckett, supra. In fact, litigation of the hand surgery issue at the prior hearing, before a denial was issued, is not permitted under the statutory scheme and would have been premature. Syphers v. K-W Logging, Inc., supra; Kevin McAllister, supra. Therefore, claimant is not barred by res judicata from now requesting hand surgery.

Likewise, claimant is not barred from seeking compensation for his shoulder condition by failing to litigate compensability of the shoulder condition at the hearing on extent. As the Referee stated, the transcript of the first hearing reflected that claimant was aware of his shoulder claim with regard to the extent issue:

> "THE REFEREE: . . . The sole issue is extent of permanent scheduled disability, and the parties have just apparently reached a settlement of that issue and wish to put the terms of the settlement on the record. Is that correct, gentlemen?
>
> "MR. NESTING: Yes, sir.
>
> "THE REFEREE: All right. Who wants to recite?
>
> "MR. NESTING: I'll be glad to do it. Basically this was a scheduled case, and there was some medical evidence with regard to a shoulder problem, getting it to an unscheduled, but that wasn't developed. The settlement today is for an additional forty-five degrees of the right forearm ...."

This discussion clearly shows that claimant believed his

shoulder condition was a part of his September 1980 injury claim, but that he did not believe he could prove unscheduled permanent disability with regard to his shoulder. The discussion does not indicate in any way, however, that claimant believed compensability of the shoulder condition was at issue. Indeed, claimant had no reason to doubt the compensability of the shoulder claim because no denial had been issued with regard to the shoulder. As in Kevin McAllister, supra, litigation of compensability would have been inappropriate at a prior hearing on extent only and would have been premature in the absence of a denial. As with the hand surgery issue, claimant is not barred from litigating the shoulder compensability issue by having failed to do so at the first hearing. The issue was not one that properly could have been determined in that hearing. Million v. SAIF, supra; Elfreda Puckett, supra.

In the event that claimant ultimately prevails before the Referee on remand, the Referee should consider the services rendered by claimant's attorney at the initial hearing and on Board review in awarding a reasonable attorney's fee. ORS 656.388(1).

ORDER

The Referee's order dated February 9, 1983 is reversed. This case is remanded to the Referee for a hearing on claimant's entitlement to hand surgery and on the compensability of claimant's shoulder condition.

LAWRENCE M. SULLIVAN, Claimant
Kenneth D. Peterson, Claimant's Attorney
Kottkamp & O'Rourke, Defense Attorneys

WCB 81-06349
March 9, 1984
Order on Reconsideration

Claimant requests reconsideration of our Order on Review (Remanding) dated September 28, 1983. We have since abated that order and received and considered additional argument from the parties.

Claimant fell at work in September 1980, primarily injuring his left knee. His claim was accepted, processed and closed by Determination Order dated April 28, 1981. Apparently at some point after that Determination Order, claimant requested "reopening" of his claim for various upper body problems; in any event, by letter dated July 10, 1981 the insurer denied there was any causal link between claimant's upper body problems and his September 1980 compensable fall.

The matter proceeded to hearing primarily on the questions of whether the July 10, 1981 denial was proper and whether the April 28, 1981 Determination Order was premature. The Referee set aside the denial and the Determination Order.

Our Order on Review noted considerable confusion and ambiguity in the record -- a situation that usually is detrimental to the party with the burden of proof. We concluded: (1) Claimant had established that he sustained some form of soft tissue back injury at the time of his September 1980 fall at work; but (2) claimant had not established that the April 28, 1981 Determination Order was prematurely issued.

Claimant's request for reconsideration raises four issues, the first two of which can be considered together. Claimant argues:

"[1] The Board erred in finding that claimant's condition involving both his knee and back were stationary as of . . . the date the Determination Order established.

"[2] The Board erred in apparently assuming the claimant's back injury had 'completely resolved' by the time of the April 28, 1981 Determination Order."

We disagree with claimant on these points. We did not find that claimant's knee and back conditions were stationary at the time of the challenged Determination Order; instead, we found that claimant had not proven that either condition was other than stationary. That distinction may be subtle, but on this type of record we think that distinction is critical.

Claimant's third contention is: "The Board erred in apparently remanding this case to the Referee for rating the extent of left leg disability only." We agree with claimant on this point -- at least in the sense that our prior order requires clarification. The record before us on review contained absolutely no indication that claimant suffered permanent back disability as a result of the September 1980 injury. However, it may well have been that the parties did not develop evidence to this effect because claimant's back condition was in denied status. Thus, we did not intend that our remand to the Referee be limited to only the question of extent of claimant's leg disability; rather, the parties on remand are free to present and the Referee on remand is free to consider evidence regarding all of claimant's compensable permanent disability, including compensable back disability.

Claimant's fourth contention is: "The Board failed to assess any attorney fee against the insurer . . . although the Board affirmed the Referee's reversal of the insurer's July 10, 1981 denial." We agree with claimant on this point. See Kociemba v. SAIF, 63 Or App 557 (1983).

ORDER

As supplemented herein, the Board's Order on Review dated September 28, 1983 is readopted and republished effective this date except that: (1) The Board remands to the Referee to consider all compensable permanent impairment; and (2) claimant's attorney is awarded $150 for services rendered on Board review in connection with the issue of the insurer's July 10, 1981 denial, to be paid by the insurer.

BILL W. MACK, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 80-05084
February 21, 1984
Order of Abatement

The Board has received a motion to reconsider our Order on Review dated January 26, 1984.

In order to allow sufficient time to consider the motion, the above-noted Board order is abated, and the SAIF Corporation is requested to file a response to the motion for reconsideration within ten days.

IT IS SO ORDERED.

BILL W. MACK, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 80-05084
March 12, 1984
Order on Reconsideration

Claimant moves for reconsideration of the Board's Order on Review dated January 26, 1984. Claimant's motion is granted.

On reconsideration, we agree with claimant that the attorney fee awarded to claimant's attorney by our January 26, 1984 order is inadequate. Therefore, we amend our order as follows:

ORDER

The Referee's order dated June 13, 1983 is affirmed in part and reversed in part. That portion finding Reservation Ranch responsible for an aggravation claim is reversed and Gold Mountain is found responsible for claimant's occupational disease claim. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the SAIF Corporation under the Reservation Ranch claim, for prevailing on the interim compensation issue.

DAN M. MILLER, Claimant
Moscato & Meyers, Attorneys

WCB 83-01390
March 13, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Williams' order which found that claimant is not entitled to vocational assistance under the Workers' Compensation Act and applicable administrative rules. The issue is not one regarding claimant's participation in a particular authorized vocational rehabilitation program; the issue involves claimant's eligibility for any such program. See John W. Davidson, 34 Van Natta 213 (1982). There is a potential issue concerning the applicability of the administrative rule in effect at the time of claimant's injury in November of 1980, versus applicability of more recent administrative rules governing eligibility for vocational assistance. Lois E. Miller, 35 Van Natta 63, 64 (1983); Ray D. Dezellem, 34 Van Natta 213, 214-215 (1982). Compare OAR 436-61-100(1) (WCD Admin. Order 6-1980, eff. 6/1/80) and OAR 436-61-100(1) (WCD Admin. Order 4-1981, eff. 1/1/82) with OAR 436-61-100(6) (WCD Admin. Order 11-1982, eff. 1/1/83) and OAR 436-61-100(6) (WCD Admin. Order 2-1983, eff. 6/30/83). Because of our disposition, it is unnecessary for us to address this issue.

We find that the question of claimant's entitlement to vocational assistance was not properly before the Referee and is not properly before the Board, in view of claimant's failure to exhaust the administrative remedies provided by law at the time that claimant sought review of the insurer's decision regarding vocational assistance. ORS 656.728(6), 656.283(1). Those statutes provide, in pertinent part:

> "If a worker is dissatisfied with a decision by the department or by an insurer or self-insured employer regarding the eligibility of the worker to receive vocational assistance or regarding the nature or quality of

the assistance the worker is receiving, the worker must first apply to the director for review of the decision. Decisions of the director may be reviewed pursuant to ORS 656.283." ORS 656.728(6)

"Subject to ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim. However decisions of the director regarding participation in, but not eligibility for, an authorized vocational rehabilitation program may be modified only if the decision of the director . . . . " ORS 656.283(1).

Subsection (6) of ORS 656.728 went into effect on January 1, 1982. Administrative rules implementing the new review procedure were promulgated by the Workers' Compensation Department in February 1982, effective March 1, 1982. WCD Admin. Order 6-1982 (Temp.), OAR 436-61-998.

Claimant filed his request for hearing with the Board in February of 1983, contesting "the carrier's refusal to provide rehabilitation services to the claimant." There is no evidence that claimant applied to the director for review of the insurer's refusal to provide vocational assistance. Because the 1981 amendment to ORS 656.728 is procedural in nature, it provides a mandatory administrative review procedure which must be followed in resolving controversies arising on and after its effective date, irrespective of the date of a claimant's injury. Cf. Barrett v. Union Oil Distributors, 60 Or App 483 (1982); David L. Hulbert, 34 Van Natta 761 (1982).

Because claimant failed to exhaust a mandatory administrative review procedure provided by the law in effect at the time that this vocational assistance issue arose in 1983, the issue of claimant's entitlement to vocational assistance presently is not properly before us. We deem it appropriate to refer this matter to the Director for review of the insurer's decision, in accordance with the applicable statutory and regulatory provisions.

ORDER

The Referee's order dated April 25, 1983 is vacated, claimant's request for hearing is dismissed, and this matter is referred to the Director of the Workers' Compensation Department for review pursuant to ORS 656.728(6).

RICHARD L. POWELL, Claimant
Jack Ofelt, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-08438
March 13, 1984
Order of Remand

The SAIF Corporation requested review of Referee Leahy's order which set aside SAIF's denial of claimant's industrial injury claim and imposed a 25% penalty.

The Referee's order was entered on December 12, 1983. Apparently SAIF requested reconsideration of that portion of the order which imposed a penalty, by letter of December 15, 1983.

SAIF requested Board review of the Referee's order on or about December 28, 1983. On January 4, 1984, the Referee issued an amended order whereby he deleted the penalty provision from his original order. We presently have before us SAIF's request that the Board "allow the Amended Opinion and Order to be effective, despite the previous Request for Review filed by SAIF Corp. . . ," whereupon SAIF will withdraw its request for review.

Upon the perfection of SAIF's request for Board review, the Referee was divested of jurisdiction to amend his original order. OAR 436-83-480; Eduardo Ybarra, 35 Van Natta 1192 (1983). The Referee's amended order of January 4, 1984, therefore, is of no legal effect. In issuing that amended order, however, it is obvious that the Referee was attempting to cure an apparent oversight regarding SAIF's liability for payment of a penalty. It is apparent from the terms of SAIF's request to the Board that it would not consider itself aggrieved by the Referee's order in the absence of the penalty provision. No response has been forthcoming from claimant with regard to SAIF's request to the Board.

Considering the circumstances presented herein, we deem it appropriate to remand this case to the Referee for entry of an effective amended order or order on reconsideration. If either party is aggrieved by the Referee's order on remand, Board review may be requested anew.

ORDER

This case is remanded to the Referee for further proceedings.

MARVIN C. YAGER, Claimant
Burt, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys
Schwenn, et al., Defense Attorneys

WCB 83-00187, 82-08609 & 82-09187
March 7, 1984
Corrected Order on Review

It has come to our attention that the reference to the Referee's Opinion and Order was incorrect. The correct date of the order was May 18, 1983.

IT IS SO ORDERED.

PATRICIA A. ANDERSON, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-07388
March 14, 1984
Order on Reconsideration

On November 30, 1983 we issued our Order on Review which reversed the Referee's order which had set aside the insurer's February 18, 1982 denial of claimant's nasal/respiratory condition. On December 19, 1983 we abated our order to allow time for reconsideration in light of Bauman v. SAIF, 295 Or 788 (1983), because it was apparent that something was in accepted status before the February 1982 denial.

Among other things, our Order of Abatement requested the parties to address the question of what specific conditions/diseases were in accepted status prior to the February 1982 denial and, thus, cannot now be denied because of Bauman absent fraud, etc.

The insurer argues that prior to issuing its February 1982 denial, the only condition that had been accepted was a "misdiagnosed allergy condition," and that the denial issued only when subsequent medical reports from Drs. Bardana, Anderson and Smith were generated indicating that claimant's condition was actually a sarcoidosis or granulomatous process of unknown etiology. The insurer thus argues that Bauman only prohibits it from denying the misdiagnosed allergy condition.

The insurer's argument does highlight a problem that lurks in the Bauman doctrine. In our experience, it is not unusual for claims to first be accepted on the understanding that the claim is for condition "X," and then have subsequent diagnostic investigation reveal that the worker's injury or disease is, in fact, condition "Y." Does Bauman then prohibit a backup denial of condition "Y," which never really was in accepted status, or a backup denial of condition "X," which never really existed? We find it unnecessary to reach those difficult questions in this case.

Claimant filed an 801 form on June 4, 1980, indicating a date of diagnosis of occupational disease as being July 5, 1979. Medical reports beginning as early as August of 1979 indicated that claimant may have been suffering from a sarcoidosis condition. Dr. Schneider's report of August 29, 1979 stated that tissue samples revealed that: "The histologic appearance is consistent with sarcoidosis." Dr. Harless reported on February 19, 1980 that: "The biopsy is certainly compatible with sarcoidosis." Dr. Anderson reported on May 28, 1980 that pathological reports "came back with non-caseating granuloma," and noted that Dr. Smith believed claimant had nasal sarcoidosis. Dr. Lee reported on August 11, 1980 that the pathologic diagnosis was noncaseating granulomatoid disease compatible with sarcoidosis.

Although in subsequent medical reports the diagnosis seems to gradually shift to that of allergy, we believe that the reports noted above gave the insurer reasonable notice, at or about the time claimant filed her claim, that she may have been suffering from a sarcoidosis condition which may have been a component of her June 1980 occupational disease claim. However, it was not until January 1982 that the insurer decided to investigate the sarcoidosis diagnosis further by asking Dr. Bardana to review claimant's medical history. It was only after this much delayed investigation of the sarcoidosis diagnosis by Dr. Bardana that the insurer issued the denial here in issue. We conclude that it is just this type of procedure that is prohibited by Bauman.

The insurer alternatively argues that we should hold that the Bauman decision is not retroactive in effect, and that it should not be applied to cases which were processed in reliance on the court's prior holding in Frasure v. Agripac, 290 Or 99 (1980). We have previously rejected that specific argument, Walter T. VanMetre, 35 Van Natta 1792 (1983), and closely analogous arguments, Irene Penifold, 33 Van Natta 707 (1981), rev'd on other grounds, Penifold v. SAIF, 60 Or App 540 (1982).

Having concluded that the insurer's denial in this case was a backup denial which is impermissible under Bauman, it follows that we must vacate our November 30, 1983 Order on Review and affirm the

order of the Referee which set aside the insurer's February 18, 1982 denial.

ORDER

The Board's Order on Review dated November 30, 1983 is vacated, and the Referee's order dated March 18, 1983 is affirmed. Claimant's attorney is awarded $850 for services on Board review, to be paid by the insurer.

JAMES C. BALES, Claimant
Burt, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 83-02538
March 14, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer requests review of Referee McCullough's order which found that claimant had suffered a compensable worsening of his condition since the last award or arrangement of compensation and remanded the aggravation claim for acceptance and processing according to law.

The Board affirms the order of the Referee. ORS 656.273(7). Compare Oakley v. SAIF, 63 Or App 433 (1983) (aggravation claim found not compensable for lack of medical verification of a worsened condition) with Pumpelly v. SAIF, 50 Or App 303 (1981) (circumstantial evidence sufficient to establish compensability of aggravation claim in absence of medical evidence that claimant's condition had worsened since the last award of compensation); see also Bault v. Teledyne Wah-Chang, 53 Or App 1 (1981).

ORDER

The Referee's order dated May 31, 1983 is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the employer.

CALVIN C. KISHPAUGH, Claimant
Jan Wyers, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-10573
March 14, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant and the insurer request review of Referee Neal's order which increased claimant's award for unscheduled permanent partial disability for his right and left shoulder conditions from 35% (112°) to 60% (192°). Claimant contends he is permanently and totally disabled. The insurer contends the award is excessive.

The Board affirms that portion of the Referee's order which found that claimant was not permanently and totally disabled.

We agree with the insurer's contention that the award is excessive. Therefore, we modify the Referee's order.

Claimant is a 58 year old winder operator for a paper mill. Claimant experienced increasing pain in his shoulders over the last ten years of a twenty year employment with the mill.

Dr. Stewart, claimant's treating orthopedic surgeon, has diagnosed claimant's condition as chronic bilateral shoulder impingement syndrome with pain. After claimant failed to respond to conservative treatment, Dr. Stewart performed right shoulder surgery and a bilateral carpal tunnel release. Claimant testified that the surgery made his shoulder worse. He also testified that his left shoulder hurt more.

Dr. Stewart's latest report stated that claimant had essentially minimal impairment of both shoulders on a measurable, objective basis. The components for this objective basis consisted of 150° of forward flexion elevation and minimal reduction of internal rotation and adduction of his forearms to 125°-130°. Dr. Stewart reported that claimant had residual pain and tenderness, which the doctor rated as moderately severe.

Dr. Stewart restricted claimant's work activities to light work and limited his lifting to nothing over 20 pounds. The doctor felt that claimant could walk or stand for 4 hours and sit for 8 hours. Dr. Stewart reported that claimant should not be expected to do repetitive motions of his upper extremities which involved the shoulders and could do no lifting above his shoulders. He suggested that claimant was primarily capable of simple or relatively fine manipulation with his hands and forearms.

Claimant was also examined by Dr. Silverman, a rheumatologist. Dr. Silverman reported the closest he could come to a diagnosis was chronic pain syndrome involving the upper extremities. By that, Dr. Silverman reported he meant he could not identify any anatomic substrate underlying claimant's pain.

A Determination Order issued on November 9, 1982 awarding claimant 35% unscheduled disability for his shoulders. Claimant appealed the Determination Order. At hearing, he testified he had a toothache-type pain in both shoulders which radiated to his fingers. He has difficulty lifting and grasping objects. This affects his ability to perform household tasks or personal necessities. The pain prevents him from sitting for any extended period of time, and he sleeps no more than "a couple hours" at night. Claimant no longer fishes, plays ball, bowls or does yard work.

At the time of hearing, claimant had not seen a physician concerning his shoulder condition for approximately six months. He also was not taking any prescription pain medication.

Claimant has an eighth grade education. His work history has primarily centered around heavy labor.

The Referee increased the Determination Order's award by 25%, giving claimant a total of 60%. We feel the Determination Order's award should be increased. However, we find the Referee's award to be excessive.

Pursuant to OAR 436-65-600 et seq, we consider claimant's age, education, work experience, adaptability, mental capacity, emotional state, labor market findings, and physical impairment and residual pain, in rating the extent of claimant's disability. Considering the above guidelines and comparing this case to similar cases, we conclude that a total award of 144° for 45% unscheduled disability more appropriately compensates claimant.

ORDER

The Referee's order dated July 11, 1983 is modified. In lieu of the Referee's award, and in addition to the 35% (112°) unscheduled disability awarded by the Determination Order dated November 9, 1982, claimant is awarded 10% (32°) unscheduled disability for a total award to day of 45% (144°) unscheduled disability for injury to both shoulders. Claimant's attorney fees shall be adjusted accordingly.

EDWIN E. KRUSE, Claimant
Gary Susak, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-06543
March 14, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Leahy's order which affirmed the SAIF Corporation's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Claimant contends that: (1) The Referee abused his discretion in refusing to admit documents offered by claimant at the time of the hearing; and (2) his claim is compensable.

The Referee refused to admit some exhibits offered by claimant, on the ground that copies had not been furnished to the assigned Referee at least ten days prior to the hearing as required by OAR 436-83-400(3). The exhibits in question are a letter addressed to SAIF from Dr. Stephens, claimant's surgeon, and Dr. Stephens' chart notes. Copies of these documents, along with other relevant materials, were furnished by SAIF to claimant's counsel approximately four months before the hearing. When SAIF submitted its list and packet of exhibits to the Referee for hearing, it excluded the exhibits in question.

When claimant offered the exhibits as evidence, SAIF objected citing the ten day rule and alleging prejudice. Claimant contended they were admissible notwithstanding their submission at this late date. Claimant's counsel testified that SAIF had copies of the documents well in advance of hearing since it had furnished copies to him some four months before the hearing. Counsel further testified that he had discussed the substance of Dr. Stephens' letter with SAIF's counsel on at least two occasions prior to ten days before the hearing. Finally, claimant's counsel testified it had been the customary practice of the Referees to admit exhibits when they had been furnished to opposing counsel more than ten days prior to hearing.

The Referee acknowledged that it had been his custom to accept evidence under these circumstances. However, the Referee stated that under his interpretation of recent Board cases, evidence offered within the 10 day period was inadmissible. In his order finding the exhibits inadmissible, the Referee relied upon the Board's holdings in Dennis Fraser, 35 Van Natta 271 (1983), and Minnie Thomas, 34 Van Natta 40 (1982).

Since the issuance of the Referee's order, the Board decided Walter L. Hoskins, 35 Van Natta 885 (1983), and Thomas B. Ward, 35 Van Natta 1552 (1983). In Hoskins and Ward we held that the party offering the exhibit within ten days of the hearing had the burden

to show good cause for its violation of the ten day rule. Also in those cases we stated that in determining whether such documents would be admitted, we would consider whether the party offering the document had attempted to gain a strategic advantage by the late submission and whether the opposing party or the forum had been prejudiced or surprised by the late submission.

In Hoskins, we found that since the claimant had failed to provide an adequate explanation at hearing for his failure to comply with the ten day rule, the Referee correctly refused to admit the claimant's offered exhibits. Here, unlike Hoskins, SAIF alleged prejudice and claimant has offered on the record an explanation for his failure to comply with the rule.

Although SAIF alleged prejudice it presented no evidence to substantiate its allegation. Further, it did not rebut the testimony of claimant's counsel that it had supplied the documents to claimant's counsel and had discussed the substance of the Stephens' letter on at least two occasions prior to ten days before the hearing. We cannot find any surprise or prejudice to SAIF from these facts. Nor do we find any apparent prejudice resulting to the forum by admission of these exhibits.

The testimony of claimant's counsel indicates that he was either operating under the customary practices of the Referee and area, or careless in failing to submit the exhibits in a timely manner. In all likelihood he was guilty of both. While we do not condone such a practice, there was no hint of strategy or gamesmanship on his part.

Under these circumstances, we find that the excluded exhibits should have been admitted and, therefore, we reverse the Referee's evidentiary ruling. Because the exhibits offered by claimant are included in the record, we consider them in our review of the compensability of claimant's occupational disease claim. Edward Morgan, 34 Van Natta 1590 (1982).

We find claimant has failed to meet his burden of proving that his bilateral carpal tunnel syndrome was related to his work as a truck driver. Among the reasons for reaching this finding, we find it particularly noteworthy that claimant's symptoms first appeared during an approximately four month lay-off period. Further, claimant was temporarily employed as a bus driver for eight days during this lay-off.

ORDER

The Referee's order dated April 21, 1983 is affirmed.

JOE LAWSON, JR., Claimant
Olson Law Firm, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-07403
March 14, 1984
Order on Review (Remanding)

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Presiding Referee Daughtry's order which dismissed his request for hearing.

This case involves a situation in which the SAIF Corporation refused to pay billings from claimant's chiropractor for treatments

in excess of the frequency-of-treatment guidelines contained in the Workers' Compensation Department administrative rules. OAR 436-69-201. The dispute over whether these treatments are excessive has been submitted to the Department. Subsequent to the Referee's decision in this case we held in Lloyd C. Dykstra, 36 Van Natta 26 (1984), that a claimant has a right to request a hearing even though a medical services issue is also being contested pursuant to the Department's administrative procedures. Accordingly, we reverse the Presiding Referee's order for the reasons stated in Dykstra.

ORDER

The Presiding Referee's order dated September 21, 1983 is reversed, and this case is remanded to the Hearings Division for a hearing on the merits of claimant's request.

Board Member Barnes Concurring:

The record indicates that, although no final Department order has been issued, the Department has made a preliminary determination that there is insufficient support for the frequency of treatment that Dr. Davis has provided to claimant. The Board has ruled that the existence of a parallel Department remedy does not have any impact on our jurisdiction over hearing requests on the same issues. Lloyd Dyskstra, 36 Van Natta 26 (1984). That does not mean, however, that the outcome of Department proceedings is irrelevant in proceedings before this agency. Rather, in my opinion, this agency should regard the outcome of peer review in the Department (if known at the time of hearing) as very cogent evidence on the same or substantially same issue(s) before us.

JOAN E. SMITH, Claimant
John L. Svoboda, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03703 & 83-06776
March 14, 1984
Order of Dismissal and Referral to Evaluation Division

Claimant requested review of Referee Baker's order, specifically designating for review that portion of the order concerning "the denial of compensability for claimant's wrists." Claimant now has notified the Board of her intention to withdraw her request for review. Claimant also has filed with the Board a document titled "Request for Board Reclassification to Disabling Status."

It is apparent that no ruling was made concerning the compensability of claimant's "wrists," for the reason that claimant's wrist condition is in accepted status. The portion of the Referee's order concerning which claimant apparently seeks review is that portion which makes a determination of whether there are presently any disabling consequences related to claimant's wrist condition. This is a determination to be made in the first instance by the Evaluation Division, and the Referee lacked jurisdiction to consider this aspect of the claim. Anthony A. Bono, 35 Van Natta 1, 6-8, rev'd on other grounds, 66 Or App 138 (1983). Claimant's proper remedy is to request reclassification by application to the Evaluation Division pursuant to ORS 656.262(6) and 656.268.

In making a limited review of the record in order to properly

dispose of claimant's request, we note an apparent ambiguity with reference to the acceptance of claimant's wrist condition by the SAIF Corporation. As noted by the Referee, it was initially assumed by claimant's physician that claimant's wrist/hand pain and numbness was due to muscle spasm in the neck. It was not until February 1983 that claimant's attending physician performed nerve conduction studies and made a diagnosis of possible carpal tunnel syndrome, although in a letter from a chiropractic physician in June of 1981 a suspicion of carpal tunnel syndrome was expressed.

In response to correspondence from claimant's attorney, in May of 1983 SAIF requested that claimant complete a Form 801 in order to process her claim for carpal tunnel syndrome. The claim form was completed by claimant in June of 1983, and the claim was accepted by SAIF as nondisabling on July 8, 1983. The claim form designates June 2, 1982, as the "date and hour of injury or date of diagnosis of occupational disease;" and the notice of acceptance, dated July 8, 1983, designates the "date of injury" as June 2, 1982.

We have mentioned these apparent facts in an effort to assist the parties and the Evaluation Division in the proper processing of the claim which is the subject of the Form 801 completed by claimant in June of 1983 and accepted by SAIF in July of 1983. We deem it appropriate to refer claimant's request for reclassification to the Evaluation Division for performance of its statutory duty pursuant to ORS 656.268.

ORDER

Claimant's request for review of the Referee's order dated November 28, 1983, now having been withdrawn, hereby is dismissed. The Referee's order is now final by operation of law. Claimant's request for reclassification of her 1983 claim is referred to the Evaluation Division.

WILMA FORNEY, Claimant
Evohl Malagon, Claimant's Attorney
Schwabe, et al., Defense Attorney

WCB 80-07538
March 15, 1984
Order of Abatement

Pursuant to the order of the Court of Appeals entered herein, the Board issued its Order on Remand on February 24, 1984. As is customary, the Board awaited receipt of the court's final order prior to acting on remand. This would appear to be a jurisdictional prerequisite. Cf. SAIF v. Castro, 60 Or App 112 (1982).

The Board now is in receipt of claimant's motion for an order abating the above-referenced Order on Remand, in view of a petition for review filed by claimant with the Supreme Court, requesting reconsideration by the Court of Appeals, or review by the Supreme Court, of a Court of Appeals order dated January 26, 1983 denying claimant's petition for an attorney's fee. We fail to understand why, if there presently is a petition for review pending before the court, we would have received the court's final order indicating that the Court of Appeals' decision was enforceable as of February 9, 1984; however, we see no reason to refrain from acting upon claimant's request for abatement of our Order on Remand.

ORDER

The Board's Order on Remand entered herein on February 24, 1984, hereby is abated and shall remain abated until the Board is further informed by the parties.

RUSSELL CARTER, Claimant
Mike Haines, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-05764
March 16, 1984
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Fink's order which set aside its June 5, 1981 denial. The issues for review are whether claimant experienced a worsening of his preexisting multiple sclerosis condition in 1981, and if so, whether claimant's employment related stress was the major contributing cause of that worsening.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated March 9, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

Board Member Barnes Dissenting:

I would reverse the Referee's order and reinstate SAIF's denial because I am not persuaded that claimant's work stress was the major cause of any worsening of his preexisting multiple sclerosis condition.

Claimant, who was 39 years of age at the time of the hearing, was employed as a regional manager in Portland for the Field Services Division (FSD) of the Workers' Compensation Department. Claimant's responsibilities included supervision of referrals of injured workers from FSD to vocational rehabilitation organizations. Two of those organizations were owned by a Mr. Williams.

In September 1979 Mr. Williams took several state officials, including claimant, on a trip to Las Vegas. In early 1981 the media learned of this trip and reported it in considerable detail. Various investigations were conducted, which resulted in an allegation that there had been an increase in FSD referrals to the rehabilitation organizations owned by Mr. Williams after the Las Vegas trip. In the midst or the wake of these various investigations and allegations, claimant suffered an exacerbation of his multiple sclerosis condition and then filed this claim.

The battle lines on the causation issue are clearly drawn. Dr. Swank opines that employment stress was the major cause of the worsening of claimant's preexisting multiple sclerosis. Drs. Snodgrass, Stolzberg and Watson opine that stress, employment or otherwise, could not cause and did not cause any worsening of the multiple sclerosis. Although the majority is not willing to articulate its reasoning, presumably Dr. Swank's opinion is found persuasive despite the contrary opinions of Drs. Snodgrass, Stolzberg and Watson.

I

I first note that this case is virtually a carbon copy of Allen Giesbrecht, 33 Van Natta 676 (1981), affirmed Giesbrecht v. SAIF, 58 Or App 218 (1982), in all respects except that here the Board majority reaches the opposite conclusion than the Board and Court of Appeals reached in the prior case. Giesbrecht involved a claim that work exposure to high temperatures caused a worsening of preexisting multiple sclerosis. Dr. Swank was the only physician to support that position; Drs. Snodgrass, Wilson, Rich and Dow all expressed opinions to the contrary. 33 Van Natta at 676. The Board found the claim was not compensable, stating:

> "Four neurologists, all with experience in the diagnosis and treatment of multiple sclerosis, all testified in this case that medical science does not know the factors that cause or aggravate multiple sclerosis. We acknowledge Dr. Swank's interest in multiple sclerosis, but his theories of causation are not in accordance with the mainstream of medical thought in Oregon or the United States." 33 Van Natta at 677.

Despite having previously described Dr. Swank as "a leading expert in the diagnosis and treatment of multiple sclerosis," Abbott v. SAIF, 45 Or App 657, 660 (1980), the Court of Appeals also found the claim in Giesbrecht was not compensable, stating:

> "Not only did Abbott not concern the issue of heat as a cause of worsening of multiple sclerosis, but the contribution of one expert's opinion to the preponderance of evidence in one case has no bearing on the relative weight of the same expert's opinion in another case with a different mix of medical opinion." 58 Or App at 219.

I suspect that, after considering what four more physicians thought of Dr. Swank's theories, the court determined that Dr. Swank was not quite the expert it had previously thought him to be.

In any event, my main point goes considerably further than just complaining about the inconsistent results in Giesbrecht and this case: I find it distressing that such inconsistency seems at least countenanced, if not encouraged, by the courts.

In Miller v. SAIF, 60 Or App 557, 562 n. 2 (1982), the court stated:

> "The Board relied in part on our statement in Hamel v. Tri-Met, 54 Or App 503, 508 . . . (1981), that 'relatively minor activity can trigger the herniation of a vertebral disc.' That statement was made in reliance on medical evidence that was presented in that case, not as a matter of judicial notice, and we caution the Board against use in one case of evidence produced in another."

In Bales v. SAIF, 294 Or 224, 235 n. 4 (1983), the court expressed the same view of workers compensation litigation in more general terms:

> "The factfinder must discharge his task on the record made in the particular case. The facts found upon the record and evidence in one case do not become rule of law to be applied to the determination of the facts upon another record and other evidence."

These comments from Miller and Bales are undoubtedly valid up to a point; but I am concerned that these comments imply that there are never facts in medical science that can be relied on as universally accurate or that such "facts" can change from one case to the next. It is, of course, a fundamental tenent of scientific inquiry that all "facts" are subject to reconsideration and revision in light of new data. It is also a fundamental aspect of human society that decisions have to be made every day based on current understanding of medical facts. For example, it is a currently accepted scientific fact that yellow fever is a viral infection transmitted by the bite of the Aedes aeygti mosquito. Would a human society that wanted to eliminate yellow fever decide to attack that problem by adding anti-bacterial agents to its drinking water? Of course not -- at least unless and until new data led to some revision of the scientific fact about the cause and transmission of that disease.

Is there any valid reason why such reliance on known medical facts should not be permitted in workers compensation litigation? Assume that, in a case involving claimed compensation for yellow fever, a physician testifies that he is a member of the (admittedly minority) "school of medical thought" which attributes yellow fever to excessive pushing and pulling of heavy objects at work. Bales and Miller would seem to imply that it would be perfectly legitimate to accept such testimony and make such a finding. In my opinion, the only thing that would be perfect about that is that it would be perfect nonsense.

A legislature creates administrative agencies and assigns duties to agencies for a variety of reasons. One prominent reason is that, usually because of the complexity of a given subject, the legislature wants decisions in that area to be made by specialists in that field rather than by generalists, such as jurors or appellate judges. E.g. Robert Sanchez, 32 Van Natta 80, 81 (1981): "From reading literally dozens of doctors' reports in carpal-tunnel cases, this Board feels it has some expertise in the etiology of that condition." I would have thought that our expertise is an advantage, not a disadvantage, and is a prominent part of the legislative rationale for assigning workers compensation litigation to a specialized administrative agency that does nothing else. But Bales and Miller would seem to imply that, in reviewing the evidence in any one case, we should try to forget everything we have learned about the injury or disease in issue from reading the evidence in prior similar cases. I submit that is neither realistic nor desirable. See Rolfe v. Psychiatric Security Review Board, 53 Or App 943 (1981).

Turning to this case specifically, I think that the ultimate

question before us is: Is it ever possible for any environmental factor (such as job stress) to cause multiple sclerosis? Considering the medical evidence in Abbott, in Giesbrecht and in this case, a total of seven of the most qualified and most respected Oregon physicians have categorically said that question should be answered in the negative. Dr. Swank stands solitary for the contrary position. After this much exposure to this many medical opinions, I feel comfortable in concluding it is a scientific fact that no environmental factor is now known to cause or to worsen multiple sclerosis, and that fact is always true, it does not vary from one case to the next. Contaminated drinking water does not cause yellow fever. Environmental factors do not cause multiple sclerosis. It should be just that simple.

II.

Assuming the issues before us must be answered on a case-by-case basis, with the answer in this case coming only from an assessment of the record in this case, my conclusion remains the same.

Both Dr. Snodgrass and Dr. Watson are board-certified neurologists who have experience in the diagnosis and treatment of multiple sclerosis. Although both physicians acknowledged Dr. Swank's long-standing interest and involvement with multiple sclerosis, both physicians stated that they did not consider him to be an authority on that disease.

Dr. Snodgrass testified that the most respected experts in the field of neurology do not agree that stress causes or exacerbates multiple sclerosis. Dr. Snodgrass stated that there are numerous medical publications which refute Dr. Swank's contrary theory. Dr. Snodgrass cited medical studies done on military personnel who were suffering from multiple sclerosis. He stated that if there were a connection between stress and multiple sclerosis, one would expect the incidence of the condition to be higher in military personnel who had combat experience than in those who had not been in combat. Dr. Snodgrass stated that the studies failed to confirm a higher incidence of the condition in combat veterans. Dr. Snodgrass testified:

> "I don't have a philosophy that stress can never cause MS. My philosophy is that we have no evidence whatsoever that stress does cause MS except for a few anecdotes where people say, 'Yes, I've seen cases which seem possibly to be related.' * * * I think there's no evidence, no good evidence from reputable centers that this is the case."

Dr. Watson testified that he was quite familiar with Dr. Swank's theories because he had worked with him before and had followed Dr. Swank's work with "considerable interest" for 30 years. Dr. Watson stated that Dr. Swank's theories on multiple sclerosis are widely regarded to be incorrect. Dr. Watson testified that he was of the opinion that many of Dr. Swank's patients did not actually have multiple sclerosis because they have not undergone spinal fluid examinations which are necessary for a definitive diagnosis. Dr. Watson explained that Dr. Swank did not perform those tests for fear that the stress of the tests would

aggravate the patients' supposed multiple sclerosis. Although the exact etiology of multiple sclerosis is not known, Dr. Watson stated that there is general agreement in the medical community that there is no correlation between stress and multiple sclerosis.

Dr. Stolzberg reported on March 5, 1982 that he was aware of no scientific evidence to support the concept that stress and multiple sclerosis are related. He stated that the best accepted model is that patients with a certain genetic make-up are sensitized by an infectious or toxic agent in adolescence, and develop abnormal immunological activity which impairs the function of the nervous system. Although the exact details were not known, Dr. Stolzberg stated that there is no evidence linking the disease to stress.

I find a paragraph from Dr. Stolzberg's March 5, 1982 report particularly poignant:

> "It is human nature to seek explanations for our afflictions, even when there are no rational explanations available. In moralistic, traditional communities the explanation is sin. In our self-centered communities the explanation is stress. In either case, we would blame one bad thing on another rather than accept that bad things simply happen in ways which we cannot fully comprehend. I am sure that when the immunology of multiple sclerosis has been worked out to the point that remissions can be foreseen by laboratory tests and controlled by medication, there will be much less interest in 'stress' as a cause of illness. Nevertheless, if stress remains an acceptable way of obtaining financial assistance, it will remain popular with patients and their attorneys long after it has become scientifically irrelevant, like humors and vapors."

In summary, the record in this case contains only one medical opinion that supports compensability, the opinion from Dr. Swank. Although it has been said that Dr. Swank "has as many as 1,000 multiple sclerosis patients," Abbott v. SAIF, supra, 45 Or App at 661, Dr. Watson persuasively points out in the record in this case that it is doubtful that all these patients really have multiple sclerosis in the absence of spinal fluid examinations. Moreover,

and more importantly, Dr. Snodgrass, Watson and Stolzberg persuasively document in the record in this case that: (1) No respected medical research has ever found evidence of a link between stress and multiple sclerosis; and (2) considerable respected medical research has produced evidence of a lack of correlation between stress and multiple sclerosis, e.g., the finding that combat veterans had no higher an incidence of that disease than noncombat veterans. The record in this case clearly establishes that Dr. Swank's theory remains just that -- a theory that has not been verified by any research findings and has been significantly impeached by many research findings. I am at a loss to even guess

how, on the record in this case, this unverified theory can possibly rise to the level of a preponderance of the persuasive evidence in the minds of my Board colleagues.

I would reverse the Referee's order and reinstate SAIF's denial of this claim. I, therefore, respectfully dissent.

DENNIS P. CUMMINGS, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 81-06478 & 81-07564
March 16, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation, as insurer for Gold Coast Realty, requests review of Referee Shebley's order which: 1) Found that under ORS 656.029 claimant was a subject worker of Gold Coast Realty at the time of his April 1981 injury; 2) set aside SAIF's denial on behalf of Gold Coast Realty; and 3) set aside SAIF's denial as the processing agent for the claim against Bruegger and Company Signs. SAIF contends that ORS 656.029 does not operate to make claimant a subject worker of Gold Coast Realty. The Workers' Compensation Department submitted an amicus brief on Board review, requesting that the Board reverse the portion of the Referee's order that set aside SAIF's denial as the processing agent for the claim against Bruegger and Company Signs. We agree with SAIF and reverse the Referee's order as to the claim against Gold Coast Realty.

We make the following findings of fact.

At the time of claimant's injury in April 1981, claimant was working for Mr. Bruegger dba Bruegger and Company Signs, which constructed, installed and removed signs. Gold Coast Realty had engaged Bruegger to construct a "for sale" sign and install it on some Brookings property listed by Gold Coast Realty. When the listing on the property expired, Gold Coast contacted Bruegger to remove the sign. Mr. Bruegger directed claimant to remove the sign, during the course of which claimant was injured. Bruegger and Company Signs had no workers' compensation coverage.

SAIF issued two denials. As the insurer for Gold Coast Realty, SAIF denied that claimant was a subject worker of Gold Coast on the date of injury and argued that ORS 656.029 did not extend liability to Gold Coast. As the processing agent for the claim against the alleged noncomplying employer, Bruegger and Company Signs, SAIF stated in its denial that it was instructed by the Workers' Compensation Department to deny the claim against Bruegger on the basis that claimant was covered by Gold Coast Realty under ORS 656.029 and thus was not the subject worker of Bruegger.

On the date of claimant's injury, ORS 656.029(1) provided:

> "If any person engaged in a business and subject to this chapter as an employer lets a contract involving the performance of labor and such labor is performed by the person to whom the contract was let, with

> assistance of others, all persons engaged in the performance of the contract are deemed subject workers of the person letting the contract unless the person to whom the contract is let has qualified either:
> (a) as a direct responsibility employer as provided pursuant to ORS 656.407; or
> (b) as a contributing employer as provided by ORS 656.411.

The Referee concluded that Bruegger was neither a direct responsibility employer nor a contributing employer and, therefore, that Gold Coast Realty was responsible for claimant's injuries pursuant to ORS 656.029. We do not agree that the agreement between Gold Coast Realty and Bruegger and Company Signs constitutes "letting a contract" as that term is used in ORS 656.029.

Ballentine's Law Dictionary defines "letting" as "an Americanism for the act of a public body or private owner for engaging a contractor for the construction of a building or other improvement, normally after bids for the work have been received, thus entailing the selection of a contractor from a number of bidders." Ballentine's Law Dictionary 727 (3d ed. 1969). "Letting contract" is defined as "the steps in the formation and execution of a contract, particularly a public contract, including an advertising for bids, the reception of bids, and the award of the contract to the lowest bidder, provided he appears to be a responsible bidder." Ballentine's Law Dictionary 727 (3d ed. 1969).

Prior to 1965, ORS 656.124 contained language substantially similar to that now contained in ORS 656.029. In Didier v. SIAC, 243 Or 460 (1966), the court contemplated application of ORS 656.124(1), which then provided:

> "If any person engaged in a business and subject to ORS 656.002 to 656.590 as an employer, in the course of such business, lets a contract involving the performance of labor, and such labor is performed by the person to whom the contract was let with the assistance of others, all persons engaged in the performance of the contract are deemed workmen of the person letting
>
> the contract for the purposes of this section unless the person to whom the contract is let is regularly engaged in a business involving the occupation covered by the contract and has currently on file and in effect with the commission a statement or notice made under ORS 656.024, 656.034, 656.052 or subsection (2) of this section . . ."

Didier involved the following facts. The decedent operated a welding and machine shop at his home. LaRue, a wholesale gas and oil distributor, brought a portable gas tank to the decedent's home to be repaired. In the course of the repair work the tank

exploded, fatally injuring decedent. The Didier court refused to deem the decedent a covered worker of LaRue under ORS 656.124, stating: "We do not agree, however, that merely because the decedent was engaged to perform services for the covered employer the decedent became a covered workman under the covered employer's account." 243 Or at 463. The Didier court also said: "In common parlance, one who leaves an implement with a repairman is not said to have 'let a contract.'" 243 Or at 464.

Similarly, we do not believe that Gold Coast Realty, by engaging Bruegger to remove a sign, had "let a contract" to Bruegger. The definition of "letting" connotes the situation where bids normally are received and the contract is awarded to the lowest bidder. Considering the term "letting a contract" in light of the holding and reasoning in Didier, we are unwilling to apply ORS 656.029 to every contract for the performance of services. Just as contracting for the repair of a gas tank was not deemed letting a contract in Didier, contracting for the removal of a sign in the present case is not deemed letting a contract under ORS 656.029. Therefore, we do not apply ORS 656.029 to extend liability to Gold Coast Realty for claimant's injury.

By contrast, we held that a movie and amusement business that contracted for the performance of sheetmetal work in a remodel project was the employer of the sheetmetal company's worker who was injured. Richard O. Hampton (WCB Nos. 82-05869 & 82-05870), 36 Van Natta 230 (March 8, 1984). Whether the movie businessperson in Hampton received bids for the sheetmetal work is not crucial. What matters is that the movie businessperson acted as a general contractor in contracting for the work required to remodel the building. In contracting for the sheetmetal work, the movie businessperson, by written contract, let a contract for the performance of labor and invoked the application of ORS 656.029.

Therefore, we hold that claimant was not an employe of Gold Coast Realty under ORS 656.029, and instead, was the employe of the alleged noncomplying employer, Bruegger and Company Signs.

ORDER

The Referee's order dated April 20, 1982 is affirmed in part and reversed in part. The SAIF Corporation's July 29, 1981 denial on behalf of Gold Coast Realty is affirmed. SAIF's July 29, 1981 denial, issued at the request of the Workers' Compensation Department, which contended that claimant was not a subject worker of Bruegger and Company Signs, is reversed. This matter is remanded to SAIF as the processing agent for the alleged noncomplying employer, Bruegger and Company Signs.

Board Member Lewis, concurring opinion:

I agree with the result on this review. However, I differ with the reasoning. See my dissent in Richard O. Hampton (WCB Nos. 82-05869 and 82-05870), 36 Van Natta 230 (March 8, 1984).

ADAM J. GABEL, Claimant
Roll & Westmoreland, Claimant's Attorneys
Rankin, et al., Attorneys
Schwabe, et al., Attorneys
Roberts, et al., Attorneys
Frank Moscato, Attorney
Mitchell, et al., Attorneys
Richard Pearce, Attorney
SAIF CORP Legal, Attorney

WCB 81-02817, 81-03932, 81-0498, 81-04990, 81-09226, 81-10240, & 81-10404
March 16, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The self-insured employer requests review of Referee Fink's order which assigned it responsibility for claimant's hearing loss claim. Responsibility is the only issue on review.

Claimant worked for the employer as a sheet metal worker and welder for approximately thirty years. During that period the employer obtained workers' compensation insurance from a series of six different insurers. In November 1978 the employer became self-insured. During the course of his thirty years with the employer, claimant developed hearing loss. He never lost time from work as a result of his hearing loss. He retired on June 1, 1981. Claimant filed a claim for his hearing loss against all six insurers and the employer.

The Referee assigned responsibility to the self-insured employer because claimant's exposure after the employer became self-insured was the last exposure which could have contributed to claimant's hearing loss. We reverse because we think that the Referee misapplied the last injurious exposure rule.

The Supreme Court in Bracke v. Baza'r, 293 Or 239, 248 (1982), held that in an occupational disease context in which more than one employer/insurer is potentially responsible: "[T]he potentially causal employer at the time disability occurs is assigned liability for the cumulative whole." The Court of Appeals recently applied this holding to situations in which a claimant's disability never resulted in time loss, but merely in the claimant seeking medical treatment, and held that the time disability occurs is the date the claimant first sought medical treatment. SAIF v. Carey, 63 Or App 68 (1983). Therefore, the insurer on the risk at the time claimant first sought medical treatment is liable.

We find that claimant first sought medical treatment when SAFECO insurance was on the risk. Accordingly, we assign responsibility to SAFECO.

ORDER

The Referee's order dated December 15, 1982 is reversed. The self-insured employer's denial is reinstated. SAFECO's denial is set aside and this claim is remanded to SAFECO for processing. SAFECO shall reimburse the self-insured employer for compensation and attorney fees paid by the self-insured employer in reliance on the Referee's order or payable under the terms of that order.

Board Member Barnes Concurring:

Hearing loss claims are typically rather modest claims. This type of claim rarely involves any time loss. Instead, all that is usually at stake is the cost of a hearing aid and a small amount of permanent disability.

Given that understanding, I find it astonishing that seven different lawyers representing the employer and its prior insurers have filed briefs that total about 57 pages on the question of which is going to pay for this probably modest claim; which is astonishing because I would be willing to bet that the cost of that much representation exceeds the cost of this claim.

It is impossible to know what combination of factors produces such a perverse allocation of workers compensation resources. Perhaps some defense lawyers recommended litigating this case "to the hilt" despite awareness that any "victory" would be pyrrhic. Perhaps some insurers insisted on litigating this case "to the hilt" even though any "victory" would be pyrrhic.

In my opinion, however, a large part of the explanation is legislative inaction and judicial activitism. Unless the legislature really wants the costs of legal representation to exceed probable claim costs in this kind of situation, a bill to provide for apportionment of claim costs between different insurers and/or to provide for binding arbitration between different insurers should be considered. Unless the appellate courts also want legal costs to exceed claim costs, it would be desirable if judicial pronouncements on the law governing employer/insurer responsibility were characterized by greater clarity and stability than has been true in recent years.

MICHELE D. TORRES, Claimant
Allen & Vick, Claimant's Attorneys
G. Howard Cliff, Defense Attorney

WCB 83-04871
March 16, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The insurer requests review of Referee Kaffun's order which set aside the Order of Suspension of Compensation issued by the Compliance Division pursuant to OAR 436-54-283.

Subsequent to the Referee's order, the Court of Appeals issued its opinion in Carr v. SAIF, 65 Or App 110 (1983). In Carr, the court held that OAR 436-54-281 and 436-54-283, which allowed the suspension of a claimant's benefits without providing him with notice and an opportunity to be heard before the suspension, violated due process of law. The present case involves the same procedures that Carr found unconstitutional. Based on the Carr decision, we affirm the order of the Referee without reaching the issues decided by the Referee or briefed by the parties.

ORDER

The Referee's order dated August 9, 1983 is affirmed. Claimant's attorney is awarded $450 for services rendered on Board review, to be paid by the insurer.

DWAYNE G. CARY, Claimant
Douglas L. Minson, Claimant's Attorney
Roberts, et al., Defense Attorneys

Own Motion 82-0174M
March 20, 1984
Own Motion Order and Determination

Claimant, by and through his attorney, requested that the Board exercise its own motion authority and reopen his December 11, 1974 injury claim for worsened conditions allegedly related to his original injury. By an order dated July 27, 1982, the Board referred claimant's request for own motion relief to the Hearings Division for consolidation with claimant's hearing request in WCB Case No. 81-09813. The Referee conducted a consolidated hearing and entered an order in WCB Case No. 81-09813 pursuant to ORS 656.289. That order now has become final by operation of law. In addition, the Referee made a recommendation to the Board concerning claimant's request for own motion relief. In deciding what relief to grant claimant pursuant to ORS 656.278, we have considered the Referee's recommendation, as well as the evidentiary material developed before the Referee and made of record in WCB Case No. 81-09813. Since the Board's receipt of the Referee's recommendation, additional medical information has been developed, and the posture of the proceeding has changed somewhat, with regard to the relief claimant is requesting.

The issues before the Referee, including the issues arising under ORS 656.278 on referral by the Board, were whether claimant's injury-related condition had compensably worsened since the last award or arrangement of compensation, including an issue of whether an elective surgical procedure should be performed; whether claimant had perfected an aggravation claim pursuant to ORS 656.273, or whether claimant's remedy was by application to the Board pursuant to ORS 656.278; payment of interim compensation; penalties and attorney fees for the insurer's allegedly unreasonable failure to timely accept or deny claimant's aggravation claim and failure to initiate payment of interim compensation. The Referee determined that claimant had failed to perfect a request for claim reopening pursuant to ORS 656.273 within five years of the first claim closure, i.e. on or before June 24, 1981; therefore, he concluded that "aggravation reopening" was not an issue properly before him. This finding was dispositive of claimant's request for interim compensation, penalties and attorney fees, and the Referee so ruled. He overturned the insurer's denials only to the extent that those denials placed in issue claimant's entitlement to continuing medical care and services, and, apparently, only with reference to medical care and services for treatment of claimant's low back condition. There also was a claim, in the form of recommended surgery, for treatment of claimant's cervical condition. The issue of the causal relationship between claimant's current cervical condition and his original industrial injury was made the subject of the Referee's separate own motion recommendation to the Board, rather than the subject of the Referee's appealable order in WCB Case No. 81-09813.

Preliminarily, we note that the issues disposed of by the Referee's order in WCB Case No. 81-09813 are not subject to modification, in view of the fact that the order now is final by operation of law. One of the issues disposed of was claimant's

entitlement to claim reopening as a matter of right under ORS 656.273. Another issue directly addressed was the causal relationship between claimant's original injury and his current low back condition. The Referee found sufficient evidence of a causal connection and, therefore, set aside the insurer's denial of "continuing medical care and services," and remanded the claim for "processing and payment of benefits as provided by law." In his own motion recommendation, however, the Referee recommended that the Board deny claimant's request that his claim be reopened, "until such time as a more definitive medical record is developed. * * * Based upon this record, I feel there is compelling reason not to defer to the treating physician regarding claimant's need for additional medical care and treatment [i.e. surgery]. * * * * * "

Although it may have been unavoidable in this case, in view of the complicated procedural and factual issues presented, it is apparent that the Referee created a mix of issues arising under ORS 656.273, 656.245 and 656.278. When the matter came before the Referee, the primary issue was claimant's entitlement to medical services for conditions allegedly related to his original industrial injury. This was presented primarily in the context of a claim for recommended surgical treatment. Such claims arise under ORS 656.245, which provides in part that a claimant is entitled to medical services for conditions resulting from a compensable injury "for such period as the nature of the injury or the process of the recovery requires," and that the duty to provide such medical services continues for the life of the claimant. ORS 656.245(1).

> "When the time for submitting a claim under ORS 656.273 has expired, any claim for medical services referred to in this section shall be submitted to the insurer or self-insured employer. If the claim for medical services is denied, the worker may submit to the Board a request for hearing pursuant to ORS 656.283." ORS 656.245(2).

A claim for medical services, including a request that a recommended surgical procedure be authorized, is a matter concerning which the claimant has a right to hearing pursuant to ORS 656.283, which carries with it the right to an appealable Referee's order pursuant to ORS 656.289. Donald L. Lentz, 35 Van Natta 1084 (1983); Max D. Cutler, 34 Van Natta 1480 (1982). See also Willard B. Evans, 34 Van Natta 490, 491 (1982) (reversed on the substantive issue of whether claimant established a claim for medical services, Evans v. SAIF, 62 Or App 182 (1983)); Mary Ann Hall, 31 Van Natta 56 (1981).

Issues concerning the causal relationship between a claimant's current condition and the original industrial injury frequently arise after expiration of the claimant's aggravation rights pursuant to ORS 656.273. Where the issue arises in the context of a claim for medical services, see generally Billy J. Eubanks, 35 Van Natta 131 (1983); Patricia M. Dees, 35 Van Natta 120 (1983), such issues are the proper subject of a hearing request pursuant to ORS 656.283 and a Referee's order pursuant to ORS 656.289. When there is, in addition to the claim for medical

services, an associated claim for temporary and/or permanent disability compensation, and the claim is made after expiration of the aggravation period, these related questions of claimant's entitlement to disability benefits are matters to be considered by the Board pursuant to ORS 656.278.

We have taken the opportunity to discuss this procedural issue in the context of this case because of the apparent confusion on the part of the parties and the Referee. In addition, to the extent that there may exist a certain amount of confusion among the Referees and litigants at large, with regard to medical service litigation during the post-aggravation period, we are hopeful that this will serve as some clarification of the parties' respective rights and remedies. See generally William A. Newell, 35 Van Natta 629 (1983).

Addressing the merits of claimant's request for own motion relief, we find that, most recently, claimant has elected not to submit to surgical treatment, and that all physicians involved have opted in favor of additional management of a more conservative nature. By virtue of the Referee's order in WCB Case No. 81-09183, there would appear to be no viable issue concerning claimant's entitlement to conservative treatment for the conditon of his low back. The evidence clearly and convincingly indicates that claimant's low back condition is medically stationary; however, there is also substantial medical evidence to indicate that claimant's low back condition has worsened since the last award or arrangement of compensation, which was a Determination Order dated December 7, 1977, which awarded no permanent disability in addition to the 16° for 5% unscheduled disability awarded on claimant's initial claim closure. Accordingly, we deem it appropriate to award additional unscheduled disability for claimant's low back injury.

Considering the impairment to claimant's low back, his age, education and work experience, utilizing the guidelines for the evaluation of permanent disability, OAR 436-65-600, et seq., and considering this case in light of other cases involving similarly situated injured workers, we find that claimant is entitled to receive an additional 48° for 15% unscheduled disability for injury to his low back. This is consistent with the Referee's recommendation, which we have taken into consideration.

Addressing claimant's entitlement to own motion relief for the present condition of his cervical spine, the record discloses that, as a result of his original injury, claimant sustained a cervical strain with no evidence of arm pain, reflex changes, numbness or other neurological findings. In September of 1981, while working on a sign, claimant twisted to the left and developed pain in his neck on the left side radiating into his left shoulder. This history is reflected in an office note dated September 14, 1981, from the office of Dr. Anton Eilers, whom claimant consulted after this episode occurred. We find persuasive Dr. Rosenbaum's opinion concerning the question of the causal relationship between claimant's original injury, the ensuing cervical strain, and claimant's present cervical problems, diagnosed as a herniated cervical disc. We find insufficient evidence to substantiate claimant's request for own motion relief, i.e. temporary and/or permanent disability compensation, for the present condition of his cervical spine.

ORDER

Claimant's request that the Board order reopening of his December 11, 1974 industrial injury claim for payment of temporary total disability compensation is denied; however, claimant is awarded additional unscheduled disability for injury to his low back. In addition to the 16° for 5% unscheduled disability previously awarded, claimant is granted 48° or 15%, for a total unscheduled award to date of 64° for 20% of the maximum allowable for unscheduled disability, for injury to claimant's low back. Claimant's attorney is allowed 25% of the additional compensation awarded herein, not to exceed $2,000, payable out of claimant's compensation and not in addition thereto.

STACY McMAHAN, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-02934
March 20, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant and the SAIF Corporation request review of Referee Baker's order which: (1) Awarded claimant 100% permanent partial disability; (2) reversed SAIF's denial of claimant's psychotherapy; (3) refused to award penalties and attorney fees for unreasonable delay of payment of medical supplies; and (4) refused to award penalties and attorney fees for unreasonable recovery of an overpayment of time loss compensation. Claimant contends that he is permanently and totally disabled, that he is entitled to penalties and attorney fees for SAIF's unreasonable delay in payment for wrist splints, and that SAIF should not be allowed to recover any overpayment in that claimant did not receive the time loss checks deemed to be overpayments. SAIF contends that the permanent disability award is excessive and that the psychotherapy is not compensable.

The Board affirms the portions of the Referee's order which awarded claimant 100% permanent partial disability and which found the psychotherapy compensable. We also affirm the Referee's findings that SAIF is entitled to recover an overpayment and that no penalties are warranted with regard to that recovery. We reverse, however, the Referee's refusal to assess penalties and attorney fees in connection with SAIF's delay in payment for claimant's wrist splints.

In January 1982 claimant's treating doctor, Dr. Lagios, notified SAIF that claimant needed wrist splints for relief of hand numbness, which the doctor related to claimant's compensable injury. SAIF previously had been contacted by the medical supplier regarding payment for the wrist splints. Claimant's attorney wrote three letters to SAIF inquiring about payment for the splints. Not until August 1982 did SAIF agree to pay for the wrist splints, and no reasonable explanation was offered for the delay. Under these circumstances, we find penalties and attorney fees to be appropriate.

ORDER

The Referee's order dated December 30, 1982 is affirmed in

part and reversed in part. Claimant is awarded a penalty of 25% of the cost of the wrist splints for the SAIF Corporation's unreasonable delay in payment, and claimant's attorney is awarded $200 in connection with those penalties, to be paid by SAIF. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

DUANE J. VAN NESS, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-10596
March 20, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of that portion of Referee Podnar's order which set aside its' backup denial of claimant's claim for his left leg and right shoulder conditions. Claimant cross-requests review of those portions of the order which: (1) Affirmed the November 4, 1982 Determination Order which awarded 37.5° for 25% scheduled disability for his left leg (hip) and 64° for 20% unscheduled disability for his right shoulder; (2) declined to assess penalties for an allegedly untimely denial; and (3) awarded $1750 as a reasonable attorney's fee.

The Board affirms that portion of the Referee's order which set aside the insurer's backup denial. However, we do so for the following reason.

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. Here, there is no contention that the reason for the late denial was other than a mistake in claims processing. Consequently, the backup denial, issued by the insurer approximately 18 months after the claim, is invalid under Bauman.

The Board affirms the remainder of the Referee's order.

ORDER

The Referee's order dated August 22, 1983, as supplemented August 23, 1983, is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the insurer.

FREDERICK E. MEREDITH, Claimant
Callahan, Hittle & Gardner, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 84-0101M
March 21, 1984
Own Motion Order

Claimant, by and through his attorney, has requested that the Board exercise its own motion authority and set aside the SAIF Corporation's denial of February 18, 1981, which denies the compensability of claimant's alleged injury of September 16, 1979.

Claimant's injury was originally accepted as disabling. It was closed by Determination Order on December 4, 1980, which awarded compensation for temporary and permanent disability. Claimant requested a hearing contesting the Determination Order.

The SAIF Corporation thereafter issued a denial alleging that new information had been discovered indicating that claimant was not a "covered worker" at the time of his injury. This denial retroactively disclaimed responsibility for claimant's injury.

Claimant amended his request for hearing, contesting SAIF's denial. At hearing claimant argued that SAIF could not deny the claim ab initio 17 months after its acceptance. The Referee, by order dated April 13, 1981, upheld SAIF's denial. The Board affirmed and adopted the Referee's order by Order on Review dated December 15, 1982. 34 Van Natta 1973 (1982). Claimant petitioned for judicial review and raised the timeliness of SAIF's denial as an issue before the Court of Appeals. The Court affirmed without opinion on August 31, 1983. 64 Or App 499 (1983).

The Supreme Court decided Bauman v. SAIF, 295 Or 788 (1983), on October 25, 1983. The Court of Appeals had decided Bauman on March 23, 1983. 62 Or App 323 (1983). The Board received claimant's petition for own motion relief on November 16, 1983.

In support of his request that the Board exercise its authority pursuant to ORS 656.278 to "reconsider" this claim, in which a final determination concerning compensability has been made, claimant cites Fields v. Workermen's Compensation Board, 276 Or 805 (1976), and Powell v. Wilson, 10 Or App 613 (1972).

The authority of case law defining or discussing the Board's continuing authority pursuant to ORS 656.278 to modify, terminate, or otherwise change former findings, orders or awards, has been somewhat circumscribed by 1981 legislation. By virtue of 1981 Oregon Laws, c. 535 § 32, ORS 656.278(5) now provides:

> "The provisions of this section do not authorize the board, on its own motion, to modify, change or terminate former findings or orders: (a) That a claimant incurred no injury or incurred a non-compensable injury; or (b) Approving disposition of a claim under ORS 656.289(4)."

The relief for which claimant petitions the Board is not available pursuant to ORS 656.278 in view of the express proscription of ORS 656.278(5), and the apparent fact that 30 days after August 31, 1983, the court's determination of the non-compensability of this claim became final by operation of law. Whether claimant has any other remedy available is something we need not, and do not, address. It is clear, however, that the Board's own motion hands are tied.

ORDER

Claimant's petition for own motion relief is denied.

ROBERT L. CARY, Claimant
Royce, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 82-11120
March 22, 1984
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Leahy's order which affirmed the November 16, 1982 Determination Order which reclosed claimant's hernia claim after a second surgery. That Determination Order awarded temporary disability benefits to February 15, 1982 and no permanent disability. Claimant contends that he is entitled to additional temporary disability benefits to March 8, 1982 and approximately 40% unscheduled disability.

There is considerable confusion in the record, primarily because of some prior litigation involving this claim. It is reasonably clear that: (1) Claimant sustained a compensable right inguinal hernia in February 1980; (2) surgery to repair the hernia was first performed in April 1980; (3) claimant continued to experience pain following that first operation; and (4) a second surgery was performed in December 1981. The present questions concern when claimant became medically stationary and the extent of claimant's permanent disability, if any.

There are only three medical reports which address the question of permanent disability. On February 1, 1982 Dr. Reynolds reported:

> "[Claimant] should, at least for a time, avoid any heavy lifting, as with any post-status hernia repair, and observe reasonable precautions until such time as his tissues firmly heal.
>
> * * *
>
> "It is difficult to tell if [claimant] will have any permanent partial disability. He had done well postoperatively and his pain was markedly relieved. He was undergoing remarkable progression from recovery of hernia repair. * * *"

On March 12, 1982 Dr. Best, who performed the December 1981 surgery, reported:

> "My prognosis . . . is that I feel [claimant] should have no further sequelae in regard to his operative procedure or his general health . . .
>
> "I do not feel that [claimant] will end up with any permanent, partial, or minimal disability as a result of his accident . . .
>
> "The operative findings . . . did not reveal evidence of [a hernia] in the region of his previous surgery. On dissection through the

> scar tissue we were not able to ascertain whether or not the illoinguinal nerve was entrapped in the scar tissue, but since the patient's pain has completely disappeared since his second surgery we would have to assume that this probably was the cause of the pain he complained about [before the December 1981 surgery]."

From these two reports, referring to "marked relief" of pain and "complete disappearance" of pain, it would appear that the December 1981 surgery was a total success.

The third and final medical report comes from Dr. Reynolds and is dated April 17, 1983. Dr. Reynolds reported that he had not seen claimant for "nearly one year" when claimant had returned in January 1983 "complaining of right inguinal discomfort." (Emphasis added.) Dr. Reynolds opined:

> "The limitations include avoidance of any lifting, squatting, bending, stooping, pushing and pulling. He can use his upper extremities very well. He can sit for a reasonable period of time and should be able to do light work as indicated, but will need assistance in finding such ready employment.
>
> "The degree of permanent partial disability may be that of 5-10% of the whole man as related to chronic, nagging discomfort and the need to avoid heavy kinds of working activity." (Emphasis added.)

This report sounds like it is about a different person than the person discussed in the 1982 reports. While the 1982 reports contemplated claimant being totally or almost totally pain-free, without having seen or treated claimant for the prior year Dr. Reynolds opines in 1983 that claimant cannot do "any lifting." With due respect to the doctor's opinion, this simply makes no sense when considered in context with the earlier reports. Moreover, we generally think medical opinions on permanent impairment should be stated in somewhat more concrete terms than what "may be"; and we do not understand the law to permit compensation awards to be based on "nagging discomfort." See Harwell v. Argonaut Insurance Co., 296 Or 505 (1984).

For all of these reasons, we are not persuaded that claimant has proven any permanent impairment following his December 1981 surgery. And without permanent impairment, there cannot be an award for permanent disability.

Regarding claimant's entitlement to temporary total disability benefits, there is also some confusion on this point in the record. The clearest statement comes from Dr. Reynolds who found that claimant became medically stationary on March 8, 1982. The evidence to the contrary apparently consists of earlier predictions that claimant would (or probably would) be stationary on February 15, 1982. While this issue is not free from doubt, we accept Dr. Reynolds' opinion on this point as the most concrete and conclude that claimant is entitled to additional temporary disability benefits to March 8, 1982.

ORDER

The Referee's order dated May 26, 1983 is affirmed in part and modified in part. The Referee's order is modified to provide that claimant is awarded additional compensation for temporary total disability from February 16, 1982 to March 8, 1982, and claimant's attorney is allowed 25% of the increased compensation awarded by this order as a reasonable attorney's fee. The remainder of the Referee's order is affirmed.

Board Member Lewis Dissenting:

I respectfully dissent to the portion of the majority's order which declines to award claimant permanent disability benefits.

Claimant sustained a compensable right inguinal hernia on February 18, 1980. Claimant underwent surgical repair of that hernia in April 1980. The operation initially appeared to be successful and the surgeon predicted that claimant would incur no permanent impairment as a result of his injury. A September 10, 1980 Determination Order awarded claimant temporary disability benefits, but no permanent disability benefits. Meanwhile, claimant had returned to his job of fourteen years as a vehicle bumper polisher and buffer. This job required lifting of bumpers weighing up to 200 pounds.

By October 1980 claimant was experiencing a recurrence of pain and swelling at the surgery site causing Dr. Reynolds to authorize additional time loss. By December 24, 1980, Dr. Best, surgical consultant, recommended that claimant seek lighter work due to his "continuing discomfort in the right inguinal area." Claimant's pain and discomfort continued throughout 1981 while claimant remained on temporary partial disability benefits and looked for lighter employment.

Finally, Dr. Reynolds referred claimant to Dr. Best again in October 1981. Dr. Best recommended additional surgery which was performed in December 1981. Surgery revealed excessive scarring that was a result of the first surgery. On December 26, 1981 Dr. Reynolds reported that claimant felt much better sine the surgery, but he still recommended that claimant "be retrained for some other job, other than heavy lifting required on his previous occupation." On February 1, 1982, Dr. Reynolds reported claimant continued to undergo good recovery from the surgery, but that it was too early to tell if he would have any permanent disability. On March 12, 1982 Dr. Best reported that claimant had "no complaints of pain and states that he feels fine" and that he would have no permanent disability. A November 16, 1982 Determination Order awarded claimant temporary disability benefits from October 17, 1980 through February 15, 1982, but awarded no permanent disability benefits.

Although this second surgery initially appeared to be successful, claimant testified that subsequently, he continued to experience pain with lifting. He returned to Dr. Reynolds in January 1983. Dr. Reynolds reported, "after review of the [right inguinal] area and the repair, it was felt that [claimant] may have some lingering discomfort but should be able to get along doing

light work." (Emphasis added.) Even though Dr. Reynolds felt that the second surgery was excellently performed, he still felt claimant was restricted to light work and imposed limitations including "avoidance of any lifting, squatting, bending, stooping, pushing and pulling." He recommended vocational assistance to help claimant find light work. Dr. Reynolds concluded that claimant's permanent disability "may be that of 5-10% of the whole man as related to chronic nagging discomfort and the need to avoid heavy kinds of working activity."

I believe that a fair reading of the facts in this record show a consistent and persistent pattern of disabling pain in claimant's right groin. Nagging discomfort and pain which restricts a worker from returning to his job and limits him to light work is properly considered as disabling impairment. Although two different surgeries were designed to relieve claimant of that pain, they were not entirely successful. Considering Dr. Reynolds' final report as a whole, it shows that he definitely places restrictions on claimant's work activity due to right groin pain. His use of the word "may" in referring to "5-10%" impairment is a qualifier as to how great the permanent impairment is that results from these restrictions. It does not indicate that there is no permanent disability at all.

As an independent factfinder, my review of the record shows that Dr. Reynolds' estimate of 5% impairment due to right groin pain was proper. Claimant was 39 years of age at the time of the hearing, yielding an impact factor of zero. He possesses a third grade education, yielding an impact factor of +15. Claimant testified that it took a year to master his job as a vehicle bumper buffer and polisher. This coincides with the Dictionary of Occupational Titles' estimation of time required to become proficient at that job. See D.O.T. 705.684-014 and the Department of Labor D.O.T. computer printout. This work experience factor yields +5. Prior to his injury, claimant was able to perform heavy labor. He is now restricted to light labor, yielding an impact factor of +10. Given claimant's residual capacity to perform light work, his education and his work experience, which includes crop picker, cotton gin worker and vehicle bumper polisher, the Department guidelines estimate that 15% of the labor market is still available to claimant, yielding an impact factor of +1. Combining these factors and rounding to the nearest 5% results in an award of 35%. When comparing this case with other similar cases, I would find this award of permanent disability benefits appropriate under the facts of this case.

JOHN K. EDER, Claimant
Pozzi, et al., Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 82-07721
March 22, 1984
Order on Review

Reviewed by the Board en banc.

The insurer requests review of Referee Menashe's order which found claimant's asbestosis claim compensable. The insurer contends that ORS 656.807(4), which was enacted in 1981 and allows a worker 40 years within which to file an asbestosis claim, should not be applied retroactively to allow claimant's claim. The insurer also argues that claimant does not have a "claim."

The Board affirms the order of the Referee with the following comment. We find that Holden v. Willamette Industries, 28 Or App 613 (1977), requires a finding that ORS 656.807(4), which relates to "whether and when a claim can be made in situations where coverage exists," is to be applied retroactively. Barrett v. Union Oil Distributors, 60 Or App 483, 487 (1982).

ORDER

The Referee's order dated August 8, 1983 is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the insurer.

Board Member Barnes Dissenting:

Retroactive application of statutory amendments is a question of legislative intent. I find it impossible to believe that, when the legislature added ORS 656.807(4) by amendment in 1981, it intended to revive 40-year-old claims that were long since time-barred under prior law.

Sometimes, but unfortunately not very often, legislative intent is explicit. The legislature is free to expressly state that an amendment shall be applied retroactively and is equally free to state that an amendment shall not be applied retroactively. The 1981 amendment that created ORS 656.807(4) is more typical: There is no express statement of legislative intent in that 1981 act.

In this context of legislative silence, the courts have articulated a variety of doctrines in deciding retroactivity questions, both in general and in workers compensation cases. I understand the most paramount doctrine to be: "This court has refused to give retroactive application to the provisions of statutes which affect the legal rights and obligations arising out of past actions." Joseph v. Lowery, 261 Or 545, 548-49 (1972). Today's decision in this case is clearly and totally inconsistent with the Supreme Court's statement because application of current law rather than former law changes the rights and obligations arising from past events.

At the Court of Appeals level and specifically in workers compensation cases, the Board majority can find some support for its decision in cases like Holden v. Willamette Industries, 28 Or App 613 (1977). I submit that there is just as much or more support for the opposite result in cases like SAIF v. Mathews, 55 Or App 608 (1982), and Bradley v. SAIF, 38 Or App 559 (1979).

In Mathews, the statute in effect at the time the claimant was injured in 1973 provided that, when a Referee ordered a denied claim accepted, the employer/insurer had to pay for medical services pending Board and judicial review. That statute was amended in 1979 to provide that an employer/insurer did not have to pay for medical services pending the final outcome of appellate proceedings. After the 1979 amendment went into effect, a Referee ordered a denied aggravation claim accepted and the question arose of whether SAIF had to pay for medical services while appealing the compensability of the aggravation claim. The court answered that question in the affirmative, ruling that the 1979 amendment would

be applied only prospectively to claims arising after its effective date. The court explained that this result was compelled by ORS 656.202(2) which continues to provide: "Except as otherwise provided by law, payment of [workers compensation] benefits . . . 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."

ORS 656.202(2) was also cited in Bradley as one of the reasons the court would not apply an amendment to the Workers Compensation Act retroactively. The court's additional reasons were: (1) That there is a "presumption against retroactive application"; (2) that there was an "absence of any legislative history supporting retroactivity"; and (3) retroactive application would be inconsistent with the Supreme Court's analysis in Joseph v. Lowery, quoted above, because it would make the employer/insurer "liable for greater payments than those for which it would have been liable under former law." 38 Or App at 564. Every single syllable of that reasoning is just as applicable to the retroactivity issue now before us.

It would require more intelligence and/or more courage than I claim to argue that Holden, Mathews and Bradley are reconcilable. In both decisional methodology and in results, I find those cases to be irreconcilable. (Holden, for example, does not even mention ORS 656.202(2), which was a large part of the basis of the decisions in Mathews and Bradley.) In these circumstances, I suggest that we should follow the Court of Appeals precedents in Mathews and Bradley as the (1) more recent, (2) better reasoned, and (3) most consistent with Supreme Court doctrine in Joseph v. Lowery.

Mathews and Bradley lead me to the conclusion that the 1981 amendment creating ORS 656.807(4) should not be applied retroactively in this case. I would reverse the Referee's order for this reason and thus respectfully dissent.

MARION L. ELLS, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-03102
March 22, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Mannix's order which: (1) Set aside SAIF's aggravation denial to the extent it denied continuing medical treatment for claimant's knee, shoulder, neck and other problems; (2) ordered SAIF to pay Dr. Srch's billing "and any additional billings for similar treatment"; and (3) awarded a $1000 attorney's fee to claimant's attorney. SAIF asks the Board to set aside the portion of the Referee's order which states that SAIF denied continuing medical treatment. SAIF contends that it did not deny "future medically related treatment." SAIF also asks the Board to set aside the portion of the Referee's order which required SAIF to pay additional billings for similar treatment, which SAIF contends is overly broad. Finally, SAIF contends that the attorney fee awarded by the Referee is excessive.

The Board affirms the order of the Referee with the following comments.

Claimant contended at hearing that she was entitled to penalties and fees for SAIF's unreasonable refusal to pay Dr. Srch's bills. SAIF's attorney denied that SAIF had received any billings directly from Dr. Srch and contended that SAIF was not notified of Dr. Srch's bills until August 1982. The Referee found that no penalties were due because SAIF reasonably relied on its June 1982 denial in failing to pay for the bills.

After SAIF requested review of the Referee's order, claimant moved for remand for further proceedings. Claimant alleged that after the hearing she obtained bills from Dr. Srch that had been sent to SAIF, date stamped by SAIF in April 1982 and then returned to Dr. Srch. Claimant's attorney contended that SAIF had a practice of returning bills to doctors, keeping no copies of the returned bills, thereby enabling the SAIF Legal Division to take the position that no bills had been presented to SAIF. The Board remanded for further proceedings on claimant's allegations. 35 Van Natta 232 (1983).

At the hearing on remand claimant offered evidence of Dr. Srch's bills that had been date stamped by SAIF in April 1982 and had been returned to Dr. Srch. Questioning of the claims examiner responsible for claimant's file revealed that no copies of Dr. Srch's bills were kept in claimant's file. In his Response to the Board's Interim Order of Remand, Presiding Referee Daughtry noted that although no purposeful practice on SAIF's behalf was established, the record established that SAIF's procedures in this case were inadequate and penalties could be considered. Referee Daughtry suggested the possibility of referring the matter of SAIF's claims processing policies to the Workers' Compensation Department for investigation.

Claimant does not request penalties in this matter, but rather, asks the Board to comment. We agree with claimant that claims processing that involves throwing away or returning bills and keeping an incomplete claims file cannot be ignored.

Regarding the issues raised by SAIF, we affirm the Referee's order which set aside the aggravation denial to the extent it denied continuing medical treatment. We also affirm the portion of the Referee's order that ordered SAIF to pay any additional billings from Dr. Srch for similar treatment, although we note that the Referee stated in the body of his order that he was referring to other bills presently pending for treatment of the conditions which the Referee had found were related to claimant's injury. Of course, the Referee's order cannot be interpreted to mean that SAIF cannot deny some future medical bills from Dr. Srch it deems noncompensable. Finally, the Board affirms the Referee's attorney fee award.

ORDER

The Referee's order dated December 16, 1982 is affirmed. Claimant's attorney is awarded $1000 for services on remand and on Board review, to be paid by the SAIF Corporation.

CYNTHIA D. SNELL-BELL, Claimant
Coons & McKeown, Claimant's Attorneys
Brian Pocock, Attorney
SAIF Corp Legal, Attorney
Atherly, et al., Attorneys
Bottini & Bottini, Attorneys
W.D. Bates, Jr., Attorney

WCB 82-11765, 82-08072, 82-02580
& 81-03930
March 22, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of Referee Nichols' order which ordered it to reimburse ADMINCO (City of Eugene) for workers compensation benefits previously paid by the City of Eugene to claimant in connection with a July 14, 1981 industrial injury claim. The only issue on review is the propriety of the Referee's order directing that this reimbursement be made.

Claimant had filed hearing requests raising various issues involving claims filed with four different employers. When the hearing convened on February 23, 1983, all issues arising under all of claimant's hearing requests were resolved by the parties' tentative agreement, with the exception of the reimbursement issue now before us. Only that issue was submitted to the Referee for decision. The Referee determined, in effect, that the July 14, 1981 "injury" sustained by claimant while working for the City of Eugene, which was accepted and processed by ADMINCO on behalf of the City of Eugene, was not a new injury, but rather was an exacerbation of claimant's October 2, 1980 injury while employed by Harr Motor Company, insured by SAIF. This determination formed the basis for the Referee's order directing SAIF to reimburse ADMINCO (City of Eugene) for all benefits paid in connection with the July 14, 1981 claim. The Referee's order to that effect was issued the same day that the Referee approved the parties' agreement which resolved all other issues.

We conclude that ADMINCO (City of Eugene) has no right to seek reimbursement from another potentially responsible employer/insurer under the circumstances of this case.

The first injury of those involved in this case occurred on October 2, 1980, while claimant was employed with Harr Motor Supply. The claim was accepted and closed by SAIF on December 18, 1982; claimant was awarded temporary disability for the period October 20 through November 2, 1980. Claimant sustained the second in this series of "injuries" on November 21, 1980 while working for Whitey's Cafe, also insured by SAIF. This claim was accepted and subsequently closed by Determination Order in February 1981; claimant was awarded temporary total disability for the period November 21 through December 5, 1980.

Claimant filed a claim for an injury occurring on July 14, 1981, while working for the City of Eugene. This claim was accepted and subsequently closed by a Determination Order in February 1982, which awarded temporary total disability from July 20, 1981 through November 1, 1981.

On August 24, 1981 claimant sustained a non-industrial injury when she fell in a restaurant parking lot, after which she was admitted to an emergency room.

On January 8, 1982 a stipulation was approved in connection with claimant's October 2, 1980 injury with Harr Motor Supply, whereby the insurer closure of December 18, 1980, was modified to award claimant 32° for 10% unscheduled disability for injury to her low back.

On July 16, 1982, the City of Eugene issued a backup denial, which stated in part:

> "* * * [W]e must respectfully deny your claim for workers compensation benefits stemming from your employment with the City of Eugene from the outset, not only with regard to the July 14, 1981 incident, but also any other exposure/accident while you were in the course and scope of your employment with the City of Eugene."

On September 28, 1982 claimant filed notice of a claim with the fourth employer involved herein, Grocery Carts, Inc., with an assigned injury date of July 9, 1982. This claim was deferred by the employer's insurer until December 6, 1982, when it was denied.

The parties' agreement disposed of all issues raised or raisable by the various hearing requests filed by claimant in connection with each of these claims, as between claimant and each employer/insurer. Specifically, for present purposes, claimant abandoned her challenge to the City of Eugene's backup denial and thus her claim against the City is and will remain in denied status.

The situation presented herein is analogous to, but significantly different from, the situation presented in many employer/insurer responsibility cases arising under ORS 656.307. That statute provides a procedure whereby the Director of the Workers' Compensation Department is authorized to designate a paying agent from among two or more potentially responsible employers or insurers when the claim is otherwise compensable. The statute provides in part: "When a determination of the responsible paying party has been made, the director shall direct any necessary monetary adjustment between the parties involved." ORS 656.307(1). See also OAR 436-54-330 et seq.

Pursuant to the statute and implementing rules, benefits paid under an order designating a paying agent are reimbursable upon resolution of employer/insurer litigation. We are also aware that, in many instances, an insurer ultimately found responsible for payment of a claimant's compensation reimburses another insurer for compensation paid prior to entry of an order designating a paying agent or even for compensation paid without such an order having been issued. Regardless, however, of the comity that may exist in the insurance industry, we have found no authority, and the City of Eugene has referred us to none, for requiring one employer/insurer to reimburse another employer/insurer for compensation paid in connection with a claim that by agreement or otherwise is ultimately denied. Under the terms of the parties' agreement in this case, the claim filed with the City of Eugene is in denied status. We can find no logical or reasonable basis for concluding that in addition to obtaining the benefits that accrue under the terms of

the parties' agreement, the City of Eugene should obtain the further benefit of reimbursement for compensation previously paid to claimant. Although the City of Eugene entered into the agreement subject to its right to seek reimbursement from another insurer, there is no such right of reimbursement in this case.

There is another issue with regard to the validity of the City of Eugene's July 16, 1982 denial which, in turn, potentially impacts the validity of the parties' agreement. In Bauman v. SAIF, 295 Or 788 (1983), the court held that, once an employer/insurer had accepted a claim pursuant to ORS 656.262(6), it could not subsequently deny the claim in the absence of fraud, misrepresentation or other illegal activity. The Bauman court called its holding a "slight retreat" from its earlier decision in Frasure v. Agripac, 290 Or 99 (1980). Indeed, in the three years preceding Bauman, Fraseur had been universally understood to hold that an employer/insurer's acceptance of a claim did not estop the employer/insurer from later denying the compensability of the claim. See, e.g. Babb v. SAIF, 49 Or App 707 (1980); Saxton v. Lamb-Weston, 49 Or App 887 (1980); Townsend v. Argonaut Ins. Co., 60 Or App 32 (1982). The agreement in this case is one of innumerable stipulated settlements entered into and approved during the three year Frasure-Bauman interlude. At the time that the parties entered into their agreement, the Supreme Court's Frasure decision provided at least a colorable legal basis for the position that a backup denial was permissible. Therefore, we do not believe that the court's subsequent decision in Bauman is at all relevant to this pre-Bauman disputed claim settlement.

ORDER

The Referee's order dated May 2, 1983 is reversed.

CATHERINE C. BAILEY, Claimant
Kenneth Peterson, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 77-07554
March 23, 1984
Order on Remand (Remanding)

This case comes to the Board on remand from the Supreme Court. Bailey v. SAIF, 296 Or 41 (1983). Previously, the Board denied claimant's motion for remand and affirmed the Referee's finding that claimant's occupational disease was not compensable. 34 Van Natta 688 (1982). The Court of Appeals affirmed the Board. 61 Or App 225 (1982). The Supreme Court reversed and remanded 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.

On remand the Board finds that this case was incompletely and insuffiently developed before the Referee and remands to the Hearings Division for the taking of additional evidence on compensability of claimant's occupational disease claim.

Claimant was employed at Bramco, Inc., a fiberglass boat manufacturing company, between September 1974 and April 1977. In 1976 claimant was required to perform work using varnish which contained acetone. Claimant developed respiratory problems, and on September 2, 1977, she filed a report of an occupational disease

claiming her work environment caused her condition. Her claim was denied, and on April 14, 1981 a hearing was held to determine the compensability of her claim.

Although claimant had been represented by an attorney, her attorney had withdrawn and claimant, accompanied by her husband, represented herself at the hearing. The medical evidence, for the most part, indicated that claimant was suffering from sarcoidosis, a disease not related to her employment or industrial exposure. The medical report most favorable to claimant stated that her condition was most likely due to breathing "something" over a course of months or years. The record contained no evidence regarding exactly to what claimant had been exposed at her workplace.

The Referee issued an order denying compensability, and claimant appealed the order to the Board. After the hearing but prior to the Board's order, claimant retained an attorney and filed a motion for remand for taking of further evidence, alleging the record had been insuffiently developed. The new evidence claimant seeks to introduce in a hearing on remand includes a report from a doctor who previously diagnosed sarcoidosis, but who now wishes to withhold his opinion until he sees additional medical reports, medical studies and information regarding chemicals to which claimant was exposed at work. Other reports included in the new evidence state that claimant's work exposure caused claimant's respiratory condition.

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."

We agree with claimant that this case was "improperly, incompletely or otherwise insufficiently developed" at the hearing. The medical reports do not indicate that the doctors had the benefit of information regarding the chemicals to which claimant was exposed and the toxicity of those chemicals, except what claimant told them, in rendering their opinions. Also, the sarcoidosis diagnosis may need to be reevaluated by the reporting doctors in light of findings reported after the hearing.

Having found that the record was insufficiently developed, we find that this case should be remanded under ORS 656.295(5). We are persuaded in this regard by the fact that this case is a complex one, factually and medically, and that claimant was unrepresented at hearing.

ORDER

This case is remanded to the Hearings Division for the taking of further evidence on the issue of the compensability of claimant's occupational disease claim.

MILTON O. BURSON, Claimant
Pozzi, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 81-3251
March 23, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant and the SAIF Corporation have requested review and cross-review, respectively, of Referee Williams' order which denied all relief to both parties. Claimant had requested a hearing on SAIF's partial denial relating to the compensability of claimant's underlying finger and hand condition ("peripheral vascular disease"). Claimant also had requested a hearing on the Determination Order which awarded temporary total disability but no permanent disability, alleging premature closure, and alternatively, entitlement to permanent disability including permanent total disability. SAIF had requested an offset of an overpayment arising from payment of time loss beyond the medically stationary date established by the Determination Order.

We adopt the Referee's findings of fact as supplemented by our own findings as set forth herein. Claimant was employed by the University of Oregon Dental School as a dental technician for approximately 27 years. He made dental prostheses which required gripping dental prostheses with the hands and fingers and holding the prostheses against such instruments as grinders and polishers or striking them with various tools. During the greater portion of this employment, but not since about 1979, claimant also "moonlighted" making dental prostheses in a lab in his own home. Claimant did not use the variety of tools and instruments in his own home that he used in his employment. Claimant's output at the Dental School lab as compared to his home lab was approximately 95% to 5%, and of the 5% percent claimant was personally responsible for about one-third of the actual production from the home lab.

Claimant is affected by progressive systemic sclerosis, or scleroderma, which is a condition of unknown etiology and which manifested itself in claimant by thickening and hardening of the tissues, and decreased circulation of blood, in claimant's fingers and hands. In August 1979 claimant sustained a cut and a burn to fingers on his right hand, and in January and February 1980 he sustained puncture wounds to fingers on his left hand while working in the Dental School lab. These claims were accepted. Because of the effects of the underlying scleroderma, the wounds eventually ulcerated and required an extended healing period. When they eventually healed, the damaged tissue was insufficiently regenerated, leaving the fingers scarred and pitted at the injury sites. Claimant has also experienced general loss of grip strength, loss of flexion, and other impairments primarily as a result of the natural progression of the scleroderma.

I.

We are unsure whether claimant is proceeding on an industrial injury or occupational disease theory. In his opening statement, claimant took the position that specific instances of trauma to his fingers in the course of his employment at the Dental School exacerbated the underlying scleroderma condition in his hands and fingers. At other times, claimant's position appears to be that

the pressure on his fingers and hands arising from his 27 years as a dental technician using the Dental School's tools and instruments has interacted with the underlying scleroderma condition to cause severe disability in his hands and fingers.

If claimant is proceeding on an occupational disease theory and alleging that work activities exacerbated a preexisting condition, he must show that the underlying condition has pathologically worsened, Weller v. Union Carbide Corp., 288 Or 55 (1979), and that his work activities were the major cause of the worsening, SAIF v. Gygi, 55 Or App 570 (1982). On the other hand, if he is relying on an industrial injury theory, he must prove that one or more industrial injuries interacted with an underlying condition to cause another condition, Hoffman v. Bumble Bee Tuna, 15 Or App 253 (1975), or materially contributed to the worsening of an underlying condition. Patitucci v. Boise Cascade Corp., 8 Or App 503 (1972); Cochell v. SAIF, 59 Or App 391 (1982).

We find that claimant has proven a worsening of the underlying condition. Claimant's work activities hastened the onset and increased the severity of the effects of claimant's scleroderma on his fingers and hands. There has been actual tissue destruction in claimant's fingers as observed and attested to by several physicians. However, we further find that claimant has failed to prove, with respect to an occupational disease theory, that his work activities with the Dental School were the major cause of the worsening. We agree with the Referee that Dr. Porter's testimony is more persuasive to the effect that prolonged pressure from the use of dental technician's tools did not cause the worsening of the underlying condition. When we add in the fact that claimant did some work in his own lab at home and presumably used his hands in daily nonoccupational functions, we cannot find that claimant's work activities were the major cause of the worsening of the underlying condition.

With respect to the industrial injury theory, the record supports a finding that the injuries sustained by claimant in August 1979 and January 1980 and February 1980, interacted with the underlying condition, causing damage to some of claimant's fingers and leading to temporary disabilty and requiring medical services. As such, the condition of claimant's fingertips at the sites of those injuries is compensable. Aquillon v. CNA Insurance, 60 Or App 231 (1982); Saxton v. Lamb-Weston, 49 Or App 887 (1980).

However, SAIF has never denied the compensability of the condition of claimant's fingertips at the sites of the injuries. SAIF accepted the injuries and, unlike the insurer in Aquillon, continued to pay temporary total disability and medical services necessitated by the extended healing process which resulted from the effects of the underlying scleroderma. Moreover with respect to entitlement to permanent disability, we find that while there has been permanent tissue damage caused in material part by the injuries, there is insufficient loss of function at the specific injury sites to justify an award of scheduled disability. While there has been significant and permanent loss of function in claimant's hands and fingers, it is not due to his injuries or work activities but rather his slceroderma, and to that extent is not compensable. See Saxton v. Lamb-Weston, supra.

II.

The hearing in this case began on August 31, 1981 and was continued until December 4, 1981. At the December 4, 1981 session, SAIF's counsel for the first time raised the issue of whether SAIF was entitled to an offset against permanent disability arising from an overpayment of temporary total disability. Claimant argues that Wilson v. SAIF, 48 Or App 953 (1980), stands for the proposition that the failure to assert an alleged overpayment at the commencement of the hearing in August 1981 results in a waiver of the overpayment.

Subsequent to Wilson, the Court of Appeals in Hicks v. Fred Meyer, 57 Or App 68 (1982), upheld an overpayment asserted by the insurer by motion for reconsideration after entry of the Referee's order. The court distinguished Wilson on the basis that Wilson merely prohibited unilateral offsets of alleged overpayments when there had been a hearing at which the employer could have raised the overpayment issue. The court reasoned in Hicks that even though the issue was raised late in the hearing process, at least claimant had notice of the claimed overpayment at a time when the Referee could have reopened the hearing for the taking of further evidence. But for one additional fact we would find Hicks dispositive: The claimant in Hicks conceded the validity of the overpayment; here, claimant denied that there was an overpayment. Under the circumstances of this case, since neither party has had an opportunity to litigate the merits of the overpayment issue, we neither affirm nor deny the overpayment but rather leave the matter to SAIF, to be asserted by SAIF at its discretion in the proper manner in the event that claimant at some future time becomes entitled to an award of permanent disability.

ORDER

The Referee's order dated February 4, 1982 is modified. The issue whether SAIF is entitled to an offset for an overpayment arising from the Determination Order dated February 27, 1981 is reserved. The Referee's order otherwise is affirmed in all respects.

JOHN D. KREUTZER, Claimant
Van Natta & Peterson, Claimant's Attorneys
Cheney & Kelley, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-04208
March 23, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

This case is before us again for review following our prior remand, 34 Van Natta 154 (1982), for further proceedings. The insurer originally requested review of Referee Ail's order which found claimant to be permanently and totally disabled as a result of his 1975 industrial injuries. We found the record incompletely developed with regard to the question of to what extent claimant's impairment at the time of the original hearing either preexisted or was caused by his 1975 injuries, and thus remanded. The parties submitted eight additional exhibits and argument before Referee Galton on remand, and have since submitted additional argument to the Board.

The factual background is stated in our prior order and need not be repeated here.

The present problem involves application of ORS 656.206(1)(a) which defines permanent total disability as "the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." It is clear that, under this satute, not all impairment that exists at the time of hearing can necessarily be taken into account. Emmons v. SAIF, 34 Or App 603 (1978). We consider impairment caused by an industrial injury. If the injury caused the permanent worsening of a preexisting condition, then we take into account all impairment resulting from that condition. If the injury did not cause permanent worsening of a preexisting condition, we consider only impairment due to the preexisting condition as it existed on the date of injury. Frank Mason, 34 Van Natta 568 (1982), aff'd, 60 Or App 78 (1982). Stated differently, we do not consider physical impairment that arises post-injury unless caused by the injury, Emmons v. SAIF, supra; and we do not consider the post-injury progression of a preexisting condition unless that condition was worsened by the injury, Frank Mason, supra.

With those rules in mind, we turn to the evidence regarding the nature and extent of claimant's physical impairment and confront considerable difference of medical opinion. It is clear that claimant's 1975 back injuries led to a laminectomy and discectomy, and that at least some portion of claimant's impairment is a result of this surgery. However, numerous other causes and forms of impairment have been mentioned in passing, which was the reason for our prior remand. Having considered the additional evidence presented, we now find:

(1) Claimant either does not have a spinal tumor and/or no causal link has been established between any spinal tumor that may be present and claimant's industrial injuries. The parties now seem to agree on this point.

(2) Claimant either does not have any further/additional disc herniation, and/or no causal link has been established between any further/additional disc herniation that may be present, and claimant's industrial injuries. The parties now seem to basically agree on this point, although claimant's agreement here is less clear than on the prior point.

The record also contains mention of impairment due to degenerative disc disease, spinal arthritis and arachnoiditis. We consider the degenerative disease and arthritis possibilities together because, in context, it is not clear whether these are really different diagnoses or different labels for essentially the same disease process. X-rays taken in May 1975, two days after the first compensable accident, were interpreted to show "minimal to moderate degenerative osteoarthritis" of the lumbar spine and "marked degenerative osteoarthritis" of the sacrum. To this extent at least, claimant has established a preexisting problem within the meaning of ORS 656.206(1)(a) that should be part of the total-disability calculus. However, claimant was doing medium to

heavy work before May 1975, apparently without difficulty; so we think that any "preexisting disability" -- the actual wording of ORS 656.206(1)(a) -- was de minimus.

Based on the increasing frequency of mention in subsequent medical reports, claimant's degenerative disease has apparently progressed since 1975. However, we find no medical opinion in this record to the effect that the 1975 injuries and/or resulting surgery caused any acceleration or worsening of this disease process. Dr. Holm testified in the original hearing to the effect that claimant's degenerative disease could be expected to progress and had progressed notwithstanding the 1975 industrial injuries. Orthopaedic Consultants' most recent (and post-remand) report states:

> "Based on today's examination, we find evidence of a loss of function of the lumbosacral spine in the moderately severe category. We would attribute a moderate loss of function to the injury of 1975. The difference between the total impairment and the impairment due to the injury of 1975 reflects the presence of preexisting lumbar degenerative arthritis."

Although implicit, this appears to state an opinion of the lack of any connection between the 1975 injuries and claimant's present degenerative-disease impairment; in any event, it certainly does not establish the opposite, which would be part of claimant's burden of proof. Finally, the post-remand report of Dr. Tesar, who has been claimant's treating doctor since 1978 and upon whom claimant otherwise strongly relies, does not even mention impairment due to degenerative disease. For all of these reasons, we conclude that this facet of this case is controlled by Frank Mason, supra: It has not been proven that claimant's preexisting disease was worsened by his industrial injuries and, therefore, the post-injury progression of that disease cannot be taken into consideration under ORS 656.206(1)(a).

Dr. Tesar's current theory, developed most fully in his post-remand report and deposition, is that claimant's problems are due largely to arachnoiditis, i.e., an inflammation of the membrane covering the spinal cord caused by infection. There is no doubt that claimant developed a wound infection following his 1975 surgery. However, all medical mention of this infection over the next three years suggests that the infection was not regarded as very significant. Dr. Wilhelmi's September 1976 comment is typical: "[The surgery] was followed by a staphyloccic wound infection which responded favorably to oxacillin." It has only been since a repeat myelogram in 1978 that some physicians, primarily Dr. Tesar, have suggested the possibility that the infection after the surgery resulted in much more serious spinal cord inflammation. But this theory is disputed by Dr. Holm, who explained:

> "Q. And is it [i.e., infection following surgery] also a sort of complication that's likely to enhance his permanent disability . . .?

"A. It may lead to increased scar formation and the degree of enhancement of his [disability] would depend somewhat upon [the degree to] which the infection penetrated.

"Q. Do you know to what depth this infection penetrated?

"A. There is no way I can determine that, but, he had a staph wound infection that drained for two months, but, responded to antibiotic therapy and eventually healed with no subsequent drainage. If you get a deep-seated infection involving bone or osteomyolitis this usually means repeated episodes of drainage, so, based on that, it's my belief that this was more of a superficial infection."

Dr. Tesar's reasons for believing there was a more serious spinal cord infection are not expressed in this record.

We are frankly unsure how to assess this evidence. On one hand, the factual predicate for a diagnosis of arachnoiditis -- a post-surgery infection -- is clearly present. Yet Dr. Holm offers cogent reasons for finding that infection was too superficial to produce arachnoiditis. It is clear that Dr. Tesar disagrees with Dr. Holm's assessment, but the reasons for his disagreement remain unstated. It is precisely this kind of evidence that we hoped would be developed in further detail when we previously remanded this case, but was not forthcoming on remand. We conclude that this situation is of sufficient medical complexity that, not only is a medical opinion required, but also, in view of Dr. Holm's testimony, some persuasive explanation of the reasons for that opinion is required. Finding no such explanation in this record, we conclude that claimant has not proven that impairment due to arachnoiditis is a compensable consequence of his industrial injuries.

In summary: (1) The question is whether claimant has established total disability; (2) the difficult subsidiary issue, which led to our prior remand, is the extent of claimant's compensable impairment under ORS 656.206(1)(a); (4) with the benefit of additional evidence on remand, we find (if it is even contested) that claimant has not proven compensable impairment due to either a spinal tumor or any further/additional disc herniation; (5) we also find that claimant has not proven that his present impairment due to degenerative disc disease and/or spinal arthritis is compensable because claimant has not proven that his industrial injuries hastened the progression of that disease or those diseases; (6) we also find that claimant has not proven that his present impairment possibly due to arachnoiditis is compensable; which (7) means that the only compensable impairment here in issue is that directly resulting from claimant's November 1975 back surgery.

The most recent opinion from Orthopaedic Consultants, which

"would attribute a moderate loss of function to the injury of 1975," is the only evidence in the record that attempts to distinguish the compensable from the noncompensable impairment. We accept that opinion. Moderate compensable impairment, standing alone, hardly establishes total disability. The social/vocational factors are not especially adverse. Claimant is now about 50 years old and has completed high school. Before the 1975 injuries he did medium to heavy work; he is now limited to light work, although it is not clear whether this limitation is necessitated only by claimant's compensable impairment.

Claimant testified at the February 1981 hearing that he had not sought work since April 1979. Considering the seek-work requirement of ORS 656.206(3), we cannot say that claimant's failure to seek work was reasonable or that it would be futile for someone in claimant's position (considering only compensable impairment) to seek work. We conclude that claimant has not established entitlement to an award for total disability.

On the question of partial disability, taking into account our above findings of moderate compensable impairment, 50 years old, completed high school, etc., and the guidelines in OAR 436-65-600 et seq., we conclude that claimant would be properly compensated for his loss of earning capacity due to the 1975 injuries by an award of 60% unscheduled permanent disability.

ORDER

The Referee's order dated March 6, 1981 is reversed. In lieu of all prior awards, claimant is awarded 192° for 60% unscheduled permanent partial disability. Claimant's attorney's fee should be adjusted accordingly.

MICHAEL LINDGREN, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-03231
March 23, 1984
Order of Dismissal

The claimant has requested review of Referee's order dated February 15, 1984. The request for review was filed with the Board on March 21, 1984, more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

The claimant's request for review is hereby dismissed as being untimely filed.

EUGENE A. PAGE, Claimant
Olson Law Firm, Claimant's Attorneys
Brian Pocock, Defense Attorney

WCB 80-05763 & 80-07722
March 23, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of those portions of Referee McCullough's order which: (1) Overturned its denial of claimant's psychological condition; (2) granted claimant 160° for 50% unscheduled disability to his low back in lieu of the 64° for 20% unscheduled disability previously awarded; (3) awarded claimant

additional temporary disability compensation; and (4) awarded penalties and attorney fees. Claimant argues for an additional penalty for alleged unreasonable delay in payment of compensation.

The Board affirms and adopts the Referee's order in all respects except those portions which pertain to extent of unscheduled disability.

The Referee concluded that claimant is entitled to an award for 50% unscheduled disability. After applying the guidelines set forth in OAR 436-65-600 et seq., we conclude that claimant would be adequately compensated by an award of 128° for 40% unscheduled disability. Accordingly, we modify the Referee's order on the issue of extent of disability.

ORDER

The Referee's order dated January 19, 1983 is affirmed in part and modified in part. That portion of the order concerning extent of unscheduled disability is modified. In lieu of the award granted by the Referee and in addition to the 64° for 20% unscheduled disability previously awarded, claimant is awarded 64° for 20% unscheduled disability for a total award of 128° for 40% unscheduled disability for injury to claimant's low back. Attorney fees payable from claimant's compensation should be adjusted accordingly. Claimant's attorney is awarded $550 for services on Board review, to be paid by the self-insured employer in addition to claimant's compensation.

JOHN A. SHOULDERS, JR., Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 80-06247
March 23, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of those portions of Referee Quillinan's order which found claimant's tinnitus, vertigo, right arm phlebitis and right leg thrombophlebitis to be compensable consequences of claimant's July 1978 industrial injury, thus setting aside SAIF's partial denial. SAIF contends that the medical evidence does not support the Referee's findings of compensability. Claimant cross-requests review of that portion of the Referee's order which held that the claim had not been prematurely closed. Claimant contends that the Referee should have reopened the claim and awarded penalties and attorney fees for premature claim closure.

We affirm and adopt the Referee's findings and conclusions with respect to the compensability of claimant's right arm phlebitis, right leg thrombophlebitis and the premature claim closure issue.

The only remaining issue is whether claimant's tinnitus and vertigo are compensable consequences of the 1978 injury. The strongest evidence connecting claimant's tinnitus and vertigo to the industrial injury is the temporal relationship between the incident and the onset of symptoms. However, the Court of Appeals has ruled that only a temporal relationship is generally insuffi-

cient to establish causation when a medical situation is complex. Edwards v. SAIF, 30 Or App 21 (1977). We might be inclined to find this medical situation to be quite simple if claimant had sustained a head injury in 1978. But, although claimant now asserts that he did, we find he did not report any head injury to any of the doctors who treated him immediately following the 1978 accident and did not receive any treatment for a head injury at that time. Under these circumstances, we are not persuaded that claimant's tinnitus and vertigo were caused by the 1978 accident, despite the temporal relationship between the former and the latter.

ORDER

The Referee's order dated August 20, 1982 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the SAIF Corporation's partial denial of claimant's tinnitus and vertigo is reversed and the denial is reinstated and affirmed to the extent that it relates to those two conditions. The remainder of the Referee's order is affirmed.

ELAINE L. WILLIAMS, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-02412
March 23, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests that this case be remanded to the Referee to allow further evidence taking or, in the alternative, requests that the Board reverse Referee Daron's order which set aside its denial of claimant's occupational disease claim for right elbow epicondylitis. Because we decide that remand is appropriate in this case, we do not reach the merits of SAIF's denial.

It appears from statements made at the hearing that, approximately one month prior to the scheduled hearing, the Referee's secretary telephoned SAIF's attorney inquiring whether he would object to a postponement of the case. A letter in the record shows that claimant's attorney had notified the Referee of a possible conflict on the scheduled hearing date. SAIF's attorney understood the phone call to mean that the hearing had in fact been postponed, although the secretary had not stated that the hearing would be postponed. Proceeding on that understanding, SAIF's attorney did not prepare for hearing and did not submit any proposed exhibits to the Hearings Division or claimant prior to the hearing. The morning of the hearing, SAIF's attorney happened to be talking to the Referee and became aware that this case was still scheduled for hearing that afternoon and that the Referee intended to proceed with the hearing.

At hearing SAIF's attorney stated that he was not ready to proceed with the hearing and that he had not received claimant's proposed exhibits -- Exhibits 1, 2 and 5. Exhibits 1 and 2 were the 801 claim form and a copy of the denial letter. SAIF obviously had these documents prior to the hearing. Exhibit 5 was a medical report from Dr. Levy upon which the compensability of this claim turned. The transmittal letters indicate that the SAIF attorney was sent copies of these proposed exhibits, but the SAIF attorney

stated that he did not receive any exhibits from claimant. The Referee admitted Exhibit 5 over SAIF's objections and denied SAIF the opportunity to depose Dr. Levy.

At hearing, SAIF's attorney attempted to introduce into evidence Exhibits 3 and 4. Exhibit 3 is an 827 claim form executed by Dr. Levy with some accompanying chart notes. Exhibit 4 was a letter from SAIF to Dr. Levy dated May 4, 1983 with a handwritten response by Dr. Levy. SAIF had not sent copies of these exhibits to claimant or the Hearings Division prior to the date of hearing because of the understanding that the hearing had been postponed. The Referee refused to admit Exhibits 3 and 4 based on the ten-day rule.

Finally, due to SAIF's attorney's impression that the hearing had been postponed, he had not lined up his witness to testify. When he attempted to contact his witness on the day of the hearing, the witness was unable to testify on such short notice.

In short: (1) This matter has proceeded to hearing and a decision on the merits without one party, SAIF, having yet presented its case; and (2) the genesis of the unfortunate chain of circumstances that produced that result was a telephone call from this agency. In retrospect, it obviously would have been better to ask SAIF its position on a possible postponement by letter rather than be telephone so that we would have the stabilizing effect of the written word and a corresponding reduction in the danger of miscommunication. While it is not necessarily undesirable to do business with some informality, when we do things informally we have to be willing to accept some of the responsibility for any resulting misunderstanding.

We do accept that responsibility and thus conclude that, not only has SAIF not yet presented its case, SAIF has not yet had a fair opportunity to present its case.

ORDER

The Referee's order dated September 16, 1983 is vacated. This case is remanded to the Hearings Division for further evidence taking.

ERWIN BAZER, Claimant
Alan R. Unkeles, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-01820
March 28, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The SAIF Corporation requests review of Referee Podnar's order which set aside its denial of claimant's hip injury claim. The central issue is whether claimant was a subject worker at the time of his injury.

Claimant was a tenant in the Gresham Garden Court Apartments in Portland. Claimant's mother was the manager of the apartments and an employe and agent of the apartment owner. On January 2, 1978 an ice storm hit Portland. Claimant went to his mother's apartment that morning to use her telephone to call his regular

employer, and learned that he was not expected to report to work that morning. Claimant's mother then asked him if he would check on two apartments in which the water pipes had been reported frozen. Claimant checked on the first apartment and then slipped on the ice and broke his hip en route to the second apartment. Claimant filed a negligence action against the individual who owned the apartments. In his pleadings in that case claimant alleged that: "plaintiff gratuitously assisted defendant's agent and employee, Evelyn Jones [claimant's mother], and while on his way to turn off the faucets he fell and slipped on some ice." Claimant lost the negligence action.

Claimant then pressed this Workers' Compensation claim. The gist of his claim is that the employer, the apartment owner, through its agent, claimant's mother, entered into an employment relationship with claimant, thus making claimant a subject worker under ORS 656.005 and 656.027.

The evidence which might support the argument that there was an employment relationship between claimant and the alleged employer is scanty. On the morning of claimant's accident there was no discussion between claimant and his mother about any remuneration for claimant's activities. Claimant had previously worked for the alleged employer doing painting. Claimant's mother testified that he had also helped her previously doing maintenance projects. She said that if the maintenance job took more than a half hour she would pay claimant out of her own salary. She testified, however, that she would have sought reimbursement from her employer for claimant's assistance on the water pipes the morning of his injury. Claimant's mother testified that claimant was free to help her or not that morning. At one point in her testimony, claimant's mother testified that she thought her son was acting gratuitously.

> "Q. Was he doing it on that occasion gratuitously?
>
> "A. Probably.
>
> "Q. He was?
>
> "A. He would have. It's, to me, six of one and a half a dozen of the other. It was something that needed to be done and [claimant], being the type of kid he is, would have done it. Either way."

Claimant testified that he would only get paid for maintenance work he did on the apartments if it took more than one half hour. He testified that he thought he would have been working on the apartments all day that day had he not been hurt.

ORS 656.005(28) defines a worker as: ". . . any person . . . who engages to furnish services for a remuneration, subject to the direction and control of an employer." A subject worker is any worker who is subject to the statute. ORS 656.005(26) and 656.027.

We find that claimant has failed to prove by a preponderance of the evidence that he engaged with the alleged employer to

provide services in exchange for remuneration. While claimant's mother had previously engaged claimant to do maintenance chores and had remunerated him on those occasions when he worked over one half hour, this is not necessarily probative of an employment relationship in this instance. Furthermore, claimant's mother admitted in her testimony that her son could well have agreed to check on the frozen pipes because of the "type of kid he is." The allegations contained in claimant's pleadings in his negligence action may not be binding, but they are certainly some indication that claimant considered his activities gratuitous. Based on this record we are unwilling to find that claimant has proven an employment relationship which would make him a subject worker.

ORDER

The Referee's orders dated June 8, 1983 and June 16, 1983 are reversed.

ROBERT T. GERLACH, Claimant
Gary Kahn, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB TP-83008
March 28, 1984
Third Party Distribution Order

The insurer has petitioned the Board for entry of an order distributing the proceeds of a third party recovery obtained by claimant. ORS 656.593(3). There are two issues presented: (1) Whether and to what extent the insurer may be required to compromise its lien for expenditures incurred to date, ORS 656.580(2), 656.593(1)(c); and (2) whether the insurer has established to a reasonable certainty that it will incur future claim costs exclusive of compensation that may become payable pursuant to ORS 656.273 or 656.278. See generally Leroy R. Schlecht, 32 Van Natta 261 (1981), rev'd in part 60 Or App 449 (1982).

In August of 1979, while in the course of his employment, claimant sustained alkaline burns to both eyes. The left eye injury was much more severe. In addition to filing a claim for workers' compensation benefits with the employer, claimant filed a third party action. ORS 656.154. Claimant's industrial injury claim was accepted and processed to closure. A Determination Order closed the claim in October of 1981, awarding temporary total disability and 100° of scheduled permanent disability for 100% loss of vision of the left eye. The industrial insurer has incurred in excess of $40,000 for claim costs. That amount is not disputed. Part of the controversy before the Board involves claimant's contention that the industrial insurer is required to compromise a portion of this lien by a certain percentage. The facts giving rise to this controversy are as follows.

Claimant's third party action was set for trial in April of 1983. Settlement negotiations had been ongoing between claimant, the third party and the industrial insurer. See ORS 656.587. During the course of the trial, claimant entered into a tentative settlement agreement with the third party, subject to the approval of the industrial insurer. Claimant's attorney contacted the industrial insurer's representative and attorney by telephone, apparently during a recess in the trial. An agreement was reached whereby the third party would pay claimant $150,000 in

satisfaction of claimant's cause of action, and the industrial insurer would discount by 20% its total lien for compensation paid. It is apparent that all parties -- claimant, the third party and the industrial insurer -- were satisfied at this juncture that an agreement had been reached as to settlement of claimant's third party action and reimbursement to the industrial insurer (at least with respect to the industrial insurer's lien for expenditures paid to date).

Apparently after reaching an agreement with the industrial insurer's representative and attorney concerning a 20% discount of the insurer's lien, claimant's attorney continued to negotiate with counsel for the third party in order to obtain a higher settlement amount. A settlement figure of $175,000 was agreed upon. That settlement was announced to the trial court, and the jury was dismissed.

By letter dated April 6, 1983, claimant's attorney informed counsel for the industrial insurer of the fact that claimant's third party action had been settled for $175,000. By letter dated April 14, 1983, counsel for the industrial insurer expressed surprise to learn that claimant's third party action had been settled and that the settlement amount was $175,000. Counsel's letter further states:

> "During our telephone conference of April 5, 1983, the top settlement offer from [the third party] that was transmitted to [us] was $150,000. Based upon the settlement figure of $150,000, and to assist in effecting a settlement, [the industrial insurer] agreed to compromise its workers' compensation lien by 20 percent. [We] never discussed the possibility of a lien discount under circumstances of settlement over $150,000.
>
> " * * * Under these new terms, [the industrial insurer] is willing to compromise its lien by 15 percent. * * * * "

Claimant contends that he relied upon the industrial insurer's agreement to reduce its lien by 20% in entering into settlement of his third party action for the sum of $175,000. The industrial insurer contends that, in view of the necessity to submit the matter to the Board for resolution of the parties' dispute and entry of an order pursuant to ORS 656.593, the Board should order full reimbursement to the industrial insurer without any discount of its lien, citing as authority our decision in Marvin Thornton, 34 Van Natta 999 (1982).

In Thornton claimant contended that the statutory formula for distribution of the proceeds of a third party recovery obtained by judgment, as set forth in ORS 656.593(1), did not apply to the distribution of a third party recovery obtained by way of settlement, by virtue of the statutory language in ORS 656.593(3), that "the paying agency is authorized to accept such a share of the proceeds as may be just and proper" following settlement of a

third party action. Claimant was seeking an order of the Board requiring the industrial insurer to compromise its lien for claim expenditures in order to make an "equitable contribution" towards claimant's attorney's fee which, in turn, would allow claimant to obtain a larger portion of the third party proceeds. We concluded:

> " * * * There are three parties necessary to effect the settlement of a third party action: The claimant, the third party tortfeasor or that party's insurer and the workers' compensation insurer. See ORS 656.587. All three of those parties are permitted by ORS 656.593(3) to agree on any distribution of the settlement proceeds. Only if the three parties are unable to mutually resolve the question of distribution is the matter submitted to the Board under the last sentence of ORS 656.593(3): 'Any conflict as to what may be a just and proper distribution shall be resolved by the Board.'
>
> "Once such a disagreement is submitted to us, the question becomes: Given that the legislature has specifically stated what it regards to be an equitable distribution of a judgment in all cases, should we indulge in ad hoc analysis of what is an equitable distribution of a settlement in each case? We conclude that we should not and will not order distribution of a settlement in any manner other than the statutory formula applicable to distribution of judgments." 34 Van Natta at 1001-02. (Emphasis in original.)

Two of the considerations that led us to this conclusion in Thornton were a desire to avoid random, standardless and possibly inequitable distributions that might result from determining, or attempting to determine, what may be a "just and proper" distribution on an ad hoc basis; and our belief that by ordering equitable apportionment of third party settlements on an ad hoc basis, we might be injecting significant uncertainty into the settlement negotiation process. 34 Van Natta at 1002.

There is a significant difference between the situation presented by the parties' dispute in this case and the controversy in Thornton. The insurer in Thornton was seeking reimbursement from the proceeds of claimant's third party recovery in an amount that would satisfy its entire lien for claim costs incurred to date, and there was no indication that, in settling his third party action, claimant had relied upon any representation by the insurer that it would agree to discount its lien. There was no contention made that the claimant had relinquished his right to continue the prosecution of his third party action, and thereby obtain a verdict and judgment possibly more favorable than the settlement amount accepted, in reliance upon the insurer's agreement to compromise its lien. In comparison, claimant in this case settled his third party action in substantial reliance upon the insurer's apparent approval of the settlement amount of

$150,000, together with the industrial insurer's representation that it would agree to a reduction of its lien in the event of a settlement in that amount. It would be grossly unfair to conclude that, by failing to obtain the industrial insurer's approval of all of the details of a $175,000 settlement, the parties' agreement concerning distribution of a $150,000 settlement should be of absolutely no effect. This is particularly true where, as here, claimant has settled the case in reliance upon the industrial insurer's promise to compromise a portion of its lien.

Accordingly, we do not consider ourselves absolutely bound by the statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), under the facts and circumstances presented herein. In furtherance of the same policy considerations discussed in Thornton, we believe it is appropriate in this case to, in effect, reconstruct an agreement the parties substantially entered into, but which subsequently fell apart primarily due to an unfortunate failure of communication. To this extent at least, ORS 656.593(3) provides this Board with authority to depart from a distribution in strict accordance with the formula prescribed by ORS 656.593(1).

We recently have been admonished that we lack authority under ORS 656.587 to modify the terms of an agreement by which the parties have settled a third party action. SAIF v. Cowart, 65 Or App 733, 738 (1983). We do not believe that Cowart has any application to the controversy presented in this case. We are merely performing our statutory duty pursuant to ORS 656.593(3).

Considering the facts and circumstances, we do not find the industrial insurer's contention that it is entitled to full reimbursement of its lien for actual expenditures to be reasonable. Nor do we consider claimant's expectation that the insurer would agree to a 20% discount of its lien, given the larger settlement amount, to be a reasonable expectation. The industrial insurer offered to compromise its lien by 15% on the basis of the increased settlement amount. We consider this a fair compromise and, therefore, will order reimbursement to the industrial insurer in an amount equal to its lien, reduced by an amount equal to 15% of its actual expenditures for compensation.

Turning to the industrial insurer's claim for a lien based upon reasonably-to-be-expected future expenditures for compensation, we conclude that the insurer has failed to establish its entitlement to reimbursement in this regard.

The insurer claims that it is entitled to be paid and retain $10,000 from the proceeds of claimant's third party recovery. This represents the estimated cost of a corneal transplant operation that the insurer contends is reasonably certain to occur in the future. The evidence, in the form of various reports from physicians who have treated and/or examined claimant since his original injury, indicates that the prospect that claimant will undergo surgery for a corneal transplant is anything but "reasonably certain." In fact, all physicians have indicated that the procedure is entirely elective, and the decision to undergo surgery is a matter of choice for claimant. As of now, there is no indication that claimant is desirous of submitting to this surgery at any time in the future. We infer that part of this

choice is probably due to the preponderant medical opinion indicating that, considering the nature of the injury to claimant's eye, the chances of obtaining a successful corneal transplant are relatively low, somewhere between 10 and 25 percent.

The insurer argues that it is unfair to allow claimant to "elect" not to pursue his only possible medical option at the time of a third party distribution, and then several years later, when his condition remains the same, allow him to exercise his option to undergo surgery and thereby require the industrial insurer to assume financial responsibility with no recourse against the funds obtained by claimant from the ultimate wrongdoer, i.e., the third party tortfeasor. To a certain extent, we share the sentiment expressed by the insurer, concerning the relative fairness of this situation. We, however, believe that the problem is inherent in ORS 656.593(1)(c), which provides the paying agency with the right to be paid and retain a portion of claimant's third party recovery for the present value of its reasonably-to-be-expected future expenditures for compensation. See also Leroy R. Schlecht, supra, rev'd in part on other grounds, Schlecht v. SAIF, supra; Larry Campuzano, 34 Van Natta 734 (1982). We are unable to conclude that it is reasonably certain that claimant will undergo the surgery in question, in view of claimant's apparent present intentions and the contingencies and uncertainties involved in the surgical procedure. It is certain, however, that if claimant eventually does decide to have the surgery in question, the insurer will be obligated to pay this expense pursuant to ORS 656.245. As of now, there is merely a possibility that claimant may undergo surgery in the future.

In addition to its fairness argument, the insurer relies upon our decision in Gerald Herrington, 35 Van Natta 859 (1983). Herrington also involved a claimant who sustained an injury to his left eye. Claimant received an award for 35° scheduled disability for a 35% loss of vision of that eye. The claimant's medical condition was diagnosed as hyperopia (far-sightedness) and an "early cataract." The cataract was diagnosed as being secondary to a trauma to the eye, sustained in a motor vehicle accident which arose out of and in the course of claimant's employment. Claimant's treating physician indicated that the type of cataract which claimant had characteristically became more dense and eventually required surgery, and that vision after a successful surgery might well be perfect, but never as good as normal vision prior to a cataract. Claimant's physician repeatedly stated that claimant would eventually require cataract surgery, and that claimant would probably best be served by an intraocular lens implant. We concluded that it was reasonably certain that claimant eventually would require the cataract surgery contemplated by his physician; therefore, we ordered that the industrial insurer be paid sufficient funds to satisfy that portion of its lien attributable to this anticipated future medical expenditure. 35 Van Natta at 861.

The similarity between the facts of this case and the facts in Herrington begin and end with the fact that both claimants sustained an injury to the left eye. Unlike Herrington, there is evidence in this case that the success of surgery is highly contingent, due primarily to the nature of the injury to the eye

and the extensive damage resulting therefrom. Herrington is markedly different from this case and does not support the insurer's position.

In conclusion, the industrial insurer is entitled to be paid and retain from the proceeds of claimant's third party recovery an amount equal to 85% of its actual expenditures for compensation paid to date, pursuant to ORS 656.593(1)(c). The balance of the recovery shall be paid to claimant pursuant to ORS 656.593(1)(d). The insurer is not entitled to a lien for anticipated future expenditures in view of its failure to establish to a reasonable certainty that such costs will be incurred.

ORDER

The proceeds of claimant's third party recovery shall be distributed in accordance with the distribution formula set forth in ORS 656.593(1), with the modification that the industrial insurer's lien for expenditures paid to date shall be reduced by 15%. The balance of the recovery shall be paid to claimant.

KENNETH L. GREENE, Claimant
MARK LUEDTKE dba 4-Point Lumber, Employer
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Douglas Minson, Attorney
Schwabe, et al., Attorneys
Carl Davis, Ass't A.G.

WCB 82-07607, 82-07911, 82-08067, & 82-09328
March 28, 1984
Order on Review (Remanding)

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation as insurer for Kruesi Cutting, the aggravation employer, requests review of Referee Foster's order which assigned responsibility to it for claimant's low back condition. The issues are: (1) Responsibility; (2) assuming the Board reverses the Referee's finding on responsibility, the Referee's jurisdiction to determine whether Mark Luedtke, dba 4-Point Timber Co. (hereinafter referred to as 4-Point), was a non-complying employer; (3) assuming the Referee had jurisdiction to determine the non-complying issue, whether 4-Point was, in fact, a non-complying employer; (4) assuming 4-Point was a non-complying employer, whether Van Port Manufacturing is liable for the claim under ORS 656.029.

We reverse on the responsibility issue; we remand on the jurisdictional issue; consequently we do not reach the merits of the non-complying employer issue or the issue of the applicability of ORS 656.029.

Claimant compensably injured his low back on April 7, 1975 while working for Kruesi Cutting. Claimant has received a total award for 15% unscheduled disability as a result of that injury. Claimant began working for 4-Point in April 1980 and worked planting trees without time loss until May 1982. Claimant testified that he experienced some pain during this period. However, he did not seek medical treatment for his back condition between the time he started work for 4-Point and May 1982.

During May 1982 claimant was planting trees in exceptionally rough terrain. He began to experience an increase in pain as well as radiating pain in both legs. Dr. Aversano examined claimant and opined that claimant "once again, has nerve entrapment at the root level at either L4-5 or L5-S1." In June, Dr. Borman opined: "It is my opinion, based upon observation of this patient during this past month, that he is suffering from a herniated lumbar intervertebral disk resulting from the industrial injury which occurred May 15, 1982."

In September 1982 Orthopaedic Consultants examined claimant and opined:

> "I feel that the injury and necessary surgery of 1975 and the symptoms that started in May of 1982 are contributing factors and it is a combination of both that is giving him his present problem. He had pathology in his back to start with, and now it is evident that a new disc fragment extrusion has occurred and that this then, has become the major contributing factor.
>
> "He did so well for so long after his initial surgery, that it is felt that his May 1982 injury is the reason why he now is in his present state. Very probably he started to have some slight protrusion on May 13, 1982...."

The surgeon who wrote the Orthopaedic Consultants' report was Dr. Clarke, who performed claimant's earlier surgery.

Dr. Raaf also examined claimant. He opined that claimant had had a disc protrusion all along and, therefore, the work exposure at 4-Point had not contributed to claimant's condition. The Referee relied on Dr. Raaf's report and found that claimant suffered from an aggravation rather than a new injury.

We conclude that the preponderance of the evidence is to the contrary. Based on the opinion of Dr. Borman and, especially, based on the opinion of Orthopaedic Consultants, we conclude that claimant's work at 4-Point independently contributed to his increased pain, need for medical treatment and time loss in 1982. As the Supreme Court has recently reiterated in Boise Cascade v. Starbuck, 296 Or 238 (1984), in a situation like this, where claimant sustained an injury at one employment and then a later employment independently contributed to the disability, the later employment bears responsibility. Accordingly, we reverse the Referee and find that claimant sustained a new injury in 1982.

The question of which company is statutorily claimant's employer under ORS 656.029 involves a determination of whether 4-Point was a non-complying employer at the time of claimant's injury. If 4-Point was insured at the time of claimant's injury, then it is liable. However, if 4-Point was not insured for workers' compensation at the time of claimant's injury then it is conceivable that Van Port Manufacturing Company, which contracted with 4-Point to plant trees, is liable under ORS 656.029.

At the outset it is necessary to determine whether the Referee had jurisdiction to decide whether 4-Point was a non-complying employer.

The record before the Referee indicated that on August 4, 1982 the Workers' Compensation Department issued a "Proposed and Final Order" finding that Mark Luedtke, dba 4-Point, was a non-complying employer at the time of claimant's injury. The order recites that 4-Point had twenty days from the date of receipt of the order to request a hearing. The Referee intimated that 4-Point had failed to file a timely hearing request: "The evidence clearly indicates that the employer filed his request for hearing on September 7, 1982. It was not filed within 20 days of the Proposed and Final Order; the mailing date of the order being August 4, 1982."

We note that the Referee seems to confuse date of mailing and date of receipt, the latter being the critical date. In any event, shortly after the Referee lost jurisdiction of this case, 4-Point's attorney provided information from the Department which purports to show that 4-Point timely requested a hearing on the non-complying employer issue. The Board is precluded from considering this evidence. ORS 656.295(5). However, we are authorized to remand to the Referee if we find that the record was "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). We so find and remand this case to the Referee to consider the issue of whether 4-Point requested a hearing in time to preserve its right to contest the Department's finding that it was a non-complying employer. For the sake of administrative efficiency, if the Referee finds that he has jurisdiction to decide the non-complying employer issue, he should decide the remaining issues in this case.

ORDER

The Referee's order dated January 14, 1983 is reversed in part and remanded. That portion of the Referee's order which set aside SAIF's denial on behalf of Kruesi Cutting of claimant's aggravation claim is reversed, and that denial is reinstated and affirmed. This case is remanded to the Referee for further proceedings on the remaining issues, consistent with this order.

KIM D. KOLLEAS, Claimant
Welch, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 81-08951
March 28, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of those portions of Referee Braverman's order which: (1) Held that claimant's request for hearing regarding the employer's denial of authorization for additional hand surgery was not timely filed; (2) held that claimant had not shown good cause for failure to file within the 60-day time limit; (3) did not reach the merits of the denialof surgery; and (4) modified the July 30, 1981 Determination Order by increasing claimant's award from 12.1° for 55% of the left middle finger to 22.5° for 15% of the left hand.

Claimant suffered a compensable hand injury in January 1980.

Dr. Button eventually performed a total of three surgeries. The claim was closed by Determination Orders in July 1981. Dr. Melvin then became claimant's treating physician in about September 1981 and immediately proposed additional surgery.

I

The chronology relevant to the timeliness issue is:

September 29, 1981: The date that appears on the self-insured employer's denial of the additional surgery proposed by Dr. Melvin.

December 2, 1981: Claimant filed a supplemental hearing request on the issue of the September 29 denial. (Claimant had previously filed a request for hearing on other questions concerning this claim, which was then pending.)

The 60-day period in which to request a hearing, stated in ORS 656.319(1)(a), begins to run when a denial is mailed, not when it is dated, and the date of mailing must be proven before the 60-day time limit can be invoked. Madwell v. Salvation Army, 49 Or App 713 (1980); Mildred E. Swenson, 35 Van Natta 566 (1983). As is apparent from the above chronology, the mailing date is here crucial because a delay of just a few days in mailing the September 29 denial would make the difference as to whether claimant's early December hearing request was timely.

We find insufficient evidence in this record of the date that the September 29 denial was mailed. There is some testimony that claimant received that denial at the end of September, or the beginning of October or as late as October 6, 1981; however, we find this testimony to be vague and inconclusive. Other than the inference about mailing date that could arise from date of receipt, there is no evidence in the record about date of mailing. (The employer has attached a copy of a return receipt to its brief which was not introduced into evidence at the hearing; we have not considered it in our review of this issue.) Under these circumstances, we disagree with the Referee's finding that claimant's request for hearing on the September 29 denial was untimely.

II

We turn to the merits of the denial and conclude that it should be set aside.

In September 1981, and as late as December 1982, Dr. Melvin recommended that claimant receive additional surgery similar to one that Dr. Button previously performed for the purpose of easing claimant's ongoing symptoms of pain, numbness and tightness at the base of his third finger. Dr. Button has opposed the requested additional surgery because he feels that it would be only duplicating his own prior efforts and that more time is necessary for claimant to fully recover from the prior surgery. However, claimant points out that he has not improved with the passage of time, as indicated in Dr. Melvin's most recent report. Dr. Melvin also points out that he intends to perform the additional surgery at a different location than the prior surgery performed by Dr. Button:

> "[Claimant] requires exactly the same type of surgery that he had before, but in a different position, and in an area where he has not had corrective surgery previously. The pain that [claimant] is having is a direct result of his injury, and the needs of corrective surgery are exactly the same as when Dr. Button operated on his finger, pain and scar. It so happens that he requires the same type of surgery on his palm wound also."

In Dr. Melvin's December 7, 1982 report he stated that claimant required treatment to the underlying scar tissue around the common digital nerve to the third web space of claimant's left hand, and that claimant still required surgical exploration "with freeing of the nerve from the surrounding scar tissue, and also of lengthening the tightness of the skin in that area by multiple Z-plasties . . . ." In sum, it is Dr. Melvin's opinion that this surgery is the only feasible solution to correcting claimant's problem of pain and loss of grip in his left hand. Based on the above, we find that the recommended surgery is reasonable and necessary for the treatment of claimant's compensable injury.

III

Finally, claimant contends that he is entitled to a greater award for permanent partial disability for his left hand. It is somewhat awkward to even consider this issue at this time because we have found that the additional surgery proposed by Dr. Melvin offers a reasonable prospect of reducing claimant's hand disability. Nevertheless, as of the time of this hearing claimant had lost some range of motion in his left middle finger and has considerable hypesthesia on the ulnar side of that finger. He also has mild loss of grip strength and some swelling in his finger and thumb with accompanying pain. Utilizing the guidelines at OAR 436-55-510 to OAR 436-55-530, we find that the Referee's award of 15% permanent partial disability to claimant's left hand is proper at this time.

ORDER

The Referee's orders dated April 28, 1983 and May 18, 1983 are affirmed in part and reversed in part. Those portions of the order which found claimant's request for hearing on the September 29, 1981 partial denial was not timely and that did not reach the merits of the denial are reversed, and, in lieu thereof, the September 19, 1981 partial denial is set aside and claimant's claim for surgery recommended by Dr. Melvin is remanded to the self-insured employer for acceptance and processing. In addition, claimant's attorney is awarded $950 for services at hearing and $450 for services on Board review for prevailing on the partial denial, to be paid by the self-insured employer. The remainder of the Referee's order is affirmed.

FAYE L. BALLWEBER, Claimant
Olson Law Firm, Claimant's Attorneys
Keith Skelton, Defense Attorney

WCB 82-04534
March 29, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of those portions of Referee Johnson's order which set aside the insurer's denial of claimant's aggravation claim. The insurer also argues that the Referee erred in admitting certain documents which were not submitted 10 days prior to the hearing.

On the evidentiary issue, in order for the exhibits to have been submitted at least 10 days prior to hearing, as required by OAR 436-83-400(3), they would have had to be submitted at the latest on Saturday, December 4, 1982. Instead, the exhibits were submitted on Monday, December 6, 1982. After admitting the exhibits, the Referee allowed the insurer's attorney the opportunity to depose the physicians who authored the reports in issue. In view of these circumstances, any violation of the ten day rule was de minimus. In addition, in view of our decision on the merits, the evidentiary question is moot because, even considering the disputed exhibits, we find that claimant has failed to prove a compensable aggravation.

Claimant compensably injured her neck while shucking corn in September 1981. She was diagnosed as having a mild cervical strain and bilateral carpal tunnel syndrome. Dr. Tsai performed a bilateral carpal tunnel release in November 1981 with apparently good results. Dr. Tsai found claimant's neck and wrist conditions medically stationary as of March 16, 1983. A Determination Order issued in April 1982 which awarded claimant temporary disability through March 16, 1982. Claimant argued at hearing that the claim was prematurely closed. However, the Referee found that claimant was stationary as of March 16, 1982. That portion of the Referee's order was not appealed.

Prior to claim closure claimant was also receiving chiropractic treatment from Dr. Burdell. Dr. Martens examined claimant in April 1982. He noted that claimant was complaining of pain in both wrists and some aching in the right side of her neck. He felt that claimant's chiropractic treatments were palliative.

In August 1982 claimant saw Dr. Knox who reported that claimant was complaining of numbness in the third, fourth and fifth fingers of both hands and of a dull aching pain in her neck, more prominent on the right, and also complaining of headaches. Dr. Knox's report of August 18, 1982 has been treated as a claim for aggravation. On November 20, 1982, apparently on the basis of an examination of claimant by his nurse, Dr. Knox opined that claimant's condition had worsened.

On September 22, 1982 Dr. Martens opined that claimant's symptoms "remain essentially the same." On November 4, 1982 Dr. Tsai performed a complete neurological examination of claimant and opined that claimant's "neurological status has remained unchanged." On December 3, 1982 Dr. Burdell opined that claimant suffered an exacerbation in February 1982. He felt that claimant

was not medically stationary in December 1982 because she "has noted slow, fairly steady, improvement during the past few months."

The Referee relied on the reports of Dr. Burdell and Dr. Knox as well as claimant's testimony and found that claimant had suffered a compensable worsening. We disagree. We do not find that Dr. Burdell's report supports a worsening in August 1982 because he opined that claimant's condition was improving at that time. We give Dr. Knox's opinion little weight because he did not have the opportunity to compare claimant before and after she became medically stationary, and because he apparently relied, at least in part, on an examination performed by his nurse rather than on his own examination. On the other hand, both Dr. Tsai and Dr. Martens observed claimant before and after her alleged worsening and neither felt that her condition had worsened. We find Dr. Tsai and Dr. Martens convincing. Accordingly, we hold that claimant has failed to prove by a preponderance of the evidence that her condition worsened in August 1982.

ORDER

The Referee's orders dated April 15, 1983 and May 9, 1983 are affirmed in part and reversed in part. That portion of the Referee's order which set aside the insurer's denial dated October 20, 1982 is reversed, and that denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

JOHN M. BARBOUR, Claimant
Haas & Benziger, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-03508
March 29, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The self-insured employer requests review of Referee Williams' order which set aside its "partial denial" of further benefits. The issues are the merits of the denial and the significance, if any, of claimant's failure to personally appear at the hearing.

Claimant alleged that he sustained injuries in a fall at work in December 1981. The claim was accepted and processed until March 26, 1982. On that date, while the claim was in open and accepted status, the employer issued a denial which states:

> "We must notify you that we will be unable to accept further responsibility for your claim. Our denial is based on the fact it does not appear your current condition was aggravated by or arose out of and in the course of your employment, either by accident or occupational disease, within the meaning of the Oregon Workers' Compensation Law. Therefore, we must respectfully deny any and all further responsibility for your back condition."

When it issued this denial, the employer ceased paying claimant time loss benefits.

There is substantial, persuasive and uncontroverted evidence that establishes that, by March 1982, claimant had fully recovered

from the minor injuries he sustained in December 1981 but was then engaged in a course of conduct designed to prolong his receipt of workers' compensation benefits. Nevertheless, we understand the Court of Appeals to have held in Safstrom v. Riedel International, Inc., 65 Or App 728 (1983), that an employer/insurer cannot cease paying time loss on an accepted claim by issuance of a denial of further benefits, but rather must continue to process the claim and submit it to the Evaluation Division for closure when appropriate (or perhaps issuance of employer/insurer closure would be appropriate). The Referee's analysis in this case accurately forecast the court's subsequent holding in Safstrom. We, therefore, agree with the Referee's conclusion "that the employer's denial of March 26, 1982 is disapproved, and this claim is remanded to the employer to be further processed as an accepted, disabling claim" with the understanding that the Referee was ordering the employer to reinstate claimant's time loss benefits from when they were terminated in March 1982 until this claim is properly closed.

We have considered the effect of the failure of a claimant to personally appear at hearing in Edward R. Cantrell, WCB Case Nos. 80-09015 and 81-08071, 36 Van Natta 312 (decided this date), and Warren F. Stier, WCB Case No. 81-10065, 36 Van Natta 334 (decided this date). We concluded in Cantrell and Stier that: (1) There is no jurisdictional requirement that a claimant personally appear for hearing, and thus it is possible for a case to be submitted for a decision on the merits despite a claimant's absence; but (2) the statutory duty to conduct a hearing in a manner likely to achieve substantial justice, ORS 656.283(6), means that in some situations the employer/insurer should have the right to confront and cross-examine the claimant, and if a claimant does not make himself available for cross-examination, dismissal of his hearing request may be appropriate. Cantrell involved an extent of disability issue with the medical reports that contained little or no objective findings, but considerable history of the claimant's subjective complaints. When the claimant failed to appear for hearing, the Referee dismissed his hearing request. Finding the right to confrontation critical in this context, we affirmed. Stier involved a backup denial on the basis of fraud. When the claimant failed to appear for hearing, the Referee dismissed his hearing request. Finding the right to confrontation critical in this context, we affirmed.

This case, by contrast, illustrates that confrontation is not important in some situations. Under Safstrom, the employer's March 1982 denial was impermissible as a basis to terminate claimant's time loss as a matter of law. Claimant's testimony or lack thereof could not possibly change that conclusion. At most, claimant's testimony might establish that, at the time the denial was issued, he had fully recovered from his injuries and was manipulating his claim to obtain further benefits to which he was not entitled. As we understand the court's decision in Safstrom, however, even such testimony would not alter the fact that the employer's denial was statutorily impermissible. It follows that the Referee did not err in deciding the merits of this case even though claimant did not appear at hearing, and thus the employer was unable to confront claimant.

ORDER

The Referee's order dated May 12, 1983 is affirmed. Claimant's attorney is awarded $350 for services rendered on Board review, to be paid by the self-insured employer.

FORREST W. BELL, Claimant
Pozzi, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
John E. Snarskis, Defense Attorney

WCB 82-08432 & 82-08433
March 29, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The self-insured employer requests review of Referee Mulder's order which set aside its denial of claimant's aggravation claim and upheld Industrial Indemnity's denial of claimant's alternative new injury claim. The issue is employer/insurer responsibility.

The facts of this case are relatively simple. Claimant was employed as a steel burner for the self-insured employer when, on May 4, 1978, he sustained a compensable injury when he fell through a table on which he was standing. Claimant fell a distance of approximately three feet. Claimant was examined by Dr. Bell, a chiropractor, who diagnosed a cervical and left knee strain. Claimant treated with Dr. Bell until July 7, 1978; Dr. Bell then released claimant from further treatment and stated that claimant was asymptomatic. Claimant missed no time from work as a result of this injury.

Over about the next four years, claimant worked as a saw operator, warehouseman and steel shearer. Despite this fairly heavy work, between July 1978 and May 1982 claimant sought no further medical attention for his neck and missed no time from work because of his neck. Claimant testified that after the 1978 injury he continued to experience neck symptoms occasionally, that these symptoms were not particularly significant and that he could work for weeks at a time with no symptoms. He stated that neck pain would cause him to "occasionally" take an aspirin.

On May 25, 1982 claimant was working as a shearer helper. Claimant explained that the shearer would place pieces of steel on a machine; that the machine would cut the steel; and that the cut steel would then move down a conveyor belt where claimant, using a magnet, would pull the steel off the belt and stack it. Claimant stated each cut piece of steel weighed approximately 90 pounds and that he was working at a rapid pace because "we were running a lot of material through the shearer." Claimant indicated that he had not worked as rapidly as this in the past. Claimant testified: "Well, as I was pulling the material off, especially with my left hand, I -- I kept getting that pain in my neck." The longer claimant worked, the more severe the pain became. Claimant testified that the pain was much more severe than anything he experienced in the past. Claimant interrupted his working shift at about two o'clock that afternoon to see Dr. Smith.

Dr. Smith referred claimant to Dr. Silver, a neurosurgeon. Dr. Silver diagnosed degenerative cervical osteoarthritis with

possible foraminal encroachment at the left of C4, occipital neuralgia and a cervical strain. Dr. Silver's medical reports contain no mention of claimant's work activities on May 25, 1982. Dr. Silver indicates only that claimant began having increased pain in the area of the 1978 injury "without further injury."

Responding to an inquiry from Industrial Indemnity, Dr. Silver stated that, since claimant suffered no new injury in May 1982, claimant's condition represented an aggravation of the 1978 injury because the symptoms were identical and the location of the pain was the same as in 1978.

On November 22, 1982 claimant was examined by Dr. Raaf, a neurosurgeon. Dr. Raaf's history did include claimant's description of his work activities of May 25, 1982. Dr. Raaf stated:

> "The patient believes that he never entirely recovered from the neck symptoms after the May 4, 1978 injury but he improved to the point where his neck was giving him relatively little trouble. If this is true then presumably the excessive lifting which he did on May 25, 1982 aggravated the original injury . . . ."

Although it is not entirely clear, Dr. Raaf seems to suggest that claimant sustained a new injury as a result of his work activities on May 25, 1982. However, in reply to a further inquiry from Industrial Indemnity, Dr. Raaf reported on February 14, 1983 that claimant's work in May 1982 did not contribute independently to his disabling condition.

Apparently at the request of the self-insured employer, claimant was examined by Dr. Wilson, a neurologist. Dr. Wilson concluded that claimant was suffering from a cervical strain with degenerative changes at C3-4. After examining the claimant and reviewing his history, including a history of claimant's work activities on May 25, 1982, Dr. Wilson stated that it was his opinion that the heavy and repetitive work claimant was performing on May 25, 1982 resulted in left cervical distress, and that this constituted a new injury rather than an aggravation of the 1978 injury.

Dr. Wilson also testified at the hearing. After listening to the claimant's testimony, Dr. Wilson reiterated his previous opinion that claimant sustained a neck strain in May 1982 and that it was a result of his work activities of May 25, 1982. Dr. Wilson testified:

> "And I think that in going through his history, I think the thing that was most important, in my opinion, was the type of work that he was doing . . . in which he described repetitively taking those pieces of metal weighing 90 pounds -- and I thought when I interviewed him in my office it was primarily with the left arm -- repeatedly taking 90 pounds as fast as they would come off the conveyor. I'll tell you, anyone who did that and lifting 90 pounds with one

arm is going to have soreness in the shoulder or [it] can be in the neck.

* * *

"I think that the work activity [in May 1982] itself was the most significant contributing cause to his problem."

Although claimant did not experience any direct trauma on May 25, 1982, Dr. Wilson felt that the repetitive lifting of heavy weights on that day did constitute a form of trauma. Dr. Wilson also stated that, although claimant had some intermittent problems with his neck since 1978, these were not significant, and claimant would go relatively long periods without any symptoms. The Referee concluded that this case involved an injury rather than an occupational disease. We agree. Based on the reports of Drs. Silver and Raaf, the Referee concluded that claimant sustained an aggravation of his 1978 injury. We disagree.

In Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984), the court stated that in a situation where a compensable injury at one employment contributes to a disability occurring during a later employer, the original employer remains liable unless the latter employment contributed to the claimant's disability. We conclude that the evidence in this case establishes that claimant's employment activities in May 1982 so contributed, and that Industrial Indemnity is thus liable for claimant's current claim.

Industrial Indemnity's arguments that claimant did not sustain a specific injury as a result of his work activities in May 1982 are not convincing. It is not necessary for there to be a specific traumatic incident before an injury can be found to have occurred. See Valtinson v. SAIF, 56 Or App 184 (1982); Donald Drake Co. v. Lundmark, 63 Or App 261 (1983).

In this case, claimant's symptoms came on over a period of several hours during which he was engaged in rapid, heavy and repetitive work. Claimant testified that the pain he incurred while engaging in this activity was "severe," and that he had not previously experienced pain to this degree in his neck. If it is possible for an injury to occur over a period as long as several weeks, Lundmark, it is certainly plausible in this case to find that claimant sustained an injury over a period of several hours of work activity.

It is true that claimant's May 1982 condition is substantially the same condition as was diagnosed in 1978, namely, a cervical strain. It is also true that claimant continued to experience symptoms on an intermittent basis since 1978. However, as stated above, a reading of claimant's testimony indicates that claimant's symptoms between 1978 and 1982 were generally quite minor, and that claimant would go for long periods with no symptoms at all. The minimal nature of claimant's symptoms is exemplified by claimant's failure to seek medical attention, and his failure to miss any time from work as a result thereof.

Unlike the Referee, we do not find the medical opinions of Drs. Raaf and Silver to be persuasive. Although claimant testified that he informed Dr. Silver of his work activities on May 25, 1982,

there is no such history recited in any of Dr. Silver's medical reports. There is thus no way to know if Dr. Silver was rendering an opinon based on all the relevant facts. In contrast, it is apparent from Dr. Raaf's reports that he was aware of claimant's work activities of May 25, 1982. However, Dr. Raaf's opinions vacillate. We interpret his November 23, 1982 report as indicating that claimant's 1982 work activities contributed independently to his disabling condition. However, then in his February 14, 1983 report Dr. Raaf, with no explanation, apparently changes his position and states that claimant's 1982 work activities did not contribute independently to his condition.

We find Dr. Wilson's opinion that claimant sustained a new injury on May 25, 1982 to be the most persuasive. Dr. Wilson examined the claimant, reviewed his history and listened to his testimony at the hearing. Dr. Wilson explained in detail (as previously related) why he believed claimant sustained a new injury in May 1982 rather than an aggravation of the 1978 injury. Unlike Dr. Silver, it is clear that Dr. Wilson considered the entire history relative to claimant's condition in May 1982, and, unlike Dr. Raaf, Dr. Wilson did not waiver in his opinion. Moreover, we find Dr. Wilson persuasive because his opinion best comports with the historical facts of this case. To repeat, those facts are: (1) Claimant's original injury occurred nearly four years prior to his presently disabling condition; (2) claimant experienced very little in the way of symptoms subsequent to that incident; (3) claimant sought no medical attention nor missed any time from work as a result of the 1978 injury for about the next four years; and (4) claimant's May 1982 symptoms came on over the course of a few hours while claimant was engaged in heavy and repetitive work activity.

ORDER

The Referee's order dated April 28, 1983 is reversed. The August 6, 1982 denial issued on behalf of Gilmore Steel in its capacity as a self-insured employer is reinstated and affirmed. The August 3, 1982 denial issued by Industrial Indemnity is set aside. Industrial Indemnity is ordered to reimburse Gilmore Steel for all claim costs, including attorney fees, paid or payable pursuant to the Referee's order.

SHIRLEY A. BUNCH, Claimant
Hansen & Wobbrock, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-06833 & 82-06832
March 29, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of those portions of Referee Mulder's order which affirmed the Determination Orders of June 10, 1982 and October 28, 1982 (as amended) which awarded claimant a total of 25% (80°) unscheduled low back disability. Claimant contends (1) that she is entitled to a greater award of unscheduled disability; (2) that she is entitled to benefits for temporary total disability from March 19, 1982 to May 12, 1982; and (3) that she is entitled to benefits for temporary total disability from September 23, 1982 to November 22, 1982. The SAIF Corporation cross-requests review of the those portions of the Referee's order which (1) affirmed the Determination Order's award of 25% permanent disability; and (2)

which ordered the claim reopened as of November 22, 1982, on the basis of aggravation, and ordered SAIF to pay claimant benefits for temporary total disabilty from November 22, 1982 to February 8, 1983. SAIF contends that claimant's previous awards of 15% unscheduled low back disability were adequate, and that claimant failed to establish an aggravation in November 1982.

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

We first address claimant's contention that she is entitled to temporary total disability benefits from March 19, 1982 through May 12, 1982. Claimant's argument is related to the June 10, 1982 Determination Order which issued following completion of claimant's vocational rehabilitation program. Prior to entering that program, claimant had been determined to be medically stationary on September 24, 1980. Claimant entered her vocational program in September 1981, and the program terminated on March 19, 1982. Claimant was examined by the Orthopaedic Consultants on May 12, 1982. They found claimant medically stationary at that time and opined that the examination findings were essentially the same as when claimant was previously examined in June 1980.

Claimant's argument seems to be that she is entitled to temporary total disability from the date of termination of her vocational rehabilitation program to the date the Orthopaedic Consultants indicated she was medically stationary. We disagree. Claimant had previously been found stationary on September 24, 1980. There is nothing in the record indicating that claimant's condition worsened or changed in any way between September 1980 and May 1982. There is, therefore, no reason to provide time loss benefits beyond the date claimant's vocational rehabilitation program terminated. It would appear that the Evaluation Division's request for another medical report following the termination of the vocational program was related to reassessment of claimant's permanent, rather than temporary, disability. We thus agree with the Referee's refusal to allow temporary disability benefits from March 19 through May 12, 1982.

Claimant next contends that she is entitled to temporary total diability benefits from September 23, 1982 through November 22, 1982, the date the Referee ordered the claim reopened on the basis of aggravation. Following completion of her vocational program, claimant's claim was reopened on June 30, 1982 because of an aggravation. The aggravation claim was closed by Determination Order dated October 28, 1982, which awarded claimant temporary total disability benefits from June 30 to September 23, 1982, and an additional 10% disability for a total of 25% unscheduled low back disability. The claim was closed in reliance on Dr. Puziss' report of September 23, 1982, which stated that he had not seen claimant since August 3, 1982, and:

> "I felt that she had a temporary exacerbation of her back pain and by now she would be back to her pre-injury status. I felt that she would not have a permanent aggravation of her preexisting condition. Her claim can be closed with no increase in permanent impairment."

Claimant relies mainly on her hearing testimony to establish

that she was not medically stationary between September 23 and November 22, 1982. We find this insufficient. It is the claimant's burden to prove she was not stationary when the Determination Order issued. Dr. Puziss' report of September 23, 1982 indicates that claimant had only a temporary exacerbation of her condition. Dr. Puziss made the reasonable, if not inescapable, assumption that, since claimant had minimal findings when last seen and had not returned for any additional treatment, she was medically stationary. Dr. Puziss' report of November 22, 1982 also seems to confirm this conclusion. We, therefore, agree with the Referee's refusal to find claimant entitled to temporary disability benefits from September 23 to November 22, 1982. See Lawrence M. Sullivan, 35 Van Natta 1383 (1983).

SAIF contends that the Referee erred in ordering claimant's claim reopened on the basis of aggravation for the period from November 22, 1982 to February 8, 1983. SAIF argues that claimant experienced nothing more than a symptomatic flare-up, and that such occasional exacerbations are to be expected considering her permanent impairment. See Harmon v. SAIF, 54 Or App 121 (1981); Frances Knoblauch, 35 Van Natta 218 (1983).

Although we agree with the concept SAIF relies on, we do not find it applicable in the present case. The evidence, although minimal, does establish that clamant suffered a temporary aggravation of her condition. However, we do not agree with the reopening date selected by the Referee. The Referee ordered the claim reopened based on Dr. Puziss' report of November 22, 1982. We do not find that report sufficient to justify reopening the claim. Dr. Puziss reports that claimant experienced an increase in her low and mid back pain after sitting through some meetings. Claimant's physical findings were basically the same as claimant presented on previous occasions. Dr. Puziss gave claimant a prescription for an anti-inflammatory and told her to use her traction unit. He further stated, "She need return only prn. Treatment is considered only palliative at this time." There is no indication in this report that claimant was unable to work. Dr. Puziss did not indicate claim reopening would be appropriate, and he provided claimant with only minimal conservative care. All this could be provided for pursuant to ORS 656.245.

We find the appropriate date for reopening this claim to be January 7, 1983. Claimant visited the emergency room at Holladay Park Hospital on that date with complaints of increasing pain, spasm and tenderness. Dr. Puziss reported that claimant's impairment at that time was in the mildly moderate range but that it was expected to improve. In a later report dated January 17, 1983 Dr. Puziss reported that claimant would return to her stationary status within three weeks. On February 8, 1983 Dr. Puziss found claimant medically stationary. We conclude that the proper date for reopening is January 7, 1983, rather than November 22, 1982.

With regard to the issue of permanent partial disability, we affirm and adopt those portions of the Referee's order relevant to this issue.

ORDER

The Referee's order dated March 14, 1983 is modified in part.

SAIF is ordered to pay claimant benefits for temporary total disability, less time worked, if any, from January 7, 1983 through February 8, 1983, rather than from November 22, 1983 through February 8, 1983. The Referee's order is affirmed in all other respects.

EDWIN R. CANTRELL, Claimant
Michael Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 80-09015 & 81-08071
March 29, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of Referee Howell's order which dismissed his request for hearing because claimant did not personally appear at hearing, but only appeared through his attorney. The Referee concluded: "[I]t would be unfair to SAIF Corporation to deny it the opportunity to cross-examine claimant, at least with respect to the representations he made to physicians." We agree with the Referee and affirm.

These two consolidated cases began as requests for hearing on extent of disability. In WCB Case No. 80-09015 claimant requested a hearing on a September 25, 1980 Determination Order which closed his November 1979 back injury claim. In WCB Case No. 81-08071 claimant requested a hearing on a June 10, 1981 Determination Order.

After several hearings had been scheduled and postponed, these cases ultimately came on for hearing on February 12, 1982. Claimant's attorney was present, but claimant was not. Several exhibits were admitted at that time over SAIF's objection that, to the extent the exhibits contained statements attributed to claimant, SAIF wanted to confront and cross-examine claimant. The February 12 proceedings concluded with the Referee ruling that the hearing would be continued and asking the parties to file memoranda on the issue of the necessity of claimant's presence at a hearing requested by claimant.

After the parties filed memoranda, the Referee issued an interim order:

> "Claimant's counsel asked to be allowed to rest on the evidentiary record in this case in support of claimant's request for increased awards of permanent disability.
>
> "SAIF demanded that it be allowed to cross-examine claimant in that much of the medical evidence in the record was dependent upon information provided by claimant to his physicians.
>
> "Workers' Compensation hearings are to be conducted in such a manner as to achieve substantial justice. In order to obtain such an objective, both parties must be given the opportunity for a fair hearing. It would be patently unfair in this case to allow claimant to rely on evidence founded

largely upon his own representations without allowing SAIF Corporation the opportunity to cross-examine claimant for the Referee to evaluate claimant's credibility.

"In order to provide both parties the opportunity for a fair hearing claimant must appear at a hearing in Oregon and submit to cross-examination by SAIF Corporation. His failure to do so will result in an order dismissing his request for hearing."

The hearing was set to reconvene on November 3, 1982, although the only additional communication from claimant's attorney in the record indicated that his client would not be present at that time. Instead, claimant's attorney suggested an alternative approach to taking claimant's testimony:

". . . the claimant is presently unemployed and does not have the funds necessary to travel from New Mexico to Salem. It has come to my attention that recently the Hearings Division has held telephonic hearings in situations such as this and at this time I would request that such a system be set up so that the claimant, Edwin Cantrell, can have his hearing. It is through no fault of his own that he is presently unemployed and unable to travel to Oregon in order to prosecute this claim and, therefore, I feel that there would be no disadvantage in having a telephonic hearing as the only issue would be the extent of disability. I recall that [SAIF's attorney's] objection to not having Mr. Cantrell present at the last hearing was quite simply that he wanted a chance to cross examine the claimant upon statements he had made in certain documents admitted into evidence. Therefore, I feel that this would be in the best interests of justice to provide such a procedure and request that such a procedure be set up for the time already set for this hearing, November 3, 1982 at 1:30."

The Presiding Referee responded:

"Your letter of October 21, 1982, addressed to Referee Howell, has been referred to me. First, the Hearings Division does not hold telephone hearings. We do, in very rare instances which are mutually agreeable to the parties take limited evidence by phone. When I contacted [SAIF's attorney's] office to see if he was going to submit a response to your request I learned that his office was not aware of your request. Your letter of October 21, 1982 does not show a copy having been sent to [SAIF].

"This case was specially set for the November 3, 1982 hearing with the Notice of Hearing having been sent August 30, 1982. You waited until October 21, 1982 to request a change in procedure, when it is apparent there has been no change of circumstances concerning your client's situation.

"YOUR REQUEST FOR A TELEPHONE HEARING, AS A SUBSTITUTE FOR THE NORMAL HEARING SET FOR NOVEMBER 3, 1982 IS DENIED.

"THE HEARING SET FOR NOVEMBER 3, 1982 IN SALEM, OREGON SHALL BE HELD AS SCHEDULED."

The hearing did reconvene on November 3, 1982, with the parties repeating the same positions they had previously asserted. Claimant was not personally present, but claimant's attorney argued that he was entitled to submit the matter on the documentary record for a decision on the merits notwithstanding claimant's absence. SAIF continued to assert that it was entitled to confront and cross-examine claimant.

Referee Howell then issued the Order of Dismissal that is the subject of this review.

"The medical evidence offered into the record involves primarily, if not exclusively, subjective symptomology as reported by claimant to the various physicians. . . . Claimant has been given more than one reasonable opportunity for an evidentiary hearing. He has failed to take advantage of those opportunities. I, therefore, conclude that claimant has failed to prosecute his requests for hearing under OAR 436-83-310."

In considering the propriety of the Referee's order, it is important to identify the precise issue. The issue is not jurisdiction. We have repeatedly ruled that there is no jurisdictional requirement for a claimant who has requested a hearing to appear personally at the hearing. Bettie L. Rogers, 30 Van Natta 35 (1980); Wesley Skeen, 9 Van Natta 9 (1972); H. A. McCarthy, 1 Van Natta 84 (1968). We adhere to that position.

Nor do we think the Referee's reliance on OAR 436-83-310 hits the bullseye. That rule provides: "A request for hearing may be dismissed for want of prosecution where the party requesting the hearing occasions a delay of more than 90 days without good cause." It seems elementary that "want of prosecution" within the meaning of this rule means those steps necessary to submit a matter for decision on the merits; thus, the real question is whether and when a claimant's personal presence at a hearing he or she has requested is an essential prerequisite to a decision on the merits.

We think the formula for answering that question is expressed in ORS 656.283(6), which provides that hearings shall be conducted "in any manner that will achieve substantial justice." Among other things, we think "substantial justice" should generally include an

opportunity to confront and cross-examine an adverse party before there can be a factual decision on that party's claim for relief. See Goldberg v. Kelly, 397 US 254 (1970); Willner v. Committee on Character & Fitness, 373 US 96 (1963). In this case, for example, we agree with the Referee's characterization that the medical reports admitted into evidence are long on subjective history and short on objective findings. In this situation, to rely on claimant's history as recited in these reports without affording the employer/insurer an opportunity to confront and cross-examine claimant would not, in our opinion, achieve substantial justice; rather, it could create serious injustice.

We do not mean to suggest that there are never any viable alternatives to a claimant's personal appearance at a hearing if the claimant can show "a valid and substantial reason why he cannot attend." Rogers v. Donovan, 268 Or 24, 29 (1974). The Presiding Referee's letter, quoted above, notes that alternatives exist. In addition, this Board has scheduled hearings to be held in hospital rooms; and this Board has agreements with counterpart Boards in several other states which provide reciprocal procedures for hearings on matters pending before us to be held in those other states; and in one recent situation we know of, the parties agreed to a videotape deposition of a claimant who could not attend an Oregon hearing. Although these alternatives generally require the agreement and cooperation of the employer/insurer, there may be situations in which substantial justice can be achieved through these alternative means regardless of the agreement of the employer/insurer. We leave that question to another day, and here only conclude that in the circumstances of this case SAIF was entitled to test claimant's credibility by way of the classic form of face-to-face confrontation in the presence of an Oregon Referee in an Oregon hearing.

ORDER

The Referee's order dated November 4, 1982 is affirmed.

LESLIE COLVIN, Claimant
Hansen, et al., Claimant's Attorneys
G. Howard Cliff, Defense Attorney

WCB 81-03061
March 29, 1984
Order on Review

Reviewed by the Board en banc.

The insurer requests review of those portions of Referee Mulder's order which: (1) Found that claimant's claim was not untimely filed; (2) found that claimant's slip and fall injury while attending a party was sufficiently work related to be compensable and, therefore, set aside the insurer's denial; and (3) awarded claimant a penalty equal to "25 percent of time loss due for the period after the date of the office party" for the insurer's failure to timely deny the claim.

We reverse that portion of the Referee's order which held that, although claimant did not file a written claim until October 1, 1980 (which was over two years from the date of injury), her claim was not barred because she gave actual notice to two "supervisors" at work within a short time after the August 11, 1978 injury.

At the time of her injury, claimant was working as a paralegal for her employer. The senior (in time) paralegal was an individual named Janet Kreft. Ms. Kreft testified that the week following claimant's injury claimant told Ms. Kreft in casual conversation that she slipped and fell at her employer's party. The evidence shows that although Ms. Kreft sometimes acted as a spokesperson between the paralegal and management, she did not actually have any supervisory power over claimant or any other paralegals.

Another individual, Michael Lilly, who was an associate in the fall of 1978, testified that sometime in the fall of 1978 claimant told him that she had fallen at the party and hurt her back. Similarly, as with Ms. Kreft, the evidence shows that Mr. Lilly did not actually have any supervisory power over claimant, although claimant did work closely with him on cases during that time period.

There is no evidence that either individual possessed personnel responsibilities, and, in fact, neither one reported claimant's oral report of injury to anyone in management. It was not until two years later that claimant began to inquire about submitting a claim form, and it was not until October 1, 1980 that an 801 claim form was actually signed by claimant.

ORS 656.265 requires that a worker submit a written notice of an accident to the employer within 30 days or the claim will be barred, unless one of the exceptions under ORS 656.265(4) is met. The Referee found that elements of the relationships between claimant and Ms. Kreft and Mr. Lilly showed that they were claimant's supervisors and, therefore, claimant met the exception under ORS 656.265(4)(a), stating that a claim is not barred if the employer had knowledge of the injury.

We find that, although claimant had close working relationships with both Ms. Kreft and Mr. Lilly, there is not sufficient evidence to indicate that either one had supervisory authority over claimant or any duty to report an accident to management, and, in fact, they made no such report. Therefore, claimant's conversations with them did not constitute a notice of claim.

Further, we find that the employer was prejudiced by the late filing. The accident was unwitnessed, claimant failed to seek medical treatment for two years and she led an active life in the interim. The employer was deprived of the benefit of a prompt diagnosis and opinion as to causation.

Even if this claim were not time-barred, it would not be allowed due to insufficient work-relatedness of the accident and the activity in which she was engaged at that time.

On August 11, 1978 claimant attended a barbeque and pool party at the home of one of the law firm partners. A tile hallway in the house was wet because of guests walking to and from the outside swimming pool. While claimant was walking down some stairs in that hall, she fell on her buttocks.

Where the issue is work-relatedness, the facts of the case are particularly important. The Referee listed 31 criteria that he examined to help determine work connection. These factors were

gleaned from Oregon cases as well as from cases of other jurisdictions. The Referee also relied on, and quoted extensively from, 1A Larson, Workmen's Compensation Law, § 22. Larson uses a three-part test to determine the work-relatedness of recreational and social activities. This three-part test was cited with approval in Richmond v. SAIF, 58 Or App 354, 357 (1982):

> "§ 22.00, Recreational or social activities are within the course of employment when;
>
> (1) They occur on the premises during a lunch or recreation period as a regular incident of the employment; or
>
> (2) The employer, by expressly or impliedly requiring participation, or by making the activity part of the services of an employee, brings the activity within the orbit of the employment; or
>
> (3) The employer derives substantial direct benefit from the activity beyond the intangible value of improvement in employee health and morale that is common to all kinds of recreation and social life."

See also Jordan v. Western Electric, 1 Or App 439 (1970), which lists six factors that appear to us to be integral to one or more parts of Larson's proposed analysis.

Here, the party was held at a partner's private home and not at the offices of the employer law firm. The Referee suggested, "Perhaps an extension of premises concept could be referred to where an office party is at the home of a law firm partner." We decline to expand the "on the premises" rule to include a partner's home. While the party was not held on the employment premises, it was held during part of the work day. It began about noon on Friday and continued late into the night. There is evidence that workers who did not attend the party were expected to be at work, although no attendance was taken to determine who was or was not at the party or at work on Friday afternoon. As far as being a "regular incident of the employment," we find that the party had become an annual event at the law firm. However, not all employes were invited to attend. The partners and associates had always been invited. Only in recent years were employes in claimant's position of paralegal invited. The secretaries, librarians and bookkeeper were not invited.

With regard to part (2) of Larson's test, we find that the employer did not require attendance at the party. The employer organized and paid for the party. A committee was formed within the firm that helped with the organization. Invitations were sent to each invitee's desk at work. Lists for game participation at the party were circulated at work and other limited organizational activities were conducted during work time. The employer conducted the party partly during work time, and all employes were paid their regular wage for that day, regardless of whether or not they attended the party. The party cannot be termed an integral part of the employer's business since the party activities had nothing to

do with the employer's usual day-to-day business activities. The party was not held in order to entertain clients, discuss business or give the employer an opportunity to give speeches or awards related to business activity. Finally, the employer did not provide transportation to and from the party. An analysis of the above factors that fall under part (2) of Larson's test shows both positive and negative indications of work-relatedness and does not, in and of itself, determine the work-relatedness of the injury-producing activity. We find parts (1) and (2) to fall somewhat in the middle of the scale and not determinative of work-relatedness.

The final part of Larson's three-part test concerns the direct benefit the employer derives from the activity which must be beyond an improvement in employe health and morale. The Referee found that, although the magnitude of benefit to the employer was probably minimal, it was significant that business was discussed at the party. However, we find that the business discussion was not an organized discussion, but rather consisted of the party goers' casual discussion of their work. The party goers could have discussed any topics they wished, but chose to discuss business. In this vein, we conclude that the purpose of the party was a purely social one, with the only benefit derived by the employer to be "the intangible value of improvement in employe health and morale that is common to all kinds of recreation and social life." Larson, supra at 5-71.

The Referee concluded that, although the case was a close one, the claim was compensable based on the following five factors: "That the first few hours of the party were held during working hours, that if claimant had not attended, she would have worked, that the party was at a law partner's home and that 'business' was discussed. The employer initiated the party."

As we stated above, we do not find that the law partner's home could be called the "employer's premises" in this case; nor do we find that "business" was discussed as a primary purpose of the party, but rather was discussed as an incidental conversation topic. The remaining three factors do indicate work relatedness, but when weighed with the other factors that (1) the claimant's injury did not occur on the premises of the employer, (2) claimant was not obligated to participate in the party as a condition of employment, (3) business was not conducted at the party except for social conversation, (4) the party was not an ordinary risk of, or incidental to, claimant's employment, (5) there was no penalty for nonattendance, (6) there was no business benefit to the employer, and (7) no record was kept of attendance, we find there is insufficient work-relatedness of the injury-producing activity to find claimant's back injury claim compensable. Compare, Rasool Bambechi, 35 Van Natta 1060 (1983). (Claimant's death by drowning at a company picnic found sufficiently work-connected to give rise to a compensable claim.)

The third issue raised by the insurer is the assessment of a penalty by the Referee for the insurer's late claim denial. Claimant signed her low back claim on October 1, 1980. The claim was "deferred" (neither accepted nor denied) on October 10, 1980. The claim was not finally denied until January 14, 1981 -- approximately 45 days late. There is no reasonable explanation offered as to why the denial was late.

A recent Court of Appeals decision has held that an employer is obligated to pay the first installment of interim compensation to a claimant no later than the fourteenth day after notice or knowledge of the claim regardless of whether the claimant was actually losing time from work due to the injury. Bono v. SAIF, 66 Or App 138 (1983). Claimant is, therefore, entitled to payment of interim compensation beginning October 1, 1980. However, since the Bono holding is somewhat of a new twist on the interpretation of an employer's duty to pay under ORS 656.262(4), we do not impose a penalty for that failure to pay. The employer did have a clear duty, however, to accept or deny the claim within 60 days pursuant to ORS 656.262(6) which it failed to do. Therefore, it is liable for a penalty and associated attorney's fee.

ORDER

The Referee's order dated February 10, 1983 is reversed in part and modified in part. That portion which set aside the insurer's denial dated January 14, 1981 is reversed, and the insurer's denial is reinstated and affirmed. That portion which imposed a penalty and associated attorney's fee is modified. Claimant is awarded interim compensation from October 14, 1980 to January 14, 1981. The insurer is ordered to pay claimant, as a penalty, an amount equal to 25% of the interim compensation from December 1, 1980 to January 14, 1981. The insurer is further ordered to pay claimant's attorney $450.

Board Member Barnes Concurring in Part and Dissenting in Part:

I agree with the conclusion that the injuries claimant sustained at a party at her employer's home are not compensable. I disagree with two of the majority's other conclusions.

A "claim" is consistently defined as including an employer's (not its insurer's) "notice or knowledge" of an injury. ORS 656.005(7); 656.262(3); 656.265(4)(a). The threshhold problem in this case is: What does "employer" mean? Obviously, some employers, such as corporations, can only be notified of anything by notice to the employer's agents. I agree with the majority's apparent assumption that notice to an employer by notice to an agent of the employer should generally mean notice to a person in a managerial or supervisory position within the employer's business organization.

But that generalization should not cause us to overlook the fact that there are myriad types of business organizations. An illustration comes from Roscoe Howard, 35 Van Natta 329 (1983). That case involved a claim made by an employe of the Yamhill County Council on Aging.

> "The Council on Aging is operated by a small staff of salaried employes aided by numerous volunteers. The salaried employe who would ordinarily handle workers compensation matters was on vacation and, in her absence, claimant gave Dr. Stellflug's letter [i.e., his claim] to a volunteer. The volunteer did not initiate processing of a workers compensation claim or forward any information to SAIF." 35 Van Natta at 329-30.

We found that claimant in Howard had effectively notified his employer of his claim; we did not express any concern at all about whether the employer's "agent" who was actually notified of the claim was in a managerial or supervisory position within the employer's rather informal business organization.

Likewise, in the present case, I think it is fair to say that the business organization that claimant worked for, a law firm, was at least loosely structured -- if not anarchical. Shortly after her August 1978 accident, claimant told Ms. Kreft and Mr. Lilly about her injury. Ms. Kreft functioned as at least an informal supervisor over the paralegals, like claimant, in the law firm. Mr. Lilly was an associate in the law firm. Given the informal structure of the law firm, I think that a report of an accident to these two individuals was sufficient notice to the employer.

I thus disagree with the majority's hypertechnical analysis of whether Ms. Kreft and/or Mr. Lilly were "managers" or "supervisors." Those concepts are generally relevant in this context, but as indicated by the facts of Roscoe Howard, supra, and the facts of this case, I think the majority is wrong to extend those generalizations into hypertechnical absolutes.

My second area of disagreement with the majority follows from the first. The duty to pay interim compensation runs from the date of the employer's (not its insurer's) knowledge of a claim: "The first installment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim." ORS 656.262(4). Based on my conclusion that the employer in this case had effective notice of the claim not later than sometime in September 1978, it follows that we should award interim compensation from that date.

Of course, claimant continued to work over about the next two years despite her August 1978 injury. But as the majority points out, the Court of Appeals has ruled that a claimant who continues to work and continues to earn wages is nevertheless entitled to interim compensation after filing a claim. Bono v. SAIF, 66 Or App 138 (1983). In my opinion, an award of interim compensation for more than two years, running from the date when claimant just barely notified her employer of her claim and covering a period when claimant was working and earning wages, is completely absurd. Our duty, however, is to obey the ruling of the appellate courts. I would do so here and award claimant additional interim compensation in accordance with the views expressed above.

JESSE M. GOMEZ, Claimant
Allen & Vick, Claimant's Attorneys
Bauer, et al., Defense Attorneys

WCB 81-10166
March 29, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of Referee Fink's order which dismissed his request for hearing because claimant failed to personally appear for the scheduled hearing.

The Board affirms and adopts the order of the Referee with the

following additional comments. Claimant requested a hearing on the self-insured employer's denial of his claim, which is apparently for leg and back injuries allegedly sustained on August 27, 1981. The employer's denial states in part that claimant was "not at work on 8-27-81." Under these circumstances, we think that claimant's credibility is critical and, for the reasons stated in Edwin R. Cantrell, WCB Case No. 80-09015 and 81-08071, 36 Van Natta 312 (decided this date), and Warren F. Stier, WCB Case No. 81-10065, 36 Van Natta 334 (decided this date), we agree with the Referee that dismissal was appropriate when claimant failed to personally appear at hearing.

ORDER

The Referee's order dated June 27, 1983 is affirmed.

GEORGE M. GOOD, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-08689
March 29, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Howell's order which: (1) Set aside its denial of claimant's claim for musculoskeletal chest pain; and (2) ordered it to pay claimant penalties and attorney fees for failure to accept or deny the claim within 60 days. We reverse.

Claimant worked part of one day on September 30, 1980, clearing slash for the employer. Claimant testified that, while lifting some brush, he felt a pulling sensation across his chest. He told the owner he could not handle the job and then sat and waited for the remainder of the crew to finish work that day. Claimant testified he told either Robert Preston, the owner, or Calvin Preston, a foreman, about the pulling sensation in his chest. The owner, Robert Preston, testified at hearing that he does not remember claimant mentioning a problem with his chest.

On October 1, 1980 claimant was admitted into the Douglas Community Hospital complaining of tightness and pain in the chest. Tests were performed, and myocardial infarction was ruled out. Claimant was discharged October 3, 1980 with a final diagnosis of musculoskeletal chest pain. Nothing in the contemporaneous medical reports mentions work causation of claimant's chest condition.

Claimant never filled out a claim form, and his doctors never submitted a claim on his behalf. Claimant testified he was waiting for the employer to send him the claim form. Finally, by 1982, the hospital had hired a collection agency to collect the hospital bill, and claimant then sought legal advice. On March 2, 1982 claimant's attorney wrote the employer asking that the letter be considered a report of industrial injury or disease. The employer took no action on the letter. On April 20, 1982 claimant's attorney wrote SAIF notifying it of the March 2, 1982 claim filed with the employer. SAIF did not deny the claim until November 3, 1982 -- which was after claimant had filed a request for hearing.

ORS 656.265(1) requires that notice of an accident resulting in injury be given to an employer within 30 days. Claimant did not file a claim for an alleged September 1980 injury until his attorney wrote the employer on March 2, 1982. The Referee made the following statement with regard to this issue:

> "Whether the employer had notice or actual knowledge of an injury on the date claimant experienced chest pain is highly questionable. Even if claimant's testimony is accepted with respect to the conversation he had with the owner, it is doubtful that that conversation provided sufficient information to establish knowledge of an 'injury', that is, a potentially compensable injury resulting in disability or the need for medical treatment. However, the claim is not barred unless the employer shows prejudice as a result of failure to receive prompt notice. ORS 656.265(4)(a).
>
> "The insurer offered no evidence in respect to prejudice. It appears that the lack of notice had no bearing upon the availability of witnesses to testify concerning the compensability of the claim. Claimant received prompt treatment despite the lack of notice and admits that he had no continuing disability. I conclude that, even if the employer did not have knowledge of the injury, it was not prejudiced by claimant's failure to give notice."

Our review of the record indicates that SAIF was prejudiced by claimant's 18-month delay in asserting this claim. It is evident from both the claimant's and the employer's testimony that the year-and-a-half gap clouded their memories as to what was said and who was notified about claimant's chest pain on September 30, 1980. Claimant thought he told the employer about his chest pain, but the employer did not think the claimant had done so. The type of work the employer did -- contracting out to clear brush -- involved casual laborers. When questioned about whether he could recall any of the employes who were working with claimant on the date in question, the employer answered: "I had some Spanish guys and some other people, but, no, they are not around. Most of them moved out of the area now."

Furthermore, when SAIF wrote to Dr. Vajda at the Douglas Community Hospital in an attempt to get some more information on the claimant's condition for which he was treated in October 1980 and the history of activities prior to the onset of his symptoms, Dr. Vajda responded: "I have nothing to add to the information you already have in your files." As stated above, none of the contemporaneous medical reports mentioned work causation, and, undoubtedly, Dr. Vajda's memory was dimmed by the passage of time, and he was unable to add anything to the scanty medical records.

Given the lack of opportunity for timely investigation of medical causation, and the lack of opportunity to contact

potential witnesses, we find that SAIF has offered sufficient evidence to show they were prejudiced by the untimely filing. Therefore, the claim is barred by ORS 656.265(4)(a). See also Krista Larson, 36 Van Natta 66 (1984); Robert H. O'Dell, 35 Van Natta 1214 (1983).

ORDER

The Referee's order dated February 25, 1983 is reversed. The SAIF Corporation's denial dated November 3, 1982 is reinstated and affirmed.

JOYCE GROSHONG, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 81-05961
March 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer requests review of Referee McCullough's order which modified the November 23, 1981 Determination Order by awarding claimant 192° for 60% unscheduled permanent disability compensation. The November 1981 Determination Order awarded claimant no compensation for permanent disability in addition to the 32° for 10% unscheduled disability previously awarded. The employer contends that the Referee's award of 60% unscheduled disability (i.e., an additional 160° or 50%) is excessive.

In its brief, the employer has discussed the disability rating guidelines found at OAR 436-65-600, et seq., has included photocopied pages from the Dictionary of Occupational Titles, 4th Edition, 1977, and has discussed Appendix A of Selected Characteristics of Occupations defined in the Dictionary of Occupational Titles (1981). The latter two sources have been used to justify the figures the employer uses in its application of the disability rating guidelines.

Claimant has moved to strike the employer's brief, stating that the employer has improperly supplied the Board with evidence that was not submitted at hearing. See generally ORS 656.295(5). Claimant states that the photocopied pages which show the job descriptions of "sales clerk" and "stock clerk" were not introduced as evidence at hearing and, therefore, it is improper for the Board to consider such "evidence" on review. We deny claimant's motion to strike.

The federal publication entitled Dictionary of Occupational Titles, 4th Edition, 1977, is a resource regularly used by the Workers' Compensation Board and the Workers' Compensation Department as an aid in determining the extent of permanent disability. The Employment Division has available a computer printout which has broken down each one of the job descriptions found in the Dictionary of Occupational Titles into various categories. Three of the most regularly used categories are those which determine the specific vocational preparation (SVP) required for a particular job, the general education development (GED) required for a particular job and the strength (STR) required for a particular job. The numerical values assigned in those categories are then applied to the appropriate rules at OAR 436-65-600, et

seq. which, in turn, yield a number which aids in arriving at a figure indicating the claimant's disability. By supplying the Board with job descriptions from the Dictionary of Occupational Titles (which the employer felt reflected the job claimant was performing at the time of her injury), the employer is providing no more information than the Board itself would have relied on in the regular course of its duties.

In another case, Thomas C. Whittle, WCB Case No. 80-05189, 36 Van Natta 343 (decided this date), we discussed the subject of offical notice by the Board in the context of extra-record medical texts. We held that, to the extent we would ever consider such extra-record material as substantive evidence, we would only do so where the material or facts in question were capable of certain verification or not subject to reasonable dispute. See also ORS 40.065(2); Dennis Fraser, 35 Van Natta 271 (1983).

We regularly refer to the Dictionary of Occupational Titles, and we generally cite it in our orders when we have relied upon it as substantive evidence. In effect it has become a standard reference that we use in evaluating permanent disability. We consider the information contained in the Dictionary of Occupational Titles to constitute facts which are "capable of immediate and accurate demonstration by resort to easily accessible sources of indisputable accuracy." McCormick, Handbook of the Law of Evidence, 763 (2d ed. 1970). Accordingly, the Dictionary of Occupational Titles is properly subject to official notice by the Board as a standard reference in evaluating permanent disability.

Whether or not we agree that the employer has supplied the most appropriate job descriptions found in the Dictionary of Occupational Titles is another matter. However, in this case, we do agree with the insurer that claimant's job at the time of her injury appears to have been a combination of sales clerk and stock clerk found in the Dictionary of Occupational Titles at 290.477-014 and 222.387-058. We have utilized the computer analysis of those jobs in the SVP, GED and STR categories as an aid in the evaluation of the extent of claimant's permanent disability. Similarly, we see no problem with the employer's discussion of Appendix A of Selected Characteristics of Occupations defined in the Dictionary of Occupational Titles. This appendix explains the categories that are broken down in the Employment Division computer printout.

In conclusion, we are denying claimant's motion to strike because the Dictionary of Occupational Titles and Appendix A of Selected Characteristics of Occupations defined in the Dictionary of Occupational Titles are essential resources in interpreting the guidelines set out at OAR 436-65-600, et seq. Since those resources are regularly used by the Workers' Compensation Board, as well as the Workers' Compensation Department, we do not find it inappropriate that the employer discussed these resources without having formally admitted them into evidence at the hearing. The employer presented this material as part of its appellant's brief, and claimant had the opportunity to respond. Accordingly the procedural requirements discussed in Dennis Fraser, supra, have been met.

Using the disability rating guidelines at OAR 436-65-600, et seq., and the resources discussed above, we find that, although claimant's low back disability is more than that awarded by the

November 23, 1981 Determination Order, it is less than the 60% awarded by the Referee. Claimant was 38 at the time of hearing which yields an impact factor of 0. She has a high school education which also yields an impact factor of 0. As stated above, her job at the time of injury was that of a sales clerk/stock clerk which has an assigned SVP of three or four. Therefore, the work experience impact factor is a +3. The evidence shows that claimant was performing heavy work in her job (frequently lifting up to 50 pounds) but is now limited to light work due to her low back injury. Therefore, her adaptability impact figure is +10. Her mental capacity and emotional psychological reactions are normal, and, therefore, the impact factor is 0 for both. For the labor market impact factor, using a residual functional capacity of light, the highest SVP factor of four and a GED factor of four (reflecting her high school education), we find that 26% of Oregon workers are performing at that ability level which results in an impact factor of 0. Claimant's impairment impact factor is rated at +25 and includes two laminectomies at L4-5, a diskectomy at L4-5, and laminectomy and diskectomy at L5-S1 with residuals of moderate disabling pain including a chronic ache and some intermittent stabbing pains. Combination of these impact factors yields a total disability rating of +35. We find that in comparison with other similar cases this figure accurately represents claimant's permanent disability from her low back injury and, therefore, modify the Referee's order to award claimant 112° for 35% unscheduled disability compensation.

ORDER

The Referee's order dated October 14, 1982 is modified. In lieu of the Referee's award claimant is awarded 80° for 25% unscheduled permanent disability for injury to her low back. Claimant's total award to date is 112° for 35% of the maximum allowable for unscheduled disability. In lieu of the attorney's fee allowed by the Referee's order, claimant's attorney is allowed 25% of the additional permanent disability awarded herein (80°), not to exceed $2,000, payable out of claimant's compensation and not in addition thereto.

DAVID H. HANSEN, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling, et al., Defense Attorneys

WCB 82-08822
March 29, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of Referee Peterson's order which awarded claimant 30% (96°) unscheduled permanent partial disability for his low back injury, in lieu of the 10% (32°) awarded by a May 13, 1982 Determination Order. The sole issue is extent of disability.

Claimant is a 40-year-old man who compensably injured his low back while working as a dryer grader at a plywood mill. His condition has been diagnosed by his treating physician, Dr. Saez, as "recurrent left sciatic irritation and myofascial secondary to a lumbar strain." All treatment has been conservative.

Dr. Saez, a neurosurgeon, felt that with some limitations claimant could return to work with the employer. These limitations

included frequent postural changes, no bending and no twisting. Claimant was also subject to a 25-pound weight restriction for lifting and a 15-pound restriction for carrying items at waist level. Dr. Saez concluded that with a modification for postural changes, claimant could perform the duties of a dryer feeder. Dr. Saez considered claimant's former job as dryer grader less suitable due to the frequency of bending and stooping required. Claimant accepted the job as dryer feeder, subject to these limitations. He has realized no reduction of pay by this change in jobs and has been able to satisfactorily perform his duties.

Dr. Saez described claimant's condition as mild residual disability of the lumbar spine which precludes heavy physical work. The latest range of motion examination for his lumbar spine has been evaluated as 80% of normal. Another examining doctor, Dr. Affley, rated claimant's impairment as minimal. Dr. Affley indicated that eventually claimant could try his previous job as a dryer grader.

A Determination Order issued on May 13, 1982, awarding claimant 10% unscheduled disability. Claimant appealed the Determination Order. At hearing, he testified he can not stand, sit or walk for extended periods because of the pain. Neither can he bend or twist without experiencing pain. On occasion, claimant has exceeded his limitations and has had some difficulties when thinner widths of veneer are run through the mill. The Referee found that claimant does limp some of the time but not all of the time. The Referee believed there was some exaggeration on claimant's part, but not enough to discard his testimony.

Claimant has a GED. His work experience has primarily centered in jobs categorized as heavy-medium unskilled manual labor.

The Referee increased the Determination Order's award by 20%, giving claimant a total of 30%. We agree that the Determination Order's award should be increased; however, we believe the Referee's award is excessive.

Considering the guidelines in OAR 436-65-600, et seq., and comparing this case to similar cases, we conclude that a total award of 20% would more appropriately compensate claimant.

ORDER

The Referee's order dated July 15, 1983 is modified. In lieu of the Referee's award, and in addition to the 10% (32°) unscheduled disability awarded by the Determination Order, claimant is awarded 32° for 10% unscheduled permanent partial disability, for a total unscheduled award of 64° or 20% of the maximum allowable for injury to the low back. Claimant's attorney's fee shall be adjusted accordingly.

GERALD C. HOWARD, Claimant
Galton, et al., Claimant's Attorneys
John E. Snarskis, Defense Attorney

WCB 83-01055
March 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Leahy's order which affirmed the insurer's denial of claimant's low back claim. The insurer cross-requests review of that portion of the order which assessed a penalty and attorney's fee for unreasonable delay in denying the claim.

On the issue of compensability, we affirm the order of the Referee with the following comment.

The claim was filed on August 11, 1982. The claim was placed in deferred status and processed, including payment of interim temporary disability compensation, until it was denied on January 25, 1983.

Claimant contends that since the insurer processed the claim and paid time loss beyond the 60-day period for acceptance or denial under ORS 656.262(6), it has accepted the claim. Therefore, claimant argues, the insurer's subsequent denial is too late and cannot be affirmed. As support for his contention, claimant relies on the recent decision in Bauman v. SAIF, 295 Or 788 (1983).

The Bauman court held 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. The court stated as follows:

> "If, as in this case, the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity." 295 Or at 794. (Emphasis added.)

In Bauman, the claimant's bursitis condition had been accepted as a nondisabling "medical only claim" some three years before the insurer sought to deny compensability. Here, the operative facts are distinguishable. The claim was processed in deferred status until it was subsequently denied. It was never officially accepted.

We find that processing a claim in deferred status beyond the 60-day period of ORS 656.262(6) does not qualify as official notification that a claim has been accepted. Therefore, the insurer's subsequent denial of compensability is not foreclosed under Bauman.

We reverse that portion of the order which imposed a penalty for unreasonable delay in denial.

The employer first knew of the injury on August 9, 1982. The

claim was denied on January 25, 1983. The delay in denial was 109 days beyond the 60-day requirement of ORS 656.262(6). No reason was given for the delay. The Referee imposed a 25% penalty on the time loss due from August 9, 1982 to January 25, 1983 and awarded an associated attorney's fee based, in part, upon our decision in Zelda M. Bahler, 33 Van Natta 478 (1981), rev'd on other grounds, 60 Or App 90 (1982).

Since the date of the Referee's order, we have recently held that where the insurer unreasonably delays acceptance or denial of a claim but complies with its separate and distinct duty to pay interim compensation during the period of delay, the insurer is not subject to a penalty for unreasonably delaying acceptance or denial pursuant to ORS 656.262 (6). Ray A. Whitman, 36 Van Natta 160 (1984). We found this reasoning to be in accordance with the recent interpretation of the "then due" language, as contained in ORS 656.262(10), by the Court of Appeals in EBI Companies v. Thomas, 66 Or App 105, 111 (1983).

In this case, there are no amounts "then due" upon which to base a penalty because the insurer was paying interim temporary disability while the claim was in deferred status. Therefore, no penalty can be assessed. Whitman, supra; EBI Companies v. Thomas, supra.

Similarly, following Thomas, we have held that where no compensation was due and, thus, no penalty can be imposed, claimant's attorney is not entitled to an attorney's fee under ORS 656.382(1). Darrell W. Carr, 36 Van Natta 16 (1984); see also Richard Davies, 35 Van Natta 25 (1983). It follows, therefore, that the Referee's award of an attorney's fee, in addition to the imposition of a penalty, must be reversed.

ORDER

The Referee's amended order dated July 14, 1983 is reversed in part. Those portions which assessed a penalty and associated attorney's fee are reversed. The remainder of the order is affirmed.

VIRGIE KILLMER, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 83-00075
March 29, 1984
Order on Review

Reviewed by the Board en banc.

The insurer requests review of Referee Daron's order which found claimant's left leg cyst compensable. The insurer contends that claimant has failed to prove that her cyst was related to her employment.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated August 23, 1983 is affirmed.

Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

Board Member Barnes, dissenting:

I think we all agree that there is no evidence (if, indeed, it is even claimed) that work activity was the cause of claimant's groin-area cyst here in issue. We disagree on whether it is proven by a preponderance of the persuasive evidence that claimant's work activity was the major cause of an aggravation or worsening of her cyst condition.

Claimant relies on the opinions of Dr. Meharry. The reports from Dr. Meharry are quite ambiguous and somewhat contradictory. However, interpreting those reports in the light most favorable to claimant, Dr. Meharry has apparently opined that claimant's work activity was a cause of the worsening of her cyst condition. I suggest that a factfinder would be entitled to conclude that Dr. Meharry's ambiguous opinion, offered without supporting analysis or reasons, is not persuasive, but I accept for sake of discussion the doctor's apparent opinion that work activity was a cause.

The question then becomes whether work activity was the major cause of the worsening of claimant's cyst condition. The Referee's order does not identify any evidence that supports a finding of major cause. Claimant's brief does not identify any evidence that supports a finding of major cause. The Board majority does not identify any evidence that supports a finding of major cause. And I cannot find any evidence that supports a finding of major cause. At the risk of running an increasingly trite expression further into the ground, where's the beef?

DALE A. LINDSLEY, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-03716
March 29, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee McCullough's order which set aside its denial of claimant's low back injury claim.

There was some initial confusion about what was being claimed and what was being denied. When it was all sorted out, claimant's position was that he had sustained a low back injury in February 1982 and an upper back injury in March 1982, and the employer's position was that it accepted the upper back injury claim and denied the low back injury claim because there was no evidence that claimant ever required medical services or suffered disability due to anything that happened to his low back in February 1982. We are not really sure what difference it makes, since it would seem that all benefits claimant seeks can and will be obtained under his accepted upper back injury claim. But the matter has been presented to us for decision, and we have decided that the employer's position is correct.

Claimant testified that on February 9, 1982 he was pushing a cart loaded with a stack of veneer when he felt a pain in his low

back. He did not report the incident to his supervisor, lose time from work or then seek medical services due to that incident. On February 24, 1982 claimant saw his family physician, Dr. Chiapuzio, at which time claimant reported intermittent numbness in his left leg that had been going on for about a week. The cause was "unknown, possibly viral." No low back injury or pain was reported at that time.

On March 3, 1982 claimant was again pushing a loaded cart of veneer when he suffered an upper back injury. The next day claimant went to see a chiropractor, Dr. Lanway, who diagnosed a lumbar, i.e., low back, sprain and strain. Dr. Lanway reported that he treated claimant for a lumbar area injury which was incurred on February 9, 1982.

On March 16, 1982 claimant returned to see Dr. Chiapuzio, who noted:

> "He has some mid-thoracic pain relieved by rest for two or three hours. . . . After that pain was gone he noticed some lumbar backache and there is always a little of that hurting. . . . Patient wonders whether he [should] file an industrial claim because he thinks this all happened after he was pushing on a cart that is quite heavy. There are some tracks underneath the wheels and was hard to move it [sic]. This occurred on 2/9/82 although he has been off of work since 3/3."

Contrary to the above report, claimant repeatedly and rather emphatically testified at hearing that his disability subsequent to March 3, 1982 was due to his upper back and that he saw no physicians regarding his low back. The Referee nevertheless found the denied low back claim compensable, reasoning:

> "I do not believe that this discrepancy between claimant's testimony and the medical records reflect dishonesty on claimant's part. Rather, I believe that claimant simply has a poor memory as to everything that occurred during the Spring of 1982 as between his low back and upper back problems. There is certainly no logical reason for claimant, at a hearing where he is seeking to establish a low back injury claim, to intentionally testify falsely that he suffered no disability and received no medical services respecting his low back.
>
> "I conclude from the evidence that claimant did receive medical services for low back condition on and after March 4, 1982."

The Referee also concluded that the references in Dr. Lanway's and Dr. Chiapuzio's notes to a February 9, 1982 work incident established that the low back symptoms were attributable to his work activity.

To repeat, we doubt that it makes any practical difference since it would now appear that all medical services claimant has received are compensable under his accepted March 3, 1982 injury claim, but we cannot agree with the Referee's analysis. The alleged February 9, 1982 incident was not reported to any supervisors at the time. Nor was it mentioned to claimant's family doctor on February 24, 1982. Most significantly, claimant repeatedly testified that he had never sought treatment for a low back injury or that he has been disabled due to a low back injury. The evidence is that claimant suffered an upper back injury on March 3, 1982 which has been accepted by the employer, and that the medical treatment claimant sought subsequent to March 3 was as a result of that injury.

ORDER

The Referee's order dated May 9, 1983 is reversed.

ROBERT L. MOWRY, Claimant
Steven C. Yates, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-10382
March 29, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Nichols' order which upheld the insurer's denial of his aggravation claim. Claimant also moves to remand to the Referee to consider newly developed evidence.

Claimant compensably injured his low back on January 21, 1974. As of the last award of compensation, he had been awarded a total of 50% unscheduled disability and 30% scheduled disability. Claimant was last found medically stationary in March 1980. Dr. Becker was claimant's treating physician at that time. In March 1982 claimant returned to work. In August 1982 Dr. Thomas became claimant's treating chiropractor. Claimant requested reopening after seeing Dr. Thomas. At hearing a report from Dr. Thomas to the insurer was received into evidence. In that report Dr. Thomas opined, based on medical records from Dr. Becker and his own examinations, that claimant's compensable low back condition had worsened. However, he stated:

> "Since I do not have any actual means for comparison between his present state and prior to his arrival at this office, other than medical records which do not provide specific enough information to accurately determine how his condition compares, I would like Mr. Mowry to be examined by Dr. Becker. I feel he would offer an objective comparison. It would certainly seem to me that there is a worsening; but I feel that Dr. Becker would be a valuable resource, since he does have a means of comparison."

The Referee issued an order dated January 20, 1983 which upheld the insurer's denial of reopening. The Referee based her decision in part on the fact that Dr. Thomas stated that he was not in the best position to make a comparison. On the same date the

Referee's order issued, claimant was examined by Dr. Becker as Dr. Thomas had suggested. On February 17, 1983 the Referee abated her order because claimant's attorney had indicated that he would soon be submitting documentary evidence to support a motion for reconsideration. Claimant submitted a report from Dr. Becker. The Referee denied the motion for reconsideration.

Claimant now moves to remand for consideration of Dr. Becker's report. Because the record is clear that Dr. Becker treated claimant both before and after the last closure, it should have been apparent to claimant's attorney, with or without Dr. Thomas' report, that Dr. Becker would be in the best position to determine whether there was an aggravation. We find that the case has not been "improperly, incompletely or otherwise insufficiently developed or heard by the Referee." ORS 656.295(5). Accordingly, we decline to remand.

On the merits, we affirm the Referee.

ORDER

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

Board Member Barnes Concurring:

There is an interesting twist in Bailey v. SAIF, 296 Or 41 (1983) -- a twist that the Supreme Court may not have intended, but that is analytically inescapable based on what the Supreme Court said.

A Referee's only authority to reopen an evidentiary record that has previously been closed comes from OAR 436-83-480; nothing in the statute or case law grants any such authority. In Bailey, the Supreme Court interpreted OAR 436-83-480 as applying only to the post-hearing discovery of evidence that was in existence at the time of the hearing. When this interpretation is factored into OAR 436-83-480, it is apparent that a Referee now only has authority to reopen an evidentiary record for admission of evidence that was in existence at the time of the hearing but was not discovered until after the hearing.

In this case, quite obviously, Dr. Becker's report that was not written until after the hearing was not in existence at the time of the hearing. Referee Nichols thus could and should have summarily denied claimant's motion to reopen the record on the ground that there was no authority to do so for admission of this kind of "newly created" evidence.

A party's only remedy when this problem arises is to appeal to the Board and request remand to the Referee. One need not be an "efficiency expert" to appreciate that there is something inefficient about this process. But as things now stand, I am the only Board Member who thinks that OAR 436-83-480 should be amended in the wake of Bailey.

CHARLES M. SCHWAB, Claimant
Carney, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-02174 & 83-03635
March 29, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Argonaut Insurance requests review of those portions of Referee Thye's orders which: (1) Assessed a penalty against it in the amount of 15% of the interim compensation due claimant for the period March 4, 1983 through April 14, 1983, plus an associated attorney fee of $250 on the basis that Argonaut unreasonably failed to pay claimant interim compensation benefits pending denial of the claim; and (2) assessed a penalty against Argonaut in the amount of 10% of the temporary disability benefits due claimant from January 27, 1983 to the date of his order plus an associated attorney fee of $100 for unreasonable denial of compensability. Argonaut contends that the Referee's assessment of penalties and attorney fees against it was error.

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

We agree with the Referee's assessment of a penalty and associated attorney's fee against Argonaut for its failure to pay interim compensation from March 4, 1983 through the date of its April 14, 1983 denial. Claimant submitted an 801 form to his employer on March 4, 1983. Argonaut did not accept the claim, did not pay claimant any interim compensation and did not deny the claim until April 14, 1983. Although the denial was timely, Argonaut was required to commence payment of interim compensation benefits pending denial. ORS 656.262(4). Argonaut's excuse for not doing so -- problems with internal claims processing procedures -- is insufficient.

We disagree with the Referee's assessment of a penalty and attorney fee against Argonaut for unreasonable denial of compensability. Assuming that the concept of unreasonable denial is still valid after Bauman v. SAIF, 295 Or 788 (1983), it appears that unreasonable denial of compensability is a legitimate basis for imposition of a penalty in an ORS 656.307 context. Compare SAIF v. Moyer, 63 Or App 498 (1983), with EBI Companies v. Thomas, 66 Or App 105 (1984).

However, we find that in this case Argonaut had a legitimate basis to question the compensability of the claim. Argonaut's claims adjuster in charge of processing claimant's claim testified that one of the reasons that the claim was denied was that there was no evidence that any sort of injury or incident took place while Argonaut was providing coverage. Additionally, the claims adjuster testified that the medical records in Argonaut's possession at the time it denied the claim revealed that claimant had been experiencing ongoing difficulties with his left ankle for quite some time. Some of the medical reports also suggest the possibility that claimant's ankle problems could have been the result of non-work related activities, such as playing golf. Any one of the above would constitute a sufficient basis for an insurer to question compensability. Consequently, we conclude that Argonaut did not act unreasonably in denying the compensability of the claim, and we reverse those portions of the Referee's order penalizing Argonaut for unreasonable claim denial.

ORDER

The Referee's orders dated August 19, 1983 and August 30, 1983 are affirmed in part and reversed in part. Those portions of the Referee's orders which assessed a 10% penalty against Argonaut on the temporary total disability compensation due claimant from January 27, 1983 to the date of his order and a $100 attorney's fee are reversed. The remainder of the Referee's orders is affirmed.

WARREN F. STIER, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-10065
March 29, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Braverman's order which dismissed his request for hearing with prejudice because claimant failed to appear for hearing. We understand the effect of the Referee's order to be to uphold the insurer's backup denial of claimant's alleged August 1980 industrial injury, thus mooting the other issues (premature closure and extent of disability) raised in claimant's request for hearing.

Claimant's position on review is a bit hard to understand because it fails to focus on the real basis of the Referee's decision -- claimant's failure to appear for hearing. Claimant's opening brief seemingly argues that the insurer's backup denial is invalid as a matter of law. Since that brief was filed, the Supreme Court has indeed ruled that backup denials are invalid except in cases involving fraud, misrepresentation, etc. Bauman v. SAIF, 295 Or 788 (1983). After the Supreme Court's decision, claimant filed supplemental argument which states in part:

> "The records disclose no fraud, misrepresentation or other illegal activity by claimant. Neither has the insurer asserted such misconduct."

We think claimant's supplemental argument focuses on what is properly the first issue: Is this a backup denial based on fraud, etc.? Despite claimant's assertion to the contrary, we conclude that it is.

The denial states that it is the insurer's "position that [claimant] did not, at any time during [his] employment at Industrial Alloy Fabricator, experience an injury . . ." When a claimant has claimed that he did sustain an injury at work, a denial to the effect that there really never was an injury would appear to raise the issue of whether the claim was fraudulent. See Wilkins v. SAIF, 66 Or App 420 (1983). Moreover, we generally agree with the insurer's summary of the medical evidence as stated in its brief: "The exact nature of claimant's alleged injury is impossible to ascertain in view of the fact that he has given totally inconsistent and contradictory histories to the various physicians involved." (Our point is not that fraud is established; our point is that an issue of fraud has been raised in connection with the backup denial.) Finally, we note that when the hearing convened, the insurer's attorney noted, in the course of protesting claimant's nonappearance, that it had seven or eight witnesses

waiting to impeach claimant's possible testimony. Under all of these circumstances, we think it is difficult to interpret the backup denial as raising any issue other than fraud.

The next preliminary issue involves the burden of proof because the relevance of claimant's failure to appear for hearing can conceivably make a difference depending on where the burden of proof lies. The law governing backup denials, including the question of who has the burden of proof in a backup-denial case, has been somewhat unsettled lately. In Patricia G. Davis, 35 Van Natta 635 (1983), we ruled that the burden of proof in this kind of case is on the employer/insurer. If Davis were the last word on the subject, it would seem to follow that claimants could always decline to appear at hearings they requested on backup denials -- at least, unless and until subpoenaed by the employer/insurer -- because a claimant would not have to prove anything at such a hearing.

More recently, in Benjamin G. Parker, 36 Van Natta 69 (1984), we interpreted court decisions since our Davis decision to have established a different approach to the burden of proof: That in a hearing on a backup denial the employer/insurer bears the burden of going forward with some evidence of fraud, misrepresentation, etc.; and once this burden of going forward is satisfied, it is the claimant's ultimate burden to prove the compensability of the claim.

Had our decision in Parker been available to guide the Referee in this case, it may well have been preferable for the Referee to have required the insurer to call its "impeachment" witnesses to make some preliminary showing of fraud. Especially in view of the unsettled nature of backup-denial law; however, we cannot fault the Referee for not being that prophetic.

In any event, we think the insurer in this case did sustain the Parker burden of going forward with some evidence of fraud. It was the insurer's basic position before the Referee that the medical reports contained such grossly contradictory histories that it was unsure what it was expected to refute. For example, when asked by the Referee how many witnesses he intended to call, the insurer's attorney responded:

> "It depends completely on claimant's testimony. I have a list of approximately seven or eight people that during the day I could have called, depending on what he testified to and what he admitted and didn't admit."

While this falls far short of a formal offer of proof, we think that in this situation in which the insurer was reasonably confused about what it was expected to refute, it is about as much of an offer of proof as could be made. This informal offer of proof combined with the inconsistent medical reports satisfied the preliminary Parker burden of going forward in the circumstances of this case.

Against this background, we come to the central issue of what the Referee actually did and the reason he did it -- dismissal with prejudice of claimant's hearing request because of claimant's failure to personally appear at the hearing. We have concluded

that the backup denial raised a fraud issue. We have concluded that the insurer went forward with sufficient evidence indicating fraud to shift the ultimate burden to prove compensability to claimant under Benjamin G. Parker, supra. Under these circumstances, we agree with the Referee.

We have considered the effect of the failure of a claimant to personally appear at hearing in Edwin R. Cantrell, WCB Case Nos. 80-09015 and 81-08071, 36 Van Natta 312 (decided this date). We concluded in Cantrell that: (1) There is no jurisdictional requirement that a claimant personally appear for hearing, and thus it is possible for a case to be submitted for a decision on the merits despite a claimant's absence; but (2) the statutory duty to conduct a hearing in a manner likely to achieve substantial justice, ORS 656.283(6), means that in some situations the employer/insurer should have the right to confront and cross-examine the claimant, and if the claimant does not make himself available for cross-examination, dismissal of his request for hearing may be appropriate. John M. Barbour, WCB Case No. 82-03508, 36 Van Natta 304 (decided this date), illustrates the first possibility of a decision on the merits despite a claimant's absence. Cantrell and this case illustrate the second possibility -- that any decision on the merits without affording one party the right to confront and cross-examine the other party would not, in our opinion, achieve substantial justice; rather, it could create serious injustice.

Indeed, the right of confrontation may be even more important in this case than in Cantrell. As the insurer's attorney argued to the Referee:

> ". . . I have the absolute right to cross-examine the claimant. Otherwise I will object to every exhibit in this record because every exhibit lists a history from the claimant and I want to cross-examine him on the history. If I'm not allowed to cross-examine him on the history, then the [medical reports] should not be put into evidence in this case."

We basically agree with the insurer's position. In a word, resolution of a fraud contention comes down to credibility. The insurer was entitled to test claimant's credibility by way of confrontation and cross-examination and, in the absence of any opportunity to do so, any decision on the factual issue of whether claimant was injured at work in August 1980 would be fundamentally flawed.

We note that we have not considered the issue of claimant's attorney's request for a continuance when claimant failed to personally appear for hearing because we do not understand any such issue to have been raised on Board review. When the Referee orally advised counsel that he would be entering an order of dismissal, he stated that he would reconsider that action if claimant filed a motion for reconsideration indicating good cause for claimant's failure to appear for hearing. Claimant did not do so, instead requesting review and arguing issues other than the Referee's denial of his motion for continuance. On the issues raised, we agree with the Referee.

ORDER

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

GARY R. THOMAS, Claimant
Lyle C. Velure, Claimant's Attorney
McInturff, et al., Attorneys
Schwabe, et al., Attorneys

WCB 81-02240
March 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Presiding Referee Daughtry's order which (1) denied claimant's motion to reopen the record for submission of additional evidence, (2) vacated Referee Peterson's April 26, 1982 order in the above entitled matter which suspended the order entered April 1, 1982 and (3) reinstated and republished Referee Peterson's order dated April 1, 1982.

Claimant contends: (1) That he should be allowed to have his claim reopened for the taking of new medical evidence; (2) his left ear hearing loss, left knee condition and anxiety syndrome are compensable; (3) he is entitled to an award of unscheduled permanent disability; and (4) he is entitled to a greater award of scheduled permanent disability.

On November 20, 1979 claimant, then 19 years old, was working as a ground hand on a line crew engaged in telephone construction work. In the course of that work, an Alder limb he was holding touched a high-voltage power line, and he received an electrical shock of 40,000 volts through his left arm. Immediately thereafter Dr. Gould found numbness in claimant's left elbow with tingling but also found that there was good function of the arm. Dr. Gould did not expect the injury to cause permanent impairment. Claimant returned to work that same afternoon. However, within a week, claimant was unable to continue working due to stabbing pain in the left side of his back.

The claimant has had a wide variety of subjective complaints concerning various portions of his body that he attributes to the electrical shock incident. He states that his pain prevents him from working, and, in fact, the claimant has worked only a few days since the date of injury.

The Referee found:

> "He has been seen by a number of physicians, but there have been virtually no objective findings to substantiate those complaints. An electrical shock injury is certainly not the type of injury from which the areas of injury, need for treatment, and extent of disability can be established by lay testimony alone. Persuasive expert medical opinions are necessary. With respect to all issues raised by the claimant -- with the exception of the question of scheduled disability in the claimant's left arm -- the record in this case lacks such opinion.

"The claimant was the only witness presented at the hearing. I believe that he testified honestly, but he displayed a very distressed emotional state."

Our review of the record indicates that claimant has, indeed, been treated or examined by numerous physicians. Claimant's current complaints include aching, swelling and intermittent pain in the left lower interscapular area of his back as well as in the left paravertebral area of his back down to the pelvis. He also has aching, swelling and intermittent pain from the left scapular area on up to the shoulder, neck and back of the head. He has numbness along the radial border of the left forearm and occasionally has numbness in the same area on the right forearm. He sometimes has aching in his left leg which begins below the buttock and travels as far down as his ankle. Electromyelogram testing has failed to reveal any neurological damage caused by the electrical shock. Similarly, x-rays have revealed no significant findings. Neurological examination shows all reflexes to be strong and equal. The only neurological finding was decreased sensation to pin prick measuring an area two-and-a-half inches wide by ten inches long along the dorsal aspect of claimant's left forearm. There was full range of motion throughout the spine, shoulders, elbows, wrists, hands, hip and knees. Claimant showed equal and normal strength in his shoulder girdles, arms, forearms, wrists, hands, hip girdles, thigh muscles, leg muscles, big toes, abdominal muscles and gluteal muscles. In other words, no physiological basis could be determined to be the cause for the claimant's continued pain complaints.

After the hearing was over, but before the appeal time had run on the Referee's order, claimant filed a motion requesting the Referee to vacate his order, reopen the record and set the case down for a further hearing. Claimant had changed attorneys after the hearing, and this new attorney cited lack of effective counsel prior to and at the hearing as the basis for the motion. The new attorney also sought to have a new medical report by Dr. Baker submitted, citing Penifold v. SAIF, 49 Or App 1015 (1980), Egge v. Nu-Steel, 57 Or App 327 (1982), and Muffett v. SAIF, 58 Or App 684 (1982). The Referee suspended his April 1, 1982 order by order dated April 26, 1982, but later the order was reinstated pursuant to Presiding Referee Daughtry's October 4, 1982 order.

The record establishes that claimant was initially represented by the law firm of McInturff, Thom and Day. Specifically, his case was assigned to Mr. Thom, but on the day of hearing, Mr. Thom was unable to attend the hearing, and Mr. McInturff came in his place. Apparently, at hearing, Mr. McInturff told the claimant that claimant could probably try this case as well as he. Despite this comment, our review of the record does not show inadequate representation by Mr. Thom or by Mr. McInturff. The documentary record was replete with medical opinions by both the treating physicians and examining physicians reporting on the claimant's condition and possible theories of causation. At hearing, Mr. McInturff asked appropriate questions of claimant to elicit his opinion about the injury, the immediate effects of that injury, the treatment sought and the lingering residuals. Additionally, the Referee was very careful to make sure that claimant was able to say whatever was on his mind regarding his claim. We find claimant had effective

counsel prior to and at hearing and decline to remand the case on that basis.

Similarly, we decline to remand on the basis of newly discovered evidence. Claimant likened this case to Penifold v. SAIF, supra, in which multiple physicians had failed to find a causal link between claimant's skin allergy and her job, because they had failed to test her skin for an allergic reaction to specific irritants used at work. Only after the hearing was that specific testing performed yielding significant findings bearing on the issue of compensability. Remand was allowed. In Egge v. Nu-Steel, supra, none of claimant's doctors were able to find an objective reason for claimant's continuing subjective back pain complaints. Only after the hearing did a new doctor discover a hairline fracture in one of claimant's vertebra that would give an objective basis for claimant's subjective complaints. Remand was allowed. In Muffett v. SAIF, supra, an important medical report was solicited six months prior to the hearing but was not received until two months after the order was issued. Remand was allowed to admit that report.

Our examination of the new medical report by Dr. Baker does not compel the same results. Dr. Baker's report is dated May 4, 1982 -- about three and one-half months after the first hearing in this case. Dr. Baker had not examined claimant before the hearing. His report shows that he obtained a history from claimant and conducted a physical examination which revealed tender trigger points in his muscles and accompanying pain inhibition and weakness in those muscles. Dr. Baker diagnosed myofascial pain syndrome, force overload variety, and Barre -- Lieou syndrome, which is a triggering in the splenius capitus with accompanying blurring of vision and tinnitus. Dr. Baker further diagnosed a mechanical low back disorder, but he did not relate the back disorder to the left arm electrical shock. Dr. Baker also mentions claimant's anxiety as contributing to the condition. However, the anxiety problems were discussed by numerous other doctors, and those opinions are contained in the record. So far, this information of muscle pain and testing technique adds nothing new to the record. The thing that makes Dr. Baker's report different than the other doctors' reports is his theory as to how electrical shock to unprepared and overloaded muscles can cause significant muscle triggers and accompanying pain inhibition weakness.

We do not find that this is the type of new medical evidence that rises to that described in Penifold and Egge. Dr. Baker's report does not show that any new testing was performed revealing theretofore unknown objective evidence of impairment linking claimant's various complaints to the electrical shock. Although Dr. Baker refers to other electrical shock patients that he has treated, it does not appear that his credentials on this particular kind of case are so superior to the numerous other doctors who have treated claimant, and whose opinions are in the record, that the absence of his opinion results in a case that has been improperly or incompletely developed or heard by the Referee. ORS 656.295(5); cf. Myrtle E. York, 36 Van Natta 13 (1984).

Based on the above, we deny claimant's motion to remand the case for the taking of additional evidence.

As to the merits of the claim, we affirm and adopt Referee Peterson's order as republished by Presiding Referee Daughtry's order.

ORDER

The Referee's order dated April 1, 1982, as republished by the Presiding Referee's order dated October 4, 1982, is affirmed.

J.T. TIMS, Claimant
Bottini & Bottini, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-00234
March 29, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Fink's order which awarded claimant permanent total disability and additional temporary total disability benefits. The Determination Order awarded claimant 35% for 112° unscheduled permanent disability and 5% for 7.5° scheduled permanent disability for loss of use of his leg. The insurer contends that claimant is not permanently and totally disabled and is not entitled to additional temporary disability benefits.

The Board affirms the Referee's order awarding temporary total disability benefits. The Board reverses, however, the Referee's permanent total disability award.

The evidence is uncontroverted that claimant cannot return to work as a hod carrier due to his compensable low back injury and aggravation of his preexisting degenerative arthritic condition. Furthermore, we are convinced that claimant is precluded from many jobs in the labor market considering his impairment, age, education, work experience and adaptability. We are not persuaded, however, that claimant is incapable of regularly performing work at any gainful and suitable occupation.

The vocational counselors who assisted claimant suggested several jobs that claimant could perform, but claimant refused to consider them because they did not pay enough. Claimant was adamant that he be authorized to enter a training program in automobile mechanics. Near completion of the mechanics program, claimant's doctor advised that claimant was physically unable to perform the bending and lifting involved in mechanical work. Claimant then was trained in auto parts sales. Claimant testified that he could not perform the auto parts work because he could not read the manual adequately and could not prepare invoices.

Claimant's doctor stated that claimant physically could perform bench work mechanical repair and the duties of an auto parts salesman. No medical report suggests that claimant cannot perform any work. In addition, no vocational report suggests that claimant cannot be gainfully employed. In fact, the vocational reports repeatedly indicate that claimant's inability to find work is a function of the depressed labor market. Although claimant certainly has shown himself to be highly motivated, he has not shown himself to be incapable of performing gainful activity. Therefore, claimant is not entitled to a permanent total disability award.

Claimant's prior award of 35% unscheduled and 5% scheduled permanent disability is inadequate, however. Considering claimant's impairment, age, education, work experience, adaptability and other relevant social factors, we find that an award of 65% for 208° unscheduled permanent disability adequately compensates claimant for his loss of earning capacity due to this injury. We also affirm the Determination Order award of 5% for 7.5° scheduled permanent disability for loss of use of claimant's leg.

ORDER

The Referee's order dated March 25, 1983 is reversed in part and affirmed in part. That portion of the order awarding permanent total disability is reversed and claimant is awarded 65% for 208° unscheduled permanent disability and 5% for 7.5° scheduled permanent disability, in lieu of prior awards. The remainder of the Referee's order is affirmed. Claimant's attorney's fee shall be adjusted accordingly.

IRVING R. WHITING, Claimant
Myrick, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11460
March 29, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of Referee Daron's order which upheld the SAIF Corporation's October 15, 1982 denial of claimant's psoas (left abdomen) muscle strain.

On August 17, 1982 claimant was using a crimping tool while working for an electric utility. A crimper looks like a very large pair of pliers. While exerting force with this large tool, claimant experienced a very sharp pain in his left abdomen. The pain was eventually diagnosed as a psoas muscle strain. Claimant was off work until September 13, 1982 when he was released for work not involving use of the crimper. By September 29, 1982, his treating physician, Dr. Sloan, unconditionally released him for work.

In the months prior to the August 17, 1982 incident, claimant had experienced an aching sensation in the same place of his left abdomen as he experienced the sudden sharp pain. The aching did not cause him to miss work, but claimant called for an appointment to see Dr. Sloan about one week before the August 17 incident. An appointment was scheduled for August 18, 1982.

The Referee found claimant credible at hearing, and found that an incident did occur as claimant described on August 17, 1982. Claimant's testimony that use of the crimper requires considerable abdominal force was corroborated at hearing. However, the Referee found the claim not compensable because he regarded the medical evidence to be insufficient to relate use of the crimping tool to claimant's disability.

Our review of Dr. Sloan's reports reveals that use of the crimping tool caused an exacerbation of a 1960 left flank injury resulting in severe left abdominal pain. Dr. Sloan authorized time loss for a month and recommended against use of the crimping tool until the muscle strain healed. On August 31, 1982 Dr. Sloan wrote:

> "Probable psoas muscle injury dating from work related injury 1960, recent exacerbation while using crimping tools caused severe left abdominal pain. Should not utilize this tool or do other similar activity in the future."

This report indicates that the treating doctor did relate the severe abdominal pain to claimant's use of the crimping tool at work. Although claimant may have had some previous aching, he sustained a definite increase in severity of pain with immediate disability after the incident on August 17, 1982.

The only other medical evidence in the record is a report from Dr. Girod, SAIF's medical consultant, who reviewed the file and stated in his October 11, 1982 report:

> "It appears that the claimant had pain in the chest or abdomen in association with the performance of a task at work. Since the pain resolved spontaneously and since no significant abnormality has been found in his diagnostic workup, one would assume that the claimant had a minor soft tissue injury such as a muscle strain. The symptoms appear to have resolved at this time and he should not have chronic problems as a result of this incident. Thus, it seems reasonable to assume that the claimant's pain was secondary to his work activity."

We find that the medical evidence adequately relates the August 17, 1982 work activity to claimant's psoas muscle strain.

ORDER

The Referee's orders dated June 21, 1983 and July 25, 1983 are reversed. The SAIF Corporation's denial dated October 15, 1982 is set aside and claimant's claim is remanded to SAIF for acceptance and processing including, pending further order of the Evaluation Division, payment of compensation for temporary total or temporary partial disability from August 18, 1982 to September 29, 1982. Claimant's attorney is awarded a fee for his services at hearing in the amount of $900 and a fee for his services on Board review in the amount of $400, both to be paid by the SAIF Corporation.

THOMAS C. WHITTLE, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-05189
March 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Quillinan's order which upheld the SAIF Corporation's denial of claimant's lung disease claim. Claimant contends that his exposure to metal dust and fumes while working as a shop teacher caused or contributed to his mesothelioma. There also is an issue concerning the evidence which is properly before the Board. SAIF has moved to strike claimant's brief on the grounds that claimant has included evidentiary material which is not part of the record developed before the Referee. See ORS 656.295(5). First we will address the issues raised by SAIF's motion to strike and claimant's response thereto.

During the preliminary stage of the proceeding before the Referee, in opening remarks by counsel, claimant's attorney referred to written material from a medical treatise entitled Asbestos and Disease by Selikoff and Lee. This treatise had been referred to in a report written by Dr. Patterson at SAIF's request. The report was admitted into the record as one of the hearing exhibits. Page 4 reads:

> "The clinical course of patients with mesothelioma is summarized on pages 302 and 303 of Selikoff and Lee's book on Asbestos and Disease (Academic Press, New York, 1978), where most patients were dead within a year, although some had longer periods of survival, including some with an epithelial type of mesothelioma, surviving as long as 82 months and one survivor of 96 months reported."

Dr. Patterson's report does not support the compensability of claimant's claim with this employer.

In his opening remarks, claimant's attorney referred to the treatise as indicating that asbestos can incite the development of mesothelioma, referring specifically to page 281. At this juncture, counsel for the insurer interposed an objection:

> "Mr. Scheminske: I am going to object to some document which has not been authenticated or submitted into evidence.
>
> "Referee: I will sustain the objection. However, these are opening statements at this point.
>
> "Mr. Hytowitz: I am making this for reference.
>
> "Referee: Just be aware that it is not evidence.
>
> "Mr. Hytowitz: At any point, they indicate

> that any metal powder, nickel, cadmium and zinc have been cited as inciting the development of mesothelioma. This was apparently not taken into account when Dr. Patterson wrote his report and when he cited Selikoff himself."

No further reference was made to the treatise during opening statements. Claimant was the only witness to testify, after which claimant and SAIF rested. During counsel's closing remarks, which were reported and transcribed at SAIF's request, claimant's attorney again referred to the treatise in question:

> "Mr. Hytowitz: In response to Mr. Scheminske's argument, I would point out that Dr. Patterson has indicated in the textbooks that he cites that he found --
>
> "Mr. Scheminske: Argument is restricted to evidence. The book is not in evidence.
>
> "Mr. Hytowitz: The very same book he was mentioning -- If you would like to make a photocopy of this book, I would put it in evidence.
>
> "Mr. Scheminske: The Claimant has rested and the book is not in evidence.
>
> "Mr. Hytowitz: I would move to reopen the record if you want to put this in.
>
> "Mr. Scheminske: I object.
>
> "Referee: I think you had an opportunity to put it into evidence. On the other hand, these are closing arguments and they are not part of the evidence of the case."

The Referee left the record open for physicians' depositions, including Dr. Patterson's, at claimant's request. Claimant eventually decided to forego taking any depositions, and the Referee issued her order upon receipt of counsel's written argument. As stated above, the Referee upheld SAIF's denial, and claimant requested review.

In his appellant's brief claimant refers to pages 262 through 276 of Asbestos and Disease and quotes a portion of the text appearing at page 281, after which claimant's brief states: "Thus, nickel, cadmium and zinc have been cited as inciting the development of mesothelioma."

SAIF simultaneously filed its respondent's brief and a motion to strike claimant's appellant's brief on the grounds and for the reason that "it includes quotes of materials which were not admitted into evidence, which are not admissible as evidence, and which are not a part of the record of this case." Appended to SAIF's brief is a report from Dr. Lawyer, who takes issue with the theory that there is "an increased risk of mesothelioma or other malignancies associated with exposure to zinc dust or cadmium

dust," and states that he is aware of no precedent in the medical literature for such a conclusion. In addition Dr. Lawyer's curriculum vitae is submitted under cover of this letter.

In response to SAIF's motion to strike, claimant contends that, "if any error is in the record before the Board regarding evidentiary matters, the error has run against the claimant, for the Referee's refusal to admit documents into evidence (that had been previously cited in medical reports promulgated by the defendant) was clearly error." Claimant also refers to several appellate court decisions quoting extensively from and relying upon certain treatises and standard references, such as Principles of Disability Evaluation (1959), by W. C. Smith, American Medical Association Guides to Evaluation of Impairment, and Stedman's Medical Dictionary. See, e.g. Surratt v. Gunderson Bros., 259 Or 65 (1971); Dethlefs v. Hyster, 55 Or App 873 (1982), aff'd 295 Or 298 (1983); and Sloan v. Georgia Pacific Corp., 24 Or App 155 (1976).

In deciding the merits of SAIF's motion, first we must consider the issue that it raises. There is a potential issue concerning the propriety of the Referee's ruling, assuming that there was actually a ruling, on the claimant's request that portions of the treatise upon which claimant wished to rely be admitted into the evidentiary record, assuming such a request was properly made. We conclude that if any of the above-quoted colloquy is sufficient to constitute, on the part of claimant, an offer to place portions of the treatise in evidence, and an adverse ruling by the Referee, any possible assertion that the Referee's ruling was erroneous was not properly preserved in view of claimant's failure to make an offer of proof under the rule and thereby have the material included as part of the record for review. Furthermore, it would appear that if claimant intended to place this documentary material in evidence, it would have been appropriate to make any such effort during claimant's presentation of his case, rather than during closing argument.

In addition to finding that the propriety of the Referee's "evidentiary ruling" was not properly preserved at hearing, we also conclude that the issue has not been properly raised on Board review. Claimant's appellant's brief refers to the material in question as though it already were a part of the record, without discussing the propriety of the Referee's "ruling." Only in response to SAIF's motion to strike has claimant suggested that he is aggrieved or that it was error for the Referee to decline to consider the portions of the treatise referred to by claimant's attorney. Under these circumstances, we consider claimant's reply to SAIF's motion to be in the nature of a reply brief, and we do not consider a reply brief to be the appropriate vehicle for raising, for the first time on review, an issue concerning the propriety of an evidentiary ruling. Such issues should be raised in the first instance by way of the appellant's brief. Accordingly we do not rule on whether it would have been proper for the Referee to admit the material in question. See generally ORS 656.283(6); Lucke v. Compensation Dept., 254 Or 439, 442-43 (1969).

A consideration that has not directly been addressed by either party is whether the Board can or should take administrative or official notice of the textual material relied upon in claimant's brief.

We have considered the question of official notice by the Board and its Referees in the context of prior orders of the agency, and we have held that Referees and the Board have authority to take notice of such orders, without the need for formal "proof." Dennis Fraser, 35 Van Natta 271 (1983). We reached this conclusion in Fraser primarily for two reasons. First, as we stated, "[o]bviously knowledge of the date of claimant's last arrangement of compensation is necessary in order to begin to determine whether claimant's current condition is now worse than it was at that time." 35 Van Natta at 274. In addition, we determined that the "better rule" allows Referees and the Board to take notice of prior agency orders, citing McCormick, Handbook of the Law of Evidence, §330 (2d ed. 1970).

That portion of McCormick to which we made reference is concerned with judicial notice of facts "capable of accurate and ready demonstration," "capable of such instant and unquestionable demonstration, if desired, that no party would think of imposing a falsity on the tribunal in the face of an intelligent adversary," or "capable of immediate and accurate demonstration by resort to easily accessible sources of indisputable accuracy." McCormick, supra at 763. See also ORS 40.065, Rule 201(b) Oregon Evidence Code.

Orders of this agency are the proper subject of official notice because they contain or establish facts which are a matter of record. In Fraser the date of the claimant's last award or arrangement of compensation was capable of certain verification. We indicated in Fraser that if we, in a given case, intended to take notice of a prior agency order without a request from either party, we would notify the parties and allow an opportunity for comment; and, in at least one case since, we have utilized this procedure. See Dewayne D. Dunlap, 36 Van Natta 139 (February 13, 1984). Taking official notice of material contained in extra-record reference materials would have to be accomplished in the same manner.

The scope of the Board's power to take official notice of extra-record reference materials has not recently been discussed, nor has it been delineated by statute or case law. Questions concerning the use of extra-record references arise in two different contexts. The first involves use of reference materials as an aid in understanding or evaluating evidence which is presented in the record. See Bend Millwork v. Dept. of Revenue, 285 Or 577 (1979); see also Rolfe v. Psychiatric Security Review Board, 53 Or App 941 (1981). Our understanding of legal doctrine, and our policy position, is that this Board should be able to consult standard, authoritative references in order to better understand or evaluate the evidence of record. As the Supreme Court explained in Bend Millwork:

> "In our role as fact finder in this trial 'anew upon the record' it is essential that we understand the meanings of the various terms appearing in the evidence. This task becomes almost overwhelmingly difficult when persons involved as professional appraisers or as legal counsel in the trial use a given

> term differently than do others so involved or refuse to recognize the validity of a term used by another professional. When such differences occur the judge, as fact finder, must be careful to determine the meaning of the term in a way which is not violative of the rules of law governing the fact finding process in general. The temptation is to seek outside help, and in many instances this may be done properly.... The statute certainly permits resort to ordinary dictionaries compiled by universally recognized lexicographers to ascertain the 'true signification' of words and phrases even though they are not used in ordinary intercourse and are outside the active and passive vocabularies of even the well educated. The statute probably permits resort to special dictionaries or glossaries for ascertainment of the 'true signification' of words and phrases used in those fields of thought and endeavor which we describe as being 'scientific,' especially in the mathematical sciences." 285 Or at 583.

While this Board is not governed by the statutes discussed in Bend Millwork, we face similar difficulties with respect to medical and scientific terminology and concepts. We have in the past referred to medical literature in attempting to gain a better understanding of a complicated medical problem. See, e.g. Juanita M. DesJardins, 34 Van Natta 595 (1982). In DesJardins we quoted at length from a text concerning chronic pain, which we considered in order to facilitate our understanding of the evidence of record in that case, wherein the claimant contended she was permanently and totally disabled.

The second context in which the Board's use or consideration of material contained in extra-record references may arise involves the use of such material as substantive evidence. This involves the process of proof, as opposed to the evaluation of evidence; the former but not the latter being within the concept of official notice. McCormick, supra at 858-59. In any given case, the effort to distinguish these two concepts, for practical purposes, discloses that they are separated by "a fine line" which "cannot be drawn with precision," McCormick, supra at 859; therefore, it is well to keep in mind that:

> "* * * [S]elf-restraint must be exercised in order to avoid the taking of evidence from a source not subject to confrontation and cross-examination. We would not allow a jury during deliberation to send out for the opinion of an outside expert as to the true meaning of a term upon which the experts called as witnesses in open court had disagreed. It follows that we should not allow ourselves to do so when discharging our fact finding function.

> This is not to say that, given the different circumstances in which judges and juries discharge that function, judges cannot resort to outside reading in order to better understand the evidence, but the judge must be ever conscious that the material read is not to be considered as evidence itself unless the material is a proper subject of judicial notice. Even then the judge must be careful to recognize that he is actually receiving evidence by way of judicial notice and follow the governing procedural rules of law." Bend Millwork v. Dept. of Revenue, supra, 285 Or at 584.

It is necessary, therefore, to determine into which category the textual material in this case falls. It is fairly clear to us that claimant has not referred to the treatise with the intention that we merely consider its contents as an aid in evaluating the evidence of record. To the contrary, claimant appears to rely on the quoted material in order to establish facts in support of his claim. What could be more substantive?

Whether and to what extent the Board can or should consider this material falls into the "process of proof" category; and in order for us to give it our consideration as evidence, it would be necessary to take official notice. Considering the nature of the material set out in claimant's brief, we do not consider it a proper subject of official notice. It does not fall within the field of facts not subject to reasonable dispute, as do facts contained in or established by an agency order, Dennis Fraser, supra; or information "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," ORS 40.065(2), which is true of information contained in standard references. See also Joyce Groshong, WCB Case No. 81-05961, 36 Van Natta 323 (decided this date).

The appellate court decisions referred to by claimant involved the courts' use of standard references, such as medical dictionaries; and at least one case involves the use of an authoritative guide to the evaluation of industrial disability, which we believe falls into the "evaluation of evidence" category discussed above (Surratt v. Gunderson Bros., supra). To the extent that these cases lend support to any conclusion in this case, it is the conclusion that we should not take official notice. See also Bend Millwork v. Department of Revenue, supra, 284 Or at 584-85, in which the court consulted a recent publication, "as a matter of curiosity only," finding ". . . ample illustration of the point that we should not go outside the record for help in understanding such terms."

There are practical considerations which lead us to conclude that we should not take official notice of material contained in extra-record references, other than those "whose accuracy cannot reasonably be questioned." If we were to take notice of other references as a general practice, it would be necessary to follow the procedure we discussed in Fraser, also discussed by Professor Davis in his treatise on administrative law. K. C. Davis, Administrative Law Text, 312 (3d ed. 1972). We do not believe the same practice would be workable in the context of officially noting

material contained in a medical treatise because, once we decided to consider such material as substantive evidence, it would be necessary to allow the parties an opportunity to comment and present evidence and argument against the noticed material. This type of procedure with respect to extra-reference material of the nature involved herein could result in interminable delay in the review process at this level, a situation we should endeavor to avoid, not invite. See also ORS 656.295(5).

Our holding today should not be construed as a limitation upon the ability of Referees to take official notice of material contained in a medical treatise, if a situation were to arise in which a Referee deemed it necessary and appropriate to do so. In such an instance, it would be the Referee's responsibility to notify the parties of his or her reliance upon the noticed material, and to afford an opportunity to present evidence and argument, and to make all such material a part of the evidentiary record. Our holding is limited to a determination of the question presented: Whether this Board should take official notice of material contained in extra-record references, other than standard references generally considered "sources whose accuracy cannot reasonably be questioned." We hold that we should not and, therefore, will not.

Having now considered all of the questions that appear to arise by virtue of SAIF's motion to strike and claimant's response thereto, we deny SAIF's motion. We have not considered the evidentiary material referred to in claimant's appellant's brief, and we have considered claimant's written argument only to the extent that it is based upon the evidence of record. Nor have we considered the additional material submitted by SAIF under cover of its respondent's brief.

On the merits, we affirm the Referee's findings and conclusions. The issue of what caused claimant's lung condition is a complicated medical question. We find insufficient evidence to establish the requisite causal connection between claimant's lung condition and his work as a shop teacher with the employer.

ORDER

The Referee's order dated July 7, 1982 is affirmed.

ROBERT L. BARTLEY, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-00789
March 30, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Knapp's order which upheld a Determination Order's award of scheduled disability for claimant's compensable hearing loss. On review claimant argues that OAR 436-65-565(3) is invalid.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated July 29, 1983 is affirmed.

Board Member Lewis Dissenting:

I respectfully dissent. The sole issue in this case is the validity of OAR 436-65-565(3), which in pertinent part provides that in rating hearing loss: "The current audiogram showing the greatest retained levels of hearing loss will be used for rating compensable hearing loss." The effect of this regulation is that, in a hearing loss case in which more than one current and valid audiogram exists, the report showing the result most favorable to the employer/insurer will be used in evaluating hearing loss.

The Referee applied this regulation in rating claimant's hearing loss in this case. My colleagues affirm and adopt the Referee's order. It is true that the claimant has the burden of proving disability. It is also true that the Court of Appeals has said: "The doctrine of liberal construction of the Workers' Compensation Act is not transferable to the fact finding process to adjust the burden of proof." Gormley v. SAIF, 52 Or App 1055, 1060 (1981). However, the effect of this regulation is to impose an irrebuttable presumption that the report most favorable to the insurer is the report which accurately assesses a claimant's hearing loss. By adopting the Referee's order which strictly applies this regulation, the majority adopts this irrebuttable presumption in favor of the insurer.

I believe that the irrebuttable presumption created by this regulation contravenes the purpose of the workers' compensation law: "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). I do not understand how a regulation which creates an irrebuttable presumption in favor of the insurer can be considered a fair and just regulation for delivery of financial benefits to an injured worker.

I see no reason why conflicting audiograms should be treated any differently than any other medical evidence. The Referee and the Board should consider the quality of the report, any evidence about the circumstances of the report and the qualifications of the person performing the audiogram.

I would invalidate OAR 436-65-536(3) and reverse the Referee. Accordingly, I dissent.

ROBERT A. BEAL, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-01799
February 22, 1984
Order of Abatement

The Board has received a motion to reconsider our Order on Review dated January 31, 1984.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion for reconsideration within ten days.

IT IS SO ORDERED.

ROBERT A. BEAL, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-01799
March 30, 1984
Order on Reconsideration

The SAIF Corporation has requested that we reconsider our Order on Review dated January 31, 1984. 36 Van Natta 80 (1984). We abated our order on February 22, 1984 in order to give claimant an opportunity to respond to the motion and in order to give us time to consider the motion. On reconsideration, we adhere to our original order.

This claim involves SAIF's denial of an aggravation claim. In our order we held that claimant had proven a compensable aggravation. We relied on the reports and the deposition of Dr. Woolpert. We summarized his position as follows:

> "We find that Dr. Woolpert believed claimant's statements that the low back condition was worse and that Dr. Woolpert found some objective evidence to indicate that claimant's condition was worse."

We then cited Oakley v. SAIF, 63 Or App 433 (1983), for the proposition that Dr. Woolpert's reports and deposition were sufficient to sustain an aggravation claim.

SAIF takes us to task:

> "Our main concern is that you concluded Dr. Woolpert found some 'objective' evidence matter [sic] of a worsened condition. The matter was clearly explained in Dr. Woolpert's deposition (Exh. 35); in particular, see pages 9, 11 and 13.
>
> "We suggest that claimant failed the objective test. * * * *"

We note at the outset that under Oakley there is no "objective" test. Oakley suggests that a mere statement by a physician that she or he believes claimant's history may be sufficient to establish a compensable worsening. "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." Oakley, supra 63 Or App at 436 (emphasis added). The use of the disjunctive "or" in the court's opinion indicates that either a statement from the doctor that she or he believes claimant's history, or objective findings to support that history, is potentially sufficient to establish a compensable aggravation. In this case we found both a statement of belief and some objective findings to support the aggravation claim.

The portions of Dr. Woolpert's deposition to which SAIF refers indicate that Dr. Woolpert said that the objective evidence which he found which supported claimant's aggravation claim was the straight leg raising test. He testified that there is some subjective element to the straight leg raising test. However, he specifically stated:

"I have known him [claimant] for quite a while, and I feel that he's less likely perhaps to fake it than a lot of other people I treat."

He also indicated that based on conflicting results in a CT scan and a myelogram he was only able to indicate a possibility rather than a probability that claimant had a bulging disc at L4-5.

Based on these facts as well as the written reports referred to in our Order on Review, we adhere to our finding that Dr. Woolpert believed claimant's statements that his low back condition was worse, and that Dr. Woolpert found some objective evidence which supported claimant's position.

ORDER

On reconsideration of the Order on Review dated January 31, 1984, we adhere to our prior order which hereby is reaffirmed and republished.

JOSEPH BEEBE, Claimant
David Force, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 83-00260
March 30, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of those portions of Referee Peterson's order which granted claimant an additional 128° for 40% unscheduled disability for a total of 208° for 65% unscheduled disability. Extent of disability is the only issue on review.

On review, we apply the guidelines contained in OAR 436-65-600, et seq., as follows: Claimant's age of 62 yields a +10 factor. Claimant's eighth grade education yields a +10 factor. Claimant's job at the time of injury as a highway maintenance worker requires over 30 days and less than six months to learn; this yields a +3 factor. We consider claimant's work to have been heavy work. The medical evidence indicates that claimant is now restricted to light work. We thus assign a +10 factor for adaptability. We decline to assign any factors for mental capacity or emotional and psychological findings. SAIF argues that we should assign a -25 factor for labor market findings because claimant returned to his previous job. We do not so find. Although claimant ostensibly returned to his previous job, the evidence indicates that as a matter of fact his co-workers were covering for him and he was not in reality capable of doing his previous job. We apply the guidelines for determining the labor market available to claimant and conclude that only 12% of the labor market is actually available to claimant. Accordingly, we assign a +2 for labor market findings. We have some difficulty assigning a figure for impairment because the medical evidence is not well developed. However, we conclude, based on claimant's testimony and the fact that SAIF concedes that a 10% to 15% impairment rating is appropriate, we should assign a +10 for impairment. After combining these figures we arrive at a 45% disability rating. Comparing this case with other similar cases, we conclude that a 45% disability rating appropriately compensates claimant for his compensable disability.

ORDER

The Referee's orders dated August 12, 1983 and August 26, 1983 are modified. In lieu of the 128° for 40% unscheduled disability awarded by the Referee, claimant is awarded 64° for 20% unscheduled disability in addition to the 80° for 25% unscheduled disability previously awarded by Determination Order. Attorney fees shall be adjusted accordingly.

RODNEY V. CALVIN, Claimant
Hansen & Wobbrock, Claimant's Attorneys
Daniel Meyers, Defense Attorney

WCB 82-06744
March 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Fink's order which found him not entitled to benefits for temporary partial disability and, therefore, refused to assess penalties and attorney fees against the employer. Claimant contends both findings were in error.

This case was submitted for decision on the following stipulated facts.

Claimant sustained a compensable fracture to his right wrist on May 21, 1982 while employed by Wagner Mining and Manufacturing. Claimant was working five days per week at the time of the injury. Claimant was treated and released by his physician to return to modified work. Claimant returned to work at a modified duty job for which he received the same rate of pay as his regular job.

After claimant returned to modified work on June 1, 1982, the work week for the entire plant was reduced to four days per week due to the weak economy. Claimant was paid no compensation for the extra day.

Claimant's condition was found medically stationary on April 21, 1983. A Determination Order issued on June 29, 1983 awarding claimant 10% (15°) permanent partial disability for injury to his right forearm.

The issue is whether a medically unstationary claimant who has been released to and accepted modified work is entitled to benefits for temporary partial disability when a reduced work week is instituted for the employer's entire business.

The Referee concluded that claimant was not entitled to temporary partial disabilty benefits for the fifth day. The Referee stated that claimant was in no different position than all the other workers at his place of employment. Although the Referee recognized that claimant would be in a less favorable position than other workers if he were to seek a five day per week job, he did not find this argument particularly persuasive in the absence of evidence that claimant was attempting to locate such a job. Although we find that the Referee's conclusion certainly makes common sense, we do not find it to be the law.

ORS 656.212 provides:

"When the disability is or becomes partial

> only and is temporary in character, the worker shall receive . . . that proportion of the payments provided for temporary total disability which his loss of earning power at any kind of work bears to his earning power existing at the time of the occurrence of the injury." (Emphasis added.)

OAR 436-54-222(3) provides:

> "An insurer or self-insured employer shall cease paying temporary total disability compensation and commence making payment of such temporary partial disability compensation as is due from the date an injured worker accepts and commences any kind of wage earning employment prior to claim determination."

And OAR 436-54-222(1) and (2) provide a method for calculating the rate of temporary partial disability benefits:

> "The rate of temporary partial disability compensation due a worker shall be determined by:
>
> "(a) Subtracting the post-injury wage earnings available from any kind of work; from
>
> "(b) the wage earnings from the employment at the time of, and giving rise to, the injury; then
>
> "(c) dividing the difference by the wage earnings in (b) to arrive at the percentage of loss of earning power; then
>
> (d) multiplying the current temporary total disability compensation rate by the percentage of loss of earning power.

From a plain reading of the statute and rules, it is clear that, since claimant's post-injury modified work wages are less than his pre-injury wages, he is entitled to be paid temporary partial disability in accordance with the above formula.

The employer argues that temporary partial benefits need not be provided when the entire work force's hours have been reduced as a result of economic conditions, as the inability to work is purely related to poor economic conditions rather than the results of the compensable injury. We disagree with this argument. The payment of temporary partial benefits is prefaced on the availability of modified work for an injured worker. If no such work is available, the employer must continue paying claimant benefits for temporary total disability (unless the worker has refused modified employment as provided in OAR 436-54-222(5)). There is no authority which allows an employer to terminate temporary disability benefits to a worker when there is no work available due to a general plant slowdown or layoff.

Carrying the employer's argument one step further, if the plant had been completely closed due to economic conditions, the employer would not be required to provide claimant any temporary partial or total benefits, as claimant's inability to engage in modified work paying the same wage as his regular work would be due not to the injury but to economic conditions. Claimant's entitlement to temporary benefits is premised on his having sustained a compensable injury, not the fortunes of the economy. If such an approach were taken, consistency would require claimant's temporary disability rate be adjusted upward whenever a pay raise were to take effect at his place of employment, and such an approach would be contrary to ORS 656.005(27). See Lowell D. Slama, 35 Van Natta 744 (1983).

Based on the above, we conclude that claimant is entitled to receive benefits for temporary partial disability calculated in accordance with the formula set forth in OAR 436-54-222. See also Fink v. Metropolitan Public Defender, 67 Or App 79 (1984) (formula for computation of temporary partial disability comports with statute).

Claimant also requests that penalties and attorney fees be assessed against the employer for failure to pay temporary partial disability benefits as requested. We agree with claimant that a moderate penalty and attorney's fee is warranted in this circumstance.

ORDER

The Referee's order dated July 14, 1983 is reversed. The employer is ordered to provide claimant with benefits for temporary partial disability in accordance with this order, to pay claimant a penalty of 15% on such amounts and to pay claimant's attorney a fee of $250 in addition to and not out of claimant's compensation. Claimant's attorney is allowed an attorney's fee of 25% of the temporary disability made payable by this order, not to exceed $750.

ROBERT D. CRAIG, Claimant
Roger D. Wallingford, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-11435
March 30, 1984
Order on Review (Remanding)

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Mulder's order which affirmed the employer/insurer's December 10, 1982 denial of claimant's cervical condition.

Briefly, the facts are as follows.

Claimant was employed by the Portland Art Association as a maintenance and custodial worker. In January 1980 claimant and several other employes were moving a large filing cabinet with a hand truck, when the tires on the hand truck collapsed and caused the weight of the cabinet to be shifted against claimant's neck and shoulder for a few seconds.

Claimant consulted Dr. Freistat, who advised him to warm up before working. No claim was filed and claimant sought no further medical treatment until April 1981. Claimant then consulted Dr.

Bosworth, a chiropractor (there are no reports from Dr. Bosworth in the record). Apparently claimant also saw Dr. Silverman, an arthritis specialist, from November 1981 until February 1982.

Claimant indicated that he missed some time from work in 1980 and 1981 as a result of pain, although he was able to continue practicing Karate.

Claimant filed a Form 801 in February 1982. He testified that he did not file a claim earlier because he was not sure whether his symptoms were related to the file cabinet incident.

The claim was accepted and claimant thereafter treated with Drs. Podemski and Markham. Cervical nerve root compression was diagnosed. Following a course of conservative treatment, Dr. Markham reported on April 5, 1982 that claimant's symptoms had resolved and that he could return to full employment with no limitations.

An April 22, 1982 Determination Order awarded claimant benefits for temporary total disability only.

On October 19, 1982 claimant underwent a myelogram. Dr. Markham concluded claimant was suffering from a herniated disc at C6-7 with a smaller defect at C5-6.

On December 2, 1982 claimant was examined by Dr. Rosenbaum, a neurosurgeon. Dr. Rosenbaum recorded a history that claimant suffered an injury in January 1980 while moving a file cabinet, and suffered increased symptoms as time progressed. Claimant stated, however, that he was essentially able to live with the pain until he stepped off of a curb in January 1982 and had an immediate onset of excruciating neck spasm. Dr. Rosenbaum's is the first recorded history of the curb incident. Dr. Rosenbaum was of the opinion that claimant's condition was related to the curb incident rather than the January 1980 cabinet incident.

On December 10, 1982, the employer issued a denial which purported to deny the claim in its entirety. The denial was based on the grounds that claimant's condition was related to the January 1982 curb incident, rather than the January 1980 cabinet incident.

There is additional medical evidence on the issue of compensability. However, since it has no relevance to our disposition of this case, we see no need to discuss it.

When the hearing convened on April 22, 1983, the employer indicated that it was appealing the April 22, 1982 Determination Order (claimant concedes that the employer's appeal was timely). Counsel for the employer indicated that it was taking this course of action as a result of the Court of Appeals' recent decision in Bauman v. SAIF, 62 Or App 323 (1983). The Referee concluded that since the employer appealed the Determination Order in a timely manner, the employer's back-up denial of the entire claim was permissible under Bauman. After considering all of the evidence, the Referee affirmed the denial.

Subsequent to the hearing in this matter, the Supreme Court issued its decision in Bauman v. SAIF, 295 Or 788 (1983). In

Bauman, the Supreme Court concluded that if an insurer or employer notifies a claimant that his claim has been accepted, it may not, after 60 days have elapsed, deny the compensability of the claim absent a showing of fraud, misrepresentation or other illegal activity. 295 Or at 794.

Claimant has raised several issues on review. However, we find it necessary only to consider the question of the permissibility of the employer's denial in light of Bauman.

Having recited the facts, it should be clear that since the employer accepted this claim and since well over 60 days had elapsed subsequent to that acceptance, the employer is precluded by Bauman from attempting to deny the claim in its entirety. The employer argues that Bauman represents an "abrupt and unanticipated change in the law governing claims processing," and as such, it should not be given retroactive effect. The employer also argues that if it had known Bauman would have been the standard applied, it could have marshalled evidence concerning fraud, misrepresentation or other illegal activity on the part of claimant.

It is unnecessary for us to address the employer's retroactivity argument, as we agree that there is a question of misrepresentation and/or fraud present in this case. At the time this claim was originally accepted and closed by Determination Order, there appears to have been nothing to indicate that claimant's cervical condition was the result of anything other than the January 1980 incident (at least nothing in this record). It was only after the claim had been accepted and processed to closure that a history concerning an off-the-job injury was obtained. That history indicated that claimant suffered immediate and excruciating neck pain after he stepped off of a curb in January or April 1981.

In Skinner v. SAIF, 66 Or App 467 (1984), the court concluded that the employer was entitled to deny a claim, even though it had previously accepted it. The court stated that a claimant's denial of a previous injury, when such exists, is one kind of misrepresentation which must have been contemplated by the Supreme Court in Bauman. Similarly, we think that a claimant's failure to relate a history of a potentially significant intervening injury could also amount to a type of misrepresentation contemplated by the court in Bauman.

Unlike Skinner however, there is simply not enough evidence in this record for us to determine whether in fact, such a misrepresentation took place. The parties could not have anticipated the Supreme Court's decision in Bauman, and it is not surprising that neither of them really addressed the question of fraud or misrepresentation. We feel it appropriate that the parties have an opportunity to present their respective positions in light of Bauman. We, therefore, find it appropriate to remand this case to the Referee for the taking of additional evidence on this issue. If the Referee finds find that no such misrepresentation took place, it presently appears as though the employer's denial would be precluded by Bauman.

ORDER

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

BERNARD L. DAUGHERTY, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
Cheney & Kelley, Defense Attorneys

WCB 83-04033
March 30, 1984
Order on Reconsideration

The Board issued its Order of Dismissal herein on March 9, 1984, pursuant to the self-insured employer's withdrawal of its request for Board review. Claimant has petitioned the Board for an award of attorney fees, which we regard as a request for reconsideration.

The Referee's order was entered October 24, 1983, and the self-insured employer timely requested Board review. A briefing schedule was established, and all parties, including claimant, filed their respective briefs with the Board. The Board thereafter was advised by the self-insured employer that it intended to withdraw its request for review, and the Board order was entered accordingly.

Claimant contends that he is entitled to a reasonable attorney's fee for services rendered on Board review. We find claimant's motion is well-taken, Robert Heilman, 34 Van Natta 1487, 1488 (1982); therefore, we modify our prior order accordingly. ORS 656.382(2); SAIF v. Bond, 64 Or App 505 (1983); see also SAIF v. Muehlauser, 64 Or App 724 (1983).

ORDER

On reconsideration of the Order of Dismissal dated March 9, 1984, the Board modifies that order to award claimant's attorney $400 for services on Board review, to be paid by the self-insured employer. Except as modified, the Board adheres to its prior order, which hereby is reaffirmed and republished.

NILES R. DONNELL, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-08332
March 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Mulder's order which increased claimant's 25% (80°) unscheduled permanent partial disability award from a September 8, 1982 Determination Order by 40% (128°), giving him a total award of 65% (208°) unscheduled disability for his low back injury. On review, SAIF contends the Determination Order should have been affirmed.

We agree with SAIF's contention that the award is excessive. Therefore, we modify the Referee's order.

Claimant is a 53-year-old truck driver. On January 13, 1982 he suffered a compensable low back and coccyx injury when he fell off a truck.

Dr. Schuler, claimant's initial treating orthopedist, diagnosed his condition as coccygodynia together with a lumbosacral strain superimposed on degenerative disc disease.

Claimant was examined by Dr. Kemple, an internist and

rheumatologist. On March 3, 1982 Dr. Kemple diagnosed claimant's condition as chronic sacroiliac pain and post back injury status. The doctor felt claimant's coccygodynia had resolved.

On April 22, 1982, Dr. Schuler reported that there was nothing more he could do for claimant and opined that claimant could return to work.

On May 3, 1982 Dr. Manley, claimant's current treating orthopedist, diagnosed claimant's condition as probable sacroiliatis, post traumatic. Dr. Manley disagreed with Orthopaedic Consultants, who had diagnosed claimant's condition as coccygodynia secondary to contusion and lumbosacral strain, superimposed on previously existing degeneration of the lumbosacral disc and associated osteodegenerative changes.

A Determination Order issued on September 8, 1982, awarding claimant 25% unscheduled disability for his low back. Claimant appealed the Determination Order.

By chart note dated September 24, 1982, Dr. Manley indicated that claimant "probably would never get back to his previous job." He opined that claimant's impairment was in the "neighborhood of at least 25%, as was given to him by the Workmens' Compensation." Dr. Manley noted that he would not be surprised if the impairment increased if the ankylosing spondylitis continued at its present rate.

In his most recent report, Dr. Manley felt claimant would experience permanent pain and that sometime in the future might need to be evaluated by a pain clinic in order to deal with the severe pain. Dr. Manley did not alter claimant's earlier restrictions of no repetitive bending and a weight limitation of 30-40 pounds.

At hearing claimant credibly testified to daily limitations in sitting, walking, squatting, lifting, bending, running and in sleeping. He experiences numbness and weakness in his legs, as well as varying degrees of pain radiating down his right leg. Although he has pain in his left leg, the pain is more severe in his right leg. He takes prescription pain medication on a daily basis. He owns a back brace, but he does not wear it all the time.

Mr. Davis, claimant's vocational counselor, testified he was concerned with claimant's progress. He did not believe claimant was employable at that time because claimant could not drive a truck and had no marketable skills. Mr. Davis noted that claimant was emotionally distressed and had a lack of confidence in himself.

Claimant has an eighth grade education. He recently received his GED. At the time of hearing, claimant was taking general courses at a community college hoping to become an electronics technician. However, he was not progressing successfully in math and English subjects and had "a lot of doubt" whether he could complete the program. He has been a truck driver for approximately 20 years and has experience as a cannery worker and cab driver.

The Referee found claimant credible, candid and motivated. He increased claimant's award from 25% to 65%. We feel the Determination Order's award should be increased. However, we find the Referee's award to be excessive.

Pursuant to OAR 436-65-600, et seq., we consider claimant's age, education, work experience, adaptability, mental capacity, emotional state, labor market findings and physical impairment, including residual pain, in rating the extent of claimant's disability. In evaluating claimant's physical impairment, we find that the evidence preponderates in favor of a finding that his impairment was due to his compensable injury rather than to a preexisting condition which, in any event, was asymptomatic prior to the injury.

Considering the above guidelines and comparing this case to similar cases, we conclude that a total award of 40% would more appropriately compensate claimant.

ORDER

The Referee's order dated July 21, 1983 is modified. In lieu of the Referee's award and in addition to the 25% (80°) unscheduled disability awarded by the September 8, 1982 Determination Order, claimant is awarded 15% (48°) unscheduled disability, for a total award to date of 40% (128°) unscheduled disability for his low back injury. Claimant's attorney's fee shall be adjusted accordingly.

MICHAEL R. DRAGNOFF, Claimant
Callahan, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11287 & 83-00933
March 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation and EBI Companies request review of Referee Seymour's order which found claimant's aggravation claim compensable and the responsibility of SAIF. SAIF and EBI contend that the aggravation claim is not compensable. We agree that claimant has not proven compensability of his aggravation claim and reverse the Referee.

We make the following findings of fact. Claimant suffered a compensable back strain in September 1977 when his employer was insured by SAIF. He eventually lost time from work due to the back strain. A Determination Order was issued November 24, 1978, awarding time loss benefits but no permanent disability. Claimant appealed the Determination Order, but his request for hearing was later dismissed for lack of prosecution.

The November 1978 Determination Order was claimant's last arrangement of compensation for the purposes of this aggravation claim. At that time claimant's treating doctor, Dr. Llewellyn, diagnosed claimant's condition as "chronic lumbosacral sprain with attendant intermittent muscle spasm and pain and congenital malformation of the left sacrum." Dr. Llewellyn recommended that claimant be retrained. Although in October 1978 Dr. Llewellyn stated that claimant was asymptomatic, in November 1978 Dr. Llewellyn noted that claimant was complaining of back pain and would require periodic treatment in the future.

In 1978 claimant's employer became insured by EBI. In February 1979 and in May 1979 claimant filed nondisabling claims

for back strain which were accepted by EBI. Claimant sought no further treatment for his back until September 1982 when he saw Dr. Anderson, who reported that claimant was unable to work due to back pain related to his September 1977 injury. SAIF denied the aggravation claim stating that claimant's condition had not worsened, but that it would continue to pay medical benefits under ORS 656.245. EBI denied the claim stating that claimant's condition had not worsened, but that, in any event, claimant's condition was a continuation of his 1977 SAIF claim.

Dr. Tsai, who had seen claimant in January 1979, saw claimant again in November 1982. Dr. Tsai reported that claimant's condition had not changed in the interval between January 1979 and November 1982. Dr. Poulson, who had not seen claimant previously, reported in December 1982 that claimant had no impairment, "but there would be permanent disability in the form of mild recurrent pain." The Referee found that Dr. Poulson's finding that claimant had permanent disability in the form of mild recurrent pain was evidence that claimant had sustained a worsening of his condition.

We cannot agree that Dr. Poulson's finding is sufficient to prove a compensable worsening of claimant's condition. First, the description of claimant's condition by Dr. Llewellyn in October and November 1978 is essentially the same as that reported by Dr. Anderson in September 1982. Second, Dr. Llewellyn's reports suggest that claimant was suffering mild recurrent back pain at the time of closure in November 1978. This conclusion is supported by the fact that claimant filed additional back claims in February and May 1979. Finally, Dr. Tsai reported no change in claimant's condition from January 1979 and November 1982, and he is the only doctor who examined claimant near the time of closure in November 1978 and near the time of claimant's aggravation claim in September 1982. Based on this record, we are unable to find that claimant's condition worsened since the last arrangement of compensation.

ORDER

The Referee's order dated August 16, 1983 is reversed. The SAIF Corporation's denial dated December 2, 1982 is reinstated and affirmed. EBI Companies' denial dated January 18, 1983 is reinstated and affirmed.

MERCEDES A. EVANS, Claimant
Garrett, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Schwenn, et al., Defense Attorneys

WCB 82-04068 & 82-10141
March 30, 1984
Order of Abatement

The Board has received a motion for reconsideration of our Order on Review dated March 9, 1984.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion for reconsideration within ten days.

IT IS SO ORDERED.

DEBRA L. FAULDS, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Ass't Attorney General

WCB 82-08444
March 30, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee McCullough's orders which: (1) Affirmed the Determination Order wherein claimant was awarded no permanent disability; and (2) refused to award claimant penalties and attorney fees for the unreasonable conduct of the noncomplying employer. Claimant contends that she is entitled to an award of permanent disability and to penalties and attorney fees for the noncomplying employer's unreasonable conduct, payable by the SAIF Corporation.

The Board affirms the portion of the order which awarded no permanent disability. Regarding the penalty and attorney fees issue, however, the Board remands for further proceedings.

The Referee found that ORS 656.262(9) does not provide for penalties and attorney fees against a noncomplying employer for unreasonable conduct. In Anfilofieff v. SAIF, 52 Or App 127 (1981), however, the court held that the insurer can be assessed penalties and attorney fees for the unreasonable actions of a noncomplying employer under ORS 656.262(9). Therefore, we find that the Referee erred in refusing to consider penalties and attorney fees on the basis of the noncomplying employer's conduct.

In addition, the Referee framed the issue and holding in terms of penalties and attorney fees against the noncomplying employer rather than against SAIF. Penalties and attorney fees under ORS 656.262(9) are assessable only against the insurer or self-insured employer. Roscoe Howard, 35 Van Natta 329 (1983). In Robert Williams, 35 Van Natta 1758 (1983), we faced a similar situation where the parties agreed the issue was penalties and attorney fees against the noncomplying employer, and the Referee assessed penalties and attorney fees against the employer. We stated in Williams that if penalties and attorney fees are proper they should be assessed against SAIF, as the processing agent for the noncomplying employer. Inasmuch as the case was heard and decided under the assumption that any penalties and attorney fees would be assessed against the employer, SAIF did not have an opportunity to defend against the claimant's penalty claim. Therefore, the Board remanded Williams for further proceedings. 35 Van Natta at 1759.

Likewise, in the present case we find that if any penalties and attorney fees are proper, they should be assessed against SAIF. Since SAIF did not have an opportunity to defend against any such claim for penalties and attorney fees, we remand for further proceedings.

ORDER

The Referee's orders dated August 12, 1983 and September 21, 1983 are affirmed in part and remanded in part. Those portions of the orders which held that the noncomplying employer was not

subject to a penalty are vacated, and the issue of penalties and attorney fees is remanded to the Hearings Division for further proceedings in accordance with this order. The remainding portions of the Referee's orders are affirmed.

CHARLES M. FOX, Claimant
R.T. Gooding, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-10527
March 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of those portions of Referee Cronan's order which found claimant's occupational disease claim to have been filed in a timely manner, and set aside SAIF's September 18, 1981 denial. The issues for review are the compensability as occupational diseases of claimant's ulcers, colitis and osteoarthritis, and the timeliness of the claim pursuant to ORS 656.807(1).

Claimant is a 59-year-old retired vocational rehabilitation counselor. Claimant was employed as a supervising counselor for the Department of Vocational Rehabilitation (DVR) in La Grande from 1970 through 1981. On July 28, 1981 claimant tendered his resignation from DVR, stating:

> "Because of the cavalier attitude of the Field Service supervisors over the years, I find myself physically and emotionally exhausted.
>
> "As a result of ulcers, chronic colitis and painful osteoarthritis of the spine and sternum, I can no longer carry on."

On August 17, 1982 claimant filed an 801 form alleging that his conditions were caused or aggravated by stress associated with his employment at DVR. SAIF denied the claim on September 18, 1981.

Claimant and his treating physician, Dr. Lumsden, testified at the hearing that claimant's colitis condition had been diagnosed in 1977 or 1978, and that Dr. Lumsden had informed claimant at that time that the colitis was work related. Both claimant and Dr. Lumsden testified that claimant's ulcers were diagnosed in 1978 or 1979, and that Dr. Lumsden informed claimant at that time that the ulcers were also work related. Both claimant and Dr. Lumsden testified that claimant's osteoarthritis was diagnosed in 1980, and that Dr. Lumsden informed claimant at that time that the condition was caused or aggravated by his job with DVR.

The record indicates that claimant took time off from work in 1978, and again in 1980, for medical reasons. However, there is nothing in the record which reveals the nature of the medical problems claimant was experiencing at those times.

Although claimant's physician informed him that he was suffering from conditions caused or aggravated by his work, claimant continued working until he resigned in July 1981, and filed no claim until August 1981.

A substantial amount of evidence was presented at the hearing in the form of both documents and testimony concerning stresses to which claimant was exposed. The Referee concluded that claimant first became disabled as a result of his conditions when he resigned his employment in July 1981. Since claimant filed his claim in August 1981, which was within 180 days of becoming disabled, the Referee concluded that the claim was filed in a timely manner. ORS 656.807(1). In addition, the Referee concluded that the claimant established that his work stress was the major cause of his ulcers, colitis and osteoarthritis.

SAIF contends that the Referee erred in concluding that the claimant's occupational disease claim was filed in a timely manner. ORS 656.807(1) provides in part:

> ". . . all occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer within five years after the last exposure in employment subject to the Workers' Compensation Law and within 180 days from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease whichever is later." (Emphasis added.)

Since claimant was informed that he was suffering from occupationally related colitis in 1977-8, ulcers in 1978-9 and osteoarthritis in 1980, and, since claimant failed to file an occupational disease claim until his retirement in 1981, SAIF contends that although the claim was filed within five years of the last employment exposure, it was not filed within 180 days of his being informed by his physician or becoming disabled, and is therefore, barred.

There is no question that claimant filed his claim within five years of his last injurious employment exposure; therefore, the only question is whether he filed his claim within 180 days of becoming "disabled."

SAIF's argument brings to light an underlying problem in relation to defining the term "disabled." That is, for purposes of filing a claim pursuant to ORS 656.807, when is a claimant "disabled" so as to start the clock on the 180 day filing limitation of the occupational disease statute?

Several recent appellate cases have dealt with the question of the meaning of the term "disabled" in the context of an occupational disease. United Pacific Insurance v. Harris, 63 Or App 256 (1983), SAIF v. Baer, 60 Or App 133 (1982); and SAIF v. Gupton, 63 Or App 270 (1983). The issue in all of these cases was responsibility for an otherwise compensable occupational disease. In all three cases, the court fixed responsibility on the insurer or employer on the risk when the respective claimant's disability arose. The claimants in all three cases were found to be disabled not when they actually lost time from work, but rather, when they first sought medical services for their conditions.

In United Pacific Insurance v. Harris, supra, the claimant developed low back pain over a period of several months. Although

claimant lost no time from work, she did seek medical attention while Aetna was on the risk. Claimant's employer subsequently changed insurers, and claimant was thereafter hospitalized. The court stated:

> "The decisive question then is when claimant became disabled. She sought medical treatment in December, 1979, for a condition which thereafter remained unchanged until she left work in January, 1980. Thus, in December, 1979, she was afflicted with a condition that had required medical treatment for symptoms that had interfered with her ability to work. She was disabled at that time, and the insurer then on the risk is responsible." 63 Or App at 260.

In SAIF v. Baer, supra, the claimant contracted allergic contact dermatitis as a result of his work exposure. The claim was accepted by SAIF as nondisabling. Claimant received medical attention but continued to work. Claimant suffered a severe exacerbation in July 1979, and he was forced to take several weeks off from work. Prior to July 1979, the claimant's employer terminated its workers' compensation insurance with SAIF and obtained coverage with EBI. SAIF argued that since claimant became disabled while insured by EBI, EBI was responsible. Citing Bracke v. Baza'r, 293 Or 239 (1982), the court stated:

> "We are unable to distinguish Bracke from the present case. There is no uncertainty as to the date of onset of the compensable disease. SAIF recognized as much when it accepted claimant's original claim. Nor is there any evidence of an exacerbation of the disease while EBI was on the risk. The evidence is that exposure to the chemicals caused a recurrence of the symptoms. As in Bracke, claimant proved that he contracted the allergy and suffered 'disability' when he became allergic to the chemical." 60 Or App at 137, 138.

In SAIF v. Gupton, supra, claimant began experiencing symptoms of epicondylitis while employed by an automobile repair company. Claimant received medical treatment but lost no time from work. Claimant thereafter went to work for Dave's. Claimant's pain became more acute, and he filed a claim against Dave's. Claimant next went to work for Goodyear, where he first lost time from work as a result of his condition. The court stated:

> "In this case, it is clear that, because claimant left his work at Goodyear and subsequently had surgery on his elbows, he suffered a potentially compensable disability within the meaning of ORS 656.005(8)(b). However, the evidence also shows that surgery was recommended or considered while he was working at Dave's. * * * We hold that, because claimant's job

> at Dave's worsened his bilateral epicondylitis, which culminated in time loss and the need for surgery, the onset of disability began while he was employed at Dave's." 63 Or App at 274.

If we were to apply the Harris-Gupton-Baer definition of the term "disabled" to the current case, the claim would clearly be time barred as claimant sought medical attention for his occupational diseases substantially more than 180 days prior to the time he filed his claim. The argument against defining the term "disabled" as it appears in ORS 656.807(1) in this manner however, is that Harris, Gupton and Baer all dealt with the question of disability in the context of responsibility, and had nothing to do with the question of timeliness of filing pursuant to ORS 656.807(1). Thus, it could be argued that "disabled" for purposes of assigning responsibility under the last injurious exposure rule of Bracke v. Baza'r, supra, has nothing to do with "disabled" for purposes of timeliness of filing a claim under occupational disease statute.

ORS 656.807(1) does provide that a claim may be filed within 180 days after being informed by a physician that one suffers from an occupational disease, or within 180 days from the date of disability. It would seem that a person would generally be informed he is suffering from an occupational disease when medical treatment is sought. Thus, if we utilize the Harris-Gupton-Baer analysis, we would be interpreting "disabled" as usually having substantially the same meaning as "informed by a physician." The obvious question is, why then was the term "disabled" even inserted in the statute? To give effect to the words of the statute, it would seem that "disabled" in ORS 656.807(1) must be interpreted to mean something more than merely seeking medical treatment for a disability. Certain language in Gupton would seem to support such a conclusion:

> "ORS 656.005(8)(c) defines a nondisabling compensable injury as one which 'requires medical services.' Under ORS 656.005(8)(c) a disabling compensable injury is one 'which entitles the worker to compensation for disability or death.' The two statutes imply that a disability involves more than medical treatment alone -- perhaps, for example time loss or loss of earning capacity. However, the statutes address compensability rather than fix a method for determining liability for a disability. They leave open the question of determining the onset of disability." 63 Or App at 274.

Thus, the court appears to distinguish between "disabled" for purposes of fixing liability under the last injurious exposure rule, and "disabled" for purposes of compensability. Why then should not a similar distinction be drawn with regard to defining "disabled" for purposes of timeliness under ORS 656.807(1)?

However, the difficulty with interpreting "disabled" in ORS 656.807(1) as meaning something more than "disabled" as interpreted

in Harris, Gupton and Baer is that the same problem can arise in the context of a single case. Suppose the claimant in the current case had worked at a series of equally stressful jobs for different employers covered by different insurers throughout the late 1970s and early 1980s, but had not missed any time from work due to his conditions. If claimant's conditions were otherwise established as compensable, the Harris-Gupton-Baer analysis would require that the employer or insurer on the risk when claimant first sought medical attention be found responsible. However, if "disabled" for purposes of claim filing is interpreted to mean something more than seeking medical attention, seeking medical attention would not start the statute of limitations running on filing a claim. The net result would be that a given act can resolve the question of which employer or insurer is responsible for a claim even before the limitations period on filing the claim begins to run.

However, this is not necessarily as inconsistent as it may seem at first blush. The last injurious exposure rule serves a unique function in the law of workers' compensation. The rule serves to allocate responsibility between successive insurers/employers for an otherwise compensable occupational disease or injury. Bracke v. Baza'r, supra, 293 Or at 245. Additionally, the rule serves to provide certainty so that claimants are protected from the risk of late filing after an initial filing against an employer who otherwise would be liable. Inkley v. Forest Fiber Products Co., 288 Or 337, 343 (1980). It is clear from reading Harris, Gupton and Baer that "disabled" was being defined in a manner that best served the allocation of responsibility function of the last injurious rule. What function would it serve to define "disabled" in such a restrictive fashion for purposes of timeliness under ORS 656.807(1)? Such a definition would function only as a procedural trap to either unwary workers or workers who are unsophisticated in the nuances of workers' compensation law, and who may have an otherwise compensable occupational disease. Moreover, it would serve to punish those stoic employes who are able to and prefer to continue working rather than immediately filing a claim.

We conclude that the beneficent purposes of the workers' compensation law are better served by defining "disabled" in ORS 656.807(1) as meaning something more than simply seeking medical attention. Consistent with ORS 656.005(8)(b) & (c), and SAIF v. Gupton, we conclude that the meaning of "disabled" for purposes of ORS 656.807(1) includes time lost from work. We, therefore, conclude that the claim in the current case was filed in a timely manner.

With regard to the issues concerning the compensability of claimant's ulcers, colitis and osteoarthritis, we believe that the Referee was correct in finding claimant's ulcers and colitis compensable, but that it was error to find claimant's osteoarthritis compensable.

The record clearly reveals that claimant was subjected to significant amounts of stress while employed at DVR. As SAIF correctly points out, the record also reveals that claimant was also subjected to considerable stress in his personal life. The question of course is, whether claimant's work stress, as compared to his nonwork stress, was the major contributing cause of his conditions. Dethlefs v. Hyster, 295 Or 298, 310 (1983).

The only evidence concerning the causation of claimant's conditions comes from his treating physician, Dr. Lumsden. Dr. Lumsden testified:

> "I think the first of the problems that [claimant] related to stress . . . was colitis, and you could watch this develop in an interesting way. The first thing would be his client load increased and the number of files on his desk would pile up and the money would disappear, and this is sort of a normal fluctuation in this job, I think. The legislature puts out so much money and it comes and you are rich for a few days and then you're poor for a few years. It's a fluctuating thing but, as the case load would go up and the money go down, the colitis would develop and it was almost a graphable thing."

With regard to claimant's ulcers, Dr. Lumsden testified:

> "I think, as I might have a little earlier said, the ulcers seemed to come more when the authorities, not the clients, but the authorities were putting more pressure on. [Claimant] worked--it was kind of a two-edged sword. He had his clients, the people he was trying to help on one side and the people who controlled the money and seemed to put on the pressure on the other, indeed these were the people he was working for, that hired him and they gave him direction and periodically gave him fits and it seemed to be that one that gave him the ulcer."

SAIF argues that Dr. Lumsden had no knowledge of claimant's employment stresses, and that he was, therefore, not in a position to offer a cogent opinion about predominate causation. We disagree. Dr. Lumsden testified:

> "In my estimation of things [claimant] had--has a very good home life. He has had some problems with his children but he has always handled those pretty well and I really felt all along, and still do, that this was mostly job related."

and:

> "Q. Dr. Lumsden, did the claimant ever speak to you of stresses other than work-related stresses?
>
> "A. I don't think he did. I've thought about that and I don't think that he ever did. I've been aware of other stresses in the family, his granddaughter and some other things of a lesser nature, but these

> never seemed to be things that related to what was happening to him." (Emphasis added.)

Thus, it is clear that Dr. Lumsden was aware of nonwork related stresses claimant was experiencing, and was still of the opinion that claimant's work stress was the major cause of his ulcers and colitis.

With regard to claimant's osteoarthritis, Dr. Lumsden testified that this condition was actually caused by back injuries sustained by claimant early in his life:

> "[H]e had a logging accident, he was a grown man and it changed the bone structure in the back, broke some vertebrae and this altered the shape of the bone which the muscles work on."

It is also clear from Dr. Lumsden's testimony, that claimant's arthritic condition was symptomatic:

> ""[Claimant] had some back injuries early in his life when he was a younger man and they deformed the bones in his back somewhat, and were no longer the cause of any great amount of symptoms. Still, they were problems he learned to live with."

Dr. Lumsden believed that claimant's work stress, although not the cause of his arthritis, did aggravate it. However, when read as a whole, Dr. Lumsden's testimony was to the effect that claimant's job stress worsened claimant's preexisting arthritis from a symptomatic standpoint, and that the underlying condition itself did not worsen. Since claimant's arthritis condition preexisted his employment and was symptomatic, and since this is a claim involving an occupational disease, claimant must establish that his work exposure resulted in an actual worsening of that underlying condition. Weller v. Union Carbide, 288 Or 27 (1979). He has not so established. That portion of SAIF's denial which denied the compensabilty of claimant's osteoarthritis must, therefore, be affirmed.

ORDER

The Referee's order dated January 5, 1983 is affirmed in part and reversed in part. Those portions of the order which found claimant's osteoarthritis condition compensable are reversed, and that portion of SAIF's September 18, 1981 denial which denied the compensability of claimant's osteoarthritis is affirmed. The remainder of the Referee's order is affirmed.

ELWOOD E. GREEN, Claimant
Burt, et al., Claimant's Attorneys
Cheney, et al., Defense Attorneys

WCB 82-07943
March 30, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review of Referee McCullough's order which set aside its denial of claimant's heart attack claim. Claimant asserted alternative theories: (1) That his heart attack was related on an injury basis to his work activities on August 4, 1982; or (2) that his heart attack was related on an occupational disease basis to stress from his union negotiating activities. The Referee found the heart attack compensable on the basis of claimant's injury theory and did not consider claimant's occupational disease theory.

We make the following findings of fact. Claimant is a 44-year-old electrician who suffered a myocardial infarction on August 8, 1982. Claimant was not at work or performing any work activities at the time of, or immediately prior to, his heart problems on August 8, 1982.

On August 4, 1982, claimant helped in the repair of a conveyor belt at work. During the course of the repair, claimant walked quickly up a 100-yard steep hill four times to get tools needed for the work on the conveyor belt. After that activity claimant had chest pain and nausea, was not able to eat lunch and still felt ill when he went home that night.

Claimant had no symptoms on August 5, 1982. On August 6, claimant had chest pain upon arriving at work, after walking up some stairs but before going on duty. An EKG performed at that time was completely normal. Claimant did not work on August 6, 7, or 8, and he did not do anything strenuous at home on those days. On August 8, claimant visited some friends and played cards. After returning home that evening, claimant suffered recurrent chest pain and was hospitalized.

Claimant's treating cardiologist, Dr. Wasenmiller, diagnosed coronary artery disease with probable subendocardial inferior myocardial infarction. Dr. Wasenmiller opined that claimant's physical activities on the days prior to the infarction did not contribute to the cause of the underlying coronary atherosclerosis and did not cause the infarction. Dr. Wasenmiller stated that the physical stress of claimant's work activity on August 4 may have caused a temporary imbalance in the myocardial oxygen supply and demand due to claimant's critical coronary stenosis, but that the infarction was merely a milestone in the natural history of the underlying coronary disease and was not associated with claimant's work activities. Dr. Wasenmiller concluded that claimant's chest pain on the days prior to the infarction was angina, i.e., simply a symptomatic expression of the underlying disease.

Dr. Griswold, on the other hand, opined that claimant's work activities on August 4 probably contributed to an unstable coronary artery condition, a change in claimant's "coronary vascular bed," which resulted in the myocardial infarction. Dr. Griswold also mentioned that claimant had been under a lot of pressure at work due to a strike and the presence of nonunion workers after the strike.

Claimant must establish legal and medical causation to prove a compensable heart attack. Coday v. Willamette Tug and Barge, 250 Or 39 (1968); Batdorf v. SAIF, 54 Or App 496 (1981); Ginter v. Woodburn United Methodist Church, 62 Or App 118 (1983). We conclude that claimant has not satisfied this burden of proof.

First, in a close case such as this, we give some edge to the opinion of the treating physician, Dr. Wasenmiller. Second, we are particularly troubled by the large time gap between claimant's stressful work experience on August 4 and his heart attack at home on August 8. We noted a similar problem in Harold R. Chester, 35 Van Natta 874, 876 (1983):

> "Looking at all the appellate court and Board decisions in which legal causation has been found, there appears to be an almost universal, if not literally universal, common denominator: That the heart attack probably occurred during the course of, or followed soon after, allegedly precipitating work activity. That element is missing in this case. Claimant returned from his frustrating Seattle trip very late on Friday, September 18 or very early Saturday, September 19. His heart attack was very late on Saturday or very early on Sunday, September 20. He spent the intervening approximately 24 hours resting and attending to personal matters. We conclude that claimant has not proven that his heart attack occurred sufficiently close in time to his Seattle trip or any other work activity to satisfy the legal causation element of his burden of proof."

Here the time gap between claimant's stressful work experience on August 4 and infarction on August 8 is even greater than the time gap that was present in Chester.

Third, we find Dr. Griswold's opinion less persuasive because his theory contains so much conjecture and speculation. Also, Dr. Griswold rejects the objective evidence contrary to his opinion, that is, that claimant was relatively symptom-free during the four day interval, and that the EKG performed during the interval was normal. Moreover, Dr. Griswold cannot and does not cite any objective data to support his theory.

Perhaps no one of these three reasons, standing alone, would be enough to warrant reversal of the finding of compensability. The combination of these reasons, however, persuades us that claimant has failed to prove that work exertion materially contributed to his heart attack.

Moreover, we are not persuaded that claimant's heart attack was related, on an occupational disease basis, to stress from union activities.

ORDER

The Referee's order dated June 30, 1983 is reversed. The insurer's denial dated August 24, 1982 is reinstated and affirmed.

JEANNE M. GRIMES, Claimant
Cynthia Cumfer, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07726
March 30, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Braverman's order which: (1) Upheld the SAIF Corporation's denial of claimant's November 1981 back injury claim; (2) upheld SAIF's denial of claimant's May 1982 back injury claim; and (3) refused to assess penalties and attorney fees for SAIF's failure to accept or deny the November 1981 claim within 60 days of notice. Claimant contends that both claims are compensable and that penalties and attorney fees should be awarded. Also, since the filing of the briefs on review, claimant has requested reopening of the case so that she can raise the issue of interim compensation with regard to her November 1981 claim, present evidence on that issue, and presumably, attempt to prevail then on the penalty issue by proving compensation "then due." We consider claimant's request for reopening as a motion for remand. ORS 656.295(5).

Regarding claimant's November 1981 claim, we do not necessarily agree with all of the Referee's findings of fact. Nevertheless, we find that the circumstances surrounding the cause of claimant's back complaints in November 1981 are sufficiently confusing to prevent our finding that claimant sustained her burden of proving the compensability of that claim. Therefore, we affirm the Referee's decision on this issue.

Regarding claimant's May 1982 back injury claim, however, we disagree both with the Referee's findings of fact and with his conclusion. We find that the medical and lay testimony supports claimant's May 1982 back injury claim, with little contrary evidence in the record. Therefore, we find claimant's May 1982 claim compensable, and we reverse SAIF's denial.

Regarding claimant's motion to remand so that she can raise the issue of interim compensation, we deny the motion. Claimant admits in her request for reopening that this issue was not raised at hearing. Having failed to raise the issue at hearing, claimant cannot raise the issue at this time. Inasmuch as claimant has not raised the issue of interim compensation related to her November 1981 claim and has not proven her right to compensation "then due" upon which to assess penalties, we agree with the Referee that penalties are not warranted.

ORDER

The Referee's order dated April 7, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which upheld SAIF's denial of claimant's May 5, 1982 back injury claim is reversed, and that claim is remanded to SAIF for acceptance. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $900 for services at hearing and $450 for services on review in partially prevailing on the issue of compensability, to be paid by the SAIF Corporation.

DEWEY C. HENSON, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-09351
March 30, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of that portion of Referee Fink's order which set aside its denial of claimant's aggravation claim for his low back injury.

The insurer contends claimant failed to meet his burden of proving by a preponderance of the evidence a compensable worsening of his condition since the last arrangement of compensation, a September 14, 1982 Determination Order which awarded claimant 10% permanent partial disability. We agree and reverse that portion of the Referee's order.

The Referee based his finding upon the reports of Dr. Rosenbaum, a neurosurgeon, who had examined claimant before and after the last arrangement of compensation. The Referee found these reports revealed a worsening of claimant's left leg pain. Combining these reports with the reports of claimant's osteopath and chiropractors, who opined claimant was not medically stationary, proved an aggravation to the Referee's satisfaction.

We do not find these reports and claimant's subjective complaints sufficiently persuasive to establish an aggravation. In his most recent report, Dr. Rosenbaum does attribute a greater portion of claimant's current pain to his left leg than he did before the Determination Order. Dr. Rosenbaum's examination revealed that claimant had a "marked decrease of 10 as well as light touch in the lower left extremity in its entirety in a stocking-type distribution from the groin inferiorally including the thigh anteriorally and posteriorally the calf and foot, dorsum and sole". However, Dr. Rosenbaum opined:

> "I find no change in the patient's physical examination or objective findings since last being seen here in February of 1983. His only change in complaints is a subjective increase in left leg pain. This is in the sciatic distribution but there has never been evidence of nerve root impingement either on basis of sensory examination, reflexed strength or from CT scan. I therefore do not believe further diagnostic studies would be beneficial. I do not find a worsening in his condition. I am doubtful the chiropractic treatment will be beneficial when resolving his symptoms."

In February 1983 Dr. Rosenbaum had reported that the only significant change in claimant's exam was increased subjective complaints regarding his left leg. At that time, Dr. Rosenbaum suggested a CT scan to evaluate the possibility of a herniated disc. If the test results were negative, Dr. Rosenbaum stated his diagnosis would remain a lumbar strain with no significant change in symptoms. The CT scan findings were "essentially within normal limits".

No doctor has concluded that claimant's condition had worsened. Neither is there an expression of opinion by a doctor that claimant's statement that his condition has deteriorated is believed, nor that the doctor found objective evidence from a medical standpoint to substantiate claimant's history. Oakley v. SAIF, 63 Or App 433, 436 (1983). We do not find a change in claimant's forward flexion persuasive objective evidence of a worsening. Particularly where claimant has received a permanent disability award, and where an examining doctor expected "repeated symptomatic reaggravations". Finally, we are not persuaded by the opinions from claimant's osteopath and chiropractors. We find them to be of little assistance in determining whether claimant's condition had worsened.

In aggravation claims such as this, the question of whether claimant's condition has worsened is a complicated matter, requiring expert evidence. Mary Offutt-Littell, 35 Van Natta 536, 537 (1983). We conclude that the expert evidence in this case preponderates in favor of a finding that claimant's compensable low back condition has not worsened since the September 14, 1982 Determination Order.

In view of our conclusion, it is necessary to determine the extent of claimant's permanent partial disability. The Referee found this issue to be premature since the claim had been reopened. On review, the parties do not address the issue of extent of disability.

Under these circumstances, we deem it appropriate to remand this matter to the Referee for further proceedings consistent with this order on the issue of extent of disability.

ORDER

The Referee's order dated August 18, 1983 is reversed in part. That portion which set aside the insurer's denial of claimant's aggravation claim is reversed, and the denials dated February 22, 1983 and July 15, 1983 are reinstated and affirmed. This case is remanded to the Referee for further proceedings consistent with this order on the issue of extent of disability. The remainder of the Referee's order is affirmed.

THEODORE HUSKEY, Claimant
Allen & Vick, Claimant's Attorneys
Bottini & Bottini, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-09597 & 82-11249
March 30, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Leahy's order approving Mission Insurance Company's denial of claimant's low back, upper back and upper extremity conditions and also approving the SAIF Corporation's denial of aggravation of claimant's 1976 low back injuries.

Alternatively, claimant moves the Board for remand of this case to the Referee for the purpose of receipt of additional medical reports. These medical reports refer both to claimant's low back condition and his cervical condition. The cervical condition was found not compensable by the Referee. There is no

opinion contained in any of the reports which relates claimant's cervical condition to a new injury while employed at Mission Insurance Company's insured or to an aggravation of claimant's 1976 low back injury while in the employ of SAIF's insured.

The Referee found claimant not credible as to his version of an injury on September 2, 1982, which supposedly was the basis for the new injury and aggravation claims. The Referee also found that there was no convincing evidence that claimant had suffered a worsening of his low back condition. There is nothing in the newly offered medical reports which adds objective evidence of a worsening of claimant's compensable low back condition. At best, the doctors merely repeat claimant's assertion that he is worse since the alleged September 2, 1982 incident.

Based on the above, we do not find that this case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). Claimant's motion for remand is denied.

Turning to the merits of claimant's aggravation and new injury claims, we affirm and adopt the Referee's order approving the denial of those claims.

ORDER

The Referee's order dated March 16, 1983 is affirmed.

SANDRA J. JAEGAR (GERRITSON), Claimant
Roll, et al., Claimant's Attorneys
Moscato, et al., Defense Attorneys

WCB 83-01476
March 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Pferdner's order which found that the employer was authorized to unilaterally modify claimant's temporary total disability benefits because she refused the employer's offer of employment which had been approved by her physician. Claimant contends that the employer erroneously modified claimant's temporary disability benefits. We agree with claimant and reverse the Referee.

We make the following findings of fact. Claimant suffered a compensable injury in March 1982 and was released for modified work in April 1982. On May 26, 1982 the employer offered claimant a position in Tualatin, which her treating physician had approved. Claimant declined the position because it was out of her field of sales and it was too far from her new home in Tacoma, Washington. The employer continued paying temporary disability benefits, however. On January 12, 1983 the employer notified claimant that:

> "According to OAR 436-54-222 (5) your refusal of the clerical position we offered and which was approved by Dr. Halstead provides grounds for suspension of time loss benefits. Our neglect to suspend payments constituted overpayment of time loss. The period of overpayment was from May 26, 1982 through August 30, 1982, at which time Dr. Halstead said you could no longer work.

"OAR 436-54-320 states that we may recover this overpayment in an amount not to exceed 25% of your [temporary disability] payments. Accordingly we are deducting . . 25% of your biweekly [temporary disability benefits] . . .until we have recovered the total overpayment. . ."

Claimant requested a hearing on the employer's modification of her time loss benefits. Claimant contended that the employer had not complied with OAR 436-54-222(5) in that it had not given claimant's doctor an adequate description of the job and that the job offer was unreasonable. The Referee found that the employer had complied with OAR 436-54-222(5) and that the employer's unilateral modification of time loss benefits was authorized. Claimant requested Board review of the Referee's order.

We agree with the Referee that the employer complied with OAR 436-54-222(5) in offering claimant a job, and that claimant's refusal of that job constituted grounds under OAR 436-54-222(5) for supension of claimant's time loss benefits in May 1982. The employer's unilateral recovery of the overpaid amounts, however, was improper.

After the Referee issued his order, the Court of Appeals decided Forney v. Western States Plywood, 66 Or App 155 (1983), which held that OAR 436-54-320 is invalid insofar as it permits an insurer or self-insured employer to reduce benefits without prior authorization from the Evaluation Division, a referee or the Board. We find that the employer, in following the invalid administrative rule, reduced claimant's benefits without the prior authorization required by Forney. Therefore, the Referee's order finding that the employer was authorized to modify claimant's time loss benefits must be reversed.

ORDER

The Referee's order dated August 31, 1983 is reversed. The employer is ordered to repay the amount deducted as an offset. Claimant's attorney is allowed 25% of the temporary disability made payable by this order as a reasonable attorney's fee, not to exceed $750, payable out of claimant's compensation and not in addition thereto.

MANUEL JIMENEZ, Claimant
Doblie & Francesconi, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10867
March 30, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Mongrain's order which affirmed the September 30, 1982 Determination Order which awarded claimant benefits for temporary total disability from February 12, 1982 through March 21, 1982. Claimant contends that the Determination Order issued prematurely, and that he is entitled to continued temporary disability benefits.

Claimant contends that his claim was prematurely closed as there is no evidence in the record that he was ever declared medically stationary by Dr. Versteeg. We disagree. In a chart note

dated March 15, 1982 Dr. Versteeg reported that in the absence of further difficulties, claimant was released to return to work on March 22, 1982. Claimant testified that he did, in fact, return to work and continued working until April 1982. Claimant then left his job in order to go to Mexico to care for his mother. Claimant received no medical treatment thereafter until he presented himself to Dr. Matthews on December 28, 1982. Dr. Matthews reported that:

> "The patient was not especially interested in treatment at this point, and mostly wanted an evaluation. * * * The patient apparently feels qualified to do regular mill work."

On March 23, 1983 Dr. Versteeg reported that claimant was experiencing some symptoms. Dr. Versteeg stated that claimant's pain could be resolved by an injection but that claimant had declined.

Based on the evidence related above, the Referee concluded that there had been no significant change in claimant's condition since March 22, 1982, and that claimant was, therefore, medically stationary on March 22, 1982. We agree. The fact that claimant was released to return to work by Dr. Versteeg on March 22, 1982, the fact that he did return to work, the fact that he sought no additional medical treatment for the next eight months and the fact that, when he did seek medical treatment, he declined reasonable treatment that would have resolved his rather minimal symptoms, is convincing evidence that claimant's claim was properly closed by the September 1982 Determination Order.

ORDER

The Referee's order dated August 2, 1983 is affirmed.

DEBORAH L. JONES, Claimant
Coons & McKeown, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-10155
March 30, 1984
Order on Review (Remanding)

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Mongrain's order which found that claimant's 1977 injury claim was prematurely closed in 1982 and which set aside SAIF's partial denial of psychiatric treatment.

The parties are not even in agreement about what issues are before us. To help define the issues, we first state some of our findings regarding the background facts:

(1) Claimant sustained an industrial left knee injury in July 1977 which resulted in surgery for repair of a torn cartilage.

(2) Even before the 1977 knee injury, claimant had a long-standing obesity problem and had various long-standing psychological/emotional/personality problems.

(3) Claimant's compensable 1977 injury was a material cause of an increase in her psychological symptoms. Therefore, claimant's psychological condition was a compensable consequence of her industrial injury at least to the extent that a temporary

symptomatic worsening of a preexisting condition is compensable. (It is not clear whether any party contends otherwise; if so, we find as here stated.)

(4) Claimant's claim was closed, reopened and reclosed several times since the 1977 injury. The most recent closure was by Determination Orders dated April 30, 1982 and June 1, 1982, the latter of which adhered to the former on reconsideration. It is clear that one of the issues before us is whether this 1982 claim closure, almost five years after the original injury, was premature.

(5) At the time of the 1982 claim closure, claimant's physical condition was medically stationary. (It is not clear whether any party contends otherwise; if so, we find as here stated.)

(6) On August 9, 1982 SAIF issued a partial denial:

> "Based on the information we have in the file it appears that your current condition requiring psychiatric treatment does not stem from the July 13, 1977 injury, but from conditions not related to the industrial injury.
>
> "For this reason . . . we are denying responsibility for treatment relating to psychiatric condition."

It is far from clear what was then being claimed and what was then being denied. In context with the way this case has been tried and argued, and in context with our above finding #3, we understand the basic question raised by the partial denial to be: By August 1982 had claimant's temporary symptomatic worsening of her pre-1977 psychological condition ended, meaning that claimant's psychological condition had returned to its pre-injury status, and thus meaning that SAIF was no longer responsible for future psychological treatment or disability?

(7) That question, in turn, sets the stage for another question: What is the relationship between claimant's obesity problem and claimant's psychological problem? SAIF argues:

> "Claimant's depression and her obesity are both long-standing. It is unclear which condition caused the other, but they clearly seem to be related."

Claimant responds:

> "[SAIF] argues as if claimant's obesity and depression are the same thing. They are obviously related, but not identical . . . "

Despite what, at first blush, may appear to be considerable similarity in these respective positions, we think that the parties' real differences on the obesity-depression relationship are what this case is really about. All medical opinions that claimant was not psychiatrically stationary in 1982 are based in

whole or in large part on claimant's obesity. All medical opinions that claimant required further psychiatric care beyond 1982 for the effects of her 1977 injury are based in whole or in large part on claimant's obesity. Therefore, as we understand this case, the ultimate issue becomes the compensability of claimant's obesity.

As the parties seemingly agree, there clearly is some relationship between claimant's continuing obesity and her continuing depression. Claimant injured her leg, and surgery was performed in 1977. Claimant's recovery was delayed (and possibly not as complete as it could have been) because of the extra demands that excess weight placed on claimant's injured leg. Claimant's preexisting depression temporarily worsened (1) in part because of slow recovery from her injury and surgery, (2) in part because of her inability to lose a lot of weight (and keep it off) in the face of increasingly blunt medical advice that it was imperative for her to do so and (3) probably in part because of personal problems that had nothing to do with the industrial injury.

It is almost impossible on this record to identify causes and effects. We are, however, reasonably sure that, at least by 1982 when the challenged partial denial and Determination Orders were issued, most of claimant's problems were either directly caused by obesity or were exacerbated by obesity. We are also sure that it is not established in this record that any of claimant's obesity-related problems should properly be a part of this workers' compensation claim.

> "We know of no rule or logic which requires the workers compensation system to help solve a worker's non-injury related health problems in order to effectuate recovery from a compensable injury. In fact, the law requires the injured worker to assist to the fullest in promoting recovery, in this case meaning weight loss. The responsibility for weight loss was the claimant's, not the employer's." Joda M. Ruhl, 34 Van Natta 2, aff'd 58 Or App 389 (1982).

See also Dan Lingo, 35 Van Natta 1261 (1983), and cases cited therein; Mark G. Blanchard, 34 Van Natta 1660 (1982), and cases cited therein; Nelson v. EBI, 396 Or 246 (1984).

We think it follows that, at most, claimant has established she was not medically (psychiatrically) stationary when the April 1982 and June 1982 Determination Orders last closed her claim only because further treatment was then appropriate for her obesity-related problems; but claim closure is not premature because a noncompensable condition then requires further treatment. We also think it follows that, at most, claimant has established that she required further psychiatric treatment beyond SAIF's August 1982 partial denial only because further treatment was then appropriate for her obesity-related problems. Moreover, to the extent that claimant's 1977 injury caused a symptomatic exacerbation of her preexisting psychiatric condition, one would expect that temporary exacerbation to have resolved five years later just as a matter of common sense.

Because of the Referee's conclusions on the premature closure and partial denial issues, he did not reach the issue of the extent of claimant's disability. We remand for the Referee to reach that issue.

ORDER

The Referee's order dated November 11, 1982 is reversed. The Determination Orders dated April 30, 1982 and June 1, 1982 are reinstated and affirmed as proper closures of claimant's claim. The SAIF Corporation's partial denial dated August 9, 1982, interpreted and understood as denying psychiatric treatment beyond the date of the denial, is reinstated and affirmed. This case is remanded to the Referee for further proceedings consistent with this order.

JAMES R. KUNST, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-10956
March 30, 1984
Order of Abatement

The Board has received claimant's motion to reconsiderider our Order on Review (Remanding) dated March 9, 1984.

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.

JAMES A. KURTH, Claimant
Velure & Bruce, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-00866
March 30, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee Johnson's order which set aside its denial of claimant's aggravation claim. The issue is whether a rather minor 1973 industrial back strain has been proven to be a material cause of claimant's 1981 herniated disc.

While working for this employer as a greenchain stacker, claimant strained his back while lifting a kiln truck February 8, 1973, . Claimant received some heat treatments from the employer's nurse, and he engaged in light duty work for the next two weeks. Claimant thereafter went to work as a graphic designer for Klamath Falls Creamery. Claimant testified that, after he went to work for the creamery, his back "got a lot better," but that some discomfort returned about six months later after he began working on scaffolding which required him to stand in a rigid position.

The first physician claimant saw following his 1973 back strain was Dr. Miller, who claimant saw on March 11, 1974, some 13 months after the injury. Dr. Miller referred claimant to Dr. Vinyard. Dr. Vinyard saw claimant on July 15, 1974 and diagnosed a musculoligamentous strain of the lumbar spine. X-rays revealed a narrowing of the L4-5 interspace. Apparently the only treatment received by claimant was some prescription medication.

The next medical attention claimant received in relation to

his back took place on February 7, 1975 when he was seen by Dr. Balme, with complaints of groin and right hip pain which radiated into the right knee. Dr. Balme's report states, "[Claimant] states he noted the onset of this pain early late Sunday night after spending the weekend skiing." Dr. Balme diagnosed a rectus femoris muscle strain. On February 20, 1975 claimant was again seen by Dr. Balme, this time complaining of back pain. X-rays, similar to those taken by Dr. Vinyard in 1974, indicated narrowing of the L4-5 disc space. Dr. Balme diagnosed low back and bilateral lower extremity pain of undetermined etiology and gave claimant advice on the care of his back.

In November 1975 claimant opened his own sign painting business. Claimant continued to work in this capacity up to the date of the current hearing. Claimant testified that his work required him to design, build and install signs, some being as large as 10 x 42 feet and weighing up to 100 pounds.

On July 29, 1976, claimant was admitted to a hospital in Klamath Falls. Claimant had been working on a scaffold hanging a sign when the scaffold gave way. Claimant fell about 14 feet to the ground, and another man fell on top of him. Claimant sustained compression fractures of his back at L1 and L2 and fractured his left radius and ulna. Dr. Laubengayer's chart notes of October 8, 1976 indicate that claimant was experiencing low back pain. Claimant returned to work in November 1976.

Claimant was examined by Dr. Luce in March 1977. Dr. Luce reported that claimant had experienced progressive low back pain since opening his sign painting business. Dr. Luce diagnosed degenerative disc disorder at L4-5 and L5-S1 with spondyloarthrosis.

In a comprehensive report dated March 23, 1977, Dr. Balme stated:

> "As to the relationship of any present pain to the industrial injury of 1973 or his fall in 1976, it would seem that if he in the future were found to have a significant degenerative problem involving the low back area, the L4, L5, S1 area that this might be related to his described industrial injury inasmuch as the x-ray changes were present in 1975 and preceded the most recent fall. However I would think it would be difficult to say that the fall did not aggravate his pre-existing degenerative arthritis at the L4-5 interval."

On November 23, 1977, Dr. Laubengayer reported that claimant was seen on September 16, 1977 complaining of back pain, and that x-rays revealed a slight narrowing at L4-5. Dr. Laubengayer also reported that claimant was seen on October 4, 1977 for severe low back pain following a back strain he suffered while dragging a deer out of the woods.

On January 17, 1978 Dr. Laubengayer reported:

> "It is not possible for me to know whether the symptoms [claimant] is having now are the same or worse than they were following the injury in 1973. If, indeed, the symptoms are worse at this time, the worsening in all probability is due to the severe back injury received in the fourteen-foot fall in July of 1976."

A hearing was held on January 11, 1978. The issue was the extent of claimant's disability in relation to his 1973 injury. After taking inventory of the numerous injuries claimant suffered since 1973, the type of work activities claimant engaged in since opening his own business in 1975, the fact that claimant's primary back problems arose several years subsequent to the 1973 injury, and the medical evidence, the Referee concluded that the claimant had not established that any permanent disability he suffered was a result of the 1973 injury. The Referee's order was affirmed by the Board. James A. Kurth, 26 Van Natta 219 (1978).

Claimant was examined by Dr. Klump on December 16, 1981. Dr. Klump reported that:

> "[Claimant] has been having his usual back pain over the past several months but it was markedly aggravated on 14 December 1981 when he was awakened at 3 a.m. by a very loud sneeze. He felt as though his back exploded."

Dr. Klump believed claimant had a herniated disc at L4-5. This was confirmed by a myelogram. On December 18, 1981 claimant underwent a right hemilaminectomy with excision of a free fragment of a herniated disc.

Dr. Klump reported on December 30, 1981 that both the lifting incident in 1973 and the fall in 1976 contributed to the degenerative process in claimant's back. Dr. Klump stated that the "real culprit" which culminated in claimant's need for surgery was the sneeze. Dr. Klump further reported on April 19, 1982 that, although the 1976 fall was most bothersome to claimant's upper back, the lower vertebrae and discs also shared in the injury. Dr. Klump could not say how much each injury contributed.

On December 31, 1981 the employer denied claimant's aggravation claim.

In response to a question from claimant's attorney asking if claimant's 1973 injury was a material contributing cause of the 1981 disc herniation, Dr. Klump answered yes.

A hearing convened on June 16, 1982. Dr. Klump testified that he had not been aware of claimant's 1975 skiing injury or his 1977 hunting injury. Dr. Klump stated that claimant's sneeze in December 1981 was the actual cause of the disc herniation, and that all of claimant's prior injuries, his work activities in his sign business and his leisure activities (which included golfing and hunting), contributed to claimant's degenerative process. Dr. Klump felt that claimant probably had degenerative disc disease

present before the 1973 back strain. Although he did not believe that the 1973 injury caused claimant's degenerative process, Dr. Klump did feel that it hastened it. Dr. Klump felt that the 1973 back strain was a material contributing cause of claimant's 1981 herniated disc, although he also felt that all of the claimant's subsequent injuries, work and leisure activities were "important" factors. At one point in his testimony Dr. Klump indicated he was not familiar with the term "material contributing cause."

In light of Grable v. Weyerhaeuser Co., 291 Or 387 (1981), and Peterson v. Eugene F. Burrill Lumber, 294 Or 537 (1983), the Referee concluded that the aggravation claim was compensable based on the "historical facts of the case coupled with the expert opinion tendered on the subject by Dr. Klump." We disagree and reverse.

In the prior extent-of-disability litigation, Referee Seifert concluded in his June 1978 order that, in view of all of claimant's injuries and activities subsequent to the 1973 injury, he could not legitimately find that claimant suffered any permanent partial disability as a result of the 1973 injury. We believe that Referee Seifert's reasoning in relation to the extent of disability issue is equally applicable to the question of the compensability of the claimant's current aggravation claim.

Although the Referee found that the historical facts of this case support compensability, we find that the historical facts are the best argument against a finding of compensability. The injury claimant sustained in 1973 was only a very minor back strain. Claimant lost no time from work as a result of that injury and was never awarded any permanent partial disability as a result of that injury. It was not until claimant had been working for Klamath Falls Creamery for some 13 months that he saw a physician. It was not until after eight subsequent years of medium and heavy work activities and numerous additional injuries to his back that claimant sustained a herniated disc. In light of that, it is difficult to believe that a 1973 back strain which resulted in only two weeks of light duty work could possibly be a material cause of a herniated disc which occurred in 1981 when claimant sneezed.

The injuries incurred and activities claimant engaged in subsequent to his 1973 injury which Dr. Klump indicated contributed to claimant's 1981 herniated disc include:

(1) The sign business which claimant entered in 1975 and which required claimant to engage in bending, stooping, twisting and heavy lifting of up to 100 pounds.

(2) A skiing accident in 1975 in which claimant sustained a groin and hip injury with pain radiating to his knee.

(3) The 1976 fall from a 14-foot height in which claimant broke his back at L1 & L2 and two bones in his wrist.

(4) A 1977 back strain suffered while dragging a deer out of the woods and which resulted in "severe" back pain.

(5) The 1981 sneeze which Dr. Klump indicated could, in and of itself, cause a disc to herniate.

Every one of the above appears to be as severe or more severe than the claimant's very minor 1973 industrial back strain which resulted in only a few "heat treatments" from the company nurse. Dr. Klump indicated that all of the above would be factors that would aggravate claimant's degenerative process. Dr. Klump also agreed that it would be "pure speculation" to attempt to determine the relative contribution that all these injuries and activities made to the degenerative process.

We do not think that the fact that Dr. Klump may have used the magic term "material cause" necessarily is conclusive. See Wilma H. Ruff, 34 Van Natta 1048, 1054 (1982). We are not required to terminate our analysis whenever the magic terms are drawn out of a physician. Edwin Bolliger, 33 Van Natta 550 (1981), aff'd without opinion, 58 Or App 222 (1982). Dr. Klump was not even certain of the import of the term "material contributing cause," and his testimony on the whole is equivocal and inconclusive.

We conclude that claimant has failed to establish by a preponderance of the persuasive evidence that he has sustained an aggravation of his 1973 injury.

ORDER

The Referee's order dated July 15, 1983 is reversed. The employer's denial dated December 31, 1981 is reinstated and affirmed.

JOE LAWSON, JR., Claimant
Olson Law Firm, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-07403
March 30, 1984
Order on Reconsideration

The Board issued its Order on Review (Remanding) herein on March 14, 1984. 36 Van Natta 252 (1984). Claimant has submitted an inquiry concerning the absence of any provision in that order for a reasonable attorney's fee. We regard claimant's inquiry as a request for reconsideration. On reconsideration, we modify our prior order as follows.

The Presiding Referee entered an order dismissing claimant's hearing request based upon his determination that no justiciable controversy was present between claimant and the SAIF Corporation under the provisions of ORS 656.245. We reversed the Referee's order of dismissal and remanded the matter for further proceedings in light of our decision in Lloyd C. Dykstra, 35 Van Natta 26 (1984). We made no provision in that order for an attorney's fee at either the Hearings level or Board level.

By virtue of 1983 legislative action, ORS 656.388(1) now provides:

> " * * * In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum."

In this case, and in every other case in which we remand to the

Hearings Division for further proceedings, the Referee is authorized on remand to award claimant's attorney a reasonable fee for services rendered during the original hearing proceedings, for services on Board review, and for services on remand, if claimant ultimately prevails on remand. See also Hubble v. SAIF, 57 Or App 513 (1982).

In view of the fact that the Referee on remand has the authority to award claimant's attorney a reasonable fee for services rendered at all prior levels of this litigation, if claimant ultimately prevails, it is not appropriate for the Board to award an attorney's fee. Cf. James v. SAIF, 290 Or 849 (1981).

ORDER

On reconsideration of the Order on Review (Remanding) dated March 14, 1984, except as modified herein, the Board adheres to its prior order, which hereby is republished.

DELMAN L. McCALLISTER, Claimant
Bottini & Bottini, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-08954
March 30, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Leahy's order which: (1) Affirmed the denial of claimant's aggravation claim; (2) affirmed the June 2, 1982 Determination Order which awarded 20% (64°) unscheduled permanent disability for low back injury; and (3) refused to order SAIF to pay for Dr. Thompson's bill and related mileage. Claimant contends that his aggravation claim is compensable and, in the alternative, that he is entitled to additional permanent disability benefits. Claimant also contends that SAIF should be ordered to pay Dr. Thompson's bill and related mileage.

The Board reverses the order of the Referee as to the aggravation claim and the payment of Dr. Thompson's bill. We make the following findings of fact.

Claimant suffered a low back injury in December 1980. In October 1981 claimant underwent a lumbar laminectomy and discectomy, and a June 2, 1982 Determination Order awarded claimant 20% permanent disability. Claimant returned to his treating doctor, Dr. Parsons, in October 1982 complaining of increased low back pain. Dr. Parsons opined that claimant's symptoms were on the basis of increased muscular tone in the low back and paraspinal muscles and suggested that claimant was able to participate in his training program. Claimant was dissatisfied with Dr. Parsons and asked his attorney for the name of another doctor. Claimant's attorney suggested Dr. Thompson, claimant made an appointment with Dr. Thompson and saw him in November 1982.

At the initial appointment, Dr. Thompson examined claimant, took x-rays and recommended treatment for claimant's continuing low back pain. Dr. Thompson also reported that the x-rays indicated a bony overgrowth into the area of the laminectomy site on the right at L4-5, which he later termed a distinct change in claimant's findings since Dr. Parsons' examination in May 1982. Further, Dr.

Thompson stated that claimant was not medically stationary and his claim should be reopened. In February 1983 claimant was examined by the Northwest Evaluation Group, who opined that claimant's claim should remain closed. The Northwest Evaluation Group indicated that it did not obtain x-rays, and previous x-rays were not available.

We find that claimant has proven that his condition worsened by the time he saw Dr. Thompson in November 1982. We are persuaded by Dr. Thompson's opinion that claimant's findings distinctly changed since Dr. Parsons' May 1982 examination. Dr. Thompson's opinion was supported by his x-ray findings, and those findings were not contradicted. Therefore, we find claimant's aggravation claim compensable.

We also disagree with the Referee's finding that claimant's visit to Dr. Thompson was for litigation purposes and that SAIF did not have to pay for the visit and related mileage. Dr. Thompson's initial report clearly reveals that claimant was examined, x-rays were taken and treatment recommended. That claimant's attorney referred claimant to Dr. Thompson does not negate the fact that Dr. Thompson provided medical services to claimant which are compensable. We are not persuaded by SAIF's argument that claimant had not yet submitted a change of attending physicians form at the time of the initial Thompson examination. SAIF is ordered to pay Dr. Thompson's bill and any related mileage expenses for which claimant has requested reimbursement.

Having found the aggravation claim compensable, we do not reach the issue of permanent disability.

ORDER

The Referee's order dated March 28, 1983 is reversed in part and affirmed in part. The SAIF Corporation's denial dated January 19, 1983 is set aside, and SAIF is ordered to accept claimant's aggravation claim. SAIF is further ordered to pay Dr. Thompson's bill and any related mileage expenses for which claimant has requested reimbursement. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,000 for services at hearing and $550 for services on Board review, to be paid by the SAIF Corporation.

RONALD MEACHAM, Claimant
Doblie & Francesconi, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 82-01800
March 30, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Foster's order which upheld a Determination Order's award of 52.5° for 35% scheduled disability to claimant's right leg and which awarded claimant an additional 192° for 60% unscheduled disability for a total unscheduled award of 256° for 80%. Claimant contends that he is permanently and totally disabled.

Claimant was 47 years old at the time of hearing. As a child he developed osteomyelitis which affected his right hip. Claimant functioned adequately until about 1975 when pain and stiffness became so bad that Dr. Neumann, claimant's treating physician,

decided that a complete hip joint replacement was appropriate. In September 1975 Dr. Neumann performed a hip joint replacement. The surgery was quite successful. Within two months claimant was able to go elk hunting, and within three months he was back on the job working in a mill.

Claimant was without problems in his hip until May 15, 1978 when he slipped while pushing a cart of veneer at work. Dr. Neumann noted tightness in claimant's low back as well as the possibility of loosening of the right hip prosthesis. Claimant did not initially miss any work, but his pain became progressively worse. In May 1979 x-ray studies revealed that the femoral component of the right hip prosthesis was indeed loosened. Claimant was taken off work by Dr. Neumann at that time and was scheduled for surgery.

Surgery was performed on May 9, 1979. During the surgery to repair the right hip prosthesis, claimant's right femur sustained a longitudinal spiral fracture. Following surgery, shortening of claimant's right leg was noted. Claimant's fracture had not totally healed by April 1980.

In June 1980 claimant entered the Callahan Center for vocational assessment and treatment. The Callahan Center reports indicate that claimant's right leg was 3 1/2 inches shorter than the left leg and that his pelvis was tilted. Ranges of motion were limited in the right hip. Claimant was considered to be of normal intelligence. However, the Callahan Center staff felt that claimant was not totally cooperative because he felt that the Callahan Center staff could not do anything for him that he was not already doing for himself. The Callahan Center staff felt claimant's sitting and standing tolerance was about 30 minutes.

In October 1980 a psychiatrist, Dr. Straumfjord, evaluated claimant. He opined that claimant was substantially depressed by his inability to work.

In December 1980 a neurologist, Dr. LaFrance, evaluated claimant. He described claimant as having pain in the right hip. He also noted that claimant had radiating left leg pain. He opined that claimant was suffering from S-1 radiculopathy. He related the left leg problems to claimant's industrial injury. He felt that it was exacerbated by claimant's abnormal walking posture.

In March 1981 Dr. Neumann wrote:

> "As far as lifting restrictions, the patient will be unable to bend frequently irregardless of weight lifted because of restricted motion in his hip and also restriction secondary to his back condition. I do not feel that he has the ability to sit six out of eight hours in that the patient cannot normally sit in a chair now because of restricted hip flexion. He cannot even bend the hip to a right angle which would be a prerequisite for a position involving sitting in one position for any length of time.

> "I think his lifting should be restricted by his symptoms and I feel this would be quite restricted because of loss of range of motion. He will not be able to stand for prolonged periods of time because of discomfort. Walking any distances over uneven ground is impossible. I do not feel at the present time he can perform any substantial gainful employment."

In May 1981 Dr. Neumann stated:

> "His case is such that I think it is stationary and stable. I do not feel that the patient is employable at present. He does find that such simple things as climbing stairs produce significant discomfort in his back. Other activities are those of bending, squatting, stooping or lifting, standing in one position for a long period of time or sitting for a prolonged period of time such as when riding in a car. In my opinion the patient will be needing further symptomatic supportive treatment, and this may extend for an indefinite period of time."

In July 1981 claimant attended the Northwest Pain Center. Dr. Miller noted at that time that claimant was unable to maintain any position for any considerable length of time. He said it was necessary for claimant to alternate positions frequently all day between "lying down, sitting and being up and about." In the discharge summary Dr. Miller reported that claimant "tends to wish to continue to try, and in the process, overengages himself." He concluded by stating:

> "The prognosis for returning to work must be stated as somewhere between zero and poor."

In August 1981 David Rollins, Ph.D., a vocational consultant, interviewed the claimant and reviewed the file. Mr. Rollins opined:

> "He possesses a number of positive occupational features and has the skills, abilities and aptitudes to engage in work opportunities or the preparation for those opportunities."

In January 1982 Dr. Neumann reiterated his belief that claimant was permanently unable to work. In February 1982 a Determination Order awarded claimant 20% unscheduled disability and 35% scheduled disability. In March 1982 claimant, through his attorney, requested the employer to reemploy him at a modified job.

In July 1982 Robert Dodson, a vocational consultant, opined:

> "[I]t is felt that his chances of returning to gainful employment in the near future are poor (Category IV). It is also felt that

> the long term chances of returning him to gainful employment without substantial improvement in his physical condition would also be poor (Category IV)."

In August 1982 Dr. Neumann noted that he did not feel claimant was physically capable of doing the jobs which Mr. Rollins had listed as re-training possibilities for claimant. At the same time, Dr. Neumann wrote to Mr. Dodson stating:

> "At the present time, I do not feel that the patient can function in the light or sedentary job training program."

In light of that opinion Mr. Dodson revised his opinion:

> "In view of this information, I would feel that Mr. Meacham's chances of returning to gainful employment at this time would be remote (Category V)."

At hearing, Mr. Rollins testified that in his opinion claimant could work as a social service aide interviewing people for human services activities and could perform a job enforcing regulations in the law enforcement area without retraining. Dr. Neumann testified that claimant needs to be able to lie down during the day. He testified that claimant cannot do bench type work because of his inability to actually sit. Dr. Neumann said he would encourage claimant to try certain jobs, but he would not say that he actually believed claimant was physically capable of doing any of the jobs about which he was questioned.

Mr. Wise, a vocational consultant at the Callahan Center, testified that in his opinion claimant could not be employed without additional training. Ms. Carney, another vocational consultant with whom claimant had recently been working also testified that in her opinion claimant could not be employed without further training.

Claimant testified that he had attempted to work operating a combine and operating a windrower. He had also attempted to work on a barge where his wife worked as a cook. That job consisted of servicing diesel engines and doing general handywork. Claimant testified that he was physically unable to do any of those jobs. He also testified that he had sought work at a mobile home manufacturing plant and at an auto parts store.

As the Court of Appeals has said:

> "There are two types of permanent total disability: (1) that arising from medical or physical incapacity...and (2) that arising from physical conditions of less than total incapacity plus nonmedical conditions, which together result in permanent total disability." Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977).

We find that claimant is in the first category. He has proven by a preponderance of the evidence that from a physical standpoint alone

he is permanently and totally disabled. In addition, the weight of the vocational evidence is that without retraining, claimant is unable to work. Finally, we note that claimant has made some effort to find work and has been unable to do the work he has found. Claimant is entitled to an award for permanent total disability.

ORDER

The Referee's order dated March 16, 1983 is reversed. Claimant is granted an award for permanent total disability. In lieu of the fee allowed by the Referee's order, claimant's attorney is allowed 25% of the compensation awarded herein, not to exceed $3,000, as a reasonable attorney's fee for services at hearing and on Board review. This fee is payable out of claimant's compensation and not in addition thereto.

VIRGINIA L. MORTON, Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07303
March 30, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Daron's order which awarded claimant 160° for 50% unscheduled permanent partial disability for her low back injury, which was in lieu of Determination Orders which had awarded claimant 64° for 20% unscheduled permanent partial disability.

Claimant is a 29-year-old crane operator who compensably injured her low back on June 3, 1980. Her treating orthopedist, Dr. Potter, first diagnosed claimant's condition as lumbar back spasm. Dr. Potter later diagnosed a secondary problem of some mild lumbar lordosis. All treatment has been conservative.

In October 1980 claimant was declared medically stationary. Dr. Potter did not feel claimant could return to her former job. He restricted claimant to lifting nothing greater than 15 pounds and recommended frequent posture changes. Dr. Potter encouraged vocational rehabilitation.

On December 10, 1980 a Determination Order issued awarding claimant 20% unscheduled disability. Claimant enrolled in a vocational rehabilitation program at a community college in which she studied bookkeeping and accounting. She completed the one year program and received an accounting certificate. Her objective was to work in tax preparation.

Prior to completion of the rehabilitation program, claimant was reexamined by Dr. Potter. He diagnosed claimant's condition as resolved low back pain secondary to her industrial injury. Following the completion of the program, a second Determination Order issued on July 28, 1982. Claimant was awarded no further unscheduled disability. Claimant requested a hearing on this Determination Order.

In October 1982 claimant was examined by Dr. Degge, an orthopedist. Dr. Degge diagnosed claimant's condition as resolved lumbosacral spine strain by history and mild idiopathic scoliosis of the lumbar spine. He opined that the scoliosis was causing

claimant's ongoing occasional low back symptoms, but it was not work-related. Dr. Degge rated claimant's loss of function due to the injury to be none. He rated claimant's total loss of function, on the basis of the idiopathic scoliosis and postural low back complaints, to be minimal.

Dr. Potter reexamined claimant in November 1982. He reported that claimant stated she was feeling much better, like she had before she started seeing him. However, Dr. Potter noted that claimant stood with a marked amount of lumbar lordosis and had some spasm in her low back. He diagnosed her condition as recurrent low back pain, secondary to lumbar lordosis.

At hearing, claimant testified that she no longer hiked, skiied, rode horses, hunted, fished or played volleyball because of the pain. She also has modified her gardening activities. Claimant testified that wages for entry level bookkeeping positions would be about $4 an hour. Claimant's last hourly wage as a crane operator had been $8.15. She had not yet been able to secure a bookkeeper or tax preparer position.

The Referee increased the Determination Order's award by 30%, giving claimant a total of 50%. We find the Referee's award to be excessive. Both medical experts have opined that claimant's low back strain attributable to her industrial injury has resolved. The experts have related claimant's current symptoms to her preexisting condition, be that scoliosis or lordosis. Neither expert has indicated that the preexisting condition was worsened by the compensable injury. Under these circumstances we do not consider the permanent impairment attributable to claimant's preexisting condition when rating the extent of her disability.

Pursuant to OAR 436-65-600, et seq., we consider claimant's age, education, work experience, adaptability, mental capacity, emotional state, labor market findings, and physical impairment (including disabling pain) in rating the extent of disability. Considering the above guidelines, we conclude that the Determination Orders' awards of 20% unscheduled permanent disability were proper.

ORDER

The Referee's order dated April 11, 1983 is reversed.

TIMOTHY J. NELSON, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04002
March 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Shebley's order which set aside its denial of claimant's aggravation claim. SAIF contends that: (1) The Referee erred in refusing to admit documents offered by SAIF within 10 days of the hearing; and (2) claimant's aggravation claim is not compensable. We agree with SAIF on both issues and reverse the Referee.

Regarding the Referee's evidentiary ruling, the relevant facts

are as follows. On April 27, 1983, claimant requested an expedited hearing, contesting SAIF's denial of his aggravation claim. By letter dated May 10, 1983, 13 days after the date of claimant's request for hearing, SAIF provided claimant's attorney with copies of medical reports pertaining to this claim. The Notice of Hearing dated May 12, 1983 set the hearing for June 7, 1983. By letter dated May 16, 1983, claimant's attorney submitted documents for inclusion in the record. SAIF submitted additional documents for inclusion in the record by letter dated May 27, 1983. SAIF's documents were received by the Board and by claimant's attorney on June 1, 1983. Therefore, SAIF's documents were received six days before the hearing.

At hearing claimant objected to the admission of SAIF's documents on the basis of the ten-day rule, OAR 436-83-400(3), and the Board's decision in Donald J. Young, 35 Van Natta 143 (1983). SAIF argued that good cause existed for its failure to submit within 10 days of hearing in light of the fact that the hearing was scheduled in an expedited manner, that SAIF had mailed the documents 11 days before the hearing and that the documents were mailed on the Friday before the Memorial Day weekend. The Referee agreed with claimant that Young was controlling and sustained claimant's objection to the admission of SAIF's documents. In so doing, however, the Referee stated that he did not like to exclude the documents under those circumstances, but that he did not believe he had the discretion to admit the documents in light of the Board's then-recent decisions.

Since the issuance of the Referee's order, the Board decided Walter L. Hoskins, 35 Van Natta 885 (1983), in which we noted that the phraseology of the rule in Young was overly restrictive and that other situations than that presented in Young could constitute good cause for failure to comply with the ten-day rule. See Thomas B. Ward, 35 Van Natta 1552 (1983), in which the Board found that the Referee did not abuse his discretion authorized by OAR 436-83-400(4) in admitting a document offered by claimant within 10 days of the hearing. In Hoskins and Ward we held that the party offering the exhibit within 10 days of the hearing has the burden to show good cause for its violation of the ten-day rule. Also, in those cases we stated that whether such documents would be admitted depended on whether the party offering the document has attempted to gain a strategic advantage by the late submission and whether the opposing party or the forum has been prejudiced or surprised by the late submission.

Applying the rule discussed in Hoskins to the facts of this case, we find that the documents offered by SAIF within 10 days of the hearing should have been admitted and considered by the Referee. SAIF's explanation constitutes an adequate excuse for its late submission and satisfies the requirement of showing good cause. Furthermore, after receiving notice of claimant's request for hearing, SAIF promptly provided claimant's attorney with copies of the documents related to the claim. Claimant's attorney did not deny that he had possession of copies of the documents in question prior to 10 days before the hearing. Also, claimant did not contend that he was prejudiced or surprised by the late submission of the documents, and we find no evidence of strategy on the part of the parties. Under these circumstances, we find that the excluded exhibits should have been admitted, and we reverse the

Referee accordingly. Because the medical reports offered by SAIF are included in the record, we consider those reports in our review of the compensability of claimant's aggravation claim. Edward Morgan, 34 Van Natta 1590 (1982).

Claimant compensably injured his low back in December 1981, for which he sought treatment from Dr. Holman, D.C., and Dr. Puziss, orthopedist. Claimant also was examined by Dr. Pasquesi, orthopedist, and a panel of doctors at the Orthopaedic Consultants during 1982. In October 1982, claimant and SAIF stipulated to a permanent disability award of 5%. In February 1983, Dr. Holman notified SAIF that claimant's condition had aggravated. Thereafter, claimant again was examined by Drs. Puziss and Pasquesi, both of whom opined that claimant's low back condition had not worsened since claim closure. Both doctors described examination findings that supported their conclusions that claimant's condition had not worsened. We find Drs. Puziss' and Pasquesi's opinions more persuasive than Dr. Holman's. Therefore, we find that claimant's aggravation claim is not compensable and reverse the Referee accordingly.

ORDER

The Referee's order dated June 20 1983 is reversed. SAIF's denial dated April 25, 1983 is reinstated and affirmed.

PATRICK J. PATZKE, Claimant
Velure & Bruce, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-00758
March 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Johnson's order which found that although claimant's occupational disease claim otherwise would be compensable, the claim was barred because it was not timely filed. Claimant contends that his occupational disease claim was filed timely. We agree with claimant and reverse.

Claimant worked as a timber faller for 30 years. In November 1979 claimant's doctor told him that his work was causing progression of the arthritis in his shoulders, elbows, arms, neck and other parts of his body. Claimant continued working as a tree faller, however, until September 30, 1982, when his arthritis forced him to change jobs. In November 1982 SAIF was notified that claimant was claiming that his work activities had worsened his arthritic condition. SAIF denied responsibility for claimant's arthritic condition.

At the hearing on the denied occupational disease claim, SAIF contended that the claim was barred because claimant failed to file the claim within 180 days from the date he became disabled or was informed by a physician that he was suffering from an occupational disease, whichever is later, as required by ORS 656.807(1). The Referee found that claimant became "disabled" within the meaning of ORS 656.807(1) when he sought medical treatment for his shoulder and arm problems in November 1979 and his neck and back complaints in February 1981. Finding that claimant failed to file the occupational disease claim within 180 days from the date of disability, the Referee held that the claim was barred.

At the time of the Referee's order, the only reported decisions addressing "date of disability" were cases involving responsibility between two or more insurers or employers. In another case decided today, we distinguished between date of disability for responsibility purposes and date of disability for timeliness purposes. Charles M. Fox, WCB Case No. 81-10527, 36 Van Natta 363 (decided this date). In Fox, we held that the date of disability for purposes of ORS 656.807(1) was the date that the claimant stopped working due to his occupational disease, and not the date that claimant sought medical attention.

Therefore, we find that claimant became disabled on September 30, 1982, the last day he worked as a tree faller. Inasmuch as SAIF received notice of the occupational disease claim on November 3, 1982, we find that the claim was timely filed within 180 days from the date of disability. We agree with the Referee's finding that the claim otherwise is compensable, based upon the three doctors' opinions that claimant's work caused progression of his arthritis.

ORDER

The Referee's order dated July 15, 1983 is reversed. SAIF's denial dated December 8, 1982 is set aside, and this occupational disease claim is remanded to SAIF for acceptance and processing. Claimant's attorney is awarded $1000 for services at hearing and $700 on Board review, to be paid by the SAIF Corporation.

JOHN H. SNIVELY, Claimant
Gatti, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-03148
March 30, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Baker's order which set aside its March 23, 1983 denial. The issue for review is compensability.

Claimant, a then 60-year-old truck driver, sustained a compensable injury to his low back on April 19, 1976 when he fell from the top of a load of chips to the ground. Claimant had previously injured his back in 1955 and in 1968. Claimant missed about two and a half months of work as a result of his 1968 injury and received chiropractic treatments on a regular basis thereafter. Prior to his 1976 injury, claimant had been examined by Dr. Schmidt, a chiropractor, on March 3, 1976. Between March 3, 1976 and the injury on April 19, 1976, Dr. Schmidt administered numerous chiropractic adjustments to claimant's back. Dr. Schmidt felt that claimant's back condition at that time was "quite acute." X-rays pre-dating claimant's 1976 injury indicated that claimant's L4-5 disc space was narrowing.

Following his 1976 injury, claimant received three treatments per week from Dr. Schmidt. On July 2, 1976 Dr. Schmidt reported that claimant could return to work and that claimant was "100% improved." Dr. Schmidt "reduced" claimant's treatments to only twice a week.

On July 16, 1976 claimant was examined by Dr. Becker, an orthopedist. Dr. Becker diagnosed an acute lumbosacral strain and

an old herniated intervertebral disc on the right at L3-4. Dr. Becker felt that claimant's symptoms from the April injury had resolved and that claimant was medically stationary. An August 23, 1976 Determination Order awarded claimant temporary total disability benefits from April 19, 1976 through June 29, 1976.

Thereafter, claimant continued to treat with Dr. Schmidt one to two times per week and more frequently when he experienced increasing symptoms in his legs, feet and various portions of his spine.

Claimant was again examined by Dr. Becker on August 19, 1977. Dr. Becker noted that claimant had recently experienced a flare-up of symptoms. Claimant was found to have a good range of back motion and negative straight leg raising. X-rays revealed osteoarthritic changes in the lower lumbar levels. Upon further examination on December 6, 1977, Dr. Becker found claimant to be "actually better at this time than he was when his claim was closed in 1976."

Claimant retired in 1979.

On March 6, 1979 claimant was examined by Dr. Kelly at the Western States Chiropractic College in Portland. Dr. Kelly examined claimant and thoroughly reviewed his medical history. Claimant informed Dr. Kelly that he was "as limber as a kid." Dr. Kelly reported that claimant was "remarkably agile for his age," and that "I am truly amazed at [claimant's] ability to actively and passively perform the orthopedic maneuvers . . . with no discomfort, dysfunction or impairment." Dr. Kelly felt that claimant had no residuals from the 1976 injury, that he had returned to his pre-injury status and that claimant required no additional chiropractic care as a result of the 1976 injury.

In March 1979 SAIF apparently denied further chiropractic care. This denial, however, was subsequently withdrawn by stipulation of January 9, 1980, and claimant continued treating with Dr. Schmidt.

On August 9, 1982 claimant was examined by Dr. Murphy, an orthopedist. At the time of Dr. Murphy's examination, claimant's complaints consisted of morning stiffness in the lumbar region, aching in the feet and continued weakness in the lower right extremity. X-rays revealed narrowing of the L4-5 interspace. Dr. Murphy was of the opinion that the pre-1976 injury x-rays revealed degenerative changes at the L4-5 level, changes that were probably initiated by an earlier 1968 injury. Dr. Murphy was unable to state what degree claimant's 1976 injury contributed to claimant's current symptoms.

On February 2, 1983 claimant was examined by Dr. Gatterman, D.C. At the request of Dr. Gatterman, further x-ray studies of claimant's back were performed on February 8, 1983. Degenerative changes were noted at C5-6 as well as at L4-5. However, the changes at L4-5 were considered to be "slight." Dr. Gatterman found claimant to have excellent ranges of back motion and noted that he had few complaints of low back pain. Dr. Gatterman stated:

"Based on the patient's history, records

> and examination, it is my considered opinion that [claimant] suffers from degenerative discogenic spondylosis with resulting intervertebral disc syndrome. As noted previously, degenerative changes were present at the time of the 1976 injury and may be partially the result of the two prior injuries to the spine. I feel that this patient's symptoms as the direct result of the 4-19-76 injury have long been resolved and that his current symptoms are due primarily to ongoing degenerative changes."

At the request of SAIF, Dr. Fechtel, D.C., examined claimant's past medical records and prepared a report. Dr. Fetchel was of the opinion that claimant's current treatment was due to his preexisting degenerative condition which resulted from claimant's 1968 injury. Dr. Fechtel apparently did not believe that claimant's 1976 injury materially contributed to claimant's degenerative condition, but that this was primarily the result of the claimant's more serious 1968 injury.

On March 23, 1983 SAIF denied that claimant's current back symptoms were the result of the 1976 injury.

Dr. Schmidt continues to maintain that claimant's current treatment is due to the 1976 injury. Although he stated that claimant probably would have sought continued chiropractic care whether or not he sustained the 1976 injury, Dr. Schmidt believed that claimant would not have required as many treatments in the absence of the injury. Dr. Schmidt's testimony at the hearing was to the same effect. Additionally, on cross-examination, Dr. Schmidt admitted that he was involved in a lawsuit that he and a group of chiropractors instituted against SAIF, and that he had requested claimant's permission to use his file in that lawsuit. Dr. Schmidt admitted that there had been ongoing difficulty between his office and SAIF for several years.

Relying mainly on Dr. Schmidt's opinions, the Referee set aside SAIF's denial. We disagree. We find that a preponderance of the evidence does not establish claimant's 1976 injury to be a material contributing cause of his current low back symptoms.

Claimant experienced a significant injury in 1968 which resulted in muscle wasting in his right leg. This injury set in motion a degenerative process at L4-5. This L4-5 degeneration was plainly visible on claimant's pre-1976 x-rays. Following the 1968 injury, claimant received chiropractic treatments from Dr. Bolin at a frequency of two treatments per month for the next eight years. When claimant presented himself to Dr. Schmidt in March 1976 prior to the 1976 injury, Dr. Schmidt felt that claimant's back was "quite acute," and he administered approximately 12 treatments to claimant's back in the period between March 3 and April 17, 1976.

Following his 1976 injury, claimant received continuous and considerable chiropractic care from Dr. Schmidt for what we understand to have been diagnosed as a simple back strain. There is no indication in any of the medical reports that claimant suffered anything more than a simple back strain. By the time claimant was

examined by Dr. Becker in July 1976, his symptoms resulting from the 1976 injury had virtually resolved. When claimant was examined at the chiropractic college in March 1979, Dr. Kelly could find no residuals whatsoever from the 1976 injury. Dr. Kelly found claimant to be remarkably agile, and claimant himself admitted that he was "as limber as a kid." Dr. Kelly concluded that claimant was in need of no further treatment as a result of the 1976 injury. Similarly, when claimant was examined by Dr. Gatterman in February 1983, he exhibited few, if any, symptoms whatsoever. Dr. Gatterman felt that claimant's symptoms resulting from the 1976 injury had long since resolved.

With regard to claimant's degenerative disc disease at L4-5, x-rays taken prior to the 1976 injury revealed that the degenerative process had already begun. As claimant exhibited right leg weakness and muscle wasting following the 1968 injury, and since he required continuous chiropractic treatment thereafter, Dr. Murphy concluded that it was the 1968 injury that caused the degenerative process. Although he felt that the 1976 injury also may have made some contribution, Dr. Murphy could not say how much. Based on the fact that claimant's degenerative disc disease preexisted the 1976 injury, the fact that claimant's symptoms had virtually completely resolved and current x-ray studies, Drs. Gatterman and Fechtel were of the opinion that claimant's degenerative disc disease was caused by the 1968 injury.

Although it is true that Dr. Schmidt testified at the hearing that claimant's 1976 injury was a material cause of claimant's current symptoms, it would appear that Dr. Schmidt's testimony was flawed in several respects. For example, Dr. Schmidt testified that but for the 1976 injury, claimant would not have degenerative disc disease in his spine. This, of course, overlooks the fact that claimant did have degenerative changes present at L4-5 as documented by x-rays taken before the 1976 injury. Additionally, Dr. Schmidt stated that this opinion was based on the fact that claimant did not have degenerative changes at any other level of his spine. However, as noted previously, x-rays taken at the request of Dr. Gatterman did reveal degenerative changes at other levels in claimant's spine. Dr. Schmidt admitted that even in the absence of the 1976 injury he would probably still be treating claimant on a regular basis.

For all of the above reasons, we conclude that the opinions of the numerous independent examiners (who are all in general agreement), to the effect that claimant's current symptoms are unrelated to the claimant's relatively minor 1976 injury, are more persuasive than the opinion of Dr. Schmidt. Accordingly, we affirm SAIF's denial.

ORDER

The Referee's order dated September 19, 1983 is reversed. SAIF's denial dated March 23, 1983 is reinstated and affirmed.

ROBERT G. PERKINS, Claimant
Roll & Westmoreland, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-02991
January 27, 1984
Order of Abatement

The Board has received a request to reconsider our Order on Review dated December 29, 1983.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the request for reconsideration within ten days.

IT IS SO ORDERED.

CARLOS IGLESIAS, Claimant
Marvin S. Nepom, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-06774
February 3, 1984
Order of Abatement

The Board has received a motion for clarification of our Order on Review dated January 13, 1984. We consider that motion a motion for reconsideration.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion within ten days.

IT IS SO ORDERED.

DONALD G. MOORE, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-09680
February 28, 1984
Order of Abatement

The Board has received a motion to reconsider our Order on Review dated January 31, 1984.

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 Daniel Leary, Claimant.

LEARY,
Respondent on review,

v.

PACIFIC NORTHWEST BELL,
Petitioner on review.

(No. 80-01939, CA A23101, SC 29169)

On review from the Court of Appeals.*

Argued and submitted April 7, 1983.

Mildred J. Carmack, Portland, argued the cause for petitioner on review. On the petition and brief were Katherine H. O'Neil, William H. Replogle and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Robert K. Udziela, Portland, argued the cause for respondent on review. With him on the response to the petition and brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Keith D. Skelton, Portland, filed a brief amicus curiae on behalf of himself and the Association of Workers' Compensation Defense Attorneys.

Darrell E. Bewley, Appellate Counsel, filed a brief amicus curiae on behalf of the State Accident Insurance Fund.

Stephen R. Frank of Tooze, Kerr, Marshall & Shenker, Portland, filed a brief amicus curiae on behalf of The Hartford Insurance Group.

Before Lent, Chief Justice,** and Linde, Peterson, Campbell, Carson and Jones, Justices.

---

* Judicial review from Workers' Compensation Board. 60 Or App 459, 653 P2d 1293 (1982).

** Justice Lent was Chief Justice when case was argued; Justice Peterson was Chief Justice when decision rendered.

JONES, J.

Remanded to the Court of Appeals.

JONES, J.

The claimant seeks workers' compensation benefits for physical disease and disorders allegedly arising out of on-the-job stressful conditions and events. The Court of Appeals reversed the Workers' Compensation Board and allowed an award of benefits. We allowed review in this case and *McGarrah v. SAIF,* 296 Or 145, ___ P2d ___ (1983), to consider these claims for stress-related occupational disease.

We quote the facts and testimony as related by the Court of Appeals:

> "Claimant, age 54 at the time of the hearing, had been employed by Pacific Northwest Bell (PNB) for 33 years installing and repairing telephones. In December, 1977, he began experiencing headaches, upset stomach and diarrhea. At the hearing he testified that he was under considerable stress at work because of the constant turnover of supervisors, many of whom were younger than he and had less experience; that his supervisors gave conflicting instructions and instituted varying work methods; that they supervised his work too closely, which he considered unnecessary given his experience; that they harassed him about his production, which he believed to be about the same as other employes; and that they criticized him for refusing to work overtime, which he did not believe was mandatory. Several of claimant's supervisors testified at the hearing or by affidavit that he produced less than other employes, was easily agitated, disliked authority, had difficulty adjusting to changing policies and felt persecuted by them.
>
> "In December, 1977, claimant told Dr. Howell that he was experiencing stress at work and was particularly concerned about the company's hiring of young, inexperienced women and placing them in supervisory roles ahead of older, more experienced men. The doctor tentatively diagnosed a duodenal ulcer. When treatment failed to remedy claimant's intestinal condition, he was hospitalized in February, 1978, for a gastroscopy which revealed duodenitis, peptic ulcer and peptic esophagitis. On Dr. Howell's advice, he took a three-month leave of absence. Dr. Howell informed PNB that claimant's condition 'is directly aggravated by his work situation and a leave of absence is considered imperative.' Claimant's condition improved, and he returned to work in May, 1978.
>
> "Claimant's intestinal problems recurred. In December, 1979, he contacted Dr. Parent, an internist, and related that

> he was dissatisfied with his job and was undergoing great tension at work. Dr. Parent diagnosed hypertension, diarrhea with possible ulcerative colitis, duodenitis and reflux esophagitis with persistent ulceration. He concluded that '[a]ll [claimant's] problems appear to be tension or stress related.' Although he did not believe claimant's work directly caused his problems, he concluded that 'his work situation and attitude towards it are directly aggravating these problems.'
>
> "Claimant filed a claim for occupational disease. PNB denied that claim. Dr. Parent wrote PNB:
>
> > 'It is my opinion that a dominant factor in this patient's life is his job stress. I feel his hypertension is probably on an essential basis, however, as you are aware stress does affect this adversely as it does irritable bowel or colitis. It is also a factor in increasing acid which is a factor in the etiology of dueodenitis *[sic]* and esophagitis. * * *'

At PNB's request, claimant was examined by Dr. Colbach, a psychiatrist, who reported:

> 'What I think we have here is a man who is really not smart enough and does not have the personality flexibility to cope well with change. For many years, he apparently did all right. Now, at a time when he is aging and slowing down in many ways, he is confronted at the same time

with an increasingly complex and changing society and work situation. He feels unappreciated, alienated, and angry. He develops psychosomatic symptoms. He is too limited to really understand what is going on, so he projects most of the blame on certain individuals in his work environment.

'It doesn't appear that his work has forced him into any particularly stressful situations. But his selective perceptions of what is going on at work do cause him distress and do, in turn, contribute to his psychosomatic problems. These selective perceptions, of course, are unconscious results of his intellectual and personality limitations.

'I have described a complex situation. Whether this is properly compensable under workers' compensation law is impossible for me to say. It is more of an administrative law decision than a medical one.

'I don't think any particular psychiatric intervention is indicated here.

'* * * * *

'If I had to give claimant a particular diagnostic label, I would say that he has elements of what has been termed "the paranoid personality," although he isn't quite so bad as to deserve the full implications of this label.' "

The Court of Appeals found that claimant suffered a greater and different degree of stress when he was at work, that there was no evidence he suffered from any unusual stress from non-employment sources, and that his work-related stress was the major contributing cause of his disability, notwithstanding that it was largely due to his own reaction to his working conditions. Compensation was allowed.

The Court of Appeals based its conclusion that the work-related stress was the major contributing cause of the claimant's disability on the subjective test we rejected in *McGarrah v. SAIF, supra.* The Court of Appeals stated the "work-related stress appears largely to be his own reaction to his working conditions" and quoted Dr. Colbach's testimony:

"It doesn't appear that his work has forced him into any particularly stressful situations. But his selective perceptions of what is going on at work do cause him distress * * *."

This occupational disease case is remanded to the Court of Appeals to apply the objective standard set forth in *McGarrah v. SAIF, supra.*

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Henry McGarrah, Claimant.

McGARRAH,
Respondent on review,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Petitioner on review.

(No. 79-05440, CA A22990, SC 29084)

On review from the Court of Appeals.*

Argued and submitted April 7, 1983.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the petition and brief for petitioner on review.

Robert H. Grant, Medford, argued the cause for respondent on review. With him on the brief was Grant, Ferguson & Carter, Medford.

Evohl F. Malagon, Eugene, filed a brief amicus curiae on behalf of the Oregon Workers' Compensation Attorneys Association.

Before Lent, Chief Justice,** and Linde, Peterson, Campbell, Carson and Jones, Justices.

JONES, J.

The Court of Appeals is affirmed.

Lent, J., filed a concurring opinion.

* Judicial review from Workers' Compensation Board. 59 Or App 448, 651 P2d 153 (1982).

** Justice Lent was Chief Justice when case was argued; Justice Peterson was Chief Justice when decision rendered.

JONES, J.

The claimant seeks workers' compensation for a mental disorder allegedly arising out of and in the scope of his employment. The Court of Appeals reversed the Workers' Compensation Board and allowed an award of benefits. We allowed review in this case and *Leary v. Pacific Northwest Bell,* 296 Or 139, ___ P2d ___ (1983), to consider these claims for stress-related occupational disease.

We quote the facts and testimony as related by the Court of Appeals:

> "Claimant, 40 years old at the time of the hearing, was a deputy sheriff in Jackson County from the fall of 1975 through December 4, 1978. He had worked previously as a deputy from 1969 to 1973, when his back was injured in a job-related automobile accident. After a period of recuperation, he

was rehired in 1975. Sometime thereafter, claimant wrote a memorandum to his superiors requesting an investigation into the low morale within the department and apparently suggesting that a certain officer known as 'B.J.' not participate in the investigation. Subsequently, B.J. became a captain and claimant's superior.

"A series of events ensued that convinced claimant that he was being subjected to a personal vendetta by Captain B.J. to encourage him to resign or quit. Those events included the removal of claimant one month early from a public relations job, which he enjoyed, in order to transfer him back to patrol, where it appeared to claimant and to a chief deputy that he was not really needed; his transfer from the day shift to the night shift (which claimant considered a rookie shift), despite his high seniority in the department; failure to promote him to senior deputy status, despite his seniority and his achievement of advanced officer status, when others eligible at that time for the promotion were granted it; frequent oral reprimands in the presence of others by the captain or his subordinates about claimant's appearance, which claimant felt was satisfactory; reprimands for not writing enough traffic tickets; oral reprimands in public for having left his post without authorization when his son was injured at school, although claimant had unsuccessfully attempted to reach his supervisor; a reprimand for abandoning his vehicle, which was stuck in a snowdrift in an area where radio communications were blacked out; and a memorandum inquiring into the possibility that claimant had allowed narcotics to go aboard an airplane while he was supervising security personnel at the

airport, although no investigation was ever conducted to permit claimant to exonerate himself. The reprimands, standing alone, were not as upsetting to claimant as was the fact that they were usually made in the presence of others.

"Claimant did not initiate a union grievance concerning any of the above incidents, although he did write a letter invoking the union contract in response to his early transfer back to patrol. By the same token, the reprimands were unofficial disciplinary actions. That Captain B.J. was the source of low morale in the department was corroborated at the hearing by a former colleague of claimant. Another former officer confirmed that Captain B.J. exhibited a pattern of putting pressure on individual officers through manipulation of shift scheduling and excessive criticism of the quantity and quality of the individuals' work. These pressures evidently reached a critical point for claimant on the day he learned of his shift change. He went home in a state of acute depression with violent feelings of hostility about Captain B.J. That condition persisted for some time. Claimant did not return to work as a deputy sheriff. Eventually, he turned to selling real estate, which he had done earlier in his career.

"A psychiatrist testified at the hearing that claimant suffered from anxiety and depressive neurosis directly related to his job as deputy sheriff, as a result of the perceived vendetta and the natural stresses of the job. No psychiatrist consulted found otherwise, and there was no evidence of stress outside the job that was a contributing cause of claimant's condition." *McGarrah v. SAIF,* 59 Or App 448, 450-51, 651 P2d 153 (1982).

The Court of Appeals found it to be "clear that the

events about which claimant complains did, in fact, occur," and that:

> "* * * [claimant did prove] that supervisory action and criticism relating to his performance on the job, to which he was not ordinarily subjected or exposed other than during a period of regular employment, was the major source of stress triggering his psychological disability.
>
> "* * * Both the medical and other evidence establish that job-related stress caused claimant's mental disorder." *Id.* at 457-58.

It seems that no problem in recent years has given courts and commissions administering workers' compensation more difficulty than on-the-job mental stress which

results in either emotional or physical illness.[1] The causal relationship between employment stress and a resulting mental or emotional disorder presents one of the most complex issues in workers' compensation law.[2]

To understand the difficulty the courts have encountered in trying to resolve mental stress cases, one need only review selected cases from other jurisdictions,[3] which vary widely in their treatment of these claims. Of course, a great deal of the variance results from different wording in state statutes.

One well known case from another jurisdiction is *Carter v. General Motors Corp.*, 361 Mich 577, 106 NW2d 105 (1960). The Supreme Court of Michigan in *Carter* viewed mental disabilities as being identical to physical disabilities and sustained a compensation award for a psychosis resulting from cumulative emotional pressures suffered on the job by an assembly line worker. The court sustained the award despite the fact that the employe had considerable emotional difficulties in his background and his job involved no extraordinary stress, hazardous condition or identifiable risk of employment. The court rejected the contention that a traumatic event be required in mental disease cases to insure that the disease is work-related.

The claimant in *Carter* worked on a hub assembly job at defendant's automobile manufacturing plant. Claimant's work required him to take an assembled hub from a table to his workbench, "remove burrs with a file, * * * grind out holes in the assembly with a drill, and place the assembly on a conveyor belt." Claimant could not "keep up with the pace of the job unless he took 2 assemblies at a time to his workbench." *Id.* at 580. His foreman, however, repeatedly instructed him against this because the assembly parts became mixed on the conveyor belt. Although claimant attempted to keep up with the job for fear of layoff if he failed,

---

[1] *See* Note, *Emotional Stress—Now a Cause of Compensable Injury?*, 34 La L Rev 846 (1974).

[2] *See* Joseph, *The Causation Issue in Workers' Compensation Mental Disability Cases: An Analysis, Solutions, and a Perspective*, 36 Vanderbilt L Rev 263, 289 (1983).

[3] *See* Annot., *Mental Disorders as Compensable Under Workmen's Compensation Acts*, 97 ALR3d 161; Note, 66 Minn L Rev 1194 (1982); and Joseph, 34 La L Rev at 851, *supra*.

he continued to fall behind the pace and to mix up the assembly parts. Consequently, his foreman berated him. As a result of the employment dilemma, claimant suffered an emotional collapse diagnosed as paranoid schizophrenia and a residual type schizophrenic reaction.

The issue in *Carter* was the compensability of a mental disorder when the disorder allegedly was caused by "emotional pressures * * * not * * * unusual in any respect,—that is, not shown * * * to be any different from the emotional pressures encountered by * * * fellow workers in similar employment." *Id.* at 585. The court stated that Michigan law did not compel limiting recovery in a mental disability case to fact situations in which the claimant suffered a single physical injury or a single mental shock. The court added that claimant's mental collapse brought on by gradual mental stimuli was compensable. The court then granted claimant recovery because the record revealed that his disability arose out of the pressures of his work.

The *Carter* court articulated as the policy rationale for its conclusions that the basic purpose of the workers' compensation system compelled that a worker disabled as a result of work-related mental stress receive treatment identical to a worker disabled by a work-related physical injury.

In *Baker v. Workmen's Comp. Appeals Bd.,* 18 Cal App 3d 852, 96 Cal Rptr 279 (1971), the California appellate court adopted the *Carter* approach, reasoning that the claimant was suffering from a psychoneurotic syndrome described as "cardiac neurosis" which was caused by the pressures, dangers, and general conditions of his work as a fireman. The court annulled a decision of the Workmen's Compensation Appeals Board which had denied compensation. Finding no evidence that the claimant was feigning his symptoms of severe chest pains, shortness of breath, intermittent expectoration of blood and mucus, and cyanosis, and observing substantial evidence supporting the board's determination that he did not have heart disease or a disabling pulmonary disorder, the court said the only logical inference was that he suffered from a psychoneurotic syndrome. The court added that the claimant's testimony concerning the origin and progression of his symptoms, together with expert medical evidence, led to a clear inference of industrial causation. It

reasoned that psychoneurosis caused by the work environment was compensable, even in the absence of a physical accident or trauma, and even if the mental disorder resulted from the cumulative effect of daily stresses and strains.

In *Royal State Nat'l Ins. v. Labor Bd.,* 53 Hawaii 32, 487 P2d 278 (1971), the Hawaii Supreme Court upheld an award of compensation benefits to claimant, who was employed by an insurance company as director of agent training. Medical evidence showed that the pressures of his work resulted in his mental collapse and the physicians diagnosed the condition as schizophrenia with suicidal ten-

dencies. Taking the position that a person may succumb to the pressures of work even though he is not under any unusual exertion or strain, the court noted no conflict in the evidence that the cause of the claimant's mental collapse was the pressure of his work. The court concluded with this thoughtful analysis:

> "* * * In today's highly competitive world it cannot be doubted that people often succumb to mental pressures resulting from their employment. These disabilities are as much a cost of the production process as physical injuries. The humanitarian purposes of the Workmen's Compensation Law require that indemnification be predicated not upon the label assigned to the injury received, but upon the employee's inability to work because of impairments flowing from the conditions of his employment. * * *" (Footnote omitted.) *Id.* at 38.

In *Yocom v. Pierce,* 534 SW2d 796 (Ky 1976), the Kentucky court upheld a compensation award for a claimant who suffered a non-traumatic work-related anxiety neurosis in the course of her employment by a clothing manufacturer. The court found the demands made by her job, which required her to match threads with the dominant color of garments, aroused a dormant condition into a disabling reality.

In *Deziel v. Difco Laboratories, Inc.,* 403 Mich 1, 268 NW2d 1, 97 ALR3d 121 (1978), the Michigan court continued its allegiance to *Carter,* and determined that workers' compensation benefits had been improperly denied to the claimant, McKenzie, an employe of an automobile manufacturer, who suffered a disabling mental disorder which he believed was caused by the pressures of his job. Compensation benefits had been denied on the ground that claimant's job, when viewed

objectively, had not aggravated, accelerated or combined with a long-standing personality defect from which he suffered to produce his disability. Evidence showed that assembly line workers took defective parts from claimant's work area and installed them on new automobiles, thus causing the claimant to worry about the safety of the cars, recount the remaining parts and account for those that were missing. The court reasoned that the medical evidence as to the claimant's perception of the cause of his mental disorder satisfied the subjective standard, and that it was a sufficient basis upon which to award compensation benefits.

In contrast to the decisions from Michigan, California, Hawaii and Kentucky, other jurisdictions refuse to allow any recovery in cases of mental disorders brought on by the stress of gradual strain and worry. These decisions represent the "[H]ow could it be real when * * * it was purely mental?" judicial reasoning criticized by Professor Larson in his article, *Mental and Nervous Injury in Workmen's Compensation,* 23 Vand L Rev 1243 (1970). He wrote:

> " '[H]ow could it be real when * * * it was purely mental?'
>
> "This poignant judicial cry out of the past, which I occasionally quote to put down my psychiatrist friends, contains the clue to almost all of the trouble that has attended the development of workmen's compensation law related to mental and nervous injuries. This equation of 'mental' with

'unreal,' or imaginary, or phoney, is so ingrained that it has achieved a firm place in our idiomatic language. Who has not at some time, in dismissing a physical complaint of some suffering friend or relative, airily waived the complaint aside by saying, 'Oh, it's all in his head?'

"The impact of this pervasive preconception on compensation decisions can be briefly stated. A high proportion of the cases display a search for something—anything—that can be called 'physical' to supply the element of 'reality' in the injury. If the courts find this element, they are quite happy to award compensation even though the injury viewed as a whole is preponderantly mental or nervous. But if no such 'physical' component can be identified, even some of the more sophisticated appellate courts still find themselves unable to justify compensation for a work-connected mental or nervous disability."

For cases representing this restrictive point of view, *see Transportation Ins. Co. v. Maksyn,* 580 SW2d 334 (Tex 1979);

Marable v. Singer Business Machines, 92 NM 261, 586 P2d 1090 (1978); *Erhart v. Great Western Sugar Co.,* 169 Mont 375, 546 P2d 1055 (1976); *Vernon v. Seven-Eleven Stores,* 547 P2d 1300 (Okla 1976); *Begin's Case,* 354 Mass 594, 238 NE2d 864 (1968); *Samson v. Southern Bell Telephone & Telegraph Co.,* 205 So 2d 496 (La App 1967); and *Jacobs v. Goodyear Tire & Rubber Co.,* 196 Kan 613, 412 P2d 986 (1966).

A less restrictive test for mental stress cases is found in decisions from Wisconsin, Arizona and Maine.

The Supreme Court of Wisconsin directly confronted the threshold policy limitations in gradual stress mental disability cases in *School District No. 1 v. Department of Industry, Labor & Human Relations,* 62 Wis 2d 370, 215 NW2d 373 (1974). In that case, claimant, a high school guidance counselor, was given a list of recommendations by the school's student council which requested the removal of several staff members and other changes. The counselor's copy of this list was difficult to read and she did not learn until after questioning students that the list recommended her removal from the staff. The counselor became emotionally upset about this recommendation; she was unable to sleep or eat and suffered nausea, severe headaches and acute anxiety. The counselor alleged that the incident with students caused her condition, which doctors diagnosed as a "severe neurosis tension state with gastro intestinal signs and symptoms." *Id.* at 372.

The court began its analysis by declaring that the Wisconsin Workers' Compensation Act clearly did not intend to limit recovery to physical injuries and traumatically caused mental injuries. That court adopted a standard under which mental disorders, not resulting from trauma, must arise from "a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience." Applying this test, the court denied claimant compensation on the ground that her experience "could not be deemed" different from "the countless emotional strains and differences that employees encounter daily." *Id.* at 377-78.

In two cases, the Supreme Court of Arizona established a standard that stress encountered by the claimant at work must be greater than that ordinarily encountered by employes performing the same type of work: *Fireman's Fund*

Ins. Co. v. Industrial Com'n, 119 Ariz 51, 579 P2d 555 (1978), and *Sloss v. Industrial Commission,* 121 Ariz 10, 588 P2d 303 (1978).

In *Fireman's Fund,* claimant's mental disorder allegedly resulted from constant, psychologically intolerable work responsibility. The claimant was an underwriter for defendant's insurance agency. Within a short time of her arrival, the agency experienced a period of explosive growth. Claimant, "a conscientious employee and a perfectionist," undertook duties that placed her "under constant pressure." The defendant agency purchased another agency and added another employe. The agency made claimant the supervisor of the new employe and gave her responsibility for merging the books of the two agencies. Claimant began to feel frustrated and ineffective and experienced difficulty relating to her coworkers. After a severe emotional outbreak, she was hospitalized for a mental breakdown. Claimant alleged that she suffered a disabling mental condition brought on by the gradual build-up of the stress and strain of her employment.

The claimant in *Sloss* was a highway patrolman who suffered from a condition doctors diagnosed as "chronic anxiety." Claimant alleged that his condition developed from the pressures of his work. The administrative law judge, without the benefit of the decision in *Fireman's Fund,* denied recovery because the "stresses to which [claimant] was exposed in his employment were [the] same as, and no greater than, those imposed upon all other highway patrolmen in [the] same type of duty." *Sloss,* 588 P2d at 303-04. The Arizona Supreme Court approved this decision, adding that under *Fireman's Fund* a showing of more than ordinary and usual work-related stress was necessary.

The Supreme Judicial Court of Maine in *Townsend v. Maine Bureau of Public Safety,* 404 A2d 1014 (Me 1979), expressly adopted the standard that on-the-job stress must be greater than found in employment generally. The claimant, Ms. Townsend, was employed as a civilian dispatcher with the Department of Public Safety from June of 1973 until March of 1976. After being reprimanded by her supervisor on March 18, 1976, for an infraction of the Department's rules, Ms. Townsend became emotionally distraught and left work early that day. Suffering from what the claimant described as a "nervous

breakdown," she thereafter voluntarily entered the hospital where she remained for approximately four weeks suffering from a "situational reaction" with depression.

The claimant testified she was subjected to work-related "harassment" beginning in the winter of 1973 due to a

relationship she had with a state police officer which the Department attempted to discourage. She related a series of incidents in which she was followed, received annoying telephone calls and was summoned to court, all perpetrated by Department employes who were out to get her. Ms. Townsend stated that even after the relationship ended she was exposed to repeated and unjustified disciplinary hearings and suspensions until she was no longer able to cope with her job.

Justice Delahanty, writing for the court, said:

> "It is clear that this Court has never found talismanic the physical-mental dichotomy for purposes of our workers' compensation law. * * *
>
> "If both physical trauma leading to mental injury and mental stimulus leading to physical injury would be compensable, it would follow that mental stimulus leading to mental injury would come within the reach of our Act. * * *" *Id.* at 1016.

And concluded:

> "In sum, where there is a sudden mental injury precipitated by a work-related event, our typical workers' compensation rules will govern. Where, however, the mental disability is the gradual result of work-related stresses, *the claimant will have to demonstrate either that he was subjected to greater pressures and tensions than those experienced by the average employee or, alternatively, by clear and convincing evidence show that the ordinary and usual work-related pressures predominated in producing the injury.*" (Emphasis added; citations omitted.) *Id.* at 1020.

The court expressly stated the policy reason for its adoption of the limiting threshold standard: "[A] higher threshold level than simply the usual and ordinary pressures that exist in any working situation would erect an appropriate buffer between the employer and a host of malingering claims." *Id.* at 1019.

The Maine court's analysis reveals an underlying methodology to counterbalance the policy problems that emanate from the subjective nature of mental injuries by providing an objective measurement.

We now review some Oregon cases dealing with the issue of on-the-job mental stress causing physical disease or mental disorders.

In 1969, this court in *Clayton v. Compensation Department,* 253 Or 397, 454 P2d 628 (1969), held that a heart attack resulting from ordinary on-the-job stress conditions was compensable. No special tests were set forth in the opinion to aid us in determining when mental disorders arising from on-the-job stress are compensable. However, the court demonstrated no reluctance to approve compensation for a physical illness arising from on-the-job stress.

In *Paresi v. State Accident Insurance Fund,* 44 Or App 689, 606 P2d 1172 (1980), *remanded on other grounds* 290 Or 365, 624 P2d 572 (1981), a liquor control officer observed

what she perceived were illegal activities on the part of the Oregon Liquor Control Commission involving preferential treatment accorded certain licensees. Her activities brought her into conflict with her supervisors. She in turn perceived her supervisors' criticism of her as harassment and became anxious and depressed. The Court of Appeals allowed her disability benefits and commented that emotional disorders need not be analyzed objectively and that employers must accept workers as they find them with all their latent and obvious physical and mental deficiencies.

In *Korter v. EBI Companies, Inc.*, 46 Or App 43, 610 P2d 312 (1980), an insurance claims consultant was demoted at work and became anxious, insecure and depressed. The Court of Appeals found that the worker proved he was disabled and his disability arose out of and in the course of his employment. With regard to causation, the Court of Appeals set out the following principles from its decision in *James v. SAIF*, 44 Or App 405, 409-12, 605 P2d 1368 (1980):

> "(1) the mental disorder does not have to be the result of an extraordinary unanticipated event; it can result from the cumulative effects of each day's exposure to specific conditions at work;

> "(2) the conditions of employment, claimed to be the precipitating cause of the mental disability, do not have to be unusual; the disability is compensable if it results from the usual and ordinary job stress; and
>
> "(3) the claim is compensable even if the individual has a preexisting emotional disorder if he proves that his work activity and conditions caused a worsening of his underlying disease resulting in an increase in pain to the extent that it produces disability or requires medical services." *Korter*, 46 Or App at 50.

On review, we noted in *James v. SAIF*, 290 Or 343, 624 P2d 565 (1981), that the claimant complained she was being unfairly reprimanded and criticized by her supervisor, from which she developed a nervous disorder. The claimant suffered from anxiety and depression neuroses. We held such a claim would be compensable if the claimant's mental disorder was caused by circumstances "to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment." We specifically said that claimant's mental illness, neuroses, was an occupational disease.

In *James* the evidence indicated that the claimant's mental illness was caused by criticism from her supervisor to which the claimant was subjected and exposed only during employment. However, the evidence also showed that it was not the source of the criticism, but any criticism or unsympathetic or unfriendly conduct from any source that was stressful to the claimant. We found that there was a fact question whether the claimant's mental disorder was caused by circumstances "to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment." The case was remanded to the Court of Appeals for a factual finding on that issue and the court subsequently found that the claimant's mental disorder was work related and granted compensation. *SAIF v. James*, 61 Or App 30, 33, 655 P2d 620 (1982).

The decision in *James* left unanswered the major question whether and under what circumstances our occupational disease statute provides compensation for mental disorders emanating from on-the-job mental stress. In *James,* SAIF did not contend that mental illness was never compensable. Without addressing this key issue, this court in *James* merely set forth a rule to apply in mental stress cases — that

the claimant's mental disorder must be caused by circumstances "to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment." 290 Or at 351. This issue is now squarely before us.

The adoption of the "restrictive" rule is suggested by the employer in the companion case of *Leary v. Pacific Northwest Bell.* In a memorandum to this court, Pacific Northwest Bell asserts:

> "The statutory definition of occupational disease does not contain any language which even suggests that worsened symptoms of mental disorders should be compensable while worsened symptoms of physical disease should not. In fact, the only provision of the occupational disease law which makes the mental/physical distinction in any form indicates that the legislature never intended to provide compensation for mental disorders at all. ORS 656.806 provides:
>
> > 'As a prerequisite to employment in any case, a prospective employer may, by written direction, require any applicant for such employment to submit to a *physical* examination by a doctor to be designated by the Director of the Workers' Compensation Department, and paid by such prospective employer. * * *' (Emphasis added.)
>
> "Under the authority of this provision, a prospective employer can attempt to identify and screen out those employees who suffer from physical diseases which could be exacerbated by the specific working environment. No such method is authorized for identifying prospective employees who suffer from mental disorders which could become worse as a result of stress they are likely to encounter on the job.
>
> "It may be that this court would refuse, in light of cases previously decided, to now consider a contention that mental disease is not compensable under the occupational disease law. It does not appear that that argument has ever been squarely presented. *See, e.g., James v. SAIF, supra,* 290 Or at 346 ('SAIF does not contend that mental illness can never be compensable.'). The argument was not made to the Court of Appeals in this case.
>
> "Nevertheless, given the legislature's express focus on physical conditions in the provisions of the occupational disease law, it certainly cannot be said that there is any warrant for providing compensation associated with mental disease under circumstances where the law does not authorize compensation related to physical disorders."

The Court of Appeals, in the companion case of *Leary v. Pacific Northwest Bell,* 60 Or App 459, 653 P2d 1293 (1982), rejected this contention and held that in order to qualify for a compensation award for a physical disorder the claimant would be required to prove only that the stress arose out of and

in the course of the employment and that the employment-connected stress suffered by the claimant was the major contributing cause of the claimant's mental disorder. Such a test is backed by the logic and reasoning expressed in *Carter* and allied cases.

Dissenters from such a rule argue that workers' compensation claims are already a substantial cost of doing business in any state[4] and that unless substantial restrictions are placed upon mental stress and disorder claims the entire scheme of workers' compensation will be threatened to the extent that its original purpose will be defeated. Justice Coleman of the Michigan Supreme Court in his dissenting opinion in *Deziel v. Difco Laboratories, Inc.*, 403 Mich 1, 61-62, 268 NW2d 1, 27 (1978), expressed his concerns about the economic effect the decision could have on that state:

> "There is no doubt that the decision today will be a costly burden to Michigan employers, small and large, who compete with out-of-state business and to the consumers who absorb those costs. The concern here expressed, however, is not only for employers and consumers but for employees. We have engaged in a seemingly inexorable march towards limiting the hiring of workers to only those persons in the top echelon of physical and mental condition.
>
> "While workmen's compensation costs are burgeoning, the benefits must be spread ever more thinly among the workers to accommodate new categories of disorders (and ever more remote accidents) which cannot be guarded against or controlled by an employer. Moreover, when businesses close or move to another state, jobs and tax revenues are lost. When expansions of existing businesses are taken to other states, Michigan residents lose opportunities for employment. These economic facts of life should not be overlooked when we expand legislation by judicial fiat.
>
> "We do no service to the people of Michigan with this open-door opinion * * *." 268 NW2d at 27.

It is not our task to rely on supposed economic disasters that might befall this state in deciding to adopt one rule versus another. If a legislature chooses to open the door of its workers' compensation law for all mental stress cases it is free to do so. If it chooses to eliminate all mental stress claims for workers' compensation, it may do so. A legislature may wish to consider the scholarly work and suggestion for a "worker's disease protection system" which would substantially and structurally reform the present methods of compensation for mental disorders and resulting disabilities.[5]

Workers' compensation systems are founded on political compromise. For decades, labor, management and the insurance industry in this state have waged fierce political wars over who receives what and when. Legislatures first

---

[4] The total premiums paid for workers' compensation in Oregon for fiscal year 1982-83 was $330 million.

[5] This interesting proposal is set forth by attorney Lawrence Joseph of the New York Bar in his challenging law review article: *The Causation Issue in Workers' Compensation Mental Disability Cases: An Analysis, Solutions, and a Perspective*, 36 Vand L Rev 263 (1983).

enacted workers' compensation laws early in this century in response to an increase in industrial accidents and because of the inadequate recovery provided employes under common law doctrines and procedures.[6]

Workers' compensation laws provide a form of strict liability requiring employers, regardless of fault, to compensate employes for injuries arising out of and in the course of employment.[7] In exchange for that relief under this no-fault

recovery system, employes are limited to a fixed schedule of recovery and must abandon any common law right of action against their employers. The theory underlying workers' compensation acts is that the financial burden of losses due to injuries occurring in business should be treated as business expenses or production costs to be borne, not by the employe, but by the employer, who can transfer the burden to the consumer. Our current occupational disease law is based on the same social and economic concerns.

Those ultimate social and economic decisions are for the legislature and not for the courts. The courts must decide whether an occupational disease is compensable based on legislative directives.

The intention of the Oregon legislature was manifested when it enacted Oregon's occupational disease law. The law was designed to provide protection only for any disease or infection which arises out of and in the scope of employment and "to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment." ORS 656.802(1) defines an occupational disease as follows:

> "As used in ORS 656.802 to 656.824, 'occupational disease' means:
>
> "(a) Any disease or infection which arises out of and in the scope of the employment, and *to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein.*

---

[6] In upholding the constitutionality of Oregon's original workers' compensation law, this court recognized that trade off in *Evanhoff v. State Industrial Acc. Com.*, 78 Or 503, 523-24, 154 P 106 (1915):

> "* * * Before its enactment one workman out of three received a large compensation for his injuries by an action at law, while the remaining two were defeated and got nothing. Now every workman accepting its provisions receives some compensation if injured; and, taken as a whole, it will be found that more money in the way of compensation is received by the whole body of injured workmen than by the inadequate remedies afforded in the courts. It has been a boon to the employers, the employed, and the community, which latter could formerly only offer to the injured laborer the charity of the almshouse instead of that just compensation which he may now receive without the humiliation of pauperism or the loss of self-respect."

[7] ORS 656.012(2) provides in pertinent part that:

> "* * * the objectives of the Workers' Compensation Law are declared to be as follows:
>
> "(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents; * * *"

"(b) Death, disability or impairment of health of fire fighters of any political division who have completed five or more years of employment as fire fighters, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and resulting from their employment as fire fighters." (Emphasis added.)

Professor Larson comments about statutory definitions which are common in occupational disease cases. He states in his treatise on workers' compensation law:

"A number of statutes contain detailed definitions of the term 'occupational disease,' and these statutory definitions give the clue to the distinction which is controlling for present purposes. The common element running through all is that of the distinctive relation of the particular disease to the nature

of the employment, as contrasted with diseases which might just as readily be contracted in other occupations or in everyday life apart from employment. * * *" 1B Larson, Workmen's Compensation Law § 41.32, p 7-361 (1979).

The vast majority of workers, if not all, face and deal with job stress on a daily basis. The Oregon occupational disease statute speaks of diseases the worker is exposed to on the job, but not ordinarily exposed to off the job. On-the-job stress is not a disease. On-the-job events and conditions produce stress which in turn can cause mental disorders. We recognize that if we conclude the occupational disease law allows compensation for mental diseases and disorders caused by on-the-job stressful events or conditions, that interpretation of the statute may open a floodgate of claims from workers who simply cannot mentally cope with usual working conditions.[8] Researchers tell us that people who suffer from psychological problems occupy more hospital beds in the United States than those who have a physical illness or injury. It is estimated that at any given time between 15 and 30 percent of the general population have diminished efficiency as a result of some type of mental or emotional dysfunction.[9] The legislature must have been aware of the shift in costs from general welfare or general insurance to workers' compensation that would occur if workers' compensation provided coverage for mental and physical disorders caused by job stress. We find no legislative words nor any evidence of legislative intent to indicate that the legislature either intended or did not intend to place that burden on the workers' compensation system.

If the legislature wants employers and compensation carriers to be relieved from the burden of such claims and wishes to change the occupational disease law to exclude

[8] Some commentators and courts assume the reason to exclude disorders resulting from on-the-job stress conditions is to avoid fraudulent claims, but we do not agree with that assumption. On the contrary, we presume most mental stress claims are made in good faith. *See* 1B Larson, Workmen's Compensation Law § 42.23(b); Joseph, 36 Vand L Rev at 291 n 113, *supra* at nn 2 and 5; Comment, *Workers' Compensation for Mental Disabilities Resulting from Protracted Stress*, 17 Will L Rev 693, 702 n 65 (1981).

[9] *See* P. Carone, S. Kieffer, L. Krinsky and S. Yolles, The Emotionally Troubled Employee: A Challenge to Industry 57 (1976), cited in Note, *When Stress Becomes Distress: Mental Disabilities Under Workers' Compensation in Massachusetts*, 15 New Eng L Rev 287, 304 (1980).

mental disorders, such as exhaustively set forth in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (3rd Ed 1981),[10] then the legislature can amend the statute to exclude specifically compensation for mental or physical disorders arising from job stress events and conditions. As we have said, this is a judicial body, not a legislative body, and we refuse to make, by judicial intervention, such a major conversion of our legislature's workers' compensation occupational disease act.

We agree with the Hawaii Supreme Court's analysis in *Royal State Nat'l Ins. v. Labor Bd.*, 53 Hawaii 32, 487 P2d 278 (1971), that stress-caused claims for benefits arising out of mental and physical disorders are compensable if they flow from the conditions of the worker's employment, provided causation, as hereinafter discussed, has been proven. We all

know that stress may flow from work conditions. However, the on-the-job stress conditions causing the disorders must be real. That is, the events and conditions producing the stress must, from an objective standpoint, exist in reality. A worker's inability to keep up the pace of the job, *Carter v. General Motors Corp.*, 361 Mich 577, 106 NW2d 105 (1960), is real stress. Pressures, dangers and general conditions of a fire fighter's work are real stress, *Baker v. Workmen's Compensation Appeals Board*, 18 Cal App 3d 853, 96 Cal Rptr 279 (1971). The pressure of an executive or management position is real stress, *Royal State Nat. Ins. Co., supra.* The day-after-day intricate matching of threads in a garment factory is real

---

[10] This 494-page work was compiled by many prominent psychotherapists. One group was called the "Task Force on Nomenclature and Statistics." The term "disease" is not used as an accurate diagnostic assessment. However, the term "mental disorders" is the constant classification reference. The Diagnostic and Statistic Manual-III (DSM-III) attempts to describe comprehensively what the manifestations of the mental disorders are, and only rarely attempts to account for how the disturbances came about. DSM-III contains a glossary of terms. The words "mental disease" are not defined.

The World Health Organization developed a separate chapter for mental disorders in its Ninth Revision of the International Classification of Diseases (ICD-9), thereby distinguishing Mental Disorders from Infectious Diseases, Diseases of the Blood, Diseases of the Nervous System, and the like.

If the legislature chooses to include mental disorders within the definition of occupational diseases, it might observe that DSM-III defines, among hundreds of other mental disorders, the following:

Attention deficit disorders - hyperactivity
Conduct disorder - unsocialized, aggressive
Stuttering
Alcoholism
Cocaine intoxication
Amphetamine intoxication
Cannibis intoxication
Tobacco withdrawal
Caffeine intoxication
Paranoid disorders
Neurotic disorders, including anxiety
Affective disorders, including depression
Somatoform disorders, including hypochondriasis
Psychogenic amnesia
Psychosexual dysfunctions, including inhibited sexual desire.

The manual also includes codes not attributable to a mental disorder. Listed are V.62.20 Occupational problems and V.65.20 Malingering.

stress, *Yocom v. Pierce*, 534 SW2d 796 (Ky 1976). However, concern that cars might not be safe, emanating from a worker's long-standing personality defect, when there is no objective evidence to substantiate such a fear, is not real stress, *Deziel v. Difco Laboratories, Inc.*, 403 Mich 1, 268 NW2d 1 (1978). A worker's misperception of reality does not flow from any factual work condition. We disagree with the Michigan Supreme Court standard set forth in *Deziel* that all that is needed for compensation for stress-induced physical disease or mental disorders is a strictly subjective causal nexus based upon a worker's honest perception. A worker may honestly believe that the employer plans to kill him and as a result of that fear cannot work, but if that belief emanates only from the worker's own paranoia and there was no evidence the employer had any such plan, no stress condition factually existed on the job and the resulting impairment would not be compensable. On the other hand, a worker with a non-disabling paranoid personality may lapse into a totally disabling psychotic paranoia if managers pile too heavy a workload on such a susceptible employe. Honest perception exists in both cases, but workers' compensation would be properly denied in the first case and properly allowed in the second.

Under a "strictly *subjective* causal nexus" standard, a claimant is entitled to compensation if it is factually established that claimant *honestly perceives* some event occurred during the ordinary work of his employment which "caused" his disease. This standard applies where the claimant alleges a disease resulting from mental stimulus and honestly, even though mistakenly, believes that he is disabled or impaired

due to that work-related event and therefore cannot resume his normal employment.

This standard is no standard at all in the reality of application. In cases where the disability or impairment is established, the subjective test for causal nexus would result in an award of compensation for virtually all, if not all, claims based on mental disorders. If the claimant perceived that the job conditions caused the mental disorders, *even if this were not true*, the employer would be liable. The subjective formulation ignores the fundamental statutory requirement that diseases or disorders arise out of and in the scope of employment. An honest perception of that which does not factually exist is an insufficient causal nexus for an occupational disease claim.

The stressful conditions must actually exist on the job.[11] That is, they must be real, not imaginary. The views of an average worker or average person or the perceptions by the

---

[11] *See* Dr. Colbach's comments as set out in in *Leary v. Pacific Northwest Bell*, 296 Or 139, ___ P2d ___ (1983).

> "It doesn't appear that his work has forced him into any particularly stressful situations. But his selective perceptions of what is going on at work do cause him distress * * *." (Slip op at 2-3.)

It was most helpful to this court in the present case that the Court of Appeals made specific findings of fact rather than merely referring to the testimony of the witnesses. It was most difficult in *Leary v. Pacific Northwest Bell*, 60 Or App 459, 653 P2d 1293 (1982), to distinguish a finding of fact from a mere recitation of testimony.

claimant may be relevant, but are not determinative. The existence of legal cause of stress-related occupational disease must be determined objectively.[12]

In the present case, the Court of Appeals found that there were actual stress conditions at work, not simply conditions perceived by the claimant in his own subjective view.[13]

The worker proved stressful conditions, viewed objectively, existed on the job.

In addition to proving that stressful conditions objectively existed on the job, the worker must also prove that employment conditions, when compared to non-employment conditions, were the "major contributing cause" of the mental disorder. In *Dethlefs v. Hyster Co.*, 295 Or 298, 310, 667 P2d 487 (1983), we said:

> "* * * [I]f a causative agent at the work place and a causative agent away from the work place are different in kind and concur to cause an indivisible disease which requires medical services or causes disability, a claim therefor is compensable if the causative agent at the work place is the major cause of the disease."

We agree that ORS 656.802(1)(a) does not require that the occupational disease be caused or aggravated *solely* by the work conditions. If the at-work conditions, when compared to non-employment exposure, are *the major contributing cause* of the claimant's disease or disorder, then the claimant is eligible for compensation. The Court of Appeals found this claimant suffers a greater and different degree of stress when he is at work. That court further found no evidence this claimant suffered from any particular stress from non-employment sources.

Applying the facts as found by the Court of Appeals to the standards set forth in this case, we hold that this occupational disease is compensable. Claimant was subjected to actual stress conditions at work when viewed objectively. Furthermore, the at-work conditions, when compared to non-employment exposure, were the major contributing cause of claimant's mental disorder.

The Court of Appeals is affirmed.

[12] We hasten to point out that this objective test for stress does not inject an element of fault into the Workers' Compensation Law. The evidence in cases of this kind has nothing to do with legal blame or fault. The appropriate findings should address whether the circumstances are in fact stressful, irrespective of fault. The fact that a worker is mentally ill usually is due to no fault of his own. Also, the fact that a worker misconceives reality is usually due to no fault of his own. If an employer hires stress-causing supervisors, that situation can be avoided, just as safety measures can be installed to prevent accidents, but that does not convert stress problems into "who is at fault" problems, which as mentioned have no place in the Workers' Compensation Law.

[13] The objective test is criticized by Joseph, 36 Vand L Rev at 311, *supra* at nn 2 and 5.

LENT, J., concurring.

I write separately only to express what I perceive to be the thrust of the opinion of the court. "Stress" is not the disease. It is a word which describes the mechanism by which

conditions or events actually present at the work place result in mental disease.

An occupational disease is considered an injury except as otherwise provided in the Occupational Disease Law, ORS 656.804. As such, the disease may be a nondisabling compensable injury if it requires medical services only, ORS 656.005(8)(c), or a disabling compensable injury if the disease results in disability or death, ORS 656.005(8)(b).

If conditions or events actually present at the work place are the major contributing cause of a mental disease necessitating medical services or resulting in disability, the worker is entitled to compensation as defined in ORS 656.005(9) under the Occupational Disease Law.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Terry L. Starbuck, Claimant.

BOISE CASCADE CORPORATION,
Petitioner on review,

v.

STARBUCK et al,
Respondents on review.

(CA A23754; SC 29434)

In Banc*

On review from the Court of Appeals.**

Argued and submitted July 7, 1983.

Brian L. Pocock, of Cowling, Heysell & Pocock, Eugene, argued the cause and filed a brief and petition for petitioner on review.

Darrell E. Bewley, Salem, argued the cause and filed a brief for respondent SAIF Corporation.

No appearance for Respondent Starbuck.

PETERSON, C. J.

The Court of Appeals is affirmed.

---

* Justice Lent was Chief Justice when case was argued; Justice Peterson was Chief Justice when decision rendered.

**Appeal from Order on Review of the Workers' Compensation Board. 61 Or App 631, 659 P2d 424 (1983).

PETERSON, C. J.

This workers' compensation case involves a back injury sustained in one employment followed by a worsening of the condition during a later employment. The first employer, Boise Cascade Corporation, was held to be the responsible employer and seeks review in this court, invoking the last injurious exposure rule. It claims that even though there was no "definable accident or event" in the later employment, the later employer nonetheless is liable under the last injurious exposure rule because the working conditions in the later employment were capable of causing the disability. Under *Sahnow v. Firemen's Fund Ins. Co.*, 260 Or 564, 568, 491 P2d 997 (1971), the findings of fact of the Court of Appeals are binding upon us, and our review is limited to errors of law. We therefore briefly restate the history and the pertinent findings of that court.

Claimant hurt his back in January, 1978, while employed by Boise Cascade. He filed an injury claim and was paid for medical expenses incurred. He lost no time from work and asserted no disability claim.

Claimant left his job with Boise Cascade in June, 1978, and started working for Northwest Quality Cabinets (Northwest) in August, 1978. The Court of Appeals opinion described his later back problems as follows:

> "* * * He testified that there was no single, identifiable, injurious incident at Northwest, but that lifting cabinets may have irritated his back. The lifting was occasional, involving weights of about 50 to 60 pounds. He stated that his low-back condition gradually worsened from January, 1978, to January, 1979. In December, 1978, he fell over several times when his leg folded up under him because it was numb. He sought further medical treatment in January, 1979, and was diagnosed as having a herniated disc. He underwent surgery in February, 1979." *Boise Cascade Corp. v. Starbuck*, 61 Or App 631, 633, 659 P2d 424 (1983).

The Court of Appeals noted that claimant had no history of back trouble before his injury at Boise Cascade and stated that "[t]he preponderance of the evidence establishes not that claimant's work exposure at Northwest actually contributed to his back disability, but only that it could have." 61 Or App at 639. The Court of Appeals found

> "* * * that claimant's back condition was a recurrence or worsening of the original injury; that is, that [there] was no second injury, and the second employment did not independently contribute to the condition. Boise is the responsible employer." 61 Or App at 641.

Boise Cascade claims that because the conditions at Northwest "were capable of causing" the plaintiff's back problems, under the last injurious exposure rule stated in *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982), Northwest is the responsible employer.

In Oregon, as in most states, the last injurious exposure rule arose in an occupational disease context. We

first applied it in a case involving a hearing loss claim. *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1980).[1] In an occupational disease context, the rule is this: If a worker establishes that disability was caused by disease resulting from causal conditions at two or more places of employment, the last employment providing potentially causal conditions is deemed to have caused the disease. The result is that, once the requirement of some contributing exposure has been met, the last employer is liable even though the worker has not proved that the last employment was the actual cause of the disability. 288 Or at 342-43. *Accord, Bracke v. Baza'r, supra,* 293 Or at 244-249. *See also* 4 Larson, Workmen's Compensation Law §§ 95.00-95.21 (1983).

Since *Inkley,* this court has applied the rule in a number of occupational disease cases, but we never have applied the rule in a case involving a claim of disability arising from successive injuries or, as here, in a case involving an injury followed by exposure to conditions of employment which could have contributed to the disability.

Claimant relies on language in *Bracke v. Baza'r, supra. Bracke* involved a claim of disability arising from an occupational disease, meat wrapper's asthma. The opinion contains these statements:

> "The common reference to the rule as if it were unitary is somewhat misleading. There are at least two last injurious exposure rules, each serving a different function in different types of cases. One is a substantive rule of liability assignment; another is a rule of proof. The dichotomy is evident in the caselaw and in Larson's text, although it has not, to our knowledge, been previously expressed.
>
> "The substantive rule of liability is perhaps the most common. It operates to assign liability to one employer in cases of successive, incremental injuries. The rule serves as a substitute for allocation of liability among several potentially liable employers, each of whom would otherwise be liable for a portion of the disability. Typically in such cases, causation is readily determinable, but the task of allocation among several partially liable employers would be difficult and impractical. For example, where a worker suffers successive back injuries while working for successive employers, it would be difficult to determine the exact proportion of the resulting disability attributable to each employer. Allocation would also require undesirably duplicative and costly litigation. Instead, the rule assigns liabilty for the entire aggregate disability to the employer at the time of the last injury and dispenses with the need for allocation. * * *.
>
> "The other rule, the rule of proof, was the basis of our decision in *Inkley.* There, the claimant suffered incremental hearing loss caused over a period of time when claimant was subjected to conditions which could cause the disability. During that period, however, his employment was insured by successive insurers. It could not be determined whether

[1] In *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1979), the parties agreed that "liability should be determined according to the last injurious exposure rule." 288 Or at 344. In *Bracke v. Baza'r,* 293 Or 239, 242, 646 P2d 1330 (1982), we stated that the rule was adopted in *Inkley.* Whether or not the rule originally was adopted in *Inkley,* it is now an established rule in Oregon.

> employment under the last insurer actually caused any additional hearing loss. This court held that the last insurer would be liable for the entire disability if the conditions of employment were of a nature which could have contributed to the disability. In such a case, the last injurious exposure rule was applied not only as a substitute for allocation, as in the first class of cases, but also for an altogether different purpose: to relieve the claimant of the 'burden of proving medical causation,' as to any specific insurer, 288 Or at 345. Thus, it is seen that one rule is to efficiently assign liability and another distinct rule fulfills a requirement of claimant's burden of proof." (Footnotes omitted.) 293 Or at 245-46.

The opinion states that the last injurious exposure rule applies to cases of occupational disease as well as injury cases. 293 Or at 248. The *Bracke* opinion also makes clear that the rule has a dual function: It assigns liability between

employers; and it eases the claimant's burden of proof by relieving the worker of the burden of proving specific causation as to one of several potentially liable employers.

When, as here, the evidence shows that a disability[2] is caused solely by an injury occurring during an earlier employment, there is no reason to apply the rule. As in *Bracke,* the finding that the earlier employment caused the disability obviates the need for the rule. By summarizing the results of our previous decisions applying the rule, the inapplicability of the rule in this case is apparent.

(1) In an occupational disease context, if a worker's disability results from exposure to potentially causal conditions in multiple employments and the onset of the disability is during a later employment or thereafter, the last employment providing such conditions is deemed proved to have caused the disease even though the claimant has not proved that the conditions of the last employment were the actual cause of the disease and even though a previous employment also possibly caused the disease. *Fossum v. SAIF,* 293 Or 252, 646 P2d 1337 (1982), is such a case. *Accord, Inkley v. Forest Fiber Products Co.,* 288 Or 337, 605 P2d 1175 (1980); *see also Bracke v. Baza'r, supra,* 293 Or at 249.

(2) In an occupational disease context, if a disease is contracted and disability occurs during one employment as a result of conditions of that employment, even though work conditions of a later employment could have caused that disease, the earlier employer is liable if the later employment "did not contribute to the cause of, aggravate, or exacerbate the underlying disease." *Bracke* is such a case, 293 Or at 250.

(3) In a successive injury context, if an on-the-job compensable injury and a later off-the-job injury materially contribute to a disability, the last injurious exposure rule does not operate to free the employer from responsibility to pay disability benefits. *Grable v. Weyerhaeuser Company,* 291 Or 387, 402, 631 P2d 768 (1981), is such a case. *Compare, Peterson v. Eugene F. Burrill Lumber,* 294 Or 537, 543, 660 P2d 1058

[2] We use the term "disability" throughout the remainder of this opinion because almost all cases applying the last injurious exposure rule are claims for a disability award. The doctrine also might be applicable to claims for medical benefits. ORS 656.245.

(1983) (rule does not apply under successive injury theory unless evidence shows a second injury materially contributes to disability).

(4) In the situation where a compensable injury at one employment contributes to a disability occurring during a later employment involving work conditions capable of causing the disability, but which did not contribute to the disability, the first employer is liable. In *Bracke,* the disability was caused by and arose during the first employment. Even though the conditions of the later employment were capable of causing the disability, the later employer was not liable because that employment did not contribute to the disability. In the case at bar, as well, the later employment did not contribute to the disability; responsibility is properly placed upon the employer whose employment caused the disability.

The last injurious exposure rule is not intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not.[3] Once a worker proves that the disability is work-related, he or she need not prove that any one employment caused the disability. The rule accomplishes that and makes liable the last employer whose conditions of employment might have caused the disability. However, the rule does not prevent a worker from proving that an earlier employment caused the disability; nor does it prevent an employer from proving that the claimant's disability was caused by a different employment or that the disability did not arise from any work-related injury.

In a procedural context, if a worker presents substantial evidence of successive work-related injuries causing disability, a prima facie case for recovery from the last employer is made out. Either or any employer against whom a claim is made still can present evidence to prove that the cause of the worker's disability is another employment or a cause unrelated to the employment. In such a case, the trier of fact

decides the case on the basis of the evidence presented. If the trier of fact is convinced that the disability was caused by successive work-related injuries but is unconvinced that any one employment is the more likely cause of the disability, the finding is for the worker against the last employer whose employment may have caused the disability. On the other hand, if the trier of fact is convinced that the disability was caused by an earlier injury, or was not work related, such a finding may be made.

[3] In some cases, a worker might assert a disability claim against two employers and establish the claim against the later employer by application of the last injurious exposure rule. That would not prevent the later employer from proving that the earlier employment was the sole cause in fact of the disability, in which event the earlier employer would be liable to the worker. But, as *Bracke v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982), makes clear, the worker is not compelled to invoke the rule. The worker always has the option of proving that an earlier employment caused the disability.

True, there is evidence in this case that straining and lifting at the later employment concurred with the first injury to cause the disability. Had the trier of fact made that finding, the second employer would be liable.[4] But the trier of fact (in this case, the Court of Appeals) concluded otherwise, and we are bound by that finding.

The Court of Appeals is affirmed.

[4] The referee made such a finding and ruling. The Board and the Court of Appeals found otherwise, that claimant sustained no injury, new or otherwise, while employed by Northwest. There is evidence to support their findings.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Patricia R. Nelson, Claimant.

NELSON,
Petitioner on review,

v.

EBI COMPANIES,
Respondent on review.

(No. 81-1037, CA A25536, SC 29918)

On review from the Court of Appeals.*

Argued and submitted December 6, 1983.

Richard W. Condon, Salem, argued the cause and filed the petition and brief for petitioner on review.

James N. Westwood, Portland, argued the cause for respondent on review. With him on the brief were Donald P. Bourgeois and Miller, Nash, Yerke, Wiener & Hager, Portland.

Before Peterson, Chief Justice, and Lent, Linde, Campbell, Carson and Jones, Justices.

JONES, J.

The Court of Appeals is affirmed.

* Judicial review from Workers' Compensation Board. 64 Or App 16, 666 P2d 1360 (1983).

JONES, J.

Claimant appealed from an order of the Workers' Compensation Board that reversed a referee's order awarding her 25 percent unscheduled permanent partial disability and reinstated a determination order awarding her only 5 percent unscheduled disability. The Board held that claimant's failure to continue a weight-loss program recommended by her physi-

cians was keeping her from recovering from her injury as fully as she otherwise would and down-rated her degree of permanent partial disability accordingly. The Court of Appeals affirmed the holding of the Board. *Nelson v. EBI Companies,* 64 Or App 16, 666 P2d 1360 (1983). We allowed claimant's petition to review the issue of which party bears the burden of proving whether claimant unreasonably failed to follow needed medical advice or otherwise to mitigate damages.

The Court of Appeals set out the history and facts of this case as follows:

> "Claimant is a 30-year-old certified nurse's aid who sustained a lower back injury on June 18, 1979, when, in the course of her employment at a convalescent center, she attempted to grab a patient who fell while being moved from a wheelchair to a bed. Claimant is 5' 4" tall and, at the time of injury, weighed 300 pounds.
>
> "Dr. Stellflug, a chiropractic physician, initially treated claimant on June 20, 1979. He diagnosed acute lumbar and cervical strains and, in his report of August 10, 1979, noted that her obesity was prolonging her healing time. He referred her to Dr. Todd, an orthopedic surgeon, for evaluation. Dr. Todd's evaluation report concluded that claimant had sustained an acute low back strain and that 'her only source of help' was weight reduction.
>
> "In February, 1980, Dr. Stellflug referred claimant to Dr. Lautenbach, an internist. Dr. Lautenbach's March 7, 1980, report confirmed the earlier diagnoses, noted that she was suffering from anxiety depression and acknowledged that her healing process was hindered by her excessive weight. Dr. Pasquesi examined claimant for evaluation on March 17, 1980, at the request of respondent. At that time she weighed 290 pounds. Dr. Pasquesi found no objective cause for her symptoms 'other than obesity and a large abdomen.' He did note, however, that her subjective symptoms were consistent with lumbosacral instability.

> "Apparently because of Dr. Pasquesi's report, respondent requested further information from Dr. Todd, who stated in a report dated June 27, 1980, that claimant had 'concrete radiographic evidence of degenerative disc disease * * *' and that she was 'seriously working on a weight control program.' In April, 1980, Dr. Todd had arranged for an endocrinological evaluation by Dr. Bouma. In his September 15, 1980, report Dr. Todd stated that Dr. Bouma had found claimant to be euthyroid, nondiabetic and not suffering from Cushing's Syndrome; *i.e.,* he found no physiological cause for her obesity.
>
> "In October, 1980, claimant once again consulted with Dr. Lautenbach, who placed her on a 1,000 calorie per day diet and medication. On March 11, 1981, Dr. Lautenbach reported that claimant had achieved a 37 and one-half pound weight loss. However, on July 21, 1981, prior to the hearing, Dr. Lautenbach signed a statement, prepared by respondent, that no further progress had been seen in claimant's weight loss for two or three months, that she had lost any enthusiasm to proceed further with the weight loss program and that her weight problem was completely within her control.
>
> "The Determination Order found that claimant had a 30 percent, unscheduled disability but awarded her only 5 percent, because the Evaluation Division believed that most of her disability was attributable to voluntary obesity. Claimant

requested a hearing. The referee found that claimant's excessive weight significantly contributed to her overall disability. He found, however, that her overall disability was probably in excess of 30 percent and rated disability due to the injury at 25 percent. He also found that claimant had not wilfully disobeyed her doctor's orders and that she had shown that she had tried to lose weight." (Footnotes omitted.) *Id.* at 18-20.

The Board reversed the referee and reinstated the Determination Order, concluding that, "although claimant made some effort to lose weight, considering all the factors, it was not a reasonable effort." In reaching its conclusion, the Board reasoned as follows:

"Resolution of the parties' contentions requires a discussion of two fundamental but potentially inconsistent principles of workers compensation law. The first is that the employer takes the worker as he finds him; the second is that an injured worker has a duty to mitigate his or her damages. The principle that the employer takes the worker as he finds him is recognized in that a worker is entitled to compensation

for the disabling effects of a pre-existing, nonindustrial condition, provided that the pre-existing condition and work activity combined to produce temporary or permanent disability or required medical services, and the work activity were *[sic]* a material contributing cause. *Hoffman v. Bumble Bee Company,* 15 Or App 253 (1973). The principle that an injured party has a duty to mitigate damages is recognized in that a worker is not entitled to an award of permanent disability to the extent that the worker unreasonably refuses treatment for a pre-existing condition where such treatment would reduce the extent of disability of the compensable condition. *Brecht v. SAIF,* 12 Or App 615 (1973); *Wilson v. Gilchrist Lumber Co.,* 6 Or App 104 (1971)."

The Board then applied these principles to the rating of disability of a compensable injury affected by obesity and concluded:

"(1) A worker is entitled to compensation when work activity interacts with obesity to cause an injury which results in permanent disability, provided that work activity was a material contributing cause for the injury; but (2) a worker is not entitled to compensation for disability attributable to obesity to the extent that (a) the evidence establishes that weight loss would reduce or eliminate the degree of disability, and (b) it is within the voluntary control of the worker to follow such medical advice and lose weight, and (c) the worker has not made a reasonable effort to follow such medical advice. We further conclude that, where a case involves the rating of disability and the issue is raised, *the burden of proof is on the claimant to show that he or she did not unreasonably fail to follow the medical advice to lose weight.*" (Emphasis added.)

The Court of Appeals addressed an analogous problem in *Clemons v. Roseburg Lumber Co.,* 34 Or App 135, 137-38, 578 P2d 429 (1978), and identified

"* * * two threads running through our cases dealing with the effect upon compensation of unreasonable refusal to submit to medical treatment which might promote recovery and expedite reintegration into the labor market: one relating

to proof and the other to restoration. The first emphasizes the burden upon the worker to prove the extent of disability. * * * The other line of cases treats refusal of available treatment as a negative factor in determining extent of compensable incapacity." (Citations omitted.)

The Court of Appeals stated in *Clemons* that the rationale for reduction of benefits when treatment is unreasonably refused is that an employer should not be held responsible for the full extent of a claimant's permanent disability if there is significant likelihood that such disability is partly attributable to the claimant's unreasonable rejection of appropriate treatment. We agree with the test set forth in *Clemons*, 34 Or App at 139, for determining whether a permanent disability award should be adjusted because of the claimant's refusal to submit to recommended treatment. The test is "reasonableness" in this context:

"* * * 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 Industrial Acc. Com.*, 102 Or at 45; *see* 1 Larson, Workmen's Compensation Law [§ 13.22]."

In the present case, the Board commented on the applicability of ORS 656.325(4), which provides:

"When the employer of an injured worker, or the employer's insurer determines that the injured worker has failed to follow medical advice from the attending physician or has failed to participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to ORS 656.001 to 656.794, the employer or insurer may petition the director for reduction of any benefits awarded the worker. Notwithstanding any other provision of ORS 656.001 to 656.794, if the director finds that the worker has failed to accept treatment as provided in this subsection, the director may reduce any benefits awarded the worker by such amount as the director considers appropriate."

The Board said:

"None of the provisions of ORS 656.325 directly pertain *[sic]* to the issue in this case. Subsections (1) and (2) of that statute authorize suspension or reduction of temporary disability payments under various circumstances. Subsections (3) and (4) presume that a claimant has received an award of permanent disability. The issue here is rating of extent of permanent disability. We understand ORS 656.325 to be an

application to specific circumstances of the general principles, applicable to the circumstances of this case, that an injured party has a duty to mitigate damages and that the worker's compensation system is generally not liable for pre-existing, nonindustrial conditions."

ORS 656.325 does not directly apply to this case. However, it indicates that a claimant who has suffered per-

sonal injury has a duty to minimize his or her damages in workers' compensation cases. An unreasonable failure to follow needed medical advice is a form of lack of minimization.

In the common law injury case of *Zimmerman v. Ausland*, 266 Or 427, 432, 513 P2d 1167 (1973), this court said:

> "In considering whether plaintiff is required to mitigate her damages by submitting to surgery we must bear in mind that while plaintiff has the burden of proof that her injury is a permanent injury, defendant has the burden of proving that plaintiff unreasonably failed to mitigate her damages by submission to surgery. * * *"

In workers' compensation cases, we believe the allocation of the burden of proving a claimant unreasonably failed to mitigate damages should follow the common law. We, therefore, hold the Board erred in concluding "where a case involves the rating of disability and the issue is raised, the burden of proof is on the claimant to show that he or she did not unreasonably fail to follow the medical advice [of her physician]." The law allocates to the employer the burden of proof to persuade the trier of fact that the worker unreasonably failed to follow needed medical advice or otherwise to mitigate her damages.

The Court of Appeals found in this case

> "* * * that claimant was able to lose weight for a while, but she eventually lost enthusiasm for her prescribed weight program. There is no indication in this record other than that she could have continued to lose weight, had she gone back to the regimen Dr. Lautenbach prescribed. There was no medical impediment to success, no severe pain or other contraindications; all that was required was an exercise of will. Her failure to make further efforts was unreasonable." *Nelson v. EBI Companies*, 64 Or App at 23.

It appears to us that the Court of Appeals did make its finding upon the prepondrance of the evidence. We affirm.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Noble Price, Claimant.

PRICE,
Petitioner on Review,

v.

SAIF CORPORATION,
Respondent on Review.

(CA A27755; SC 29817)

In Banc

On Review from the Court of Appeals.*

Argued and submitted December 7, 1983.

Evohl F. Malagon, Eugene, argued the cause for petitioner on review. On the brief were Christopher D. Moore and Malagon & Associates, Eugene.

Darrell E. Bewley, SAIF Corporation, Salem, argued the cause for respondent on review.

ROBERTS, J.

Reversed and remanded to the Court of Appeals.

---

* Judicial Review from Workers' Compensation Board. Appeal dismissed by the Court of Appeals June 15, 1983.

ROBERTS, J.

The question in this workers' compensation case is whether the Court of Appeals properly dismissed claimant's appeal from the Workers' Compensation Board as premature.

The record in this case includes the petition for review of the order of the Workers' Compensation Board, with the order of the Board attached, and the documents related to the motion to dismiss. There is no transcript or referee's decision because the Board refused to forward them to the court on the basis that it, not the court, had jurisdiction. We take the following facts from the Board's order.

In October, 1979, claimant suffered a compensable low back strain while lifting lumber at work. During his treatment by three different doctors he expressed a fear of returning to work, and when released for work, arranged to return on a part-time basis. On his second day back at work in March, 1980, claimant began to experience chest pains at the beginning of his four hour shift. The pain became progressively worse after he had finished his shift and he sought treatment at a medical center. After seeking medical information on whether there was a possible relationship between the back injury and claimant's heart condition, SAIF denied the heart condition claim on the basis of insufficient evidence relating claimant's condition to his work activities. Claimant was then evaluated by various doctors including an anesthesiologist specializing in the control of chronic pain, a psychiatrist and two cardiologists.

The Board's order states:

> "[T]he Referee found that claimant suffered some cardiac damage in March and that this was compensably related to his employment by virtue of the stress claimant experienced in relation to his return to work and his fear of reinjuring himself or someone else, or not being able to competently perform his job duties. The Referee alternatively concluded that, if future diagnostic procedures were to reveal that claimant did not have a heart problem and that the etiology of his chest pains was solely psychological, claimant still had established a sufficient causal connection between his chest pains in March of 1980 and his back injury in October of 1979.
>
> "The Referee did not find, nor does the claimant contend on review, that his chest pains were directly caused by work

> activity. Claimant's sole contention is that his chest pain, which he claims constituted a 'heart attack', are within the range of compensable consequences of his original low back injury. This was the Referee's finding, and claimant maintains that the evidence supports this conclusion, based primarily upon the fact that claimant was extremely anxious over the prospect of returning to work in his former capacity, feeling that he was neither physically nor mentally prepared to do so."

After analyzing the range of consequences of an injury, the Board said,

> "We find, as a matter of fact, that, regardless of whether claimant sustained a myocardial infarction after returning to work, the physical symptoms complained of were the result of anxiety experienced in connection with his return to work. We do not find, however, that this anxiety is a 'natural and direct result of' claimant's 1979 low back injury. Our review of the record leaves us with the impression that, even before his back injury, claimant was frustrated with and weary of his vocational situation as a plywood mill worker because of numerous layoffs, loss of seniority and financial insecurity. Although Dr. Holland's interviews with claimant preceded the onset of claimant's chest pain, we find his analysis of claimant's pre-existing feelings about his job helpful. It thus appears that, rather than being a direct and natural result of claimant's 1979 back injury, his 1980 anxiety-induced chest pain was more likely a result of his unhappy vocational situation. Stated differently, we are unable to find that claimant has proven that it is more likely than not that his chest pain on March 4, 1980 and thereafter was within the range of compensable consequences of his 1979 low back injury."

Because the Board reversed the referee's order holding the heart condition[1] compensable, it remanded to the referee for a determination of the extent of disability of the back condition. Claimant filed notice of appeal to the Court of Appeals and SAIF moved to dismiss on the basis that the Board's order was not a final appealable order. The Court of Appeals dismissed the appeal as premature.

We allowed review because we were concerned that claimant presented two separate claims, in which event the determination that the chest pains were not compensable would have been a final order and appealable because no further action would have been required to dispose of the claim. *Winters v. Grimes,* 124 Or 214, 216-17, 264 P 359 (1928). We now conclude from the language in the Board's opinion that this was one claim; all the parties, at the hearing and Board level, treated the heart problem as a new development resulting from the back injury. That, however, does not mean that claimant is precluded from appealing the denial of the heart condition.

[1] We use the words "heart condition" but we note the Board's opinion makes reference to "chest pains" and "heart problem." Our use of "heart condition" is only a way of characterizing this claimed ailment; nothing in our opinion should be interpreted to mean claimant has established a heart condition.

We noted in *Ohlig v. FMC Rail & Marine Equip't Divn.*, 291 Or 586, 596, 633 P2d 1279 (1981) that "partial denials" are recognized and litigated in practice and provided for by administrative rule. The rule cited there, OAR 436-83-125, is still in effect. It provides:

> "Every notice of partial denial shall set forth with particularity the injury or condition for which responsibility is denied and the factual and legal reasons therefor. The notice shall be in the form provided for in [OAR 436-]83-120. Hearing and appeal rights and procedures shall be as provided for claim denials in ORS 656.262(6) and (7), 656.319 and these Rules."

We also pointed out in *Ohlig* that the Workers' Compensation Bar is aware of the practice of partial denials by referring to "Workers' Compensation (Oregon CLE 1980)" § 24.24 which states:

> "A question arises under what might be called a 'partially rejected claim.' A simple demonstration follows: The worker sustains an injury to the lower back. He or she reports the injury and starts receiving compensation. After a period of time, the doctor commences treatment for a neck problem. The worker believes the neck problem is related to the back accident, but the carrier takes a different position. By administrative rule and custom, it is obligated to issue a denial of responsibility for the condition using the same form and giving the same notice of hearing rights as in a denial of claim in the first instance. OAR 436-83-125. Several of these cases have gone to the appellate courts on the merits. Dicta, at least, indicates approval. The supreme court's opinion in *Cavins v. SAIF*, 272 Or 162, 536 P2d 426 (1975) would seem to expand

> the meaning of 'claim' sufficiently to validate partial denials. * * *"

An order which addresses two separate aspects of the same claim, extent of disability on the accepted claim and compensability for an additional allegedly related disease, infection or injury, may finally determine one issue but not the other. Such is the case here. It is clear that there is nothing to be accomplished with reference to the heart condition on remand. The referee would be precluded from considering it again and would calculate extent of disability on the back injury alone; assuming the extent of disability would be appealed, the Board would refuse to consider compensability of the heart condition having already denied compensation.

We deem SAIF's denial, and the Board's affirmance of the denial, of the heart condition to be a partial denial, and it is, therefore, appealable. The remand by the Board is effective only to that portion of the order requiring a determination of extent of disability of the back injury. Extent of disability may be decided while compensability is being litigated. *SAIF v. Maddox,* 295 Or 448, 667 P2d 529 (1983).

The Court of Appeals dismissal was error; we remand for a consideration of whether the heart condition is compensable.

Reversed and remanded.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Norman S. Harwell, Claimant.

HARWELL,
Petitioner on Review,

v.

ARGONAUT INSURANCE COMPANY et al,
Respondents on Review.

(WCB No. 79-08902; CA A25835; SC 29603)

In Banc

On review from the Court of Appeals.*

Argued and submitted October 3, 1983.

Quintin B. Estell, Albany, argued the cause for petitioner on review. With him on the brief was Emmons, Kyle, Kropp, Kryger & Alexander, P.C., Albany.

LaVonne Reimer, Portland, argued the cause for respondents on review. With her on the brief were Robert E. Babcock and Lindsay, Hart, Neil & Weigler, Portland.

CAMPBELL, J.

Remanded to the Workers' Compensation Board.

Carson, J., concurred and filed an opinion.

* On Judicial Review from Workers' Compensation Board. 62 Or App 662, 662 P2d 813 (1983).

CAMPBELL, J.

In this workers' compensation case the claimant suffered a compensable injury to his low back. The referee awarded him 60 percent unscheduled permanent partial disability. The Workers' Compensation Board decreased the award to 15 percent. The claimant appealed to the Court of Appeals which affirmed without opinion. The claimant petitioned this court for review, claiming that the Board's order was in error because it

> "ignored the credible testimony of claimant and his wife concerning such subjective impairment aspects as disabling pain and * * * limited the physical impairment aspect of evaluating permanent disability to the '* * * objective physical findings.' "

If we had determined that the Court of Appeals affirmed after an evaluation of the facts pursuant to the correct rule of law, we would not have allowed the petition for review. We allowed review because the "Court of Appeals may have affirmed the Board as the result of an erroneous inter-

pretation of the law." *Gettman v. SAIF*, 289 Or 609, 612-13, 616 P2d 473 (1980).[1]

We do not review the evidence de novo. *Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979). We accept the following facts which were undisputed in the administrative record.

Claimant was 38 years old at the time of the Workers' Compensation Board hearing. He had worked as a welder, carpenter, housepainter, driver, and in a variety of other occupations. He completed two years of college. He injured his back twice before this injury. The injury with which we are concerned happened in September, 1978 while claimant was employed by defendant, Big Sky Ranch, as a bale wagon operator. The bale wagon was not working correctly, and

claimant moved the 90-150 pound hay bales by hand. The compensability of the claim is not now at issue. The sole issue before the Workers' Compensation Board was the extent of unscheduled permanent partial disability.

Until this injury claimant had worked at jobs which required medium to heavy lifting. After the injury, the medical advice was that he should do no more than light lifting. Claimant received conservative treatment, with no hospitalization or surgery. Treating physicians have uniformly diagnosed claimant's condition as a chronic low back strain, but differed on the extent. Claimant received vocational rehabilitation assistance, and was cooperative in attempting to locate employment. The referee found no evidence of malingering. Claimant is free from non-industrial psychological problems that could affect his disability status. However, the prolonged administrative confusion concerning his claim[2] may have magnified his subjective complaints. His condition is medically stationary. A decreased portion of the job market is open to him since the September, 1978 injury.

Claimant testified that since the injury he has pain in his back and legs. The pain is not constant, but is felt during and after exertion, and is worse some days than others. Claimant testified that on "bad days" almost any movement causes pain.

The claimant's wife corroborated his testimony. She further testified that he had trouble sleeping, avoided lifting, and soaked each morning in the bathtub to relax his muscles.

The Board entered an order in which it reviewed the medical reports and found:

---

[1] For example, where the Court of Appeals affirms with a citation to *Bowman v. Oregon Transfer Company*, 33 Or App 241, 576 P2d 27 (1978), or *Hoag v. Duraflake*, 37 Or App 103, 585 P2d 1149 (1978), it is a strong indication that the case was affirmed by exercise of the Court of Appeals fact finding function.

The determination that the Court of Appeals affirmed on an issue of law is simplified where the Court of Appeals cites a statute or a prior case decided on an issue of law. *See, e.g., Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980). However, the absence of such a signal does not preclude review.

[2] After claimant filed this claim for his back injury, he filed another claim for an unrelated injury to his hand. The claims were consolidated. At least one hearing was postponed due to surgery on claimant's hand. The claim for his hand was settled.

"Based on the guidelines set forth in OAR 436-65-600 et seq., we find based on the objective physical findings that claimant has a 5% impairment rating. Claimant is 38 years of age (0 value), with a high school education and two years of college (−10 value). Claimant's injury occurred while employed as a baleswaggon operator (SVP 4, impact +3). He is now restricted to light work whereas his previous work was classified as medium (+10 value). Combining claimant's education, work background and limitations, claimant has at

least 54% of the labor market still open to him (−25 value). After combining all of the above factors based on the above cited guidelines we conclude claimant would be adequately compensated for his loss of wage earning capacity due to this injury by an award of 48 degrees for 15% unscheduled disability."

Claimant contends that the Board, contrary to Oregon law, mechanically followed its guidelines and ignored the credible testimony concerning the disabling pain he suffered.

Before we reach the claimant's assignment of error we must consider: (1) whether pain which reduces a claimant's earning capacity *must* be considered in establishing the extent of his unscheduled permanent partial disability, and (2) at what point in the compensation scheme does the factfinder consider pain to determine if it reduces the claimant's earning capacity.

We have previously discussed pain in permanent partial disability cases. In *Wilson v. State Ind. Acc. Comm.*, 189 Or 114, 124, 219 P2d 138 (1950), we said:

"It is not the intention of the law to compensate for pain, suffering or nervousness in and of themselves, but the disabling effects of such *may* be considered in determining the disabling effect of any particular injury." (Emphasis added.)

See also, Walker v. Compensation Department, 248 Or 195, 196, 432 P2d 1018 (1967). Both cases interpreted predecessor statutes to the present ORS 656.214(5), which provides:

"(5) In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria [sic] for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, training, skills and work experience. The number of degrees of disability shall be a maximum of 320 degrees determined by the extent of the disability compared to the worker [sic] before such injury and without such disability. For the purpose of this subsection, the value of each degree of disability is $100."[3]

While it is not expressly mentioned by the legislature, disabling pain affects an injured worker's ability to obtain and hold gainful employment. While both the *Wilson* and the

[3] The predecessor statutes did not include the first two sentences, but did include the substance of the third sentence.

Walker cases use the permissive term "may," it was not our intention to give the factfinder discretion to determine whether disabling pain should be considered. When pain has disabling effects, they *must* be considered in establishing awards for unscheduled permanent partial disability.

Board decisions on awards of unscheduled permanent partial disability are determinations of the extent of a claimant's loss of earning capacity due to a compensable injury. This procedure is sometimes aided by use of guidelines, OAR 436-65-600 *et seq.*[4] These regulations divide the decisional process into three steps: (1) setting the impairment rating;[5] (2) modifying this rating by relevant factors[6] and obtaining a percentage;[7] and (3) determining the final award expressed in degrees of disability. We agree with a prior Court of Appeals decision that steps (2) and (3) are distinct from each other, and that the figure obtained by use of the guidelines is not a substitute for a "fair assessment" of the percentage of disability. *Fraijo v. Fred N. Bay News Co.*, 59 Or App 260, 269, 650 P2d 1019 (1982).

We hold that pain is to be considered in setting the "impairment rating." This is true whether the factfinder uses the guidelines or not. If the present guidelines are used, then pain is to be considered in step one. If the guidelines are not used, then pain shall be considered when the impairment to the body function is determined. Pain is compensable only if it results in impairment of the function of the body and therefore pain must be considered when that determination is

made. If pain does not impair function, it is not to be considered. Only if pain causes impairment must the factfinder turn to the question of whether that amount of impairment results in loss of earning capacity.

It appears from the previously quoted portion of the Board's order that it used the guidelines to "find based on the objective physical findings that claimant has a 5% impairment rating."[8]

---

[4] The legislative history supports the Court of Appeals approval of the flexible use of these guidelines as part of the evaluation system, *OSEA v. Workers' Compensation Dept.*, 51 Or App 55, 64-65, 624 P2d 1078 (1981). Minutes, Senate Committee on Labor, Consumer and Business Affairs, April 12, 1979; Minutes, House Labor Committee, June 20, 1979.

[5] This is done pursuant to OAR 436-65-609 to 675 (percentage of the "whole person" impaired), *see* OAR 436-65-600(2)(a).

[6] These factors are listed in OAR 436-65-602 to 608 and include age, education, work experience, adaptability, mental capacity, emotional and psychological impact, and labor market availability.

[7] This is done pursuant to the formula in OAR 436-65-601, *see* OAR 436-65-600(2)(b). For an example of this sort of computation, *see Fraijo v. Fred N. Bay News Co.*, 59 Or App 260, 268, 650 P2d 1019 (1982).

[8] It appears that the Board in arriving at the "5% impairment rating" may have used OAR 436-65-620(2) (SPINAL RANGES OF MOTION):

"* * * * *

"(2) Thoracolumbar region.

"(d) Right or left rotation. For the complete loss of thoracolumbar or low back right or left rotation, a maximum of 5% impairment of the whole person is allowed."

We are unable to find any reference to "pain" in OAR 436-65-600 *et seq.* Cf OAR 436-65-530(3)

The claimant argues that to reach the "5% impairment rating," the Board followed OAR 436-65-600(2)(a) which in part provides:

> "Injury-related impairment of the whole person must be documented in the medical record."

It is the claimant's position that the Board followed its guidelines in a mechanical fashion, considering the medical records only and ignoring the testimony of the claimant and his wife as to subjective complaints of pain.[9]

The claimant further argues that unless "medical record" under OAR 436-65-600(2)(a) is construed to include his and his wife's testimony under oath at the hearing, the rule is contrary to law. ORS 656.283 provides that the claimant is entitled to a hearing. If the testimony of the claimant and his witnesses is not to be considered, then the referee would be required to consider only the medical records and a hearing would be unnecessary. A claimant is a competent witness to testify as to the pain he suffers and his impaired ability to

perform physical labor. *Uris v. Compensation Department,* 247 Or 420, 427, 427 P2d 753, 430 P2d 861 (1967).

The claimant's interpretation of how the Board arrived at its result may or may not be correct. We cannot tell from the record. Our calculation using the complicated mathematical guidelines provides a modified unscheduled permanent partial disability of 11.70 percent. A strict application of the guidelines requires "rounding to nearest five percent." OAR 436-65-601(4). Instead of rounding down to 10 percent, the Board granted an award of 15 percent disability. The Board may have found that the use of steps one and two of its guidelines did not compensate the claimant for his loss of earning capacity adequately by reason of his impairment including pain and therefore added the additional percentage to reach the total of 15 percent.

The Board's order also quoted a conclusion from three physicians of the Orthopaedic Consultants, who examined the claimant. After agreeing that the loss of function from the back injury was minimal, they stated:

> "In our opinion, this man's continuing subjective complaints have been magnified to a great extent as the result of the prolonged administrative confusion which has occurred in this instance."

This may be an indication that the Board considered the claimant's subjective complaints of pain and either rejected them or gave them a minimal rating as a part of impairment.

Another possibility is that all physicians in recom-

[9] In his assignment of error, the claimant says that the Board ignored the "credible testimony of the claimant and his wife." The question of whether the testimony of any witness is "credible" is solely within the province of the factfinder. The finder of fact is not required to believe the testimony of a witness because it is uncontradicted. Reasonable minds might draw different inferences from the testimony. *Rickard v. Ellis,* 230 Or 46, 368 P2d 396 (1962).

mending that the claimant return to a lighter form of work considered his subjective complaints of pain without saying so directly. In this manner, the Board may have considered the claimant's subjective complaints of pain after they had been filtered through the physicians as "preliminary" factfinders.

On the other hand, the referee, the Board, or the Court of Appeals could not be faulted if they read our cases of *Walker v. Compensation Department, supra,* and *Wilson v. State Ind. Acc. Comm., supra,* as giving the factfinder discretion to consider or disregard pain. It may be that they did not give any consideration to pain in this case. Now that we have clarified the rules of the game, it is only fair that we remand this case for reconsideration.

This case is remanded directly to the Board: (1) to determine if its previous decision considered the claimant's subjective complaints of pain, (2) if the complaints were not considered, to proceed to make that consideration, and (3) to consider if OAR 436-65-600 *et seq* are correct in view of this opinion.[10]

Remanded to the Workers' Compensation Board.

CARSON, J., concurring.

I write separately for the purpose of setting forth what I consider to be a clearer statement of the role of pain in workers' compensation cases involving unscheduled, permanent partial disability, although not in contradiction of the majority opinion.

Two fundamental concepts of the law of workers' compensation control the role of pain in this case. The first concept is that pain, in and of itself, is not compensable in workers' compensation cases. *Walker v. Compensation Department,* 248 Or 195, 196, 432 P2d 1018 (1967); *Wilson v. State Ind. Acc. Comm.,* 189 Or 114, 124, 219 P2d 138 (1950); *Lindeman v. State Ind. Acc. Comm.,* 183 Or 245, 250, 192 P2d 732 (1948); 2A Larson, Workmen's Compensation Law § 65.51(c). The second concept is that, in unscheduled, permanent partial disability cases, the disability for which compensation is awarded is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). Thus, as noted by the majority, it is only the *effect* of pain that may result in compensation.

From the statutes, caselaw, and literature, I perceive three levels of pain in cases of unscheduled, permanent partial disability: Pain, pain that impairs, and pain that results in compensable disability.

1. **Pain.**

This first level in the hierarchy of pain frequently is referred to as "pain" or "pain and suffering"

[10] We also note that ORS 656.214(5) requires that the present disability be compared with the worker's condition before the injury. It directs the consideration to a comparison of this particular worker's condition before and after the injury, while OAR 436-65-600(2)(a), discussing impairment, refers to "the average functional capacity normally present in *an* injured worker." (Emphasis added.) This regulation, which directs a comparison of the injured worker's post-injury condition with the pre-injury condition of some hypothetical worker is seemingly at odds with the statute.

and is a generic reference to a sensation of hurting most often found in the usual tort case. It is an injury for which damages may be awarded, both for past and for future pain. As noted above, this level does not result in any compensation in workers' compensation cases.

2. **Pain that Impairs.**

The next level in the examination of pain is pain that impairs function of the body or its parts. It should be pointed out that the impairment may be a contributing factor to, or an indication of, disability, but not necessarily so. For instance, it is conceivable that one would have pain which produces a minor impairment or loss of function that has no effect upon one's earning capacity. No compensation may be awarded for this level of pain, absent impairment of earning capacity.

3. **Pain that Results in Compensable Disability.**

It is this level of pain for which compensation may be awarded. Thus, pain that results in a permanent loss in one's ability to obtain and hold gainful employment in the broad field of general occupations (earning capacity) is disabling pain and compensation may be awarded.

It can be seen that pain is compensable not for what it is (pain), or for what it causes (impairment), but for the effect it has on earning capacity. Thus, using a labeling adjective such as "disabling" in describing pain at any other than the third level blurs the analysis. In fact, it short-circuits it.

Another impediment to the clear application of pain in the workers' compensation context is the legislatively-chosen verb "consider" (or "take into consideration"). It is a word of varying meanings.[1] Thus, with the wide sweep in meaning from "examine" or "look at" to "calculate", the

judicial move to a mandatory requirement ("must") from a discretionary requirement ("may"), as done in the majority opinion, accomplishes little, particularly, if "consider" merely means "to look at". But all of this is irrelevant if the approach spelled out above were followed. In unscheduled, permanent partial disability cases, I would prefer a rule that directs that pain always would be "considered" by the factfinder but only if the factfinder determines that there is pain and that pain causes impairment and that impairment effects a permanent loss of earning capacity, would there be compensation.

[1]Webster's New International Dictionary, 2nd Edition (1934), listed, in part, the following definitions for "consider":

"*Transitive:* 1. To look at attentively; to inspect; to examine.

"2. To fix the mind on; hence, to think on with care; to ponder; to study; to meditate on; also, to bear in mind.

"3. To estimate; calculate. * * *

"*Intransitive:* 1. To look attentively. * * * to reflect; to deliberate. * * *"

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Eugene Thomas, Claimant.

EBI COMPANIES,
Petitioner,

v.

THOMAS et al,
Respondents.

(81-07043 and 81-07044; CA A27118)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 30, 1983.

Deborah S. MacMillan, Portland, argued the cause for petitioner. With her on the brief was Moscato & Meyers, Portland.

No appearance for respondent Eugene Thomas.

Richard Wm. Davis, Portland, waived appearance for respondent Argonaut Insurance Company.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

NEWMAN, J.

Reversed as to penalties and attorney fees.

NEWMAN, J.

Petitioner (EBI) seeks review of an order of the Workers' Compensation Board (Board). EBI assigns as error that the Board awarded claimant penalties and attorney fees. We reverse.

Claimant was employed by O.K. Delivery Systems. He suffered a compensable injury to his back on October 31, 1977. At that time EBI insured the employer. Claimant was released to return to his job on February 19, 1979. On March 5, 1981, claimant again injured his back. At that time, Argonaut Insurance Company (Argonaut) insured employer.

On March 13, 1981, claimant filed an aggravation claim with EBI for the second injury. On June 10, 1981, EBI denied the aggravation claim on the ground that the 1981 injury was a new injury for which Argonaut was responsible:

> "We have reviewed the medical reports and the request for reopening of your claim which was closed by Determination Order dated February 8, 1979. Our investigation indicates that you have not been under active medical treatment since February 19, 1979, and have continued to work at your regular job until March 5, 1981, when you had a definite new incident while lifting a 300 pound pipe. It is therefore, necessary for us to deny the reopening of your claim for aggravation.

"By copy of this letter to Dan Zahn of the Workers' Compensation Board and to Argonaut Insurance Company, we are requesting the appointment of a designated paying agency [under ORS 656.307] to process your claim until the responsibility for your present condition can be determined."

On the same date, EBI informed the Compliance Division that (1) it was sending Argonaut all the medical reports with a notice of EBI's request and (2) it had reinstated temporary total disability benefits for the period from March 5, 1981, and had paid them through June 11, 1981.

On July 20, 1981, Argonaut denied responsibility. It claimed that the 1981 injury was an aggravation of claimant's 1977 injury and that EBI was the responsible insurer. On July 23, 1981, EBI again requested the compliance division to issue an order pursuant to ORS 656.307[1] designating a paying agent, pending final determination of responsibility. On August 19, 1981, the Compliance Division issued a ".307 order" designating EBI as the paying agent.

Claimant requested a hearing on both claims. Each request for hearing named as an issue "Failure to meet requirements of ORS 656.307 and OAR 436-54-332."[2] The referee held a hearing and concluded that EBI was the responsible insurer, because claimant had suffered an aggravation of his 1977 injury. The referee's decision also stated:

"Counsel for claimant labored to show that claimant suffered a new injury rather than an aggravation but was unsuccessful. In view of the court's ruling and comments in *HANNA vs. McGREW BROS. SAWMILL* (45 Or App 757) claimant is not entitled to an attorney fee where responsibility, but not compensability, is the issue.

"However, claimant's counsel claims that if he is not otherwise entitled to an attorney fee, claimant is entitled to penalties and attorneys fees for the insurers' failure to meet the requirements of ORS 656.307 and OAR 436-54-332.

"There is no specific failure to meet the requirements of the statute or rule pointed out. ORS 656.307 and OAR 436-54-332 do not spell out any definite time period for obtaining a '307' Order from the Compliance Division or provide a penalty for delay in the issuance of a '307' Order.

---

[1] ORS 656.307 provides:

"Determination of issues regarding responsibility for compensation payment. (1) where there is an issue regarding:

"(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

"* * * the director shall, by order, designate who shall pay the claim, if the claim is otherwise compensable. Payments shall begin in any event as provided in subsection (4) of ORS 656.262. When a determination of the responsible paying party has been made, the director shall direct any necessary monetary adjustment between the parties involved. * * * (3) The claimant shall be joined in any proceedings under this section as a necessary party, but may elect to be treated as a nominal party."

[2] OAR 463-54-332 provides in part that the Compliance Division shall designate who is to pay a compensable claim when there is an issue regarding which insurer is responsible for payment of compensation, that insurers with knowledge of such a situation shall "expedite the processing of the claim by immediate priority investigation" to determine responsibility and compensability and that insurers shall "immediately notify" any other affected insurers.

"Presumably claimant refers to delays. Claimant's doctor notified EBI of the aggravation claim by letter dated March 11, 1981. Acceptance or denial was due within 60 days (ORS 656.273(6); ORS 656.262(6). EBI's denial was not issued until June 10, 1981. This late denial is presumed to be unreasonable, there being no explanation advanced by EBI. A penalty on this basis would be assessable. However, penalties are based on "amounts then due" (ORS 656.262(9)) and there is no proof of any unpaid compensation due at any point in time and there is uncontradicted evidence that claimant's time loss had been reinstated (EBI's letter of June 10, 1981).

"There was delay in the issuance of the "307" Order and the delay was occassioned [sic] by EBI. Although EBI requested the "307" Order on the same day that it denied the aggravation claim, the denial itself was unreasonably delayed. Without this unreasonable delay, it is presumed that the request for the "307" Order would have been more promptly made and the unreasonable delay in asking for the "307" Order justifies an award of an attorney fee payable by EBI, pursuant to ORS 656.262(9)."

The Board concluded, and it is not challenged here, that Argonaut was the responsible insurer, because the 1981 incident contributed to claimant's subsequent disability. The Board then took up the issues of penalties and attorney fees:

"* * * Although claimant's aggravation claim was dated March 11, 1981 and received by EBI on March 13, 1981, EBI neither denied the claim nor requested an order pursuant to ORS 656.307 until June 10, 1981, about 90 days later. We believe that all denials, whether of compensability or responsibility, have to be issued within 60 days. ORS 656.262(6). In addition, when insurer responsibility issues arise, OAR 436-54-332 requires all involved insurers to "expedite" claim processing by "immediate priority investigation." The 90 day period between EBI's receipt of claimant's aggravation claim and action on that claim does not conform to the letter or spirit of the statute or administrative rule.

"* * * Also, * * * assessment of an attorney fee pursuant to ORS 656.382(1) is appropriate in this case.

"The Referee declined to assess a penalty because EBI was paying interim compensation until the date of its denial; the Referee thus reasoned that there were no amounts of compensation "then due" upon which to assess a penalty. In *Norman J. Gibson,* 34 Van Natta 1583 (1982), we admitted that the

"then due" language of ORS 656.262(9) has created considerable confusion in this kind of situation, but concluded that when a denial is unreasonably late we will assess a penalty on the interim compensation paid between the sixtieth day and the date of the denial."

The Board ordered that EBI pay a penalty to claimant equal to 25% of the compensation for temporary total disability due for the period from May 12, 1981, through June 20, 1981, and also an attorney fee of $400 in lieu of the $500 fee awarded by the referee.

EBI's denial of the aggravation claim was not issued until June 10, 1981, 90 days after it received notice of the

claim. 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."

Claimant's request for hearing designated the issue as "Failure to meet requirements of ORS 656.307 and OAR 436-54-332." EBI argues, and we agree, that this does not raise whether penalties or attorney fees should be allowed for a late denial under ORS 656.262(9). The following exchange took place between the referee and counsel at the hearing:

> "So the issues before us today, as I understand it, are first the question of whether there has been a new accident or an aggravation; there being no contention that this claim is not compensable, and the possibility of an attorney fee to claimant should he prevail against either employer or insurer. I understand that Mr. Roberts on behalf of Argonaut is asserting that the recent decision in the case of *National Farmers Union Insurance v. Dale Scofield* eliminates the possibility of an attorney fee in this case; and because of that, Mr. Turner is asserting the issues originally raised in the request for hearing, to wit, and in effect, penalties and attorney's fees for failure or delay of the insurers to meet the requirements of ORS 656.307 and OAR 436-54-332, that is in a case where an attorney fee is not otherwise allowable.
>
> "Have I correctly stated the issues, gentlemen?
>
> "MR. TURNER: (Counsel for claimant) Yes.

> "MR. MOSCATO: (Counsel for EBI) I will join in Mr. Roberts' contention that claimant's counsel is not entitled to a fee under a 307 Order pursuant to the Scofield decision.
>
> "HEARING REFEREE: I don't remember what that decision said, but I understand that the Board came down with it and ruled on the 307 cases, but I will look into that.
>
> "MR. MOSCATO: I could give you a brief synopsis of it, as it was my case.
>
> "HEARING REFEREE: You might do that in your closing.
>
> "MR. MOSCATO: All right."

This exchange does not include an agreement that penalties or attorney fees for late denial of the claim were issues. Although the referee apparently believed that the issues were raised, he did not award a penalty, stating that "there is no proof of any unpaid compensation due at any point in time and there is uncontradicted evidence that claimant's time loss had been reinstated." Even if claimant had raised the penalty issue, and he did not, there were no "amounts then due" upon which a penalty could be assessed within the meaning of ORS 656.262(9).

EBI also challenges the Board's award of attorney fees to claimant. The referee ruled that EBI's late denial, in the absence of an explanation, was presumed to be unreason-

able, caused the unreasonable delay in asking for the .307 order and justified an award of attorney fees, pursuant to ORS 656.262(9). The Board reduced the attorney fee to $400 and stated that it was "for services rendered in connection with the penalty issue." ORS 656.262(9) provides that insurer shall be liable for "any attorney fees which may be assessed under ORS 656.382" if the insurer "unreasonably delays * * * to pay compensation, or unreasonably delays * * * denial of a claim." As stated above, the issues of penalties or attorney fees for late denial were not raised. EBI requested the .307 order on June 10, 1981. ORS 656.307 and OAR 346-54-332 do not provide for attorney fees (or penalties) if an insurer unreasonably delays a request to designate a paying agent. Neither does 656.262(9) so provide. EBI's request for a .307 order might have been more prompt if its denial of the claim had not been delayed,

but in the absence of specific statutory authority for imposition of attorney fees (or penalties) the Board may not impose them, even if the delay in requesting the .307 order results from unreasonable delay in denial of a claim.

Reversed as to penalties and attorney fees.

---

118 December 7, 1983 No. 649

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Thomas D. Parker, Claimant.

PARKER,
Petitioner,

v.

NORTH PACIFIC INSURANCE CO.,
Respondent.

(80-10438; CA A27534)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 30, 1983.

Charles D. Colett, Portland, argued the cause for petitioner. On the brief were John M. Pitcher, and Galton, Popick & Scott, Portland.

William H. Walters, Portland, argued the cause for respondent. With him on the brief were Brian B. Doherty, and Miller, Nash, Yerke, Wiener & Hager, Portland.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

NEWMAN, J.

Affirmed in part; and remanded for reconsideration.

NEWMAN, J.

Claimant appeals an order of the Workers' Compensation Board affirming the referee's opinion that upheld insurer's denial of three aggravation claims. He first suffered a compensable back sprain on July 25, 1979. Insurer accepted the claim on August 19, 1979. Claimant returned to work at a lighter job in December, 1979. The Evaluation Division issued a determination order on March 3, 1980, that held that he was entitled to temporary total disability for the 1979 injury from July to November, 1979, but not an award of permanent partial disability.

In early February, 1980, claimant again injured his back. On February 13, 1980, his treating physician wrote insurer:

> "Mr. Thomas Parker was seen in my office on February 4, 1980, for a reoccurrence of back pain. The symptoms were similar to his previous back injury. He has had no other back injury since."

On the basis of this letter, insurer accepted the February incident as an aggravation and paid time loss benefits. Claimant was released to return to work on April 28, 1980.

On August 5, 1980, and again on November 24, 1980, claimant suffered off-the-job back injuries, the first while playing softball and the second while reaching into the trunk of his car. Insurer accepted both as aggravation claims. A determination order closed all three aggravation claims on May 5, 1981, and on the basis of a report by an examining physician that claimant was medically stationary on February 23, 1981, awarded claimant time loss for periods through February 23, 1981.

On March 5, 1981, insurer received information from a second treating physician indicating that claimant's injury in February, 1980, occurred while claimant was "wrestling" with his wife. On May 22, 1981, insurer contacted that doctor by telephone to obtain additional information. On July 2, 1981, the doctor affirmed to insurer that "it is medically probable that Mr. Parker's wrestling activities caused the time loss and medical treatment he was incurring prior to and after his visit with [me] on September 24, 1980." Insurer then denied compensability of the February, 1980, injury, and

responsibility for all benefits and treatments from and after that date. Insurer asserted that recent medical evidence showed that the February, 1980, injury was a new injury and that it and the two subsequent injuries were not aggravations of the 1979 injury.

Claimant raises several assignments of error: the Board erred in upholding insurer's denials issued after it had accepted the claims and paid benefits; the denials of the second and third aggravations claims were unreasonable and should be reversed with penalties and attorney fees; claimant was not medically stationary on February 23, 1981, and is

entitled to additional time loss benefits for the third aggravation claim for the period February 23 through May 26, 1981, and penalties and attorney fees for insurer's asserted failure to provide the Evaluation Division with all medical and vocational reports.

Following oral argument in this case, the Supreme Court decided *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983). In *Bauman* the claimant alleged that a bursitis condition was compensable. The insurer accepted the claim as a non-disabling medical claim only. After the claimant's condition worsened, the insurer reversed its acceptance of the claim and denied it as non-compensable on the ground that it did not arise out of or in the course of the claimant's employment. The court held:

> "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."

Here, insurer accepted all three aggravation claims. Accordingly, with respect to that portion of the Board's order affirming the insurer's denial of the three aggravation claims, we remand the case to the Board for reconsideration in light of *Bauman* as to fraud or misrepresentation.

We affirm the Board's order to the extent that it rules that claimant was medically stationary on February 23, 1981, and was not entitled to time loss benefits after that date or penalties or attorney fees for not paying such benefits.[1]

Affirmed in part; and remanded for reconsideration.

[1] Insurer, in fact, paid time loss benefits to claimant to May 10, 1981, because, according to the referee, claimant did not receive the May 5, 1981, determination order until May 10.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Anthony A. Bono, Claimant.

BONO,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(80-11418; CA A27151)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 26, 1983.

Guy B. Greco, Newport, argued the cause for petitioner. With him on the brief was Greco & Escobar, Newport.

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.

BUTTLER, P. J.

Reversed and remanded for determination of penalties and attorney fees.

BUTTLER, P. J.

Claimant appeals the decision of the Workers' Compensation Board denying him "interim compensation,"[1] as well as penalties and attorney fees that he claimed as a result of SAIF's failure to pay interim compensation within 14 days and its failure to accept or deny his claim within 60 days. We reverse and remand.

ORS 656.262 requires that an insurer or employer pay the first installment of compensation no later than the 14th day after notice or knowledge of the claim.[2] ORS 656.262(6) requires that written notice of acceptance or denial of the claim be furnished to the claimant by the insurer or employer

[1] "Interim compensation" is the term used by the court in *Jones v. Emanual Hospital*, 280 Or 147, 570 P2d 70 (1977), to describe compensation payable under ORS 656.262 before a claim is either accepted as compensable or determined to be for a compensable injury. The amount is the same as temporary total disability compensation.

[2] ORS 656.262(4) provides:

"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."

within 60 days after the employer has notice or knowledge of the claim.[3]

Although claimant was injured on October 9, 1978, in an automobile accident that all parties concede was within the course and scope of his employment, neither he nor the employer, who had immediate notice of the accident, believed that he could file a workers' compensation claim stemming from that accident, and he did not then do so. Instead, claimant retained an attorney to pursue an action against the driver of the other vehicle. After that attorney died, claimant retained his present counsel and was advised to file a workers' compensation claim. The employer received written notice of the claim August 26, 1980. SAIF accepted the claim as nondisabling on November 1, 1980. The evidence is inconclusive as to whether claimant was employed in any manner from August 26 to November 14, 1980.

The Supreme Court and this court have construed liberally a claimant's entitlement to interim compensation. Interim compensation is payable even if the claim is ultimately held noncompensable, *Jones v. Emanuel Hospital,* 280 Or 147, 570 P2d 70 (1977), and even if the claimant voluntarily retires before filing his claim. *Stone v. SAIF,* 57 Or App 808, 646 P2d 668, *rev allowed* 293 Or 653 (1982), *appeal dismissed* 294 Or 442 (1983). In addition, this court has, at least impliedly, held that a claimant is entitled to interim compensation even though he was actually employed during the time between the employer's notice of the claim and the denial or acceptance of the claim. In *Likens v. SAIF,* 56 Or App 498, 642 P2d 342 (1982), the Board had disallowed interim compensation, because there was no proof that the claimant was off work or entitled to time off during the time in question, although the Board recognized that under *Jones* failure to prove a compensable claim did not defeat a claimant's right to interim compensation. In reversing, we noted that in *Jones* the court "did not condition that recovery [for interim compensation] on a claimant's proof of entitlement." 56 Or App at 501. The claimant was awarded interim compensation and penalties and attorney fees for the late denial and the nonpayment of interim compensation.

The material facts of this case are indistinguishable from *Likens.*[4] SAIF failed to accept or deny the claim within 14 days after it had received notice of the claim, and claimant is therefore entitled to interim compensation from that day until the date when SAIF accepted the claim. The fact that the claim was accepted as non-disabling is irrelevant to entitlement to interim compensation. SAIF contends that, unless claimant missed work for three days following the injury, he is not entitled to any compensation, because he was not disabled within the meaning of ORS 656.210(3).[5] That statute, how-

[3] ORS 656.262(6) provides, in pertinent part:

"(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. * * *."

[4] The fact that the claim was filed almost two years after the accident occurred does not affect any of the issues in this case. SAIF did not claim prejudice by that delay and accepted the claim without asserting that the claim was not timely filed.

ever, applies only to temporary total disability payments. If SAIF had accepted the claim as non-disabling or denied the claim within 14 days, it would not have been required to pay interim compensation, the function of which, as applied in *Jones,* is to induce prompt action by the employer. Claimant would be entitled to interim compensation even if a late denial of the claim were ultimately upheld; he should have no less right when a claim is accepted as non-disabling.

SAIF relies on two cases in support of its argument that no interim compensation is due. In *Williams v. SAIF,* 31 Or App 1301, 572 P2d 658 (1977), the claimant did not claim interim compensation for a two-week period after she had been released for work by her doctor. In determining what compensation was due the claimant on which a penalty could be assessed, we said that no compensation was due for that two-week period, because claimant made no claim for it. That case is inapplicable here.

SAIF also relies on *Candee v. SAIF,* 40 Or App 567, 595 P2d 1381, *rev den* 287 Or 355 (1979), in which we held that, for policy reasons, the claimant was not entitled to temporary total disability payments from SAIF when he was receiving payments from the non-complying employer equal to those that he would have received had he been employed. Although the issue was not whether claimant was entitled to interim compensation during a time of employment, an analogous rule here would suggest that interim compensation should be offset by wages earned during the period. In *Petshow v. Portland Bottling Co.,* 62 Or App 614, 661 P2d 1369, *rev pending* (1983), two insurers contested responsibility for the claim. One was late in denying the claim and was ordered to pay interim compensation; the other commenced payment of temporary total disability payments for the same period. We held that the insurer that paid temporary total disability payments was entitled to an offset against any future award of permanent disability for the amount of temporary total disability it had paid claimant during the time he was entitled to interim compensation.

Although those authorities do not support SAIF's contention that claimant is not entitled to interim compensation if he was not disabled, *Candee* and *Petshow* lend some support to the argument that there should be an offset for the

amount, if any, claimant earned during the period in question. Both of those cases, however, involved offsets against disability payments, not against interim compensation. We understand the rationale in *Jones* to be that interim compensation is primarily to induce insurers to deny a claim promptly or be required to pay interim compensation, regardless of the validity of the claim. It is not really payment for a compensa-

[5] ORS 656.210(3) provides:

"No disability payment is recoverable for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of his compensable injury unless the total disability continues for a period of 14 days or the worker is an in-patient in a hospital. If the worker leaves work the day of the injury, that day shall be considered the first day of the three-day period."

ble loss; its function is to protect a claimant against unreasonable delay in processing the claim. Here, as in *Jones*, if the insurer knew that claimant was working and that it could offset his earnings, there would be little, if any, incentive to process the claim expeditiously. Accordingly, we conclude that SAIF is obligated to pay claimant interim compensation with no offset for time worked.

Claimant also contends that the Board erred in failing to award penalties and attorney fees, both for the failure to pay interim compensation and for the late acceptance. It is clear that SAIF failed to pay interim compensation timely and also failed to deny or accept the claim within the 60 days prescribed by ORS 656.262. Because SAIF fails to advance a valid excuse for failure to comply with the statutory time limits, claimant is entitled to penalties and reasonable attorney fees, both for the late acceptance and for the late payment of interim compensation. *Jones v. Emanual Hospospital, supra; Likens v. SAIF, supra; Stone v. SAIF, supra.*

Reversed and remanded for a determination of penalties and attorney fees.

No. 655 December 14, 1983 155

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wilma Forney, Claimant.

FORNEY,
Petitioner,

v.

WESTERN STATES PLYWOOD,
Respondent.

(WCB No. 80-07538; CA A25760)

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.

J. P. Graff, Portland, argued the cause for respondent. With him on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed and remanded for an order requiring employer to repay the amount deducted as an offset.

WARREN, J.

Claimant appeals a decision of the Workers' Compensation Board, which affirmed the referee and held that employer had acted within its authority in unilaterally recovering an overpayment of permanent partial disability by deducting the amount from payments of temporary total disability.

The parties have stipulated to the facts. Claimant was injured on January 21, 1974. A determination order was issued on July 20, 1976, awarding temporary total disability and 20 percent unscheduled permanent partial disability. Those awards were paid in full. On March 10, 1977, a second determination order was issued which set aside the first determination order on the basis of additional evidence. On November 27, 1978, a third determination order was issued awarding temporary total disability and again awarding 20 percent unscheduled disability. Again, both awards were paid in full. By stipulation of the parties on July 6, 1979, claimant was awarded an additional 15 percent unscheduled disability, which was paid in full.

In October, 1979, claimant filed an aggravation claim which, following a hearing, was ordered accepted on June 23, 1980. At some point, employer became aware that an overpayment had been made of 20 percent permanent partial disability, or $4,480. On July 10, 1980, employer notified claimant of that overpayment and that it intended to deduct the overpayment at the rate of 25 percent of the retroactive temporary total disability and 25 percent of the ongoing temporary total disability. At the time that the stipulated facts were filed, the entire overpayment had been recovered and claimant was receiving temporary total disability with no reduction.

The issue before this court is whether an employer may, without prior approval by the Evaluation Division, referee or Board, recover an overpayment by deducting it from current or future payments due. Employer relies on OAR 436-54-320:

> "Insurers and self-insured employers may recover overpayment of benefits paid to a worker on an accepted claim from benefits which are or may become payable on that claim. Payment of benefits paid prior to denial pursuant to ORS

> 656.262(5) or paid during appeal pursuant to ORS 656.313 shall not be recoverable under this section.
>
> "(1) Overpayments may be recovered by:
>
> "(a) reduction of continuing temporary disability benefits in an amount not to exceed 25 percent of the benefit without prior authorization from the worker or beneficiary;
>
> "(b) withholding reimbursement of related services to the worker; or
>
> "(c) adjustment in compensation benefits determined due pursuant to ORS 656.268, to include permanent partial disability, permanent total disability and fatal disability benefits. Recovery of overpayment from a permanent partial

disability award may result in partial or total offset against the award. Recovery from a permanent total disability or fatal award shall be made as in (a) above.

"(2) Recovery of overpayment by the insurer or self-insured employer shall be explained in written form to the worker, or to the dependent(s) of the worker if a fatality, and include:

"(a) an explanation for the reason of overpayment;

"(b) the amount of the overpayment; and

"(c) the method of recovery of the overpayment.

"(3) Overpayments may not be recovered by withholding payments to the providers of services or from reimbursable temporary disability paid during an approved vocational rehabilitation program."

Claimant apparently acknowledges that, if OAR 436-54-320 is authorized and valid, recovery of the overpayment in this case was proper. However, she argues that under our prior decisions OAR 436-54-320 is clearly inconsistent with the law.

The only specific statutory basis for any offset by an employer or carrier of prior overpayments against currently due payments is ORS 656.268(4):

"Within 10 working days after the Evaluation Division receives the medical and vocational reports relating to a disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the director's supervision. If necessary the Evaluation Division may require additional medical or other information with respect to the claim, and may postpone the determination for not more than 60 additional days. *Any*

determination under this subsection may include necessary adjustments in compensation paid or payable prior to the determination, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid. The Evaluation Division shall reconsider determinations made pursuant to this subsection whenever one of the parties makes request therefor and presents medical information regarding the claim that was not available at the time the original determination was made. However, any such request for reconsideration must be made prior to the time a request for hearing is made pursuant to ORS 656.283. The time from request for reconsideration until decision on reconsideration shall not be counted in any limitation on the time allowed for requesting a hearing pursuant to ORS 656.283." (Emphasis supplied.)

The offset is provided by that statute only for determinations "under this subsection," which deals exclusively with determinations "under the director's supervision" or by the Evaluation Division. ORS 656.268(6) provides that any interested party may request a hearing on a determination made under subsection (4). Thus, a referee and the Board have the authority to authorize offsets.

We do not interpret ORS 656.268(4) to provide the only circumstance in which an insurer or self-insured employer may obtain authorization to recover overpayments

from future compensation. That statute relates only to proceedings leading to a determination order and permits an employer or an insurer to obtain authorization to recover overpayments in that proceeding. If, for example, an employer should discover an overpayment after a determination has become final, but while future compensation, subject to reduction, is owed, the employer may request a hearing pursuant to ORS 656.325(6), which 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."

We do not decide whether the right to recover an overpayment may be waived by the employer's unreasonable delay in raising the issue.

The Board, in enacting OAR 436-54-320, exceeded its authority by attempting to expand the precise language of ORS 656.268(4) and 656.325(6), to allow an offset by an employer or carrier without requiring it to go through the procedure specified by either statute. Insofar as OAR 436-54-320 permits or has been interpreted to permit an insurer or self-insured employer to reduce benefits without prior authorization from the Evaluation Division, it is invalid. This is consistent with our previous holdings in *Wilson v. SAIF,* 48 Or App 993, 618 P2d 473 (1980) and *Hicks v. Fred Meyer, Inc.,* 57 Or App 68, 643 P2d 1311, *modified* 58 Or App 18, ___ P2d ___ (1982), in which we held that ORS 656.268(4) does not allow unilateral recovery of an overpayment by an employer or a carrier.[1]

Reversed and remanded for an order requiring employer to repay the amount deducted as an offset.

---

[1] Because of our disposition of this case, we do not need to discuss the additional arguments of petitioner.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dalia Mesa, Claimant.

MESA,
Petitioner,
v.
BARKER MANUFACTURING CO. et al,
Respondents.

(WCB No. 81-00393; CA A25571)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 14, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Deborah MacMillan, Portland, argued the cause for respondents. With her on the brief were Frank A. Moscato, and Moscato & Meyers, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed as to extent of scheduled disability; reversed and remanded for an order requiring employer to repay amount deducted as an offset.

WARREN, J.

Claimant seeks reversal of a decision of the Workers' Compensation Board, claiming two errors. First, she alleges that the Board erred in holding that employer had acted within its authority in unilaterally recovering an overpayment of temporary total disability payments by deducting it from currently due temporary total disability payments. Second, she alleges that the Board erred in reducing the award of scheduled disability so that claimant would not receive any compensation for her functional overlay. We reverse and remand on the first issue and affirm on the second.

We held in *Forney v. Western States Plywood,* 66 Or App 155, ___ P2d ___ (1983), that OAR 436-54-320 is invalid and that employers and carriers are not allowed unilaterally to deduct overpayments from current amounts due under compensation awards without prior approval from the referee or the Board. The facts in this case are indistinguishable from those in *Forney.* We therefore reverse that portion of the Board's order and remand for an order requiring employer to repay the amount deducted as an offset.

The Board ruled that functional overlay was documented by several physicians but that the record was "still devoid of proof that the condition was caused or aggravated by

the injury or that such condition is permanent." The Board therefore held that the functional overlay should not have been considered in this case. Employer argues that a functional overlay can never be considered in evaluating the extent of a scheduled injury.

ORS 656.214(2) provides that the standard for determining the extent of permanent partial disability of a scheduled injury "shall be the permanent loss of use or function of the injured member due to the industrial injury." Nothing in the statute requires that the loss be solely due to physical disability or cannot include loss resulting from a psychological inability to use the member by reason of a functional overlay. Employer argues that *Woodman v. Georgia-Pacific Corp.*, 289 Or 551, 614 P2d 1162 (1980), is controlling in the case. In *Woodman,* the Supreme Court merely stated that the applicable standard under the statute was permanent loss of use or function and that loss of earning capacity cannot be considered. *Woodman* does not stand for the proposition that a

functional overlay, that contributes to the permanent loss of function or use of the scheduled member cannot be considered in determining the permanent award.

In *Lucky v. SAIF,* 27 Or App 565, 556 P2d 712 (1976), this court held that a functional overlay may be considered in determining the extent of a permanent unscheduled disability. We have found no case in which this court has resolved the issue of whether a functional overlay may be considered in rating a scheduled disability. However, so long as the functional overlay is related to the injury and it, together with the physical injury, permanently limits the use or function of a claimant's scheduled member, we see no reason why it should not be considered in determining the extent of permanent disability.

The Board states that the record is devoid of proof that the functional overlay was caused or aggravated by the injury or that such condition is permanent. However, Dr. Button stated that the functional overlay is related to claimant's left wrist and arm condition, and we believe the record supports a finding that the functional overlay was related to the accident. That functional overlay increases the loss of use or function of claimant's wrist and arm. However, we have reviewed the evidence and find that, taken as a whole, the evidence does not convince us that claimant's functional overlay permanently limits her use or function of the scheduled member.

The order of the Board is affirmed as to extent of scheduled disability; reversed and remanded for an order requiring employer to repay the amount deducted as an offset.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent,

v.

HARRIS,
Appellant.

(50932; CA A27568)

Appeal from District Court, Washington County.

John J. Tyner, Jr., Judge.

Argued and submitted September 26, 1983.

Allen T. Murphy, Jr., Portland, argued the cause for appellant. With him on the brief were Marla J. McGeorge and Richardson, Murphy & Tedesco, Portland.

Darrell E. Bewley, Appellate Counsel, SAIF, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Order vacated.

WARREN, J.

Claimant appeals from a district court order which allowed SAIF to recover funds paid to claimant as a result of a workers' compensation permanent partial disability award. After claimant received payment of the award, the award was reversed by the Board. Claimant argues that the district court has no jurisdiction in cases regarding overpayment of workers' compensation benefits. We agree and vacate the order.

Claimant suffered an injury to his back while working for an employer insured by SAIF. He filed a claim and was awarded $2,720 for permanent partial disability on May 1, 1980. After SAIF paid the award, the order was set aside and the Workers' Compensation Department issued a new determination order that provided no permanent partial disability. SAIF brought this action in the district court on a theory of money had and received, seeking to recover the amount previously paid claimant. Thereafter, claimant filed a request for a hearing under the Workers' Compensation Act. One of the issues before the referee was whether SAIF's conduct in attempting to collect an overpayment in district court was proper. The referee ruled that SAIF could not recover the overpayment in district court. SAIF did not appeal that order but filed a motion for summary judgment in the district court action. Claimant also moved for summary judgment. The district court awarded summary judgment to SAIF, and claimant appeals, asserting that the district court action was improper, because it had no jurisdiction to consider the case.

Although we have previously interpreted ORS 656.268(4), this is the first time we have addressed its application to trial court jurisdiction. In previous cases, this court has strictly construed the authority of employers under ORS 656.268(4) to recover overpayments. *Wilson v. SAIF,* 48 Or App 993, 618 P2d 473 (1980); *Hicks v. Fred Meyer, Inc.,* 57 Or App 68, 643 P2d 1311, *modified* 58 Or App 18, ___ P2d ___ (1982).

The jurisdiction of the Hearings Division and the Board are established by the Workers' Compensation Act. In ORS 656.704(3), the authority of the Director and the Board is expressly provided for "matters concerning a claim under ORS 656.001 to 656.794." "Matters concerning a claim" is defined as "* * * those * * * in which a worker's right to receive

compensation, or the amount thereof, are directly in issue." The authority of the Hearings Division is set forth in ORS 656.708(3), which states, in pertinent part:

> "* * * The division has the responsibility for providing an imparital forum for deciding all cases, disputes and controversies arising under ORS 654.001 to 654.295, all cases, disputes and controversies regarding matters concerning a claim under ORS 656.001 to 656.794, and for conducting such other hearings and proceedings as may be prescribed by law."

The legislature has unequivocally provided that the Hearings Division and the Director shall have jurisdiction over "all cases, disputes and controversies" arising under ORS 656.268(4), which governs recovery of an overpayment. In another portion of the act, specific provision is made for resolution in circuit court of a dispute over attorney fees. ORS 656.388(2). If the legislature had intended that other kinds of disputes arising under the workers' compensation law be heard in trial courts, it could have expressly so stated. On the contrary, a review of the entire act reveals a deliberate purpose to separate jurisdiction over workers' compensation cases almost totally from the trial courts. The District Court had no jurisdiction.

Given our disposition of the case, we do not need to reach claimant's second issue that the district court's order was barred by *res judicata* or collateral estoppel.

Order vacated.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

TOOTHMAN,
Plaintiff,
v.
CONCEL, INC. et al,
Appellants,
v.
BOISE-CASCADE CORPORATION,
Respondent.
(A8012-07196; CA A26308)

Appeal from Circuit Court, Multnomah County.

Richard Maizels, Judge Pro Tempore.

Argued and submitted April 29, 1983.

James H. Gidley, Portland, argued the cause for appellants. On the briefs were Timothy R. Volpert and Cosgrave, Kester, Crowe, Gidley & Lagesen, Portland.

Barnes H. Ellis, Portland, argued the cause for respondent. On the brief were Joyce M. Bernheim and Charles F. Adams, and Stoel, Rives, Boley, Fraser and Wyse, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Third-party plaintiffs, Concel, Inc. and APL Corporation (Concel), appeal from a summary judgment for third-party defendant Boise-Cascade (Boise) on Concel's claim for indemnity.

The case arose from a personal injury suffered by a Boise employe operating a paper machine owned by Concel but located in Boise's paper mill in St. Helens. Boise and Concel entered into a contract in 1968, under which Boise agreed to

> "operate, service and maintain [Concel's] paper machine up to full capacity * * * as Concel may direct * * * including the furnishing of all labor, materials, parts, supplies and sundries as may be reasonably necessary * * *."

In February, 1979, Boise's employe was injured when her arm was caught in the machine. Boise paid workers' compensation benefits to the employe, fulfilling its statutory obligation under ORS 656.017(1). The employe subsequently filed an action against Concel, as owner of the paper machine, alleging negligence and a violation of the Employers Liability Act, in that Concel failed properly to instruct the employe,

required the employe to use a razor knife while the machine was in motion, failed to inspect the machine and failed to provide a proper guard and mechanical cutters for the paper. Concel filed a third-party complaint against Boise, seeking indemnity for any liability it might incur as a result of the injury to Boise's employe. Boise moved for summary judgment, and the trial court granted it.[1] We affirm.

When a motion for summary judgment is supported by affidavits or other documents, the adverse party may not rest on allegations of the pleadings to raise issues of fact but must respond by affidavit or otherwise. ORCP 47D; *Gleason v. International Multifoods Corp.*, 282 Or 253, 258, 577 P2d 931 (1978); *Verret v. DeHarpport*, 49 Or App 801, 804, 621 P2d 598 (1980). Boise filed an affidavit and documents in support of its motion and asserts that there are no factual disputes and that no independent duty runs from Boise to Concel to maintain a safe workplace or otherwise protect Concel from liability for

injury to Boise's employes on a theory of negligence or under the Employers Liability Act. As a result, Boise contends that it cannot be liable to Concel as a matter of law and that the trial court was correct in granting summary judgment. Concel filed nothing in opposition to the motion.

Summary judgment may be granted

> "* * * if the pleadings, depositions, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. * * *" ORCP 47C.

Whether Boise was entitled to a judgment as a matter of law depends on whether, from the materials before the trial court, an issue of fact exists that an independent duty, express or implied, was owed by Boise to Concel. Because we find that there was no such issue of fact, we need not resolve whether ORS 656.018(1)[2] bars this action for indemnification.

Concel argues that Boise voluntarily assumed an independent duty based on Boise's express contractual promises, that Boise breached that duty causing an employe's injury and that Boise should therefore be liable for the resulting judgment against Concel. It relies on *U.S. Fidelity v.*

---

[1] The jury subsequently returned a verdict against Concel in favor of plaintiff, finding Concel 67 percent negligent and plaintiff 33 percent negligent.

[2] The current version of ORS 656.018(1) provides:

"(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to his subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in ORS 656.001 to 656.794.

"(b) This subsection shall not apply to claims for indemnity or contribution asserted by a corporation, individual or association of individuals which is subject to regulation pursuant to ORS chapter 757 or 760.

"(c) Except as provided in paragraph (b) of this subsection, all agreements or warranties contrary to the provisions of paragraph (a) of this subsection entered into after July 19, 1977, are void."

Kaiser Gypsum, 273 Or 162, 539 P2d 1065 (1975). The court held there that, when a third-party plaintiff's liability to an injured worker has resulted from a breach of an independent duty, express or implied, owed by the employer to the third-party plaintiff, an action for indemnity is not barred by ORS 656.018(1), which generally relieves an employer who has

satisfied the duty of paying statutory compensation from "all other liability" for compensable injuries.

The 1968 contract between Boise and Concel contains no express agreement to indemnify. In *Sandwell International Inc. v. American Can Co.*, 47 Or App 429, 614 P2d 620, *rev den* 290 Or 157 (1980), we held that an engineering firm could not recover against the employer of an injured worker for indemnity, because there was no independent duty of care from the employer to the engineering firm:

> "* * * Such an independent duty does not arise simply from the fact that defendant purchased services from plaintiff. There must be some evidence of a *particular duty*. *Boldman v. Mt. Hood Chemical Corporation*, [288 Or 121, 128, 602 P2d 1072 (1979)]. * * * American's duty to maintain a safe work environment runs solely to its employes. This duty is discharged by payment of worker's compensation benefits." 47 Or App at 434. (Emphasis in original.)

Concel points to the following specific contractual promises contained in section 8 of the 1968 agreement to support its claim that Boise has an implied independent duty of care:

> "8. *Operation of the Paper Machine.* Boise shall for the period commencing on May 1, 1969 and ending December 31, 1988:
>
> "(a) Operate, service and maintain the Paper Machine up to full capacity (now approximtely 40,000 tons of 14 lb. tissue paper per year) in such manner as Concel may direct, and handle, store and ship at the sole costs and expense of Concel the finished paper from the Paper Machine in such manner as Concel may direct, including the furnishing of all labor, materials, parts, supplies and sundries as may be reasonably necessary (or as Concel may reasonably direct in connection with such operations). Full capacity shall include any increase in productive capacity as a result of capital improvements or operating or grade mix efficiencies;
>
> "(b) Provide and maintain the No. 3 Paper Machine building at the Mill, including all structural facilities used in conjunction with the Paper Machine, but excluding the portions used for the roll grinder, and all services therein in good condition so as to assure the continued operation of the Paper Machine and, in addition, provide the necessary equipment, facilities and labor for transporting finished paper to the

> railroad, truck or barge dock facilities used in shipping finished paper from the Mill * * *."

As a general rule, construction of a contract is a question for the court and is a matter of law. *Timberline Equip. v. St. Paul Fire and Mar. Ins.*, 281 Or 639, 643, 576 P2d 1244 (1978); *May v. Chicago Insurance Co.*, 260 Or 285, 292,

490 P2d 150 (1971). The stated purpose of the quoted contract provisions is to maintain the continued and efficient operation of the machine facilities to the end that Concel receive finished paper products. Assuming that the provisions may create by implication a duty of care from Boise to Concel to protect Concel from liability to Boise's employes for injury. Even if we read the contract to require Boise to operate, service and maintain the machine in a safe manner or condition for the safety of its employes, we conclude that that duty was also assumed by Concel, which undertook in the express provisions of the contract to direct Boise in the manner in which it performed those duties. Accordingly, any such duty would be a joint duty of both Boise and Concel, for which there can be no indemnity. *See U.S. Fidelity v. Kaiser Gypsum, supra,* 273 Or at 177.

Concel argues in the alternative that an independent duty arises from the fact that Boise was a bailee of its paper machine. It does not appear from the record that that basis of liability was urged in the trial court. Accordingly, we do not consider it on appeal. *Hunter v. Walls,* 57 Or App 152, 154, 643 P2d 1352, *rev den* 293 Or 373 (1982). Summary judgment in favor of Boise was appropriate.

Affirmed.

No. 659 December 14, 1983 175

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David S. Mathews, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Petitioner,

v.

MATHEWS,
Respondent.

(WCB No. 81-06365; CA A27331)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 26, 1983.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund, Salem, argued the cause and filed the brief for petitioner.

Evohl F. Malagon, Eugene, argued the cause for respondent. With him on the brief was Malagon & Associates, Eugene.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

SAIF appeals from an order of the Workers' Compensation Board which held that claimant had sustained an aggravation for which SAIF was responsible. We affirm.

On February 28, 1978, claimant sustained an injury to his low back while employed as a clean-up man by a company for which SAIF was the insurer. The claim was closed by a determination order that awarded claimant three days temporary total disability and no permanent disability. He was released for work with no permanent impairment on May 3, 1978. In June, 1978, he quit the SAIF-covered job, and five or six weeks later he obtained employment with Carothers Sheet Metal Co. (Carothers) as a clean-up man. On August 8, 1978, he was told by his doctor to avoid restraining his back for the next four to six weeks or else his symptoms would return. No specific incident occurred while he was employed by Carothers, but his symptoms of low back and left leg pain gradually increased.

On August 18, 1978, claimant saw Dr. Gorman about the increasing back pain. He took the remainder of that day off and returned to work the next day. On October 27, 1978, SAIF issued a denial of responsibility, stating: "It appears that you re-injured your back on August 18, 1978." He did not appeal the denial. On December 8, 1978, he filed a claim with Carothers, stating that his back was re-injured and giving August 18, 1978, as the date of injury. The claim was accepted by Carothers as nondisabling. Claimant continued to work until approximately April, 1979, and did not lose any work because of his back condition during that period of time. He left Carothers for a reason unrelated to his disability. Dr. Gorman noted that objective findings after claimant's employment at Carothers were the same as they were following the injury for which SAIF was responsible.

On June 6, 1981, Dr. Gorman stated to SAIF that claimant's low back and leg problem had increased in severity with marked symptomotology. On July 9, 1981, SAIF issued a denial for that aggravation claim, stating that Carothers was responsible. On September 2, 1981, Carothers issued a denial, stating that SAIF was responsible. On December 11, 1981, claimant entered into a disputed claim settlement with Carothers that recognized a bona fide dispute as to the validity of

the claim against Carothers for the June 6, 1981, aggravation, and which purported to settle all claims against Carothers. Thereafter, a hearing was conducted, and SAIF was held to be responsible for claimant's condition. The Board affirmed the decision of the referee.

SAIF contends that it is not liable for this claim for three reasons. First, it argues that Carothers' acceptance of of a claim as nondisabling for an injury in the same area as that involved in the prior SAIF claim cuts off all future liability of SAIF for the original disability. Second, it apparently argues that claimant's entering into a disputed claim settlement with

Carothers bars recovery against SAIF, because it would amount to "double benefits." Third, it argues that, under *Boise Cascade Corp. v. Starbuck,* 61 Or App 631, 659 P2d 424, *rev allowed* 294 Or 792 (1983), Carothers is the responsible employer.

We hold that, under the limited facts of this case, SAIF is not released from all future responsibility for aggravations of claimant's condition by the fact that a second employer accepted as a nondisabling a reinjury to the same portion of the body. The claim that Carothers accepted involved a doctor's appointment and the missing of one-half day of work. By accepting the claim, the second employer is barred from later denying the same claim. *Bauman v. SAIF,* 295 Or 788, ___ P2d ___ (1983). However, it is not barred from proving that a later aggravation is attributable to the original claim and not to claimant's employment at Carothers. Instead, the evidence must be weighed to determine which employer is responsible for the most recent aggravation.

Although it is not absolutely clear from the brief, SAIF's second argument appears to be that claimant is barred from recovery against SAIF because he entered into a disputed claim settlement with Carothers for the same injury. The very essence of a disputed claim settlement is that the parties disagree as to liability. Neither forsakes its position, but both agree for the purpose of that claim only to settle the dispute for a certain amount. SAIF states that claimant gave up nothing as a result of the disputed claim settlement but obtained a benefit. To the contrary, claimant did give up a substantial right, the right to recover against Carothers. If we were to hold that Carothers were responsible for claimant's

condition, he would be barred by the disputed claim settlement from recovery against Carothers, at least for this aggravation. There is no provision in the statutes for subtracting the amount obtained on a disputed claim settlement from the amount eventually recovered from another responsible employer. Therefore, although it may in some manner be seen as a double recovery, it is one allowed by statute, and entering into the disputed claim settlement does not bar claimant's recovery against SAIF.

Finally, SAIF argues that, under all the facts of the case, claimant sustained a new injury at Carothers and that, therefore, Carothers is responsible for the current aggravation. The medical evidence does not support SAIF's contention. The preponderance of the evidence establishes that claimant's most recent aggravation is attributable to his original injury, for which SAIF is responsible.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Kenneth E. Gulick, Claimant.

GULICK,
Petitioner,

v.

CHAMPION INTERNATIONAL,
Respondent.

(WCB No. 81-10359; CA A27325)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 26, 1983.

Quintin B. Estell, Salem, argued the cause for petitioner. On the brief was Emmons, Kyle, Kropp, Kryger & Alexander, Salem.

Keith D. Skelton, Portland, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed; claimant awarded permanent total disability as of September 19, 1981.

ROSSMAN, J.

Claimant appeals an order of the Workers' Compensation Board which held that he is not permanently and totally disabled. We reverse.

Claimant is a 52-year-old man with an eighth grade education and work experience limited to heavy labor. He initially sustained an industrial injury on November 20, 1975, when he stepped off a forklift, slipped and hurt his back. He was released for modified work on December 1, 1975. He sustained a second injury while working for the same employer on May 18, 1976, when he slipped on a piece of sap board and pulled his hip. In June, 1977, he had surgery to his back as a result of the latter accident. Employer referred him to rehabilitation counselor Huddon, who, on November 20, 1979, noted that claimant was cooperative, but has only an eighth-grade education, experience only in heavy labor and no transferable skills. Huddon stated:

> "The most important factor in this individual's inability to hold a job down, is his physical complaints. * * *
>
> "It is felt that voluntary retirement due to the inability to have this individual profit from the rehabilitation process is certainly in his best interest. This is agreed upon by [claim-

ant], therefore it is this Consultant's opinion and feeling that the vocational rehabilitation process be considered not in this individual's best interest, and therefore I will be closing his case with that idea in mind."

On February 1, 1980, claimant underwent a decompression laminectomy. Thereafter, his condition continued to deteriorate. On April 9, 1981, Dr. Padel recommended treatment at a pain clinic, stating: "* * * It is to the point now where it would appear on the surface that he is near wheelchair material." After claimant had attended the pain clinic, Padel noted a dramatic improvement in his condition, reporting that he walked five miles a day and was not using a back support. Claimant was taking only Tylenol, was losing weight and was cheerful and determined. In spite of that improvement, Dr. Seres, on discharge from the pain clinic, reported that claimant had a significant disability in his low back. However, Padel continued to be optimistic until September, 1981, when claimant's right leg collapsed twice on him

and his condition again deteriorated. He reported on September 29, 1981, that claimant's condition following the two falls was such that "* * * I do not see the patient rehabilitated into any form of gainful employment. For all practical purposes his disability is permanent and total." On December 15, 1981, claimant was getting out of a car when his right leg again collapsed. He fell across a curb and rolled part way down a hill. His condition further deteriorated, and as a result of that fall he returned to the back brace and cane. Padel's reports, up to the date of the hearing, state that claimant's right leg continued to go out on him periodically and was constantly cold and numb.

The referee awarded claimant 80 percent unscheduled disability. The Board affirmed, holding that claimant had failed to meet his burden of proving that he had unsuccessfully sought employment pursuant to ORS 656.206(3) and therefore had not established that he is permanently and totally disabled.

We hold that claimant has established by a preponderance of the medical evidence that he is permanently and totally disabled. Employer has presented no medical reports which dispute Padel's conclusion of September, 1981, that claimant's disability is permanent and total. Further, we are satisifed that claimant has met his burden of proving that it would be futile for him to attempt to find work, and he is therefore relieved of the requirements of ORS 656.206(3).

As early as November, 1979, employer's own rehabilitation counselor stated that the primary reason claimant was unable to return to work was his physical disability. The counselor specifically advised claimant that he should seek voluntary retirement, because he would not profit from the rehabilitation process. Thereafter, claimant demonstrated his motivation by attending the pain clinic and achieving what his treating physician termed a dramatic improvement in his condition. He stopped the use of all medication except nonprescription Tylenol, quit using his cane or back brace and

began to walk five miles a day. He continued to be cheerful and positive in his attitude until he underwent a series of falls due to his right leg collapsing underneath him, a situation which was clearly caused by his back injury. After the first two apparently less serious falls, Padel evaluated claimant and

stated that, for all practical purposes, his disability was permanent and total. Thereafter, claimant sustained an additional fall which significantly increased his back disability and required him to go back to using a back brace and a cane. As noted by board member Lewis, who dissented in this case:

> "Claimant's medical history has been characterized by startling recoveries and disappointing setbacks. Whenever claimant makes substantial progress as a result of treatment, including participation in pain clinic programs, eventually his leg buckles, resulting in a fall which disables him again. * * *"

We agree with that evaluation of this case and find claimant to be permanently and totally disabled as of September 29, 1981, the date of Padel's report.

Reversed; claimant awarded permanent total disability as of September 29, 1981.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Juanita Trevino, Claimant.

TREVINO,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(80-07954, 81-01912; CA A24995)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 23, 1983.

Janet A. Metcalf, Portland, argued the cause for petitioner. With her on the brief was English & Metcalf, Portland.

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.

BUTTLER, P. J.

Reversed and remanded with instructions that aggravation claim be accepted and for determination of penalties and attorney fees.

BUTTLER, P. J.

Claimant seeks reversal of an order of the Workers' Compensation Board denying compensability of her claim for a knee injury, either as a new injury or as an aggravation of a 1977 injury. Although the case has developed into a procedural morass, we conclude that there was an aggravation claim made and that that claim should be allowed. Accordingly, we reverse.

Claimant is a 45-year-old farm worker, who speaks only Spanish, has never gone to school and is illiterate in any language. In July, 1977, while working for Twin Creek Farms, she fell on a trailer, striking her legs on an iron mounting. Although she was injured (primarily her right leg), she continued to work. In September or October of that year she fell again and a box fell from a trailer hitting her legs, primarily her left leg. Following that injury, both of her legs hurt, and she was off work about a week.

In April, 1978, she was seen by Dr. Lawton, complaining of pain in both legs; however, her right leg hurt worse, and treatment centered on that leg. The same month, she filed her first claim, in which she asserted that she had hurt both legs. In August, 1978, surgery was performed on her right knee. The claim was closed on March 20, 1979, with an award of 15 degrees for 10 percent loss of the right leg.

In March, 1980, claimant returned to Dr. Lawton complaining of pain in her left knee. She also filed a second claim at that time for her left knee injury, indicating the injury date of July 15, 1977. SAIF assigned a new claim number to that claim and denied it on May 21, 1980, stating that it was not timely filed because the date of injury was 1977. She filed a request for a hearing on that denial on August 26, 1980.

Claimant consulted Dr. Becker in June, 1980. His letter of June 18, 1980, indicated that claimant's current complaints were related to the prior 1977 injury. Dr. Lawton concurred in the causal relationship. In September, 1980, Dr. Stewart, to whom claimant was referred by SAIF, expressed the opinion that there was no question

> "* * * that her injury in [and] of itself was the onset of her knee problems and that claimant's knee problem could certainly be that of an aggravation of a pre-existing condition."

SAIF received copies of the three medical reports, and in August referred the matter to its medical consultant, Dr. Norton, who found no causal relation between the injury and either knee condition.[1] In September, claimant's attorney wrote SAIF inquiring about the processing of an aggravation claim under the first claim number, requesting the status of that claim. The record does not disclose any response. In February, 1981, claimant requested a hearing on what she contended was a *de facto* denial of the aggravation claim. The

[1] Dr. Norton's opinion that there was no work-related cause of injury to *either* leg was premised on SAIF's claim file; he never saw claimant.

referee found that, although the evidence established that claimant did injure her left knee in July, 1977, and that that condition did worsen after the issuance of the 1979 determination order,[2] she was not entitled to further compensation, because she had failed to file her request for hearing within 60 days after being notified that her March, 1980, claim was denied and she could not show good cause for the delay. The Board affirmed.

Claimant contended at the hearing that her claim was for an aggravation and not a new injury; however, the referee and the Board assumed that claimant was appealing the denial of her second claim, to which SAIF had assigned a new number. That claim was filed and denied before the aggravation claim was made by Dr. Becker's letter of June 18, 1980. Although claimant's request for hearing on the denial of her second claim (March, 1980) was untimely, her request for hearing on the aggravation claim, if there was one, was not.

Claimant has the burden to establish an aggravation claim. *Blair v. SAIF,* 21 Or App 229, 534 P2d 523 (1975). Although a claimant must prove a worsening of the original work-related injury since the last award of compensation, a claim for worsened symptoms believed to be related to the original injury is not precluded because the claimant did not specify a particular condition on claim forms. *See Pumpelly v. SAIF,* 50 Or App 303, 623 P2d 677 (1981); ORS 656.273(1). A doctor's report may constitute an aggravation claim. ORS 656.273(3); *Clark v. SAIF,* 50 Or App 139, 622 P2d 759 (1981). Concededly, the record here is confusing, but it establishes that claimant made an aggravation claim relating to her 1977

injury to her left knee. SAIF was required to accept or deny the claim within 60 days of notice or be liable for penalties and attorney fees. ORS 656.262(6) and (9).

The medical evidence shows that claimant originally complained of injuries to both her right and left legs in 1977 and that her initial claim was for injury to both. The right knee was worse immediately following both injuries, and treatment centered on that knee. In 1979, that claim was closed on the basis of disability to the right knee injury only. However, subsequently she sought medical treatment for her left knee, and Drs. Stewart, Becker and Lawton related the injury to the 1977 on-the-job accidents.

We conclude that claimant made an aggravation claim for her left knee injury and that she has met her burden of proving a worsening in her condition since the last award of compensation. Because SAIF failed to accept or deny the aggravation claim, in spite of its investigation and claimant's attorney's request for the disposition of that claim, it is subject to penalties and attorney fees.

Reversed and remanded with instructions that the aggravation claim be accepted and for determination of penalties and attorney fees.

[2] The referee found claimant credible.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wayne McAdams, Claimant.

McADAMS,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(81-03758; CA A25709)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 14, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Donna M. Parton, Associate 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.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

Claimant appeals from a Workers' Compensation Board order denying compensation for injuries he received as a result of a fall at work. The issue is whether claimant's fall was "unexplained" in the sense that the reason for falling is unknown, or whether his fall was "idiopathic," that is, the reason is known but is personal to claimant rather than work-related. As the Supreme Court pointed out in *Phil A. Livesley Co. v. Russ,* 296 Or 25, ___ P2d ___ (1983), if a claimant's fall is unexplained, it is compensable, but if it is idiopathic, it is not.[1] The Board held that claimant's fall was idiopathic and denied compensation. We affirm.

Claimant was employed by Harris Pine Mills. On February 20, 1981, after his arrival at work, he was running a sanding machine when he was told to set up a drill. His foreman, who helped claimant find a needed part for the set-up, testified that, when he went to get the part, he left claimant standing and leaning against some cartons. Although the foreman did not go far, claimant was out of sight for a few minutes. He said that he did not hear anything but,

[1] When this case was argued, our decision in *Phil A. Livesley Co. v. Russ,* 60 Or App 292, 653 P2d 274 (1982), was pending on review in the Supreme Court. We delayed our decision until the Supreme Court decided *Livesley.*

when he returned, claimant was lying on the floor with both hands still in his pockets. Claimant suffered a posterior skull fracture, right side, from striking his head on the floor. No one actually saw what happened. There is nothing to indicate that there was any accident leading up to the event.

Dr. Franks, claimant's treating physician, determined that claimant had suffered a spontaneous fainting spell but was unable to determine the cause, despite extensive testing. Dr. Franks stated in his February 20, 1981 report: "The etiology of the patient's fall is in question. It appears to have been associated with a syncopal type episode." In his June 8, 1981, report he stated further: "I don't know how it is work-related except that it happened at work." SAIF denied the claim. The referee, after hearing, found it to be compensable. The Board reversed.

In *Phil A. Livesley Co. v. Russ, supra,* the claimant was walking down a crowded aisle from his work station to the

time-clock to punch out when he fell and broke his hip. There was no evidence that the fall resulted from idiopathic causes; the employer conceded that it was not, but contended that an unexplained fall is not compensable. The court said:

> "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." 296 Or at 30.

In *MacKay v. SAIF,* 60 Or App 536, 654 P2d 1144 (1982), *rev den* 296 Or 120 (1983), the claimant's leg buckled while she was walking to the bus barn to punch out. She fell and hurt her back. There was no medical evidence that her leg had buckled as a result of a risk of her employment. We said that the most that could be said is that it was equally as possible that the cause of the claimant's fall was idiopathic as that it was job-connected, and held that the claim was not compensable. In *MacKay,* the cause of the fall was known: the claimant's leg buckled. Here, the cause of claimant's fall is also known: he fainted. In both *MacKay* and this case the fall was not unexplained; in *Livesley,* the cause was truly unexplained.

The only evidence, both medical and lay, in this case is that the cause of claimant's fall was idiopathic, although Dr. Franks was unable to document the cause of claimant's fainting spell. He stated that claimant had no previous history of passing out, but both of his reports conclude that claimant did faint. There is no medical evidence that he fainted as a result of a risk of his employment. His supervisor stated that, when he told claimant to wait for him, he appeared to be drowsy and was leaning against a pallet load of merchandise.

Unlike *Livesley*, all idiopathic factors of causation have not been eliminated here. As in *MacKay*, the most that

claimant's evidence shows is that it was equally possible that the cause of his fall, his fainting spell, was idiopathic as that it was work-related. That is not enough to satisfy his burden of proof. Therefore, the injury is not compensable.

Affirmed.

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.

On petititioner's petition for reconsideration filed November 7, 1983, and respondent's petition for reconsideration filed November 3, 1983. Former opinion filed October 5, 1983. 64 Or App 826, 669 P2d 1154.

Robert K. Udziela, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland for petitioner's petition.

Brian L. Pocock, Eugene, for respondent's petition.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Petitioner's petition for reconsideration denied; respondent's petition for reconsideration allowed; former opinion withdrawn; affirmed.

WARREN, J.

Both parties petition for reconsideration. We deny claimant's petition. SAIF petitions for reconsideration of our decision reversing the Workers' Compensation Board and holding that SAIF acted unreasonably in delaying five years before issuing a denial and, therefore, was barred from denying the claim on that date. Subsequent to our decision in this case, the Supreme Court issued *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), which held that, once a claim is accepted, it cannot later be denied in the absence of "a showing of fraud,

misrepresentation or other illegal activity." 295 Or at 794. We grant SAIF's petition for a further analysis of the facts in light of *Bauman*.

SAIF alleges that claimant's entire claim was a fraud, because the accident did not happen. The referee, after evaluating all of the evidence, stated that "it is impossible to believe that the accident occurred." The Board agreed with that finding. Both the referee and the Board found claimant not credible. Although we are not bound to do so, we normally defer to a referee's findings of credibility, because he was actually able to observe the witnesses. *Miller v. Granite Construction Co.*, 28 Or App 473, 477, 559 P2d 944 (1977). After a *de novo* review of the evidence, we agree with the referee and the Board that the preponderance of the evidence supports SAIF's contention that the accident alleged by claimant never actually occurred.

In claimant's testimony he gave an improbable description of the accident, in which he claimed he suffered a double hip dislocation. His testimony was filled with inaccuracies as to objective factors, such as the weather on the date in question. He asserted that it had felt like an explosion in his hips when he fell to the ground, that he crawled to his truck and that he was thereafter able to drive the truck a substantial distance. He did not seek medical attention until seven days later. He testified that he told his foreman about the accident and attempted to use the company radio to get help. However, the uniform testimony of all of his co-employes is that he never reported the accident to anyone until the date on which he sought medical attention seven days later.

Medical evidence indicates that it is "highly unlikely" that a double hip dislocation would occur from a fall described by claimant. That a double hip dislocation would spontaneously resolve itself, as claimant described, is even less likely. Dr. Brooke testified:

> "Q Okay. Do you have an opinion, based on reasonable medical probability, whether or not it is probable that Mr. Wilkins dislocated his hip, one or both hips, on November 6th, 1975 and that a reduction occurred spontaneously at that time?
>
> "A Yes, sir.
>
> "Q What is your opinion?
>
> "A Think it's highly unlikely.
>
> "Q And why do you have that opinion?
>
> "A Well, I have been at this a long time. I've not seen any cases of a dislocation that was spontaneously reduced — of the hip — nor have I ever heard of one. And the, if a hip is spontaneously dislocated, the pain is pretty severe. They are difficult cases to put back in, in the first place, even if they are dislocated. So I would doubt that this actually happened.
>
> "* * * * *
>
> "A Well, when the hip is dislocated, they are in extreme pain, usually with a hip flexed. And with internal rotation, they are, they bitterly resent any movement or examination of

that extremity. After the hip is reduced, a considerable amount of pain persists for three to six weeks until the capsule heals.

"Q Okay. How is dislocated hip normally reduced, medically?

"A Well, to dislocate — to reduce a dislocation of the hip requires rather profound general anesthesia, so you get a relaxation of the powerful hip muscles. Without that, they usually won't go back.

"* * * * *

"Q Okay. Now, you have expressed the opinion that it's highly unlikely for this to occur with regard to one hip.

"A Yes, sir.

"Q How unlikely is it for that to occur with both hips?

"A Well, I think that's almost a ridiculous statement, to have occurred simultaneously."

The evidence also establishes that before the asserted accident claimant had mild to moderate degenerative arthritis in both hips and a severe problem with alcohol, which the medical evidence indicates could have caused the current problem in his hips. Claimant has asserted a claim for an accident that we conclude never occurred. A carrier's proof that a claim was fraudulent justifies its denial, even after the claim has once been accepted.

The Supreme Court in *Bauman* did not place any time limitation on denying a claim for fraud. We therefore withdraw our former opinion, grant reconsideration and affirm the Board.

Petitioner's petition for reconsideration denied; respondent's petition for reconsideration allowed; former opinion withdrawn; affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

VAN HORN,
Petitioner,
v.
JERRY JERZEL, INC. et al,
Respondents.
(80-02851 and 80-05095; CA A28060)

On Judicial Review from the Workers' Compensation Board.

Argued and submitted November 21, 1983.

James P. Cronan, Milwaukie, argued the cause for petitioner. With him on the brief was Roger S. Rook, Milwaukie.

Jerald Keene, Portland, argued the cause for respondents Royal Globe Insurance and Jerry Jerzel, Inc. With him on the brief was Griffith, Bittner, Abbott & Roberts, Portland.

Deborah S. MacMillan, Portland, argued the cause for respondents Charles F. Berg, Inc., and Giesy, Greer & Gunn. With her on the brief were Frank A. Moscato and Moscato & Meyers, Portland.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

VAN HOOMISSEN, J.

Affirmed.

VAN HOOMISSEN, J.

Petitioner appeals an order of the Workers' Compensation Board denying her aggravation claim against respondent Jerry Jerzel, Inc. (Jerzel) and, as to respondent Charles F. Berg, Inc. (Berg), making an inadequate penalty and attorney fee award based on Berg's failure to pay interim compensation. She alleges that her worsened back condition was causally related to her compensable industrial injury and that the Board's award of a ten percent penalty and $100 attorney fee was insufficient. We review *de novo* and affirm.

Petitioner, aged 64, was injured in February, 1978, while employed by Jerzel's. Her back strain claim was accepted, and she received compensation for time loss, ORS 656.210, but not for permanent disability. In April, 1978, she began working for Berg. She alleges that she sustained an injury at Berg's in December, 1979. She then filed a new injury claim against Berg and an aggravation claim against Jerzel. Both carriers denied responsibility, and the referee affirmed those denials. The Board affirmed the denials. However, it found that claimant was improperly denied interim disability payments, which it awarded, plus penalties and attorney fees. ORS 656.262(9).

In order to establish her aggravation claim, claimant had the burden of proving that her condition had worsened and that the worsening was causally related to her industrial injury. *Anderson v. West Union Village Square,* 43 Or App 295, 297, 602 P2d 1092 (1979), *modified* 44 Or App 685, 607 P2d 196 (1980). Claimant places primary reliance on the medical reports of Dr. Weinman, who stated that he suspects claimant is suffering from a herniated disc.[1] He points to little objective evidence of that condition, however. He relies instead on claimant's subjective evaluation of her condition.

Evidence of a worsening of a lumbosacral spine condition must be supported by expert medical evidence. *Jacobson v. SAIF,* 36 Or App 789, 792, 585 P2d 1146, *rev den*

[1] The referee questioned claimant's credibility. For that reason, he relied on the medical reports. We accord great weight to a factfinder's credibility evaluation. *Anfilofieff v. SAIF,* 52 Or App 127, 627 P2d 1274 (1982). Although the referee did not directly address Dr. Weinman's medical reports, they were admitted in evidence; and the referee found that they did not support her assertions "with any degree of certainty."

284 Or 521 (1978). In *Oakley v. SAIF*, 63 Or App 433, 436, 664 P2d 431 (1983), we noted:

> "An aggravation claim based solely on a claimant's statement that his condition has deteriorated is statutorily insufficient. Likewise, a medical report which only sets forth *claimant's* statement that his condition has deteriorated is insufficient. At the very least, an expression of opinion by the doctor that he believes the claimant or that he finds objective evidence from a medical standpoint to substantiate claimant's history, is necessary. *Larson v. Compensation Department*, 251 Or 478, 482, 445 P2d 486 (1968); *Collins v. States Veneer, Inc.*, 14 Or App 114, 119, 512 P2d 1006 (1973)."

Dr. Post, who examined claimant's deposition testimony and medical records, characterized Dr. Weinman's diagnosis of a herniated disc as "highly theoretical at best." He stated:

> "Upon reviewing those reports today, I don't find any specific evidence of objective findings recorded by the various examining physicians. * * *
>
> "Assuming that the patient's description of her symptomatology is not accurate, either intentionally or unintentionally, then I find no definite evidence of injury at any time in this case, either in 1978 or 1979."

Two of claimant's examining physicians suggested that her difficulties may be rooted in underlying psychological problems. The referee concluded:

> "One can come to the conclusion in this case that it is just as believable that if claimant, in fact, does have some symptoms they do not arise organically, they arise emotionally. There is no evidence that either incident gave rise to or exacerbated claimant's hysteria suggested by more than one doctor."

When the evidence presented reflects two explanations for a claimant's condition that are equally plausible to the factfinder, and one is noncompensable, the claimant has failed to sustain the burden of proof. *Gormley v. SAIF*, 52 Or App 1055, 630 P2d 407 (1981); *Raines v. Hines Lbr. Co.*, 36 Or App 715, 719, 585 P2d 721 (1978). We conclude that claimant's aggravation claim was properly denied.

Claimant asserts that the penalty and attorney fee award is insufficient to deter dilatory claims processing by

insurers. *See* ORS 656.262(9); *Stone v. SAIF*, 57 Or App 808, 812, 646 P2d 668 (1982), *petition dismissed* 294 Or 442 (1983). The penalty and fee were awarded because Berg did not pay interim compenation within 14 days after notice of the claim. ORS 656.262(4). *See Bono v. SAIF*, 66 Or App 138, ___ P2d ___ (1983). Berg issued its denial on the 21st day. ORS 626.262(9) provides for a penalty of up to 25 percent of the compensation awarded.

Berg argues that the penalty is sufficient, given the confusion in the law concerning the defense of untimely notice of an injury by a claimant. Notice must be given within 30 days, ORS 656.262(1), or the claim is barred, unless the

insurer has begun payment. ORS 656.262(4)(b). An insurer has 60 days to accept or deny a claim, ORS 656.262(6), but must begin making payments within 14 days. ORS 656.262(1). Berg argues that this places the insurer in a "Catch-22" situation.

The Board explained:

> "Thus, a claimant may be barred from pursuing an untimely claim unless the insurer begins making payments on the claim. But, if insurers are required to make interim compensation payments, they will lose their right to assert the defense of lack of timely notice. This puts the insurers in the position of having to deny a claim without adequate time to make a reasonable determination of compensability or face losing the right to assert the untimely notice defense. We do not believe that the legislature intended this result.

It concluded that ORS 656.262(4) imposes a duty to pay interim compensation if the claim was not denied within 14 days, but that payment will not waive the untimely notice defense if the claim was denied within 60 days. We disagree. ORS 656.262(4) is unambiguous. If an insurer begins making interim payments, it waives its right to assert the untimely notice defense. *Jones v. Emanuel Hospital,* 280 Or 147, 151, 570 P2d 70 (1977); *Logan v. Boise Cascade Corp.,* 5 Or App 636, 485 P2d 441 (1971). That result works no injustice. Unlike issues concerning legal and medical causation, which the insurer has 60 days to investigate, it is relatively easy for an insurer to determine if notice is timely. If the defense is not raised within 14 days, it is waived.

Here Berg did not raise the untimely notice defense within 14 days. It also delayed paying interim compensation. The amount awarded as a penalty and attorney fee was within the Board's discretion. *See Logan v. Boise Cascade Corp, supra,* 5 Or App at 642. We find no abuse of discretion.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Arnold L. Webber, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Petitioner,

v.

WEBBER et al,
Respondents.

(WCB No. 80-03390, 81-04831; CA A27731)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 31, 1983.

Donna M. Parton, Associate Appellate Counsel, SAIF, Salem, argued the cause and filed the brief for petitioner.

Martin J. McKeown, Eugene, argued the cause and filed the brief for respondent Webber.

Deborah S. MacMillan, Springfield, argued the cause for respondent EBI Companies. With her on the brief were Daniel L. Meyers and Moscato & Meyers, Springfield.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded for determination of extent of disability.

ROSSMAN, J.

SAIF appeals an order of the Workers' Compensation Board which affirmed the referee and held that claimant had suffered both an aggravation of his pre-existing injury for which SAIF was responsible and a new injury for which EBI was responsible. In our *de novo* review, we reject the holding of split responsibility and find that claimant sustained only a new injury.

Claimant initially injured his low back in 1976, while working for an employer insured by SAIF. He underwent a laminectomy and discectomy and was awarded temporary total disability through June 1, 1980. He completed an auto technology program at Lane Community College and began work in early June, 1980, at Springfield Rock Quarry as a dump truck driver, requiring him to do occasional tire changes. On August 14, 1980, he was changing tires, which each weighed approximately 250 pounds. After he changed the first three tires, he reported that his back was tired and sought assistance from his supervisor. Thereafter, when he attempted to change the fourth tire, he felt a sharp pain on his right side, from the middle of his back down his legs, necessitating that he quit work.

The referee and the Board awarded benefits from both SAIF and EBI on the theory that, when he changed the first three tires, he sustained an aggravation of his original injury and, when he changed the last tire, he sustained a new injury.

Claimant repeatedly testified that his back was merely tired after changing the first three tires. There is nothing in the evidence to indicate that, if he had not changed the fourth tire, he would have filed any claim for compensation or would have suffered more than a momentary tiredness in his back. Therefore, we view the tire changing on August 14, 1980, as a single incident, which must be either a new injury or an aggravation and cannot be both.

The determination of whether a claimant has suffered a new injury or an aggravation is controlled by our decision in *Boise-Cascade Corporation v. Starbuck*, 61 Or App 631, 638, 659 P2d 424, *rev allowed* 294 Or 792 (1983), in which we held:

> "* * * [T]otal liability is assigned to the last employer, even though the prior injury may be the major cause of the claimant's disability following the second injury."

The second incident need only contribute independently to the injury to make the second insurer solely liable, even if the injury would have been much less severe in the absence of an existing condition. 61 Or App at 638. In this case, although there is a divergence in the medical evidence as to which accident was the major contributing cause of claimant's condition, the evidence is virtually uniform that the second incident contributed independently to his disability. That is consistent with the nonmedical evidence of claimant's having a sudden, sharp increase in pain as a result of the incident at the second employer and being unable to work after that date. We therefore find that he suffered a new injury, for which EBI is responsible.

Reversed and remanded for determination of the extent of disability.[1]

[1] EBI argues in its brief that SAIF failed to perfect the appeal as to them, because it did not specifically set out a verbatim portion of the record in its assignment of error and did not inform EBI that SAIF intended to appeal against it. The petition for review by SAIF indicates that both EBI and EBI's counsel were served with copies of the petition for review. EBI does not state that it did not actually receive the petition for review. The reason cited for review is: "The order on review should be reversed on the ground and for the reason that there was no aggravation as a matter of law." SAIF adequately perfected the appeal as to EBI. The imperfections in SAIF's brief did not require the court to search the record for review or otherwise hamper this court's review of the case. Therefore, although it is within our authority to strike the brief, ignore the issue or dismiss the appeal under ORAP 7.19(6) or ORAP 12.05(1), we decline to do so.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Donna M. Skinner, Claimant.

SKINNER,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(WCB No. 80-03100; CA A27249)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 31, 1983.

Robert J. Guarrasi, Eugene, argued the cause for petitioner. On the brief was David C. Force, Eugene.

Brian L. Pocock, Eugene, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed; referee's opinion and order reinstated.

ROSSMAN, J.

Claimant appeals a decision of the Workers' Compensation Board, which affirmed SAIF's denial of claimant's cervical back condition. On *de novo* review, we conclude that claimant's back condition is compensable.

In 1972, claimant sustained an on-the-job injury while employed as a green chain puller. She slipped and immediately complained of neck and shoulder pain. An acute cervical strain of the right posterior neck was diagnosed. The claim was closed with no award of permanent disability. In 1974, claimant again incurred an on-the-job injury to her neck as the result of pulling wood on the green chain. A strain of the right neck and shoulder was diagnosed. The claim was again closed with only temporary benefits. On September 1, 1977, claimant again hurt her neck by quickly turning her head while working. She underwent a fusion in August, 1978. A determination order was issued on June 1, 1979, granting claimant 10 percent permanent disability. On July 27, 1981, SAIF issued a denial of compensability of the original claim and of an aggravation claim as well. The denial was based primarily on a report by Dr. Baker that the torn ligament had occurred in an automobile accident in 1965. Before his report, claimant had seen numerous physicians and had specifically denied any previous neck injury to two of those physicians, Dr. Filarski and Dr. Baker.

Claimant requested a hearing on the denial. The referee entered an opinion disapproving SAIF's denial of the

original injury, but approving that portion of the denial which relates to the request to reopen by Dr. Smith. Further, claimant's permanent disability was increased to 20 percent for her neck. The Board issued an opinion reversing the referee and reinstating SAIF's denial in its entirety.

The initial issue is whether the carrier can deny the claim under the Supreme Court's recent decision in *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), which held that, after an employer has accepted a claim, it may not later deny it "unless there is a showing of fraud, misrepresentation or other illegal activity." It is undisputed that the employer here had accepted the claim. Therefore, it was powerless later to deny the original claim, unless it established fraud, misrepresentation or other illegal activity.

On our *de novo* review we conclude that the employer did show a misrepresentation in the nature of a failure to disclose. In response to specific questions by at least two doctors, claimant denied any previous injury to her neck. Yet, it is undisputed that in 1965 she was involved in a serious automobile accident in which the car rolled and she hit her head on the roof of the car and suffered headaches and neck soreness. She was hospitalized for four days after that accident. A claimant's denial of previous injury, when such exists, is one kind of misrepresentation which must have been contemplated by the Supreme Court in *Bauman.* We therefore hold that the employer was entitled to deny the claim, even though it had previously accepted it.

However, that there was misrepresentation and that the employer could deny the claim does not necessarily resolve the case. Claimant may still prevail over the denial if she can establish by a preponderance of the evidence that, although she had a pre-existing condition, the injury which she sustained at work materially worsened her condition. *Larson v. Brooks-Scanlon,* 54 Or App 861, 636 P2d 984 (1981), *rev den* 292 Or 581 (1982). We conclude that under the facts of this case claimant has met her burden of proof.

The undisputed evidence establishes that, after the initial medical care following the 1965 automobile accident, claimant did not seek any treatment for her neck until she sustained the compensable injury in 1972. She testified that she had no difficulty with her neck during that period of time. She also recovered after the 1972 and 1974 industrial injuries, and she testified that she had been without any neck problems for a few years when she reinjured her neck in 1977. Before 1977, she went deer hunting, fishing, clam digging and crabbing. She and two of her friends testified that she did not complain of any problems with her neck during any of these activities before 1977. After 1977, she was unable to do any fast dancing, deer hunted only from the road or from a stationary post and was no longer able to throw a baseball. Thus, the evidence establishes that, although claimant had injured her neck in a 1965 automobile accident, she had had no residual problems from that accident for at least seven years thereafter.

The medical evidence is divided as to causation. Dr. Baker stated that claimant's cervical condition was probably

caused by the auto accident in 1965 and that the 1977 incident only caused temporary symptoms and did not change the course of her pre-existing condition. His opinion appears to be based, at least in part, on his anger that claimant did not initially tell him about the 1965 car accident. Dr. Eaves stated that all treatment for claimant's cervical condition was related to her work and compensable. Dr. Smith stated that claimant's work-related injuries "represent the final physical aggravation of a pre-existing condition" which, once it became symptomatic, would remain so. Dr. Smith termed the 1977 incident a "severe aggravation of a pre-existing condition." We find that claimant has met her burden of proving by a preponderance of the evidence that her neck condition is causally related to her employment.

Reversed; referee's opinion and order reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lorrie L. Widman, Claimant.

WIDMAN,
Petitioner,

v.

PECO MANUFACTURING COMPANY et al,
Respondents.

(WCB No. 81-04271; CA A26833)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 31, 1983.

Glenn M. Feest, Portland, argued the cause and filed the brief for petitioner.

John M. Pitcher, Portland, argued the cause for respondents. On the brief were Emil R. Berg and Griffith, Bittner, Abbott & Roberts, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded for acceptance of claimant's hand condition claim and determination of extent of disability.

ROSSMAN, J.

Claimant seeks reversal of an order of the Workers' Compensation Board which affirmed the carrier's denial of her hand condition. We hold that she has established the compensability of the hand condition by a preponderance of the evidence. Accordingly, we reverse.[1]

On February 19, 1981, claimant began her employment with Peco Manufacturing Company (Peco). Her previous employment had included working as a barmaid, where her hands were repeatedly exposed to cold, but she had never had any difficulty with her hands before her employment at Peco. Her job at Peco consisted of placing small rubber components into a solution of trichlorethylene (TCE), removing them from the solvent and attaching them to thin copper rods. She was provided with rubber gloves and wore them during the entire period of time that she was performing the job. The gloves would normally wear out quite rapidly. A worker could go through two pairs of gloves in one day, or a pair of gloves might last for three to four days. Although claimant testified that she did not know how it occurred, she stated that the TCE somehow got on her hands. She observed a film on her hands which smelled like TCE. Further, throughout the course of her working at her job, she could taste TCE. On the very day she began work, claimant experienced burning, aching and stiffness in her hands, and her hands turned a reddish-blue color.[2] All those symptoms got progessively worse as the day wore on. She worked at the job for the remainder of the day and returned to the job the next day, working approximately two to three hours. At that point, she reported her irritation to her supervisor, who transferred her to another job that did not involve TCE. She worked for the rest of that day and the entire next week before quitting

because of the pain and discomfort in her hands. On April 30, 1981, employer issued a denial for claimant's hand condition.

The medical evidence in this case consists of the reports and testimony of three doctors. Dr. Lindquist, the first physician to examine claimant, reported on February 28, 1981, that claimant has a "probable primary allergy reaction to unknown chemical" on her hands. Her treating physician, Dr. Leveque, originally noted that her hands had the appearance of Raynaud's Phenomenon, but in the absence of a previous history it seemed unlikely that that was the problem. He stated:

"I feel she has symptoms typical of solvent poisoning by

[1] Claimant also appeals the denial of her motion for consideration of newly discovered evidence. Since we hold that, based on the evidence before the Board, without the additional report of Dr. Bardana submitted with this motion, there is sufficient evidence to establish claimant's claim, we do not consider this assignment of error.

[2] Beach, who worked with claimant, stated that she observed claimant before she started working with the TCE and that she was nervous and her hands were not a normal color but were "reddish-blue." Claimant's supervisor, Shattuck, also testified that when claimant began work she was shaking and her hands were "a little bluish-red color." Neither woman noted swollen hands, and Shattuck testified that she primarily noticed the shaking.

mechanics from cleaning greasy machinery or diesel jet testers who get diesel fuel forced into their fingers. It is not an allergy.

"* * * * *

"I feel, based upon my examination and conversation with the patient, that she does suffer from solvent exposure. * * *"

Dr. Leveque stated that he believed Raynaud's Phenomenon symptoms were caused by the chemical dissolving

"* * * the fatty material of the sheath and/or the nerve itself causing it to become super sensitive to outside influences such as cold, producing the effects of which she complains."

In his testimony at the hearing, he again concluded that, based on medical probability, claimant's hand condition was related to her employment. He stated that he was not clear in his own mind whether claimant suffered from Raynaud's Phenomenon, "but it's a nerve damage caused by the trichloroethylene."

Dr. Armbruster testified that claimant had Reynaud's Phenomenon that could not have been caused by her employment, because she was not exposed for a long enough period of time to TCE.

We hold that claimant has met her burden of proving that her hand condition is causally related to her employment. Other than testimony of co-workers that her hands were somewhat discolored before her work, there is no evidence that claimant ever had any problems with her hands before her employment at Peco. She had never sought any medical attention in the past, even though she had worked as a

barmaid with her hands exposed to various conditions. Almost immediately after beginning her employment at Peco, she began to have problems with her hands. Although she was unaware of the precise manner of how she was exposed to the chemical, the evidence that her hands worsened almost immediately after she began employment, that the gloves wore so quickly that they had to be replaced as often as twice a day and that she had a film on her hands and could taste the chemical while working clearly establishes that in some manner claimant's hands were exposed to TCE while she was employed at Peco.

Although the medical evidence is divided as to whether the short term of claimant's exposure to TCE at her employment could have caused the condition in her hands, we are persuaded by the reports and testimony of claimant's treating physician, Dr. Leveque, who stated repeatedly that exposure to TCE at her employment was the cause of her disability in her hands. *See Hamlin v. Roseburg Lumber,* 30 Or App 615, 567 P2d 612 (1977). The Board erred in affirming employer's denial of claimant's hand condition.

Reversed and remanded for acceptance of claimant's hand condition claim and a determination of the extent of disability.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Claude Lyon, Claimant.

LYON,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(WCB No. 81-11497; CA A27782)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 31, 1983.

Robert J. Guarrasi, Eugene, argued the cause for petitioner. On the brief was Christopher D. Moore, Eugene.

Darrell E. Bewley, Appellate Counsel, SAIF, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Affirmed as to medically stationary date and extent of disability; remanded for referral for pain therapy.

PER CURIAM

Claimant appeals an order of the Workers' Compensation Board, arguing that the Board erred (1) in prematurely closing his claim, (2) in holding that he is not permanently and totally disabled, and (3) in holding that he is not entitled to pain therapy. On *de novo* review of the record, we conclude that the Board was correct both as to claimant's medically stationary date and the extent of his disability. We therefore discuss only the issue of entitlement to pain therapy.

Claimant is entitled to medical treatment, including pain therapy, "for such period as the * * * process of the recovery requires." ORS 656.245(1). Although SAIF is correct that the medical evidence in this case specifically recommends against pain treatment, all of those recommendations are based on the fact that claimant was uncooperative and addicted to a particular drug. Claimant has cured his addiction and has been cooperative in the therapy sessions that he attended with Dr. Dunn before SAIF terminated treatment. Claimant is entitled to treatment for the alleviation of pain.

Affirmed as to medically stationary date and extent of disability; remanded for referral for pain therapy.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Virginia S. Shilling, Claimant.
STATE ACCIDENT INSURANCE FUND
CORPORATION,
Petitioner,
v.
SHILLING,
Respondent.
(77-07450; CA A26282)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 13, 1983.

Darrell E. Bewley, Appellant Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for petitioner.

John M. Silk, Eugene, argued the cause for respondent. On the brief were Michael Strooband, and Bischoff & Strooband, P.C., Eugene.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

SAIF appeals an order of the Workers' Compensation Board holding that claimant's emotional disability is a compensable occupational disease. This is the second appeal in this case. In the first, we affirmed the Board's original order finding claimant's disability to be compensable. *Shilling v. SAIF*, 46 Or App 117, 610 P2d 845 (1980). The Supreme Court granted review and remanded, 290 Or 301 (1981), and we in turn remanded to the Board for further proceedings. 51 Or App 2. On remand the parties did not present further evidence, and the Board ruled on the existing record that the condition was compensable. We affirm.

As set forth in our previous opinion in this case, claimant worked for the Department of Motor Vehicles in Coquille, where her duties included

> "* * * changing automobile titles, processing drivers' licenses, administering vision and written driver examinations, handling vehicle registration, answering telephones, ordering office supplies, taking inventory and completing required reports. * * *" 46 Or App at 119.

Over the years that she worked there, the increase in area population caused the workload to increase. In July, 1976, the

photographic driver's license was introduced, and the time required to prepare a license increased. As we described claimant's disability:

> "In the fall of 1976, claimant began experiencing chest pain. The pains occurred when she was very busy at work. She did not consult a doctor at that time because the pains abated when her job became less stressful. The frequency and severity of the pains continued to increase, and on August 29, 1977, she was examined by Dr. Nolan. On October 17, 1977, claimant was admitted to the hospital, complaining of a three day history of increasing chest pain. The diagnosis was coronary artery disease. She was released after four days. On October 25, 1977, claimant was again hospitalized because of chest pains. Tests indicated no organic cardiac problems. She was referred to the South Coast Psychiatric Associates. * * *" 46 Or App at 119-20.

Claimant stated that she was "tense, exhausted, cried a lot and had extreme chest pains" and was afraid to go out in crowds or drive her automobile. 46 Or App at 120.

SAIF contends that the claim is not compensable because claimant's workload was not actually excessive and she should not be compensated for a condition resulting from her merely "perceived overwork" or "perceived stress". SAIF also argues that off-the-job conditions were the primary cause of claimant's disability.

In *James v. SAIF,* 290 Or 343, 624 P2d 565 (1981), the Supreme Court discussed which on-the-job causes, if any, could render a mental disability compensable. The issue of whether and the extent to which such mental disorders are compensable was not considered by the Supreme Court until its recent opinion in *McGarrah v. SAIF,* 296 Or 145, ___ P2d ___ (1983), which rejected what it called the "strictly subjective causal nexus" standard by which some courts had found that a

> "* * * claimant is entitled to compensation if it is factually established that claimant *honestly perceives* some event occurred during the ordinary work of his employment 'caused' his disease. This standard applies where the claimant alleges a disease resulting from mental stimulus and honestly, even though mistakenly, believes that he is disabled or impaired due to that work-related event and therefore cannot resume his normal employment." ___ Or at ___ (slip opinion at 25).

As an example of the application of such a standard, the Supreme Court cited *Deziel v. Difco Lab,* 403 Mich 1, 268 NW2d 1 (1978), where, because of a long-standing personality defect, an auto assembly line worker was disabled by worry that the cars being assembled were not safe, when there was no objective evidence to substantiate the fear. The Supreme Court stated:

> "A worker's misperception of reality does not flow from any factual work condition. We disagree with the Michigan Supreme Court standard set forth in *Deziel* that all that is needed for compensation for stress-induced physical disease or mental disorders is a strictly subjective causal nexus based upon a worker's honest perception. A worker may honestly

believe that the employer plans to kill him and as a result of that fear cannot work, but if that belief emanates only from the worker's own paranoia and there was no evidence the employer had any such plan, no stress condition factually existed on the job and the resulting impairment would not be compensable." ___ Or at ___ (slip opinion at 24-25).

"* * * [S]tress-caused claims for benefits arising out of mental and physical disorders are compensable if they flow from the conditions of the worker's employment, provided causation * * * has been proven. We all know that stress may flow from work conditions. However, the on-the-job stress conditions causing the disorders must be real. That is, the events and conditions producing the stress must, from an objective standpoint, exist in reality. A worker's inability to keep up the pace of the job, *Carter v. General Motors Corp.*, 361 Mich 577, 106 NW2d 105 (1960), is real stress. * * *" ___ Or at ___ (slip opinion at 24).[1]

The Supreme Court also disapproved a standard some courts call "objective" (which might perhaps be called the "average worker standard"), under which a mental disability caused by stress is not compensable if the pressures encountered in the employment are no greater than those on other workers in the same kind of work. *See, e.g., Sloss v. Industrial Commission,* 121 Ariz 10, 588 P2d 303 (1978). The court did agree with the analysis in *Royal State Nat'l Ins. v. Labor Bd.,* 53 Haw 32, 487 P2d 278 (1971), noting that that court took the position that "a person may succumb to the pressures of work even though he is not under any unusual exertion or strain." ___ Or at ___ (slip opinion at 6). As the Supreme Court stated in *James v. SAIF, supra:*

"* * * In injuries or diseases other than mental illness, the inquiry is not would an average worker have incurred the injury or disease? The question is did the claimant worker sustain the injury or disease? Workers' compensation is covered by statute and there is nothing in the Oregon Workers' Compensation Law that would distinguish between the test for mental illness and other kinds of injury or disease." 290 Or at 347.

Thus the stress-causing work condition must be "objective" in the sense that the condition must be real, as opposed to imaginary; but its effect on the worker is nevertheless measured in terms of the individual worker's actual reaction rather than by whether it would cause disability in the average worker.

In its order on remand the Board stated:

"* * * [C]laimant perceived a significant increase in her workload. Other evidence documents that there was some increased workload between about mid-1976 and late 1977; claimant's perception of the gravity of the situation, however, exceeded the objective reality of the situation. * * *

[1] At times in its opinion, the Supreme Court speaks in terms of "real stress"; it might have been more accurate to refer to "real stress-causing conditions."

> "* * * [H]ere claimant's perception of her increased workload was out of touch with the reality of her increased workload. * * *"

The Board concluded that under the standards expressed in our opinion in *McGarrah,* it did not matter whether claimant's subjective perceptions were "out of touch with reality" and found the claim compensable.

SAIF argues that claimant's "perceived stress" or "perceived overwork" cannot legally cause a compensable mental disability:

> "It is clear that perceived stress cannot arise out of the employment. Such stresses instead arise out of the worker. Such perceptions cannot be a risk of doing the employer's task. To arise out of the employment, the stressor must be an actual one which is a part of the particular employment."

SAIF also argues that claimant should be required to prove that she was, in fact, overworked and cites statistics comparing the workload of her office with other DMV offices. It is true that the standard to be applied is different following the Supreme Court's *McGarrah* opinion. Now a mental disability caused by an imaginary condition at work could not be compensable. However, the Board and SAIF frame the issue here incorrectly when they discuss the imaginary nature of claimant's "overwork." The question is not whether claimant's perception of overwork was accurate, or whether claimant was overworked as judged by a standard of what would constitute overwork to the average person on her job. The question is whether there were stress-causing pressures on her job that were "real." In applying the standards expressed in *McGarrah* and *James,* we conclude that the causes of claimant's on-the-job stress are the kind that do not preclude a claim based on the resulting mental condition.

As we noted in our previous opinion in this case, claimant was frequently required to tend the office alone and contend with long lines of people waiting for assistance and often had to work through her morning and afternoon breaks

and sometimes into her lunch hour. Those are "real" pressures, and claimant's reactions to them were not reactions to mere imaginary conditions. That she was more susceptible to the conditions than others might be, that she characterized them as "overwork" when someone else would not have or that they were more stressful for her does not preclude her claim.

We must still address the issue of whether claimant's on-the-job pressures, when compared with off-the-job conditions, were the "major contributing cause" of her mental disorder, *McGarrah v. SAIF, supra,* ___ Or at ___ (slip opinion at 27); *SAIF v. James,* 61 Or App 30, 33, 655 P2d 620 (1982), and whether her off-the-job conditions are "substantially the same as [those] on the job *when viewed as a cause* of the particular kind of disease claimed as an 'occupational disease,' " *James v. SAIF, supra,* 290 Or at 350. (Emphasis in original.) SAIF argues that claimant was under stress from off-the-job conditions and that that caused her illness. In our

previous opinion, we concluded that there was no evidence that the alleged off-the-job pressures caused her illness, and we do not alter that finding here.

Although our analysis is different, we conclude that the Board did not err in finding this claim compensable.

Affirmed.

---

620 January 25, 1984 No. 63

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kevin D. Wheeler, Claimant.

WHEELER,
Petitioner,

v.

BOISE CASCADE,
Respondent.

(81-06963; CA A26809)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 3, 1983.

Michael T. Garone, Portland, argued the cause for petitioner. With him on the brief was Jolles, Sokol & Bernstein, P.C., Portland.

Allan M. Muir, Portland, argued the cause for respondent. With him on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded for reinstatement of referee's opinion and order.

BUTTLER, P. J.

Claimant appeals from an order of the Workers' Compensation Board, which reversed the referee's opinion and order and held that claimant's rash was not a compensable condition.

Claimant began work at Boise Cascade in June, 1980. At that time, he had no rash of any kind. In October, 1980, while working as a green chain off-bearer with fir and hemlock, he developed a rash on his eyelids and arms. During the winter of 1980, the rash cleared up, leaving only scars on his arms. In March, 1981, while claimant was still working for Boise Cascade, the rash reappeared on the inside of his arms and on his neck and cheeks. In July, 1981, he missed work because of the rash. He still had the rash when he was laid off in December, 1981, after which time it disappeared.

Claimant, whom the referee found credible, testified that the only rash he had had prior to his employment by Boise Cascade developed in late 1979 or early 1980 when he was working as a glue spreader for Henderson Plywood. At that time, he developed glue poisoning, which resulted in a rash on one arm. He was treated by an injection, and the rash cleared in a few days. Although he continued in the same employment for one or two months, he remained asymptomatic.

Claimant was involved in high school football, basketball and track without ever having a rash of any kind. While in high school, he worked occasionally cutting weeds but developed no rash. He had also worked as a mason for three months in Haiti in extremely hot weather without developing a rash of any kind.

The medical evidence on causation is sparse. Dr. Stark, a dermatologist, stated that claimant had atopic dermatitis, which he defined as "an inherited predisposition to have sensitive skin." He stated: "I feel that his work activities have probably caused this problem to become symptomatic." Dr. Stark noted that persons having that predisposition normally react to heavy exercise and activity that cause them to perspire. He also noted as contributing factors claimant's use of "fairly harsh body soaps" and showering frequently because of the heavy perspiring he experienced at work. He

stated that claimant's skin condition could become symptomatic any time his skin became dry or had excess perspiration or if he wore clothing that was irritating to his skin. He said that it was "debatable" whether claimant's employment caused a worsening of the underlying pathological condition and that he thought that it probably did not. His final report states:

> "It is still my impression that Mr. Wheeler has a preexisting condition of atopic dermatitis and it is aggravated by working in an area where there is dust and debris as well as the opportunity for him to perspire profusely. * * * He was advised that he may well have to get out of the sawmill business."

It is apparent from the referee's opinion and order, and from the two opinions of the Board, that there is an underlying uncertainty as to whether it is necessary for a claimant to show that there was a worsening of his underlying preexisting condition in order to establish compensability. In *Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979), the court held that it was necessary. It applied that rule to deny compensability in *Weller* and in *Stupfel v. Edward Hines Lumber Co.,* 288 Or 39, 602 P2d 264 (1979), decided the same day.

However, in *Hutcheson v. Weyerhaeuser,* 288 Or 51, 56, 602 P2d 268 (1979), also decided the same day, the court said:

> "* * * If the 'mill conditions' caused temporary exacerbation of his preexisting chronic obstructive pulmonary disease, sinusitis and bronchitis so as to require medical services that would not have otherwise been necessary or if that exacerba-

tion resulted in even temporary disability, this claim is compensable."

On that basis, the court there held the claim compensable with no requirement that there be a worsening of the underlying disease. The referee thought *Hutcheson* controlling, as did the Board dissenter. The Board majority thought *Weller* controls.

If there is a distinction between *Weller* and *Stupfel,* on the one hand, and *Hutcheson,* on the other, it is not articulated in the court's opinions. However, the opinions were written with all three cases in mind; we assume, therefore, that there is a distinction, and we believe that it lies in

the fact that in *Weller* and *Stupfel,* the claimants apparently were receiving medical attention before the claimed exacerbations of the symptoms at work. Therefore, the court held that the exacerbations were not compensable, because there was no worsening of the claimants' underlying conditions for which they were being treated. In *Hutcheson,* however, the claimant was asymptomatic and not being treated at the time of the exacerbation of symptoms at work. The court expressly stated that the mill conditions caused temporary exacerbation of the claimant's preexisting condition "so as to require medical services *that would not have otherwise been necessary* * * *." 288 Or at 56. (Emphasis supplied.)

Here, the record does not support the *Weller* and *Stupfel* requirement that there be a worsening of the underlying condition. It does, however, indicate that claimant had been asymptomatic and was not receiving medical care for his disease until the conditions at the mill caused his symptoms to appear and to require medical treatment that would not otherwise have been necessary. The claim is compensable.

Reversed and remanded for reinstatement of the referee's opinion and order.

---

640 January 25, 1984 No. 65

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James B. Johnson, Claimant.

JOHNSON,
Petitioner,

v.

INDUSTRIAL INDEMNITY,
Respondent.

(81-03979; CA A27349)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 31, 1983.

Diana Craine, Salem, argued the cause for petitioner. On the brief was Rolf Olson, P.C., Salem.

John E. Snarskis, Portland, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

Claimant appeals an order of the Workers' Compensation Board, claiming that the Board erred in (1) affirming the referee's denial of compensability of his back condition; (2) disallowing an increased permanent disability award for his shoulder injury following its reclassification as an unscheduled injury, and (3) failing to find him permanently and totally disabled. On *de novo* review, we agree with the Board that claimant has failed to establish by a preponderance of the evidence that his back condition is causally related to his industrial accident. His back problems would only be relevant if his compensable shoulder injury were to be reclassified as unscheduled, in which case the disability award would be measured by his loss of earning capacity.

We, therefore, turn to the issue of whether claimant is entitled to an increased disability award for his shoulder injury. On May 20, 1980, a determination order awarded claimant 20 percent scheduled disability for loss of use of his right arm (shoulder) and 15 percent scheduled disability for loss of use of his left leg (knee). Because claimant did not appeal that order, it became final. Claimant's knee condition worsened, and a hearing was held to determine the extent of his knee disability. At the hearing, claimant asserted that his shoulder injury had been wrongly classified as a scheduled disability. The referee agreed that the shoulder injury should have been classified as unscheduled and should be re-evaluated. As a result of the re-evaluation, claimant was awarded additional permanent disability. The Board reversed that portion of the referee's order, holding that claimant was precluded by the earlier determination order from receiving additional permanent disability for his shoulder injury unless he had established a worsening of that condition.

The general rule is that, following a final determination of extent of disability, a claimant's compensation is limited to medical services unless a worsening of the condition is proven. ORS 656.273(1); ORS 656.245. The only statutory exception to this general rule is contained in ORS 656.268(5), which provides that a redetermination of disability must be made when an injured worker ceases to be enrolled and actively engaged in an authorized vocational rehabilitation program. There is nothing in the record indicating that

claimant was enrolled in a program of vocational rehabilitation. Therefore, in order for claimant to obtain an additional award following the final determination of May 20, 1980, he

must establish a worsening of his shoulder condition. He has not done so.

Claimant argues that he is entitled to additional compensation, because the shoulder was wrongly classified initially as a scheduled injury and that he is entitled to have it reclassified as an unscheduled injury and re-evaluated under the standards applicable to unscheduled injuries. Claimant had one year within which to appeal the determination order and to argue that his shoulder injury should have been classifed as unscheduled. Having failed to do so, he is bound by the determination order, however wrong it might have been. The Board was correct in reversing the referee and holding that claimant was only entitled to the amount which he had already been awarded for his shoulder condition.

From our review of the record, we agree with the Board's conclusion that claimant is not permanently and totally disabled.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Mabel A. Griffith, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Petitioner,

v.

GRIFFITH,
Respondent.

(81-04743; CA A26441)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 11, 1983.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for petitioner.

Charles D. Maier, Salem, argued the cause for respondent. With him on the brief was Gatti & Gatti, P.C., Salem.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

VAN HOOMISSEN, J.

Reversed.

VAN HOOMISSEN, J.

SAIF appeals from an order of the Workers' Compensation Board that found claimant's worsened psychological

condition compensable. We reverse.

All members of the Board concluded that claimant was not in reality subjected to any form of harassment or discrimination in connection with her work. The Board stated:

> "Contrary to the referee's finding that part of the harassment which claimant believed she was suffering at work was real, substantial and deliberate, we find that the overwhelming majority of this harassment was merely imagined. The medical evidence is nearly unanimous in this regard, and the testimony of the hearing is even more supportive of our conclusion.
>
> "* * * * *
>
> "There is nothing in this record indicating that claimant was harassed, spied upon or singled out in any way by her supervisors. Rather, the record establishes that she was being subjected to normal, ordinary, and reasonable supervision in the same manner as were her co-workers, and that her underlying maladaptive personality disorder caused her to overreact to this normal workaday environment."

Nevertheless, a majority of the Board affirmed the referee's finding that the claim was compensable.[1] In so finding, the majority relied on our decision in *McGarrah v. SAIF,* 59 Or App 448, 651 P2d 453 (1982), that a claimant's subjective perception of harassment by her supervisor is sufficient to establish compensability.

In *McGarrah v. SAIF,* 296 Or 145, ___ P2d ___ (1983), the Supreme Court held that a worker's honest perception of harassment, standing alone, is not sufficient ground for awarding compensation. The court stated:

> "We all know that stress may flow from work conditions. However, the on-the-job stress conditions causing the disorders must be real.[2] That is, the events and conditions producing the stress must, from an objective standpoint, exist in reality. * * * A worker's misperception of reality does not flow from any factual work condition." *McGarrah v. SAIF, supra,* 296 Or at ___.

On *de novo* review, we agree with the Board's conclusion that the alleged harassment of claimant was merely perceived. Therefore, she has not met her burden of proving that the factors contributing to her stress-related worsening existed in reality.

Reversed.

---

[1] Board member Barnes agreed that claimant was not in reality subjected to harassment or discrimination in her work. He dissented from the majority's conclusion that the claim was compensable on the ground that, as a factfinder, he did not find claimant's testimony about her perception of harassment and discrimination at work credible.

[2] "At times in its opinion, the Supreme Court speaks in terms of 'real stress'; it might have been more accurate to refer to 'real stress-causing conditions.' " *SAIF v. Shilling,* 66 Or App 600 n 1, ___ P2d ___ (1983).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Rhea A. Ramberg, Claimant.

RAMBERG,
Petitioner,

v.

GEORGIA PACIFIC CORPORATION,
Respondent.

(WCB No. 81-10707; CA A28024)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 9, 1984.

Brian R. Whitehead, Eugene, argued the cause for petitioner. With him on the brief were Malagon & Associates, and Evohl F. Malagon, Eugene.

Jerald P. Keene, Portland, argued the cause for respondent. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Joseph, Chief Judge, and Van Hoomissen and Young, Judges.

JOSEPH, C. J.

Remanded to referee with instructions.

JOSEPH, C. J.

On the eve of the hearing on this denied claim for medical services, claimant's boyfriend died. Her counsel became aware of that only minutes before the hearing commenced, and he requested a continuance because claimant was too distraught to testify. After extended colloquy, the referee denied the continuance on the ground that her "testimony is not necessary." He issued an order denying the claim, which was based entirely on the medical record. The Board, after acknowledging that it was "strongly tempted to remand * * * and allow claimant the opportunity to be heard * * *," concluded "that resolution of the medical causation issue requires reference to expert medical opinion and that claimant's testimony, even assuming it to be most favorable to her position, would not resolve the causation issue." It affirmed the referee.

Although claimant's own testimony might not have *resolved* the causation issue, her testimony and its credibility could have been relevant to what one of the medical witnesses called the "complex etiology" of her condition. Although the medical evidence was necessary, and might well have been decisive, claimant was entitled to be heard in support of her

claim.[1] *See J.C. Compton Co. v. DeGraff,* 52 Or App 317, 628 P2d 437, as modified on reconsideration 52 Or App at 1026 (1981).

Under the authority of ORS 656.298(6), we remand the matter to the referee to take the testimony of claimant. If the referee concludes that the testimony supports a different conclusion on the claim, a revised opinion and order shall be entered and the Board shall conduct a new review. Otherwise, the referee shall affirm the previous order, and the Board shall forward the transcribed testimony of claimant to this court for inclusion in the record on *de novo* review within 90 days of the effective date of this decision.

Remanded to the referee with instructions.

---

[1] At the time of this hearing, the Board had on review another referee's opinion and order denying an earlier aggravation claim by claimant. The referee here had reviewed that opinion and order and the exhibits on which it relied. Claimant had testified at the hearing on that claim, but it is not clear on this record whether the referee reviewed that testimony. In any event, defense counsel at the hearing agreed that her new testimony might have related to a worsening of her compensable condition and the need for surgery.

No. 124 February 15, 1984 67 OrApp 3 (1984)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Clarence Zwahlen, Claimant.

ZWAHLEN,
Petitioner,

v.

CROWN ZELLERBACH CO.,
Respondent.

(81-07457; CA A27610)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 28, 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.

Cynthia S. C. Shanahan, Portland, argued the cause for respondent. With her on the brief were Ronald C. Holloway, and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

PER CURIAM

Reversed and remanded for an order requiring employer to repay amount deducted as an offset.

PER CURIAM

In this workers' compensation case, claimant was overpaid certain amounts of temporary total disability after his vocational rehabilitation program was terminated. Relying on OAR 436-54-320, employer unilaterally began to recover the overpayment by deductions from each temporary total disability payment made after the claim was later reopened. The rule does not validly authorize such unilateral recovery. *Forney v. Western States Plywood,* 66 Or App 155, 672 P2d 1376 (1983).

Claimant requests penalties and attorney fees. ORS 656.262(10) provides for assessment of attorney fees and penalties against a carrier for "unreasonable refusal to pay compensation," and ORS 656.382 requires a carrier to pay attorney fees if it "unreasonably resists the payment of compensation." Assuming that those provisions are applicable, we conclude that attorney fees and penalties are not warranted. Although the rule could not validly authorize employer's action, until our decision in *Forney* an employer could have a "legitimate doubt, from a legal standpoint" as to its liability for the full amount of claimant's temporary total benefits, *see Norgard v. Rawlinsons,* 30 Or App 999, 1003, 569 P2d 49 (1977), and it was not unreasonabe to rely on the rule. *Cf. Sandstrum v. SAIF,* 46 Or App 773, 613 P2d 96, *rev den* 289 Or 677 (1980) (though benefits paid by insurer not subject to wage assignment, carrier acted reasonably in relying on circuit court order and case law).

Reversed and remanded for an order requiring employer to repay amount deducted as an offset.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jack Steimer, Claimant.

STEIMER,
Petitioner,

v.

BOISE CASCADE CORPORATION,
Respondent.

(81-08623; CA A28143)

On Judicial Review from the Workers' Compensation Board.

Argued and submitted December 9, 1983.

Christopher D. Moore, Eugene, argued the cause for petitioner. With him on the brief was Malagon and Associates, Eugene.

Paul J. DeMuniz, Salem, argued the cause for respondent. With him on the brief was Garrett, Seideman, Hemann, Robertson & De Muniz, P.C., Salem.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

PER CURIAM

Reversed and remanded.

PER CURIAM

Reversed and remanded to the Board to determine under ORS 656.295(5) whether the case should be remanded to the referee, because it has been "improperly, incompletely or otherwise insufficiently developed or heard by the referee." *Bailey v. SAIF,* 296 Or 41, 672 P2d 333 (1983).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard Davies, Claimant.

DAVIES,
Petitioner,
v.
HANEL LUMBER CO. et al,
Respondents.

(80-05224, 80-02635; CA A27317)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 18, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. On the brief were Daniel C. Dziuba 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 respondents Universal Drywall and SAIF Corporation.

Schuyler T. Wallace, Jr., Portland, argued the cause for respondents Hanel Lumber Company and Argonaut Insurance Company. With him on the brief was Mitchell, Lang & Smith, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded with instructions to order acceptance of the claim for new injury.

BUTTLER, P. J.

Claimant appeals a decision of the Workers' Compensation Board, which denied both his aggravation claim

against Hanel Lumber Co. (Hanel) and its carrier, Argonaut Insurance Co., and his new injury claim against Universal Drywall (Universal) and its carrier, SAIF. On *de novo* review, we find that claimant has met his burden of establishing that he suffered a new injury, and reverse.

Claimant was injured initially at Hanel in September, 1974, when he jumped off of a log and twisted his right knee. He underwent surgery, which relieved his symptoms, and was released to return to work in January, 1975. No permanent disability was awarded as a result of that injury. He testified that his right knee continued to hurt for about one year after the surgery and then became symptom free until he went to work for Universal in June, 1979. During the intervening years, he engaged in a variety of jobs involving heavy labor. Claimant alleges that, on November 28, 1979, while working for Universal, he picked up a sheet of wallboard and felt pain in his right knee. He was treated for a twisted right knee on that date.

Universal's contention, apparently accepted by the referee and the Board, is that claimant failed to establish that he was actually employed by Universal on November 28, 1979, the date shown on the claim form as the date he was injured. On January 2, 1980, Universal responded to the portion of the form which asks, "Did the injury happen during the course of employment?", by stating "Yes." The only additional comment by Universal was, "We would like to know whether or not this is an old injury." On March 5, 1980, SAIF denied the claim, stating that claimant's condition was related to a preexisting injury. At no time before the hearing on January 19, 1981, did Universal assert that the accident had not occurred or that claimant was not employed by Universal on the date in question.

At the hearing, Mr. Erickson, Universal's general manager, testified that claimant's last day of work with Universal was November 19, 1979. The basis for that testimony was that he had a time card for claimant on November 18 and 19, but none for any time thereafter. Erickson brought to the hearing only the time cards for the 18th and 19th and no

other evidence relating to claimant's employment. He admitted that he keeps in his office a dispatch sheet that would show claimant's name opposite any job to which he was assigned and would show whether he was working on the date in question. He did not state whether he consulted that record prior to testifying. Further, neither he nor any other representative of Universal attempted to explain why claimant would not have been working on that date; there is no evidence that he had been fired or that he had quit.

One plausible explanation for the failure for there to be any time cards for an extended period of time is contained in claimant's somewhat confused testimony, in which he states that he took a vacation to go elk hunting before the accident. When he came back to work, he started working on a new apartment that required a new time card, was injured and never filled out the time card.

Claimant was confused during his testimony as to the

dates in question. For that reason, the referee felt that his testimony is hard to believe. Although we defer to the referee with respect to findings of credibility, where, as here, that finding or conclusion is based on an objective evaluation of the substance of a witness' testimony, the referee has no greater advantage in making that assessment than we do on *de novo* review. It appears to us that the claimant's confusion over dates is understandable, because he had no reason before the hearing to believe that the employer would deny that he had worked on the date in question. The hearing occurred over a year after the accident, and it is understandable that claimant would have been confused when he was suddenly confronted with employer's denial that he was employed on the day in question. In spite of his confusion, claimant's testimony, from an objective standpoint, impresses us as more credible than that of Mr. Erickson, who did not consult the record that would have answered the question, brought inadequate documentation to the hearing and offered no explanation why claimant would not have been working on the day he said he was injured. Universal's argument is weakened further by the fact that shortly after the accident it stated that the accident had occurred at work; four months after the accident it denied the claim, not because claimant did not work on that date, but because claimant's disability was the result of a preexisting injury.

It is reasonable to conclude that, if claimant had not been employed by Universal for over a week prior to the date when he claims to have been injured, Universal would have denied that the injury occurred during claimant's employment. It is also reasonable to expect an employer to raise the question prior to the hearing and to bring its relevant records, solely within its control, to the hearing to support its surprise defense.

The preponderance of the evidence establishes that claimant did sustain an accident while he was employed by Universal on November 28, 1979, and that that job-related accident independently contributed to claimant's disability. He has sustained a new injury at Universal for which SAIF is responsible. *Boise Cascade Corp. v. Starbuck,* 296 Or 238, ___ P2d ___ (1984).

Reversed and remanded with instructions to order acceptance of the claim for new injury.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Robert L. Marvin, Claimant.

MARVIN,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(81-06759; CA A28120)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 13, 1983.

Gerald A. Martin, Bend, argued the cause and filed the brief for petitioner.

Donna Parton Garaventa, Associate Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause for respondent. On the brief was Darrell E. Bewley, Appellate Counsel, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded for award of permanent total disability as of June 17, 1981.

BUTTLER, P. J.

Claimant appeals the decision of the Workers' Compensation Board, which affirmed the referee and held that claimant was not permanently and totally disabled. On *de novo* review, we conclude that claimant has established that he is permanently and totally disabled, and reverse.

Claimant is a 65-year-old man who suffered a compensable injury when he broke his hip in 1978. He has a fifth-grade education and has been employed only in heavy labor. He underwent total hip replacement surgery in September, 1980. Before the injury, he had marked atrophy and partial paralysis in his left leg as a result of polio. Prior to the surgery, he was enrolled in a vocational rehabilitation program, and in August, 1979, DVR terminated him, stating that "[his] condition and age are against employment possibility * * * med. and age not feasible."

After the surgery, in June, 1981, Dr. Mahoney, claimant's treating physician, reported that claimant had some residual anterior left-thigh pain, which was significantly disabling as far as the hip was concerned. He used a cane to walk and could only walk 10 to 15 blocks. He was physically limited in squatting, bending and getting up from a squat, limited to

lifting ten pounds and permanently precluded from working at his regular job as a welder. Dr. Mahoney concluded:

> "* * * In fact, considering his education level and training, I would imagine that he is pretty much precluded from returning to work at all. * * *"

Orthopedic Consultants examined claimant in October, 1981, and noted that he stated that his left hip hurt more then than it did prior to the hip replacement surgery and that he could not get around as well now as he could before. Orthopedic Consultants stated that claimant could not return to his old job, even with limitations, but might return to a lighter job and should be given vocational rehabilitation. They rated his total loss as moderate.

Our evaluation of the record leads us to conclude that claimant is not only unable to return to his former occupation, but that he is also unsuited for retraining for any other occupation because of his age, physical disability and educational level. If there is a troublesome aspect to this case, it is

that, approximately one month before the hearing, the employer requested that claimant undergo vocational rehabilitation a second time, and he refused. The employer contends that claimant's refusal establishes his lack of motivation and should prevent him from being awarded permanent total disability compensation. It is true, generally, that refusal to accept vocational rehabilitation is strong evidence of lack of motivation to reenter the work force. However, in this case, claimant previously had enrolled in vocational rehabilitation at a time when his condition was less severe than it was in August, 1982, and his counselor concluded that retraining was not feasible because of his medical condition and age. Further, the employer was advised by Orthopedic Consultants in October, 1981, that claimant should be given vocational assistance. Yet, it did not follow that advice until nearly one year later, when, one month prior to the hearing, it attempted to force claimant into a second vocational assessment.

Under all the circumstances, the last minute request of the employer appears to be disingenuous, and we cannot say that claimant's refusal to re-enroll in a rehabilitation program, having been terminated from the earlier effort, establishes a lack of cooperation or motivation on his part. Given the evidence of the severity of claimant's disability, we find that he has established by a preponderance of the evidence that he is permanently and totally disabled as of June 17, 1981, the date of Dr. Mahoney's opinion.

Reversed and remanded for an award of permanent total disability as of June 17, 1981.

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.

On petitioner's petition for reconsideration filed November 10, 1983. Former opinion filed October 12, 1983, 65 Or App 88, 670 P2d 194.

Elden M. Rosenthal and Rosenthal & Greene, P.C., Portland, for petition.

Before Gillette, Presiding Judge, and Warden and Young, Judges.

WARDEN, J.

Petition for reconsideration allowed; former opinion supplemented to hold former OAR 436-54-225 valid and adhered to as supplemented.

WARDEN, J.

This workers' compensation case is before us on claimant's petition for review of our former opinion, *Fink v. Metropolitan Public Defender,* 65 Or App 88, 670 P2d 194 (1983). The petition for review serves as a petition for reconsideration by this court. ORAP 10.10. We grant the petition to consider whether former OAR 436-54-225 established a proper formula for computation of temporary partial disability benefits.[1]

The facts are set forth fully in our former opinion; for purposes of convenience, we repeat only those facts pertinent to our discussion here. Claimant, an attorney, voluntarily left the employment of the Metropolitan Public Defender's Office (MPD) in Portland in August, 1979, because of her symptoms of fibrositis. On October 1, 1979, she started working part-time in private practice. On September 19, 1980, she filed a workers' compensation claim with MPD for compensation for fibrositis. MPD denied the claim on May 4, 1981. The referee held that claimant was entitled to temporary total disability benefits from August 3, 1979, when she left MPD, until October 3, 1979, when she resumed working part time. He also found that she was entitled to temporary partial disability

[1] Claimant also requests reconsideration of our decision that she failed to establish a compensable disease. As to that issue, we adhere to our previous analysis. Even though her claim was not compensable, however, claimant was entitled to interim workers' compensation benefits for the time period between the filing of her claim and its denial. *See Jones v. Emanuel Hospital,* 280 Or 147, 570 P2d 70 (1977).

benefits for October, November and December, 1979, and awarded benefits for those months based on the formula established by *former* OAR 436-54-225(1). Applying *former* OAR 436-54-225(2), he found that claimant was not entitled to any benefits after January 1, 1980, because her earnings then equalled or exceeded her earnings at MPD.

Former OAR 436-54-225, provided:

> "(1) The rate of temporary partial disability compensation is determined by subtracting the post-injury wage earnings available from any kind of work * * * from the wage earnings from the employment at the time of, and giving rise to, the injury and then dividing the difference by the wage earnings at the time of injury to arrive at the percentage of loss of earning power. The temporary total disability compensation rate is then multiplied by the percentage of loss of

> earning power to arrive at the temporary partial disability compensation rate.
>
> "(2) If the post-injury wage earnings are equal to or greater than the wage earnings at the time of injury, no temporary partial disability compensation is payable."

Claimant asserts that the rule is in conflict with the enabling statute, ORS 656.212, because the rule defined "loss of earning power" in terms of actual earnings and failed to consider a potential decrease in the number of hours a worker could work. She argues that, after she left MPD, she could work only half time because of her fibrositis and that, therefore, her temporary partial disability rate should have been 50 percent of her total disability rate, regardless of her actual post-injury earnings. We do not agree.

ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, *the worker shall receive* for a period not exceeding two years *that proportion of the payments provided for temporary total disability* which his loss of earning power at any kind of work bears to his earning power existing at the time of the occurrence of the injury." (Emphasis supplied.)

As the statute indicates, compensation for temporary partial disability is to be calculated on the basis of payments for temporary total disability, which are provided by ORS 656.210.

Because of the interrelationship of the statutes, we look to the function and purpose of ORS 656.210 for guidance in construing ORS 656.212. Under ORS 656.210, temporary total disability is computed on the basis of the claimant's actual wages at the time of the injury. ORS 656.210(1). The purpose of temporary total disability is to compensate a claimant for loss of income until the condition becomes medically stationary, not to compensate for the work-related injury and disability, which is a function of a permanent disability award. *Taylor v. SAIF,* 40 Or App 437, 440, 595 P2d 515, *rev den* 287 Or 477 (1979). Considering ORS 656.212 in the context of the statutory scheme, we conclude that it too is designed only to maintain a worker's income at or near the worker's pre-injury level of earnings. "Earning power," as used in ORS 656.212, therefore, refers to a worker's pre-injury

wages. We construe ORS 656.212 to provide that compensation for temporary partial disability of a worker who is recovering from a compensable injury but is nonetheless capable of earning wages and is employed is to be proportionate to the decrease in the worker's actual earnings.

The formula established by *former* OAR 436-54-225 for computing loss of earning power comports with our construction of ORS 656.212. The rule provided for an adjustment of the compensation to be paid for the difference between the wages the worker actually received and the compensation the worker would have received for temporary total disability under ORS 656.210. If a claimant's post-injury wages exceed the claimant's pre-injury wages, the claimant suffers no loss of earning power and is not entitled to temporary partial disability benefits. We conclude that the formula under former OAR 436-54-225 for computation of a claimant's entitlement to compensation for temporary partial disability benefits accurately reflected the legislative concept of earning power.[2] Accordingly, we affirm the award of compensation for temporary partial disability as determined by the referee and affirmed by the Board, including denial of any temporary partial disability benefits after January 1, 1980.

Petition for reconsideration allowed; former opinion supplemented to hold former OAR 436-54-225 valid and adhered to as supplemented.

[2] In this case, claimant's post-injury employment resulted in a significantly higher per hour wage rate than her pre-injury employment, and she would have received greater benefits under an "hours of work" concept. Conversely, assuming that a worker secured post-injury employment at a lower rate than the pre-injury wage, an "hours of work" concept would be to the worker's disadvantage. For illustration we consider the hypothetical situation of a worker who had been employed eight hours a day at $10 per hour at the time of injury, but who, after an injury, could work only four hours a day at $6 per hour. Under *former* OAR 436-54-225, the worker would suffer a 70 per cent loss of earning power and would be entitled to temporary partial disability benefits at 70 per cent of the worker's temporary total disability compensation rate. Under the formula urged by claimant, that worker would suffer only a 50 per cent loss of earning power and would be entitled to 50 per cent of the worker's temporary total disability compensation rate. We do not believe the legislature intended that result.

No. 147 February 22, 1984 107

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Vernon D. Ellis, Claimant.

ELLIS,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(WCB No. 81-06304; CA A27140)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 31, 1983.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Donna Parton Garaventa, Associate Appellate Counsel, SAIF, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, J., Judges.

WARREN, J.

Reversed; referee's opinion and order reinstated.

WARREN, J.

Claimant appeals an order of the Board which reversed the referee's award of permanent total disability and held that claimant was not entitled to any increase in his permanent disability.

The initial issue to be resolved is whether claimant has to establish a worsening of his condition in order to be entitled to a redetermination of the extent of permanent disability. As we noted in *Johnson v. Industrial Indem.*, 66 Or App 640, ___ P2d ___ (1984), a claimant is not entitled to additional compensation following a final determination of extent of disability except for medical services under ORS 656.245, unless he establishes that (1) his condition has worsened or (2) he has been terminated from an authorized vocational rehabilitation program. Claimant has not had any vocational rehabilitation since the determination after a hearing on September 21, 1978, that he was entitled to an award of 75 percent unscheduled permanent partial disability. Claimant's treatment at a pain center after that date does not entitle him to a redetermination unless he is able to establish that his condition is aggravated. We therefore concur with the Board to that extent.

In December, 1977, before the hearing on the original claim, Dr. Bert clearly concluded that claimant could do light work. He reiterated that conclusion in June, 1979. On August 14, 1979, he reported a "slow deterioration to [claimant's] condition." He stated that claimant was taking more medication than he had in the past year but reported that there was no great increase in his symptoms. On November 20, 1980, SAIF sent a letter to Dr. Bert, stating: "From reports in file it does not appear that his condition, as related to this claim, has worsened. Is this correct?" He replied, "Yes."

On August 11, 1981, in his final report, Dr. Bert stated:

> "It is my feeling that the patient is indeed severely disabled. I feel that his disability is severe and permanent. He is approaching total disability. I could envision very few jobs that he could do that would require an eight hour day that he could do continuously. There are perhaps part time jobs of a low skill nature, such as a watchman job, where he could sit or stand at his own convenience that he might be able to do but

> even then this is difficult to predict without actually giving him a trial at such work, which is, of course, difficult to find."

A comparison of the reports of Dr. Bert before and after the 1977 hearing documents a worsening in claimant's condition. Before the hearing, he believed that claimant was capable of doing light work, the only limitation being on lifting over ten to 15 pounds. In his most recent report, he stated that claimant was incapable of doing any job eight hours a day and expressed some reservation as to his ability to handle even a part-time job. That is consistent with claimant's testimony. At the earlier hearing, claimant testified that he did not consider himself totally disabled and that he could be employed if the proper job could be located. Three years later, after continued efforts to find employment, and after treatment at the pain center, claimant remains unemployed, and his condition has deteriorated. The totality of the evidence documents a "slow deterioration" in his condition and meet his burden of proving a worsening of his condition. He is therefore entitled to a redetermination of the extent of his disability.

Claimant's impairment is described as severe and permanent by his treating doctor. He is unable to return to the type of work that he did before his injury and, according to his treating doctor, he could not return to any full-time job. It is questionable whether he could perform even part-time work.[1] He cooperated with the vocational counselor and completed a program of vocational rehabilitation but was determined thereafter to be unemployable in that field. He underwent treatment at the pain center, where the treating clinical psychologist reported that he was "an exemplary patient who was enthusiastic and participated at a high level in all classes and therapies." The conclusion of the vocational counselor was that claimant had "vigorously sought employment since being trained and was currently not employable in forestry."

Claimant is 50 years of age, has a high school education and two years of community college in forestry. He did not receive an associate degree, because he could not complete the course in elementary algebra. On the basis of our *de novo*

review of the evidence, we agree with the conclusion of the referee that claimant is permanently and totally disabled.

Reversed; referee's opinion and order reinstated.

[1] Claimant has undergone two laminectomies, a fusion and surgery on both knees and has sustained fractures of his foot and finger. He also has a preexisting ulcer.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Linda L. Reining, Claimant.

REINING,
Petitioner,

v.

GEORGIA-PACIFIC CORPORATION,
Respondent.

(80-01849; CA A28248)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 14, 1983.

Larry N. Sokol, Portland, argued the cause for petitioner. With him on the brief were Michael T. Garone, and Jolles, Sokol & Bernstein, P.C., Portland.

Deborah S. MacMillan, Portland, argued the cause for respondent. With her on the brief were Frank A. Moscato, and Moscato & Meyers, Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Reversed and remanded with instructions to order acceptance of claim.

YOUNG, J.

Claimant appeals from an order of the Workers' Compensation Board which affirmed the referee's denial of compensability. The issue is whether claimant proved by a preponderance of the evidence that her chronic urticaria (hives) is a compensable occupational disease under ORS 656.802(1)(a). We review *de novo,* ORS 656.298(6), and reverse and remand.

Claimant is 35 years old. It appears that she was free from any allergy symptoms until 1978 when she worked for a time in a cabinet-building facility and was exposed to cleaning solvent and glue. On that job, she developed "contact dermatitis," which cleared up with skin creams. The evidence is that that condition is a different disease process than urticaria.

Claimant began working for respondent in September, 1978. From September to January, 1979, she had no allergic reaction or symptoms. In January, she was transferred to a different job, which included steamcleaning glue booths and glue filters. She then developed symptoms which included an itchy rash on her arms, hoarseness, chest pains and

difficulty in breathing.[1] She continued at the same job, trying different medications, until July, 1979. Between January, 1979, and July, 1982, she was seen by six doctors. Two of the doctors, Wilson and Morgan, specialize in allergies.[2]

In September, 1979, Dr. Wilson performed multiple scratch tests and reported a positive response to all 66 tests. He stated that the positive tests indicated that claimant's skin was reacting when the test was done, which made the test results invalid. His initial opinion was that the work environment likely contributed to claimant's urticaria and that it was probably in her best interests to avoid that exposure. In November, 1980, Dr. Wilson testified by deposition that, in a

medical sense, the work environment contributed to claimant's urticaria in that "when she goes there she works, perspires, gets warm, sweats, wears possibly heavier clothing and also she firmly believes that it makes her worse." He stated that "a combination of those events means that while at work claimant is worse." He could not find anything specifically in the work environment that caused hives, although he did not test claimant for sensitivity to the glue that she was exposed to. He stated that he could not substantiate that the mill environment was a direct cause of claimant's problem and that he did not believe that that environment was a direct cause of her urticaria. He also stated that for 80 percent of chronic urticaria patients no cause is isolated.

In September, 1980, claimant was seen by Dr. Morgan. He believed that claimant has a "very convincing history of increasing sensitivity to an exposure associated with her work at the mill." He saw her four times in May, 1982. He conducted four double-blind tests using glue from the mill and found that the tests "substantiated the fact that claimant is sensitive to some component or components of the glue." She also reacted positively to certain turpenes and sawdust. His opinion is that there is convincing evidence, both historical and observed, that claimant is acutely sensitive to exposures at the mill. Claimant testified that since leaving the mill she has been symptomatic only as the result of the allergy testing or when she has been in the vicinity of the mill.

Claimant must show by a preponderance of the evidence that she has a compensable occupational disease. ORS 656.802(1)(a) defines "occupational disease":

> "Any disease or infection which arises out of and in the scope of the employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular employment therein."

[1] The hoarseness, chest pains and breathing difficulty were diagnosed as laryngitis secondary to bronchitis. Dr. Chowning, a specialist in otolaryngology, believed that the laryngitis and bronchitis were not work-related. Claimant does not contest that conclusion.

[2] Although we have reviewed all of the medical evidence, we have concentrated on the opinions of Drs. Wilson and Morgan, not only because of their specialties, but also because they were the only doctors to run substance tests on claimant.

The referee found that claimant failed to prove by a preponderance of the evidence that the uticaria was caused by circumstances to which she is not ordinarily subjected or exposed other than during periods of regular employment, *James v. SAIF,* 290 Or 343, 624 P2d 565 (1980), and that the at-work conditions were the contributing cause of her disability, citing *SAIF v. Gygi,* 55 Or App 570, 639 P2d 655, *rev*

den 292 Or 825 (1982). The Board, with one member dissenting, agreed with the referee. We disagree.

There is no persuasive evidence that claimant had urticaria prior to cleaning glue booths and glue filters, nor is there credible evidence that she was exposed to any conditions off the job which could give rise to that condition. The evidence is that, when she is exposed on the job to glue substances, turpenes and sawdust, she becomes symptomatic. Those symptoms, even though temporary, reflect a worsening of the underlying disease. Importantly, her hives cleared up when she left her employment. Dr. Wilson's reports and testimony appear to be logically inconsistent. Initially, he was of the opinion that the mill environment is the culprit and that that work exposure should be avoided. Later, he concluded that there is little connection between the environment and the urticaria. He does agree that when claimant is at work she is worse. On the other hand, Dr. Morgan was the only one to test claimant's sensitivity to the glue substances to which she was regularly exposed. He concluded that she is highly sensitive to the glue and the other allergens present on the job. Although the specific cause of claimant's urticaria is not conclusively established, we are persuaded that she has shown by a preponderance of the evidence that the major contributing cause of her urticaria, if not the only cause, is the work environment. *Penifold v. SAIF,* 60 Or App 540, 654 P2d 1142 (1982).

Reversed and remanded with instructions to order acceptance of the claim.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert Stedman, Claimant.

STEDMAN,
Petitioner,

v.

GARRETT FREIGHTLINES,
Respondent.

(81-01763; CA A28481)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 9, 1984.

Albert J. Bannon, Portland, argued the cause for petitioner. With him on the brief was Ramona G. Rosa', Portland.

Jerald P. Keene, Portland, argued the cause for respondent. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Joseph, Chief Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Reversed and remanded with instructions to order acceptance of claim.

YOUNG, J.

Claimant appeals a Workers' Compensation Board order affirming the referee's partial denial of compensability. The sole issue is whether claimant established by a preponderance of the evidence that his paralyzed right hemidiaphragm is causally connected to his compensable neck and shoulder injury. We review *de novo,* ORS 656.298(6), and reverse.

Claimant drives trucks for respondent. On October 8, 1980, he injured his shoulder and neck while trying to free a jammed "fifth wheel" pin to disconnect a trailer. On October 13, he saw Dr. Noall, an orthopedic surgeon, who diagnosed a muscle and ligament sprain of the cervical and right shoulder girdles. He recommended physical therapy and advised claimant to avoid heavy lifting. Claimant testified that he avoided such activity until he went crabbing on October 18. While pulling in a crab ring, he experienced a severe shortness of breath. He saw Dr. Wheeler, who referred him to Dr. Ironside, a pulmonary specialist. Dr. Ironside determined that claimant had a paralyzed right hemidiaphragm caused by phrenic nerve paralysis.

Claimant filed a claim for both the neck and shoulder injury and the paralyzed diaphragm. The neck and shoulder injury was accepted, but the diaphragm injury was denied.

The insurance carrier sent claimant to two pulmonary specialists, Drs. Lawyer and Vervloet. Both concurred with Dr. Ironside's diagnosis of paralysis of the right hemidiaphragm, secondary to a nonfunctional phrenic nerve. Although the doctors agreed on claimant's condition, they disagreed whether the neck and shoulder injury caused the damage to the phrenic nerve.

In Dr. Ironside's opinion, the exertion in pulling the jammed pin caused indirect trauma to the phrenic nerve. He identified three possible causes of the nerve damage, the most common being malignancy and inflammation. He tested claimant for cancer and infection without finding evidence of either. The third possibility was a traumatic pulling of the nerve. He concluded that the elimination of both malignancy and inflammation as possible causes and the short time interval between the stretching injury, shortness of breath

and discovery of the paralyzed diaphragm made it probable that the exertion and injury of October 8 caused a trauma to the phrenic nerve.

The other doctors concluded that, while the stretching injury possibly caused the phrenic nerve trauma, it was not "medically probable." Dr. Lawyer stated that the most likely cause of the nerve damage was a viral infection, although he admitted that there was no indication of an infection. Dr. Vervloet agreed with Dr. Lawyer that there was a possibility that the injury caused damage to the phrenic nerve. He reported a case in the medical literature in which a man had experienced similar damage attributed to exertion on an exercise wheel. However, he assigned the likely cause of the nerve damage as "idiopathic" or unknown.[1]

The referee relied on the opinions of Dr. Lawyer and Dr. Vervloet in determining that claimant had failed to establish "by a medical probability a connection between his frozen hemidiaphragm and his neck and shoulder injury." He determined that Dr. Ironside's opinion was not entitled to more weight by virtue of the facts that he saw claimant earlier and closer to the October injury or that he was the treating physician, because "there is nothing in the nature of treating claimant's problem near the time of injury which would enhance Dr. Ironside's diagnostic abilities." *See Hammons v. Perini Corp.*, 43 Or App 299, 602 P2d 1094 (1979). We disagree. Treating claimant closer to the time of the injury permitted Dr. Ironside to exclude the other possible causes of phrenic nerve paralysis and enhanced his ability to diagnose accurately.

All of the doctors explained that it is difficult to diagnose the cause of phrenic nerve paralysis, because the nerve is well protected deep within the body and a stretching injury itself is not visible. In the light of the difficulty in diagnosing the cause of phrenic nerve paralysis from indirect trauma with medical certainty, we conclude that claimant has

met his burden of proof to show that his paralyzed hemidiaphragm was medically caused by the initial on-the-job injury. We give more weight to the treating doctor's diagnosis, because he saw claimant shortly after the neck and shoulder injury, tested him for viral infection and malignancy and thereby ruled out the more common causes of phrenic nerve paralysis. Neither Dr. Lawyer nor Dr. Vervloet contradicted Dr. Ironside's opinion but, instead, found that the relationship between the stretching injury and phrenic nerve paralysis was medically "possible" rather than "probable." *See Harris v. Farmers' Co-op Creamery,* 53 Or App 618, 632 P2d 1299 (1981). The exclusion of other causes and the close proximity

[1] Drs. Lawyer and Vervloet were both particularly concerned with the lack of reported cases similar to claimant's in the medical literature and assessed the medical probability of such a cause in claimant's case based on the dearth of such reported cases. Statistical evidence that a causal connection is rare does not defeat the claim if an expert establishes the relationship in a particular case. *See Lucke v. Compensation Dept.*, 254 Or 439, 461 P2d 269 (1969).

in time between the on-the-job strain and the first onset of breathlessness during exertion persuades us that there is a medical probability that the compensable strain to the neck and shoulder caused trauma to the phrenic nerve, resulting in the paralysis of the right hemidiaphragm.

Reversed and remanded with instructions to order acceptance of the claim.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Olive J. Elwood, Claimant.

ELWOOD,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(80-10264; CA A27555)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 28, 1983.

Thomas A. Huntsberger, Springfield, argued the cause for petitioner. With him on the briefs was Ackerman, DeWenter & Huntsberger, Springfield.

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.

NEWMAN, J.

Reversed and remanded with instructions to order acceptance of claim.

NEWMAN, J.

In August, 1980, claimant filed a claim for occupational disease based on depression. ORS 656.802.[1] The referee and Workers' Compensation Board affirmed the insurer's denial of the claim. We reverse and remand.

In *McGarrah v. SAIF,* 296 Or 145, 164, ___ P2d ___ (1983), the court stated:

---

[1] Occupational disease means:

"Any disease or infection which arises out of and in the scope of the employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein." ORS 656.802(1)(a)

"[T]he on-the-job stress conditions causing the disorders must be real. That is, the events and conditions producing the stress must, from an objective standpoint, exist in reality. A worker's inability to keep up the pace of the job is real stress. * * * The pressure of an executive or management position is real stress. * * *

"* * * A worker may honestly believe that the employer plans to kill him and as a result of that fear cannot work, but if that belief emanates only from the worker's own paranoia and there was no evidence the employer had any such plan, no stress condition factually existed on the job and the resulting impairment would not be compensable. On the other hand, a worker with a non-disabling paranoid personality may lapse into a totally disabling psychotic paranoia if managers pile too heavy a workload on such a susceptible employe. Honest perception exists in both cases, but workers' compensation would be properly denied in the first case and properly allowed in the second.

"* * * * *

"The stressful conditions must actually exist on the job. That is, they must be real, not imaginary. The views of an average worker or average person or the perceptions by the claimant may be relevant but are not determinative. The existence of legal cause of stress-related occupational disease must be determined objectively.

"* * * * *

"In addition to proving that stressful conditions objectively existed on the job, the worker must also prove that employment conditions, when compared to non-employment conditions, were the 'major contributing cause' of the mental disorder."

See also Leary v. Pacific Northwest Bell, 296 Or 139, ___ P2d ___ (1983).

Under *McGarrah,* the questions are:

1. What were the "real" events and conditions of plaintiff's employment?

2. Were those real events and conditions capable of producing stress when viewed "objectively," even though an average worker might not have respond adversely to them?

3. Did plaintiff suffer a mental disorder?

4. Were the real stressful events and conditions the "major contributing cause" of plaintiff's mental disorder?

Claimant, age 54, was a registered nurse for 24 years. She worked full time for McKenzie Manor Home from 1966 until 1976. For the last nine years of that employment, she was the assistant director of nurses. She worked 40 hours a week with occasional week end or over-time work and rarely took vacations. She was responsible for a ward on one shift, including supervision of nurses and aides, medications for 75 patients and other administrative duties. She had frequent contact with visitors and patients' families, had to meet demands from patients and other nurses and had the responsibility of director of nurses if that person was away or ill.

The referee found claimant's testimony "essentially credible." Claimant testified that nurses made unnecessary

phone calls to the doctor about patients under her general supervision, disobeyed her instructions, ignored her, lost respect for her and encouraged aides and orderlies to disrespect her, denigrated the quality of her nursing care to families of patients and told management about complaints of patients and their families about her work. She had numerous conflicts with other nurses during the last few years of her service. She also testified that drugs and alcoholic beverages used by the residents disappeared without explanation from her ward and that she was told by an aide two or three days after she was terminated that there were rumors at the Home that she had been drinking the patients' alcohol and taking drugs. Claimant believed that that was "devastating" to her reputation.

Claimant testified that, because she was the logical choice to become the new director of nursing, the director and the nurses were attempting to force her to quit. She also testified that the administrator admitted that claimant was "being run off," but the administrator denied that. Claimant said that the director of nurses told her that her impression that the nurses were "giving her a bad time" was "in her imagination."

Although claimant had received above average to outstanding annual performance evaluations, the insurer submitted evidence that her work performance began to decline in about 1974, that she had failed to keep adequate records and charts in conformance with state regulations and had been told of the deficiency, that she was disrespectful to the administrator and one of the physicians and that patients complained concerning the care they received from her.

The record does not disclose whether the employer or other nurses, in fact, wished to force claimant out, whether claimant's imagination led her to this perception or whether there was good cause for her termination. It is clear that the employer requested and received claimant's resignation on April 1, 1976. Although the employer denied that it was trying to force claimant out, it did not try to prove that the events on which claimant based her belief that people did not want her there were not real. The record shows that numerous events and conditions of the employment, including her termination, were real and capable of producing stress when viewed objectively. *See SAIF v. Shilling,* 66 Or App 600, ___ P2d ___ (1984).

We also find that claimant suffers from a mental disorder. In the last five years of her employment, she developed frequent sore throats and gastric ailments. In the final two or three years, she became more tense and irritable and had numerous conflicts with other nurses. Her physician prescribed medications for her nervousness on an "as needed" basis. Her husband testified that for two or three years prior to her termination she was under great pressure, spent many restless nights and was reluctant to be left alone.

Claimant testified that, at the meeting at which her resignation was demanded, the director of nurses, the administrator and the owner told her that she was being terminated in part because of her illness. Although the administrator testified that claimant's termination was the result of her

failure to keep proper records, the employer listed the basis of termination on its form as "asked to resign as health didn't seem to be too good." The director of nurses wrote that claimant "was asked to resign because of inability in keeping up with workload which I feel was due to health reason." Claimant testified that one of the aides had told her that the director of nurses had "told the aides that next morning that I was emotionally ill and would not be returning to work."

In December, 1976, after her resignation, claimant's gynecologist believed that claimant was suffering from anxiety and depression. In early August, 1980, Dr. Sumlowitz, claimant's treating physician, advised her that she was suffering from "anxiety and depression and stress" and that she should obtain a psychiatric evaluation. In April, 1981, Dr. Radmore found claimant "chronically depressed." Although Dr. Holland, another psychiatrist who examined her at the insurer's request, concluded in 1981 that claimant "does not at the present time have a significant or diagnosable mental illness,"[2] we find the psychiatrists who testified for claimant more convincing. The referee found that claimant suffered from "anxiety, tension and depression." We are not persuaded by the Board's conclusion that, because claimant did not seek psychiatric help until 1980, she did not have a mental disorder. She was not advised to seek psychiatric help until 1980.

We also find that real, stressful events and conditions of plaintiff's employment, including the termination, when compared to the non-employment exposure, were the major contributing causes of her mental disorder. The referee stated:

> "There is medical opinion which generally relates claimant's psychological state to her work and termination. The lay testimony of claimant and her other witnesses is essentially credible."

The referee, however, thought that the causes of her depression— "criticism of job performance and termination from the job"—were noncompensable acts of supervision, citing *Henry McGarrah,* 33 Van Natta 584A (1981). We reversed the latter decision in *McGarrah v. SAIF,* 59 Or App 448, 651 P2d 153 (1982), before the Board's decision here. The Board believed, however, that claimant's disability was not compensable, because claimant's depression resulted from the employer's act of termination and did not arise in the course and scope of employment. Here, the employer's termination of claimant was part of her work experience and an act of supervisory authority over her in the course and scope of her employment. *See also Weiland v. SAIF,* 64 Or App 810, 669 P2d 1163 (1983).

---

[2] Dr. Holland testified:

> "* * * she has some symptoms which she admits are not related to her work experience which suggest that she has had emotional difficulty for a considerable period of time in her life."

He also noted:

> "She was usually tense and jumpy with her period, she often became nervous and shakey when approached by a superior, she had been considered a nervous person, she comes from a shy and sensitive family and her feelings have been easily hurt and criticism has always upset her."

Although claimant had received psychiatric treatment in 1964 or 1965, the first diagnosis of "depression" was made by her gynecologist in December, 1976. In August, 1980, Dr. Smulowitz diagnosed claimant's depression and stated that it was causally related to her employment:

> "On the basis of the stress produced by her firing after 10 years of service after really no well established reasons the patient claims to be disabled on the basis of this pressure put on her and is unable to work at her nursing profession because of this anxiety and depression and stress caused by her being fired after 10 years on the job at McKenzie Manor nursing home."

In April, 1981, Dr. Radmore believed that claimant's depression was caused by her work and wrote:

> "Mrs. Elwood has experienced a significant blow to her ego which has persisted throughout the years since her initial firing from her job, * * *."

Dr. Woodward wrote in July, 1981, that "there probably was a causal relationship between Mrs. Elwood's work and her depression."

Shortly after her termination claimant refused a part-time nursing position at another facility, because she felt she was no longer capable of working as a nurse. She has not worked since her termination in April, 1976, and her nursing license has lapsed. Her home life was supportive, and she had functioned satisfactorily for many years as a full-time nurse in a responsible supervisory position. That she may have been

disease as a result of stress does not render her disease noncompensable. *SAIF v. Gygi,* 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982); *see also McGarrah v. SAIF, supra.* Claimant's mental disorder is compensable.

Reversed and remanded with instructions to order acceptance of claim.

---

142 February 22, 1984 No. 153

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Ronald W. Mogliotti, Claimant.

MOGLIOTTI,
Petitioner,

v.

REYNOLDS METALS COMPANY,
Respondent.

(81-10-963; CA A28065)

On Judicial Review from the Workers' Compensation Board.

Argued and submitted November 28, 1983.

Dennis H. Henninger, Lake Oswego, argued the cause and filed the brief for petitioner.

Keith D. Skelton, Portland, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Van Hoomissen and Newman, Judges.

NEWMAN, J.

Reversed and remanded.

Van Hoomissen, J., dissenting.

NEWMAN, J.

Claimant appeals from an order of the Worker's Compensation Board that affirmed the referee's denial of medical benefits under ORS 656.245(3).[1] The issue is whether employer must pay for claimant's surgery performed in California by a California physician on December 2, 1981. The Board ruled that because employer's insurer did not approve of claimant's choice of the out-of-state doctor, employer need not pay for the surgery that the doctor performed. We reverse and remand.

Claimant suffered a compensable back injury in Oregon in 1979. Following a laminectomy in 1980, he received an award of 25% unscheduled permanent partial disability.[2] He moved to California, where he suffered increased pain and sought medical treatment from Dr. Becker. In mid-September, he was hospitalized for a myelogram that Becker performed. The insurer subsequently paid for those medical services. On September 28, 1981, the doctor sent a letter to claimant's attorney and a copy to the insurer:

> "At this time he appears to have a recurrence of pain and some apparent muscle spasm in his back and the myelogram, while reported as a negative myelogram by the radiologist does indicate a somewhat more bulging of the posterior longitudinal ligament then [sic] is usually seen. These may or may not represent further disc degeneration at these levels and may be accounting for his presnet [sic] discomfort and disability. If this is indeed so, it would have to be judged in terms of aggravation of pre-existing condition and considered as a deterioration of his condition from the time of his examination in June 1980 by Dr. Tobin. Going further back it would have to be considered related to his work injury. Whether or not this patient will require additional surgery will

[1] ORS 656.245(3) provides:

> "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."

[2] Following a hearing on October 5, 1981, claimant was awarded 112 degrees for 35% unscheduled low back disability, an increase of 32 degrees.

have to depend upon whether or not his condition clears up or remains as now or deteriorates."

In early October, 1981, claimant made a telephone call to the insurer about his medical treatment in California. He testified that the insurer told him that, although he could choose his own doctor in Oregon, he could not choose an out-of-state doctor. He also testified:

"[Claimant's attorney]: Were you in Portland?

"[Claimant]: Yes. I talked to [the insurer's representative] and asked him, you know, what the best way was to go; and he told me that I should stay up here and see a doctor up here.

"* * * * *

"Did you have any source of income at the time?

"No.

"Did you explain that to him?

"Yes.

"What did he tell you?

"He just said that there was nothing they could do about it.

"Did he mention anything to you about a doctor in the Merced or Atwater area?

"Yes.

"What was the nature of that conversation?

"I called him and I told him that I couldn't stay up here, and that I was going home, and he said that he would get a doctor for me down there.

"Did he tell you who?

"No.

"Have you ever heard mention of a Dr. Richard Thorp; did he ever mention that name to you?

"No."

The insurer did not give claimant the name of a California physician until February, 1982.

Claimant also testified that he made other telephone calls to the insurer about medical treatment. He testified that, during his last telephone call just before the surgery, he told the insurer of his plans for surgery and that the representative

said, "Fine, we will open your file." Claimant also testified concerning his conversations with the insurer:

"Q. [Claimant's attorney]: How many additional times did you call him and talk to him or call and attempt to talk to him regarding a second opinion after that first conversation?

"A. [Claimant]: Three times — well, it would be four times altogether counting the surgery time, when I told him I was having the surgery.

"Q. Did he at any of those times give you the name of any alternative doctor?

"A. No.

"Q. Did he at anytime indicate to you that Dr. Becker was not authorized to do the surgery?

"A. No."

On December 2, 1981, Becker performed the laminectomy. On December 16, 1981, the insurer denied payment for the surgery on the grounds that (1) there was no relationship between the laminectomy and the 1979 injury and (2) "You do not have your choice of attending physician outside the state of Oregon. Liberty Mutual did not give consent for your recent treatment and surgery." On December 18, Becker wrote to the insurer the details of his treatment, including the December 2 surgery.

The Board affirmed the referee's finding that, contrary to the insurer's position, the laminectomy was related to the 1979 injury. Employer does not appeal that determination. The Board, however, affirmed the referee, ruling that claimant "did not comply with the requirements of ORS 656.245 and *Rivers v. SAIF,* 45 Or App 1105, 610 P2d 288 (1980)." In *Rivers* we stated:

> "By specifically giving the worker a choice of doctors within the state of Oregon, the legislature withheld that choice outside the state. * * * Reading ORS 656.245 in its entirety, it is clear that subsection (2) limits a workers' choice of doctors when they seek treatment in another state, *but in no way diminishes their right to receive medical care, under subsection (1) of the same statute, wherever they are.*" 45 Or App at 1108. (Emphasis supplied.)[3]

Claimant asserts that the insurer's failure to respond to his requests for seventy-one days—from his first phone call

on October 5 until the denial letter of December 16—was an unreasonable denial of his right to receive medical care. *See Evans v. SAIF,* 62 Or App 182, 187, 660 P2d 185 (1983). We find that employer, on the facts here, may not refuse to pay for claimant's surgery. Although initially the insurer told claimant that he could not choose his out-of-state doctor, it did not specifically object to claimant's choice of Becker nor in a timely manner select an alternate physician. The insurer paid Becker's earlier medical bills, including the bill for the myelogram, and for claimant's mileage to see him. When claimant, just a few days before the surgery, told the insurer, "I'm going to have surgery," it responded, "Fine, we will open your file," although it knew that the claimant had chosen Becker to perform the surgery. The insurer's letter to claimant of December 16, after Becker had performed the surgery, did not state specifically that it did not consent to claimant's choice of Becker but only to "your recent treatment and surgery."

The laminectomy that Becker performed was for a condition that resulted from claimant's compensable injury. Although ORS 645.245(3) limits a worker's choice of doctor outside of Oregon, it does not limit his right to receive medical service under ORS 645.245(1), wherever he is. *Rivers v. SAIF, supra,* 45 Or App at 1108. The insurer's actions gave claimant a reasonable basis to believe before the December 2 surgery that it had approved of claimant's choice of Becker. If an insurer gives a claimant a reasonable basis to believe that it

[3] ORS 656.245(2) (*amended by* Or Laws 1981, ch 535, § 31) became ORS 656.245(3). *See* footnote 1, *supra.*

has approved his choice of doctor, the claimant need not obtain the insurer's consent to medical services that the doctor provides for conditions that result from the compensable injury. Here, employer cannot, after the surgery that Becker performed, refuse to pay for it. ORS 656.245(3).[4]

Reversed and remanded.

VAN HOOMISSEN, J., dissenting.

I respectfully dissent. ORS 656.245; *Rivers v. SAIF,* 45 Or App 1105, 610 P2d 288 (1980).

[4] Our conclusion is consistent with OAR 436-54-245(5), effective January 1, 1982:

"(5) When the worker chooses an attending physician outside the state of Oregon, the insurer or self-insured employer may object to the worker's choice and select the attending physician. Payment for treatment or services rendered to the worker after the insurer or self-insured employer has objected to the worker's choice of attending physician may be rejected by the insurer or self-insured employer."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gene R. Taylor, Claimant.

TAYLOR,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(81-10917 & 82-04748; CA A27865)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 28, 1983.

Diana L. Craine, Salem, argued the cause for petitioner. On the brief was Rolf Olson, Salem.

Donna Parton Garaventa, Associate 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.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant appeals an order of the Workers' Compensation Board awarding 25 percent loss of use of his leg as a result of a hip injury and 35 percent unscheduled permanent partial disability for a low back injury. He assigns as error the Board's failure to award permanent total disability and in the alternative seeks an increase in permanent partial disability.

Claimant, a 41 year old truck driver, sustained two separate compensable injuries. The claims were consolidated for a hearing regarding the extent of disability. Claimant concedes that he is not permanently and totally disabled from a medical standpoint but argues that he can be reemployed only after vocational retraining. He cites *Gettman v. SAIF*, 289 Or 609, 616 P2d 473 (1980), and argues that he is entitled to an award of permanent total disability until he has successfully completed a retraining program. In *Gettman*, the Supreme Court held that it was impermissible for the Board to reduce a claimant's award because of his "potential for retraining" when he had not completed a rehabilitation program.

> "In this case the claimant was found ineligible for vocational rehabilitation services, yet the Board reduced his award considering his 'potential' for retraining. ORS 656.206(1)(a) * * * provides that a 'suitable occupation' includes one which the claimant 'is able to perform after rehabilitation.' We conclude that the language of this statute, which speaks in the present tense, precludes cancellation of a permanent total disability award based upon a speculative future change in employment status. In other words, whether this claimant is permanently totally disabled must be decided upon conditions existing at the time of decision, and his award of compensation for permanent total disability can be reduced only upon a specific finding that the claimant presently is able to perform a gainful and suitable occupation." 289 Or at 614.

In *Gettman*, the court explicitly left open the question of the effect on a permanent total disability award of a claimant's unreasonable refusal to undertake or complete an offered course of vocational rehabilitation. 289 Or at 609, n 3. Even assuming the principle of *Gettman* otherwise applies, we find under the facts of this case that claimant's need for retraining does not entitle him to permanent total disability. He was referred for vocational evaluation and counseling. The

referee found, and we agree, that he did not work for any length of time with the vocational rehabilitation counselor and has done little to seek employment. The counselor said that the file was closed before a specific rehabilitation plan was devised, because claimant seemed more interested in his workers' compensation litigation than in rehabilitation. Claimant did not object to termination of the rehabilitation program. Failure to complete rehabilitation should be considered one of the "conditions existing at the time of the decision" regarding claimant's permanent disability, and the Board was entitled to consider claimant's "potential for retraining" under these circumstances.

After reviewing the record, we also find the permanent partial disability awards sufficient.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

HAWKINS,
Respondent,
v.
KENNEDY,
Appellant.
(79-277 L; CA A23694)

Appeal from Circuit Court, Klamath County.

Wayne H. Blair, Judge Pro Tempore.

Argued and submitted January 31, 1983.

Stanley C. Jones, Klamath Falls, argued the cause for appellant. With him on the briefs was Giacomini, Jones & Associates, Klamath Falls.

Blair M. Henderson, Klamath Falls, argued the cause for respondent. With him on the brief was Henderson & Molatore, Klamath Falls.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed; remanded for new trial on claim alleged in paragraph VI(b) of complaint only.

BUTTLER, P. J.

Plaintiff is a custom farmer who performs work for other farmers in Klamath County. He brought this action to recover damages he claims to have suffered because defendant did not allow him to perform certain work that he contends defendant was obligated to allow him to do under their contract. Defendant appeals a judgment for plaintiff, contending that their contract did not encompass the work at issue.

Defendant owns a large ranch in Klamath County. In 1974, he and plaintiff entered into a one-year written contract under which plaintiff was to do the haying (harvesting, hauling, baling and stacking) on defendant's ranch for specified prices. The following year, the parties agreed on a haying contract for the 1975 harvest year and signed a written contract specifying in some detail the manner in which the haying was to be done and providing that the agreement would terminate "at the close of the 1975 hay and grain harvest season." In early 1976, the parties again negotiated and agreed that plaintiff would do defendant's haying for the 1976 season but at a higher unit price. Rather than redo the contract, the parties wrote in and initialed the new price, using the 1975 contract.

About that time, the parties also discussed whether plaintiff might do certain farming on the ranch as well. An agreement was reached and a contract was signed on April 26,

1976, providing that plaintiff was to do the "following farming":

> "A. Farming shall consist of doing the reasonable and necessary cultivating, planting, and harvesting of all hays and grains and grasses for Owner;
>
> "* * * * *."

The contract specified the unit price for particular farming services, such as plowing, harrowing, cultivating and harvesting of "grain." No unit price was specified for the harvesting of hays and grasses, however, and there was no other mention of the harvesting of those crops in the contract, although it addressed the manner in which the farming services were to be performed and other details of the business relationship, including the right of defendant to perform any of the farming services himself when he had idle equipment

and personnel. By its terms, the contract terminated on January 1, 1979.

Although the farming contract did not discuss terms of payment for the harvesting of alfalfa hay or specifications as to how such harvesting would be performed, plaintiff testified that the parties agreed orally, either contemporaneously or prior to the signing of the farming contract, that defendant would compensate plaintiff for harvesting all hays, grains and grasses in the manner and amounts fixed by the 1976 haying contract and that there would be a price increase each year to account for inflation. Defendant denied the oral agreement, but plaintiff claims that, in reliance on it, he purchased special equipment for both the farming and haying of defendant's land for the 1976, 1977 and 1978 crop years.

While the farming contract was in force in early 1977, the parties again negotiated and reached agreement for haying for the 1977 season. They agreed to an increase in the per unit price, and again altered the existing haying contract to reflect the change. They also altered that contract to provide that it would terminate at the close of the 1977 hay and grain season.

In early 1978, plaintiff proposed to do the hay work that season for an increase in price greater than had been agreed to in the prior years, and he also proposed changes in other terms and conditions of that contract. Defendant rejected those proposals, and also a later one by which the unit price was slightly reduced, and informed plaintiff that he would not be doing the haying. Defendant hired another farmer to do the haying at a price higher than that in plaintiff's first proposal.

In this action, plaintiff seeks to recover profits he lost because he was not permitted to harvest defendant's alfalfa in 1978 and also those he lost because defendant performed certain work with his own equipment, allegedly in violation of the farming contract. The jury returned a verdict for plaintiff for $17,425 on the first claim and $9,000 on the second claim; a single judgment for $26,425 was entered.

On appeal, defendant contends that the trial court erred in denying his motions for a directed verdict on both claims. He argues that the parties' agreement in early 1977 that the haying contract would terminate at the close of the

1977 season, and their failure to reach agreement on plaintiff's 1978 proposals, resulted in there being no valid agreement for plaintiff to do the haying work for 1978. Regarding the claim for lost profits resulting from defendant's use of his own equipment during 1978, defendant argues that the major portion of plaintiff's claim related to work that would have been performed under the haying contract and that the portion of the claim based on an alleged breach of the farming contract was not supported by the evidence.

We agree with defendant that there was no enforceable contract on which to predicate plaintiff's claim for lost profits for haying. The separate farming contract that the parties entered into in 1976 specified in detail the farming operations that plaintiff was to perform, both as to the manner of performance and the prices to be paid. That contract also stated that farming included the harvesting of all hays, grains and grasses. Unlike the plowing, harrowing, harvesting of grain, and so forth, however, the farming contract was otherwise silent as to the harvesting of hays and grasses — it did not provide how it would be done or how much plaintiff would be paid. For that reason, the farming contract, as it related to the harvesting of hays and grasses, standing alone, was too indefinite in its terms to be enforceable. *See Phillips v. Johnson,* 266 Or 544, 555, 514 P2d 1337 (1973).

An oral agreement to utilize the written haying contract would remedy that defect so long as that oral agreement and haying contract were in force. The problem with plaintiff's position, however, is that the parties, in writing, agreed to terminate the haying contract at the close of the 1977 season. The agreement to terminate the written haying contract superseded previous oral or written contracts, and all prior terms inconsistent with the termination of the haying contract were rescinded. *See Marnon v. Vaughan Motor Co, Inc.,* 184 Or 103, 157-58, 194 P2d 992 (1948). Moreover, even if terminating the written haying contract did not rescind the provision of the farming contract that plaintiff harvest the hays and grasses, as plaintiff contends, that provision of the farming contract is too uncertain to be enforced; there was no agreement on the unit price for that work once the haying contract terminated. At most, the parties had, by their farming contract, an agreement to make a contract for harvesting with the terms and conditions to be left to future negotiations,

which were unsuccessful. Such an agreement is not binding. *See Karamanos v. Hamm,* 267 Or 1, 5, 513 P2d 761 (1973). The trial court erred in denying defendant's motion for a directed verdict on this claim.[1]

Regarding plaintiff's second claim, the farming contract provided that defendant could perform work otherwise to be performed by plaintiff when defendant had "idle equipment and personnel." The contract, drafted by defendant, provides no explanation of that phrase, and it is at least arguably uncertain when equipment and personnel would be deemed "idle" for purposes of that provision. Plaintiff produced evidence that defendant performed some of the work assigned to plaintiff under the farming contract when defendant's equipment and personnel arguably were not idle.

Accordingly, that portion of plaintiff's second claim raised a jury question. However, some of the work done by defendant with his equipment related to work plaintiff claimed he was entitled to do under the haying contract, which we have held was terminated at the end of the 1977 crop year. Defendant pointed out that problem in his motion for a directed verdict on this claim, and we conclude that he was entitled to a directed verdict on the part of plaintiff's claim relating to defendant's use of his equipment for work plaintiff was not entitled to perform under the farming contract. Accordingly, the case must be remanded for a new trial on the second claim.

Reversed; remanded for a new trial on the claim alleged in paragraph VI(b) of complaint only.

---

[1] Plaintiff did not argue that the farming contract obligated defendant to negotiate in good faith terms for harvesting alfalfa for 1978 and that defendant breached that obligation.

---

270 March 7, 1984 No. 174

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.

On respondent's petition for reconsideration filed January 6, 1984. Former opinion filed November 23, 1983, 65 Or App 659, 672 P2d 1343.

Dave Frohnmayer, Attorney General, James E. Mountain, Jr., Solicitor General, and William F. Nessly, Jr., Assistant Attorney General, Salem, for petition.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Petition for reconsideration allowed; former opinion adhered to as modified.

WARREN, J.

The Workers' Compensation Department (department) has petitioned this court to reconsider our decision in which we found that three department rules were valid and three rules were invalid. 65 Or App 659, 672 P2d 1343 (1983). We grant reconsideration to consider the effect of OAR 436-69-701(3), a rule that was not cited by either party in any of the arguments which have previously been made to this court.

As we noted in our original opinion, ORS 183.400(1) limits review in this court to consideration of the rule, the applicable statutes, the constitutions and the documents evidencing compliance with the APA. Under a strict application of the statute, we could not consider the effect of other rules which were not directly challenged, even those which were adopted at the same time and were meant primarily as supplements or amendments to the challenged rules. A more reasonable construction, however, is to construe the statute in conjunction with ORS 183.370(4) ("Courts shall take judicial notice of rules and executive orders filed with the Secretary of State") and consider the effect of all rules brought to the attention of this court that might affect the validity of the challenged rule.[1] We therefore will consider the effect of OAR 436-69-701(3) on the validity of OAR 436-69-501, which we have previously held to be invalid.

In our previous opinion we noted that, although OAR 436-59-501 deals primarily with the withholding of payment to a doctor for his failure to abide by an administrative rule, "[t]here 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." The department now points out that OAR 436-69-701(3) specifically provides that a physician cannot directly charge a worker for the treatment of a compensable illness or injury and, therefore, argues that a worker cannot be indirectly penalized for

his physician's failure to comply with the rules. The actual wording of the rule is as follows:

> "In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker is not liable for payment for any services for the treatment of that injury or illness. The vendor of medical services may charge the patient directly only for the treatment of conditions that are unrelated to the accepted compensable injury or illness."

We agree with the department's conclusion that, under this rule, the difficulty that we saw with OAR 436-69-501 of a claimant potentially being held liable for medical bills because his physician violated the rules is nonexistent.

A second problem with the rule, which was implied in our opinion, is that it imposes a direct penalty against physicians which we held was not within the statutory authorization. On further review of ORS 654.254(2) and 654.252, we have determined that the department is authorized to impose a penalty of forfeiture of fees on a physician for noncompliance with medical reporting requirements. We therefore reverse that portion of our earlier opinion and hold that OAR 436-69-501 is valid.

Petition for reconsideration allowed; former opinion adhered to as modified.

[1] Judicial notice of administrative rules has in fact previously been taken in cases involving a direct challenge of a rule pursuant to ORS 183.400. *See, e.g., Planned Parenthood Assn v. Dept. of Human Res.*, 63 Or App 41, 663 P2d 1247, *rev allowed* 295 Or 541 (1983).

INDEX CONTENTS

OVERVIEW OF SUBJECT INDEX

COURT CITATIONS

Court Case, Citation-----Page(s)

Court Case, Citation-----Page(s)

COURT CITATIONS

Court Case, Citation-----Page(s)

COURT CITATIONS

Court Case, Citation-----Page(s)

VAN NATTA CITATIONS

Name	Citation	Pages
Joyce Adair	34 Van Natta 203 (1982)	184
Arnold Androes	35 Van Natta 1619 (1983)	1
Willi Arndt	32 Van Natta 286 (1981)	135
Warren C. Bacon	35 Van Natta 1694 (1983)	1
Zelda M. Bahler	33 Van Natta 478 (1981)	114,327
Rasool Bambechi	35 Van Natta 1060 (1983)	315
John M. Barbour	36 Van Natta 304 (1984)	334
Phillip J. Barrett	35 Van Natta 789 (1983)	189
Donna Bassford	18 Van Natta 141 (1976)	133
Martha A. Baustian	35 Van Natta 1287 (1983)	114
Cletis H. Belcher	36 Van Natta 25 (1984)	26
Brent Bennett	34 Van Natta 1563 (1982)	160,230
Phillip A. Bertrand	35 Van Natta 869,873	21
Phillip A. Bertrand	35 Van Natta 1087 (1983)	21
Mark G. Blanchard	34 Van Natta 1660 (1982)	377
Edwin Bolliger	33 Van Natta 559 (1981)	90,380
Anthony A. Bono	35 Van Natta 1 (1983)	253
Rodney V. Calvin	35 Van Natta 1293 (1983)	133
Donald T. Campbell	35 Van Natta 1622 (1983)	1
Larry Campuzano	34 Van Natta 734 (1982)	293
Edward R. Cantrell	36 Van Natta 312 (1984)	304,320,334
Darrell W. Carr	36 Van Natta 16 (1984)	160,327
Ruth M. Case	33 Van Natta 490 (1981)	73
Harold R. Chester	35 Van Natta 874 (1983)	370
Joean Cisco	34 Van Natta 1030 (1982)	44
Gary L. Clark	35 Van Natta 117 (1983)	160
Angela V. Clow	34 Van Natta 1632 (1982)	114
Norman L. Cobb	11 Van Natta 224 (1974)	133
Ora M. Conley	34 Van Natta 1698 (1982)	152
Betty L. Counts	35 Van Natta 1356 (1983)	21
Max D. Cutler	34 Van Natta 1480 (1982)	265
George T. David	35 Van Natta 1703 (1983)	171
John W. Davidson	34 Van Natta 240 (1982)	61,245
Richard Davies	35 Van Natta 25 (1983)	160,327
Patricia G. Davis	35 Van Natta 635 (1983)	69,334
Patricia M. Dees	35 Van Natta 120 (1983)	114,265
Victor Derkacht	36 Van Natta 184 (1984)	182
Victor P. Derkacht	36 Van Natta 182 (1984)	184
Juanita DesJardins	34 Van Natta 595 (1982)	343
Roy D. Dezellum	34 Van Natta 213 (1982)	245
Terry Dorsey	31 Van Natta 144 (1981)	114
DeWayne D. Dunlap	36 Van Natta 139	143,343
Lloyd C. Dykstra	36 Van Natta 26 (1984)	25,40,44,77,184,252,384
Hettie M. Eagle	33 Van Natta 671 (1981)	239
Olive B. Elwood	35 Van Natta 205 (1983)	90
Richard Erzen	36 Van Natta 218 (1984)	230
Billy J. Eubanks	35 Van Natta 131 (1983)	26,44,160,265
Willard B. Evans	34 Van Natta 490 (1982)	265
Roy J. Fenton	34 Van Natta 1686 (1982)	143
Charles M. Fox	36 Van Natta 363 (1984)	393
Dennis Fraser	35 Van Natta 271 (1983)	139,251,323,343
Earl Freeman	34 Van Natta 1284 (1982)	184

VAN NATTA CITATIONS

Name	Citation	Pages
Gary Freier	34 Van Natta 543 (1982)	182
Lawrence D. French	35 Van Natta 1837 (1983)	69
Betty L. Fryer	35 Van Natta 1257 (1983)	21
Melodie A. Gage	34 Van Natta 1245 (1982)	204
Fred Gascon	34 Van Natta 1551A (1982)	131
Norman J. Gibson	34 Van Natta 1583 (1982)	160,439
Allen Giesbrecht	33 Van Natta 676 (1981)	255
Stephen R. Goode	35 Van Natta 1338 (1983)	184
Delbert Greening	34 Van Natta 145 (1982)	114
Daniel D. Griggs	35 Van Natta 154 (1983)	146
Edith Grimshaw	36 Van Natta 63 (1984)	212
Joyce Groshong	36 Van Natta 323 (1984)	343
Mary Ann Hall	31 Van Natta 56 (1981)	265
Richard O. Hampton	36 Van Natta 230 (1984)	218,260
Fred Hanna	34 Van Natta 127 (1982)	4
Donald W. Hardiman	35 Van Natta 664 (1983)	236
Thomas C. Harrell	34 Van Natta 589 (1982)	175
John R. Hart	35 Van Natta 665 (1983)	105
Robert Heilman	34 Van Natta 1487 (1982)	160,230,358
Gerald Herrington	35 Van Natta 859 (1983)	293
Bernie Hinzman	35 Van Natta 1374 (1983)	131,159
Kenneth L. Holston	34 Van Natta 952 (1982)	189
Walter L. Hoskins	35 Van Natta 885 (1983)	251,391
Roscoe Howard	35 Van Natta 329 (1983)	315,362
Thomas Huddleston	34 Van Natta 1616 (1982)	184
David L. Hulbert	34 Van Natta 761 (1982)	245
Lena Hunter	35 Van Natta 301 (1983)	122
Stephen E. Johnson	5 Van Natta 105 (1970)	133
Michael T. Kinsey	34 Van Natta 1072 (1982)	66
Richard Kirkwood	35 Van Natta 140 (1983)	160
Frances Knoblauch	35 Van Natta 218 (1983)	16,309
James A. Kurth	26 Van Natta 219 (1978)	380
Krista Larson	36 Van Natta 66 (1984)	321
Donald L. Lentz	35 Van Natta 1084 (1983)	265
Dan Lingo	35 Van Natta 1261 (1983)	377
Brad L. Loren	35 Van Natta 303 (1983)	105
Phillip E. Lowe	1 Van Natta 23 (1967)	133
Pauline Mabe	6 Van Natta 98 (1971)	133
Max Madden	34 Van Natta 1014 (1982)	26
Duane E. Maddy	35 Van Natta 1629 (1983)	1
Timothy D. Martinez	35 Van Natta 1315 (1983)	171
Frank Mason	34 Van Natta 568 (1982)	135,284
James H. Maxwell	36 Van Natta 40 (1984)	26
Kevin McAllister	34 Van Natta 158 (1982)	239
H.A. McCarthy	1 Van Natta 84 (1968)	312
Gerald McElroy	10 Van Natta 184 (1973)	133
Henry McGarrah	33 Van Natta 584A (1981)	512
Juena K. McGuire	35 Van Natta 1053 (1983)	44
Page/Gordon Medford	1 Van Natta 46 (1967)	133
Lois E. Miller	35 Van Natta 63 (1983)	245
Anthony Mims	34 Van Natta 97 (1982)	73
Lorrie A. Minton	34 Van Natta 162 (1982)	105
Edward Morgan	34 Van Natta 1590 (1982)	20,251,391
Charles A. Murray	34 Van Natta 249 (1982)	146,184,206
William A. Newell	35 Van Natta 629 (1983)	265
Robert H. O'Dell	35 Van Natta 1214 (1983)	321

VAN NATTA CITATIONS

Name	Citation	Pages
John J. O'Halloran	34 Van Natta 1101,1196	18
John J. O'Halloran	34 Van Natta 1504 (1982)	19
Mary Offutt-Littell	35 Van Natta 536 (1983)	373
Jo Wanda Orman	35 Van Natta 650 (1983)	94,139
Benjamin G. Parker	36 Van Natta 69 (1984)	193,334
Irene Penifold	33 Van Natta 707 (1981)	247
Michael Petkovich	34 Van Natta 98 (1982)	205
Walter C. Phillips	33 Van Natta 505 (1981)	59
Dean Planque	34 Van Natta 1116 (1982)	175
Elfreda Puckett	8 Van Natta 158 (1972)	239
Wilfred Pultz	35 Van Natta 684 (1983)	88,160,230
Janet S. Robb	34 Van Natta 1086 (1982)	129
Bettie L. Rogers	30 Van Natta 35 (1980)	312
William H. Ruff	34 Van Natta 1048 (1982)	380
Joda M. Ruhl	34 Van Natta 2 (1982)	377
Matthew Sampson	34 Van Natta 1145 (1982)	133
Robert Sanchez	32 Van Natta 80 (1981)	255
Lucine Schaffer	33 Van Natta 511 (1981)	146,184
Leroy R. Schlecht	32 Van Natta 261 (1981)	293
Paul Scott	35 Van Natta 1215 (1983)	21
Wesley Skeen	9 Van Natta 9 (1972)	312
Lowell D. Slama	35 Van Natta 744 (1983)	353
Carlton A. Spooner	34 Van Natta 1594 (1982)	165
Warren F. Stier	36 Van Natta 334 (1984)	304,320
William Still	34 Van Natta 1543 (1982)	139,143
William Strebendt	35 Van Natta 314 (1983)	105
Lawrence Sullivan	35 Van Natta 1383 (1983)	309
Mildred E. Swenson	35 Van Natta 566 (1983)	300
Terry D. Swindell	32 Van Natta 151 (1981)	8
Eugene Thomas	35 Van Natta 16 (1983)	160
James G. Thomas	35 Van Natta 714,827	44
John R. Thomas	34 Van Natta 1207 (1982)	236
John R. Thomas	36 Van Natta 158 (1984)	236
John R. Thomas	36 Van Natta 13 (1984)	236
Minnie Thomas	34 Van Natta 40 (1982)	251
James W. Thomason	36 Van Natta 143 (1984)	139
Charles L. Thornton	35 Van Natta 690 (1983)	165
Marvin Thornton	34 Van Natta 999 (1982)	293
Opal Triano	15 Van Natta 127 (1975)	16
Lewis Twist	34 Van Natta 290 (1982)	65,113
Donald VanDinter	34 Van Natta 1485 (1982)	44
Donald VanDinter	35 Van Natta 1574 (1983)	44
Walter T. VanMetre	35 Van Natta 1792 (1983)	247
Waunita M. Walker	36 Van Natta 44 (1984)	25,26,40
Thomas B. Ward	35 Van Natta 1552 (1983)	251,391
Ray A. Whitman	36 Van Natta 160 (1984)	146,327
Thomas C. Whittle	36 Van Natta 343 (1984)	323
Ray Williams	20 Van Natta 89 (1977)	133
Robert Williams	35 Van Natta 1758 (1983)	362
Donald Wischnofske	32 Van Natta 136 (1981)	129
Donald Wischnofske	34 Van Natta 664 (1982)	129
Casimer Witkowski	35 Van Natta 1661 (1983)	23,63,173
Leonard Wonsyld	34 Van Natta 230 (1982)	189
Lawrence Woods	34 Van Natta 1671 (1982)	171
Robert Wright	11 Van Natta 40 (1973)	133
Eduardo E. Ybarra	35 Van Natta 1192 (1983)	121,246
Myrtle E. York	36 Van Natta 23 (1984)	63,210,337
Donald J. Young	35 Van Natta 143 (1983)	391

ORS CITATIONS

page(s)

ADMINISTRATIVE RULE CITATIONS

LARSON CITATIONS

page(s)

The following Memorandum Opinions are not published in this volume. These decisions may be ordered from the Workers' Compensation Board using the numbers provided.

MEMORANDUM OPINIONS

Name, WCB Number (Month/Year)

Arent, Iracema, 82-09909 (3/84)
Arwood, Richard W., 83-03877 (3/84)
Ayoub, Mazhar, 82-11781 (2/84)
Baker, Harry E., 82-11142 (2/84)
Ball, William, 82-04585 (1/84)
Bamford, Chris B., 82-11552 etc. (1/34)
Bas, Gloria J., 83-01283 (1/84)
Basye, Betty K., 82-00797 (2/84)
Belleisle, Robert, 82-03419 (2/84)
Bender, Nolan I., 83-02504 (2/84)
Benton, Marion J., 82-10084 (3/84)
Berry, James, 80-10398 (2/84)
Bishop, Kenneth C., 82-10565 (1/84)
Black, Thomas L., 83-00857 (1/84)
Boyd, Kenneth G., 83-00923 (3/84)
Bradford, James M., 82-08839 (3/84)
Brantley, Thomas J., 82-07890 (1/84)
Brooks, Roy, 82-08049 (2/84)
Brown, Bea, 82-07977 (2/84)
Brown, Richard L., 82-10463 (1/84)
Bunch, Larry, 83-02026 (2/84)
Burks, Lloyd E., 83-04598 (3/84)
Burt, Lucy J., 83-00462 (3/84)
Caldwell, James B., 83-02290 (1/84)
Cameron, Loisel E., 81-07428 (2/84)
Carey, Collene L., 82-03590 etc. (1/84)
Carlson, Orville L., 82-08032 (2/84)
Carpenter, Philip S., 80-09663 (2/84)
Carroll, Jack S., 83-00006 (3/84)
Christensen, David C., 83-00378 (3/84)
Christensen, Jim, 83-01210 etc. (1/84)
Clugston, John W., 82-03351 (1/84)
Collins, Richard H., 82-10268 (3/84)
Comte, Karen, 82-00717 etc. (3/84)
Condu, Toni E., 82-11401 (1/84)
Conway, Michael J., 83-01887 (3/84)
Cooper, Robert W., 83-01133 (2/84)
Copley, Michael D., 83-00158 (1/84)
Cory, Lawrence A., 83-03866 (3/84)
Coulson, Gerry R., 82-05188 etc. (3/84)
Crews, William C., 82-05622 (2/84)
Crites, Michael W., 83-01778 (3/84)
Crowther, Frank L., 83-05175 (2/84)
Culp, Terryll S., 82-06467 (1/84)
Damis, Katherine K., 83-02169 (3/84)
Davisson, Harry J., 82-10465 (1/84)
Deen, Steven G., 83-03874 (1/84)
Degeer, Gaylon, 82-07024 etc. (3/84)
DeLeon, Lucas, 83-00011 etc. (1/84)
Deloney, Archie L., 82-09755 (3, 3/84)
DeRousse, William E., 82-03833 (2/84)
Dizick, Paul H., 83-00902 (3/84)
Dolezal, Steve M., 83-03735 (3/84)
Dossey, Vernon H., 82-10717 (2/84)

Name, WCB Number (Month/Year)

Drake, William A., 82-07841 (1/84)
Dryden, Raymond H., 83-00182 (2/84)
Edwards, Charles B., 82-06575 (1/84)
Faircloth, Cecil S., 81-02322 (3/84)
Fawcett, Paula, 82-08965 (3/84)
Fischer, Bernard D., 82-08014 (3/84)
Fiske, Pearl P., 82-08427 (1/84)
Fitzgerald, Larry H., 82-10460 (2/84)
Flores, Santiago, 82-11741 (1/84)
Ford, Paul M., 82-09898 (3/84)
Franks, Rose E., 82-10263 (3/84)
Fueston, Gerald R., 82-00187 (1/84)
Gardner, Walton A., 83-02658 (3/84)
Garoutte, Harold H., 82-08746 (3/84)
Gilbert, Patricia A., 83-01917 (1/84)
Gilkey, Shell H., 81-00679 (2/84)
Giumelli, Louis W., 83-02307 (3/84)
Goddard, Connie, 82-11769 (3/84)
Gonzales, Jose B., 82-07601 etc. (3/84)
Gonzalez, Manuel, 82-03176 (1/84)
Gottfried, Laronna R., 82-08262 (1/84)
Graham, John, 82-05166 (2/84)
Graham, Mary M., 83-02432 (2/84)
Graves, Daniel D., 83-00487 (1/84)
Gray, Arcola D., 82-05062 (1/84)
Gunter, LaVerna J., 82-08923 (2/84)
Guttery, Alice M., 83-00357 (1/84)
Haigler, Eugene V., 83-02615 (3/84)
Hamilton, Lloyd L., 82-11377 (1/84)
Hamlet, Kathryn J., 82-07654 (2/84)
Handy, Beverly A., 83-00847 (3/84)
Haret, Geraldine A., 82-05250 (1/84)
Harshe, Ronald L., 83-01165 (3/84)
Hart, Richard D., 82-08013 (2/84)
Hartman, Ruby L., 82-05295 (1/84)
Heamish, Abraham, 82-06973 (3/84)
Herron, Delmar L., 82-10903 (1/84)
Hobbs, Raymond E., 81-03081 etc. (2/84)
Holgate, Norman G., 81-11051 (3/84)
Holmes, Steven H., 82-06253 (1/84)
Hoover, Griffith G., 82-03843 (2/84)
Howard, Mabel J., 82-10405 (1/84)
Hunnicutt, Joe O., 82-11498 (3/84)
Hutcheson, Robert C., 82-08551 (1/84)
Jackson, Donald W., 82-09061 (3/84)
Jackson, Ivery T., 82-09174 (1/84)
Jacques, Morris R., 83-06067 (3/84)
Jeffery, Pamela D., 83-01043 (1/84)
Johnson, Everett, 81-07556 (1/84)
Johnson, Martin D., 81-06666 (2/84)
Johnson, Martin, 82-02207 etc. (1/84)
Jones, Boneta M., 83-01879 (1/84)
Jones, George E., 81-02669 (3/84)
Jones, Robert B., 82-11270 (2/84)

Name, WCB Number (Month/Year)
Karam, John S., 82-10092 (1/84)
Kassahn, Jerry E., 82-11458 (1/84)
Kazim, Mir S., 82-08825 (3/84)
Kelley, Dennis W., 82-09641 (3/84)
Kelly, Billie L., 82-10780 (2/84)
Key, Jim G., 81-10357 (3/84)
Knapp, Carol J., 82-08271 (3/84)
Krogstad, Donald, 82-09572 (3/84)
Kubly, Robert P., 82-07818 (1/84)
Layton, Jimmy K., 83-03487 (2/84)
Lebatique, Fred (Gomez),78-4014 (3/84)
Lee, Bruce W., 83-04005 (3/84)
Lessick, Joyce I., 82-00690 etc. (1/84)
Littell, Mary L., 82-09013 (2/84)
Logan, Joyce D., 83-04053 (3/84)
Loop, Robert L., 83-01093 (1/84 & 2/84)
Lunsford, Teddie D., 82-11127 (3/84)
Mack, Norman A., 83-04016 (3/84)
McCall, Cathy J., 81-08883 (2/84)
McDonald, Mary J., 82-07460 etc. (3/84)
McIlvain, Gilson, 83-03625 (1/84)
McJunkin, Eldon J., 82-00815 (2/84)
McNabb, Connie J., 82-05104 (2/84)
Meyer, Vincent L., 81-06150 etc. (2/84)
Milligan, Clell, 80-05901 (3/84)
Mills, Ronald, 81-01675 (3/84)
Minor, Ted, 81-11768 (3/84)
Moss, Donald J., 82-08699 etc. (1/84)
Myers, Karen A., 82-10676 (1/84)
Needham, Jerry R., 83-08427 (3/84)
Nelson, Patricia A., 82-10181 (2/84)
Nelson, Ronald E., 83-02406 (2/84)
Nielsen, Eva J., 82-11476 (3/84)
Nuttall, Ruby L., 82-01439 (3/84)
O'Boyle, Walter A., 82-03172 (3/84)
O'Dell, Evelyn M., 82-11009 (1/84)
O'Keefe, Brian K., 83-03916 (2/84)
Olin, Daniel E., 82-11437 (2/84)
Olinger, Joann F., 83-00091 (1/84)
Olsen, Bert J., 82-02831 etc. (3/84)
Olson, Debra L., 81-11076 (1/84)
Organ, Samuella, 82-01805 (1/84)
Otu, Samuel F., 83-03943 (3/84)
Owens, Kenneth R., 83-02142 (1/84)
Parsons, Thomas M., 82-04183 (1/84)
Patterson, Willie,83-00997 etc., (3/84)
Peacock, James P., 82-10741 (1/84)
Pepperling, Delmar, 82-11015 (2/84)
Pepperling, Gary W., 82-11015 (2/84)
Perdue, Mickey O., 83-01817 (3/84)
Peterson, Grant, 82-03285 etc. (2/84)
Picker, Deborah L., 82-01790 (3/84)
Pinkley, Mary H., 83-03423 (3/84)
Pope, Joyce M., 82-05662 (1/84)
Prater, James, 81-04573 etc. (1/84)
Purdue, Timothy J., 82-10737 (3/84)
Puttie, Steven, 82-11739 (1/84)

Name, WCB Number (Month/Year)
Ravenwood, Minx E., 80-07679 (3/84)
Reck, George S., 82-09903 (1/84)
Reynolds, Sylvia J., 83-04140 (3/84)
Robbins, Charles E., 82-09366 (1/84)
Robinson, Thomas, 83-01467 etc. (3/84)
Rondeau, Alden J., 82-08120 (1/84)
Rothenfluch, Darrell, 82-11154 (2/84)
Rush, Alice V., 82-01314 (2/84)
Sampson, Steven A., 82-06860 (1/84)
Sattler, Wendlin J., 82-09146 (3/84)
Sayre, Alvena L., 83-00212 (3/84)
Schaefer, Coralee A., 82-08773 (2/84)
Schnepp, Ramona, 82-07992 (1/84)
Schuchardt, Ronald K., 82-04706 (3/84)
Schultze, Ruby J., 82-11238 (2/84)
Scott, Ronald A., 82-09540 (1/84)
Sharp, Aubrey L., 82-08343 (1/84)
Shaver, Robert A., 82-09848 (2/84)
Shepard, Thomas M., 83-02117 (1/84)
Sherman, Patsy D., 82-11449 (3/84)
Shipman, Lyla M., 83-01968 (3/84)
Shroy, Charles F., 82-07332 (1/84)
Silva, Jeffrey A., 82-05276 (2/84)
Smith, Bettie M., 83-01809 (1/84)
Sprenger, Kari L., 82-07553 (1/84)
Stennick, Martin, 82-11254 (1/84)
Stephens, Walter M., 82-07249 (1/84)
Stockton, Jerry, 80-08953 (1/84)
Stuivenga, Norman W., 83-00975 (3/84)
Surprise, Richard G., 82-08426 (1/84)
Terry, Elva J., 81-04559 (2/84)
Thierman, Robert B., 82-06223 (2/84)
Thomas, David L., 83-01635 (2/84)
Thompson, Mike J., 83-01969 (3/84)
Toelaer, David C., 82-08971 (1/84)
Tomason, Harold, 82-07981 etc., (2/84)
Triplett, Pauline A., 82-07115 (2/84)
Unger, Ferdinand F., 82-03779 (3/84)
Vanhoof, Ralph W., 82-08659 etc. (3/84)
Vaughan, Clyde L., 81-04927 etc. (1/84)
Verhoef, Melvin L., 83-01259 (3/84)
Vetkos, David A., 83-02907 (3/84)
Volkers, Edgar B., 82-11327 (3/84)
Warfel, Ermagene, 83-01402 (2/84)
Weaver, Thomas R., 83-05062 (3/84)
Wilcock, Irene C., 83-01179 etc. (2/84)
Wilken, John L., 83-01606 (3/84)
Wilson, Bruce R., 82-10585 etc. (1/84)
Womack, Lyle A., 82-10027 (1/84)
Woods, John R., 82-05903 (2/84)
Wrightman, George E., 82-00518 (3/84)
Yates, Laurence M., 82-08911 (3/84)
Yates, Norman C., 83-00930 (1/84)

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)

Alexander, Robin, 83-0211M (2/84)
Baldock, Jo Ann, 84-0069M (3/84)
Bales, James C., 84-0052M (3/84)
Barker, Donald, 83-0364M etc. (1/84)
Bass, Donald A., 82-0056M (3/84)
Bergamo, Terry, 83-0390M (1/84)
Birdsell, Robert, 83-0241M (1/84)
Bjornsen, Bjorn, 84-0005M (2/84)
Bowers, James, 83-0392M (1/84)
Bray, Bruce D., 84-0011M (1, 3/84)
Brink, Lloyd Arthur, 83-0377M (3/84)
Britt, William T., 83-0202M (1/84)
Brown, Lois R., 83-0276M (2/84)
Bryant, Kenneth E., 82-0143M (2/84)
Burke, Barbara, 84-0118M (3/84)
Bustamante, Enrique, 83-0167M (3/84)
Camp, Noland Dean, 84-0062M (3/84)
Campbell, Betty J., 83-0235M (2/84)
Campbell, Donna J., 84-0046M (2/84)
Carmien, James, 84-0004M (2/84)
Charpentier, Adrienne, 83-0383M (1/84)
Chew, Vernon, 83-0376M (2/84)
Church, Denise M., 84-0093M (3/84)
Compton, James, 84-0001M (1/84)
Cooper, Wayne D., 83-0387M (2/84)
Corbett, Gary Lee, 84-0031M (3/84)
Davis, Wallace J., 83-0029M (1/84)
Dickerson, Ruby Lee, 82-0098M (3/84)
Dockery, William A., 84-0085M (3/84)
Donathan, Wilson W., 83-0110M (3/84)
Dority, Patrick J., 84-0039M (2/84)
Dupont, Ruben F., 84-0123M (3/84)
Durbin, David D., 83-0379M (3/84)
Durst, Leroy, 83-0360M etc. (3/84)
Duval, Roger A., 84-0042M (2/84)
Evans, Ainslee D., 83-0188M (1/84)
Fellows, Vernon L., 84-0014M (1/84)
Ferguson, Donald E., 82-0248M (3/84)
Flannery, Michael T., 83-0242M (2/84)
Fowler, Charles O., 84-0053M (3/84)
Franke, Donald M., 82-0039M (1/84)
Frear, James, 82-0291M (1, 2/84)
Funk, Robert S., Jr., 83-0371M (2/84)
Gardner, Ben D., 83-0391M (1/84)
Gergen, Georgia, 83-0145M (1/84)
Giffin, Jerry Dean, 83-0079M (1/84)
Goodlow, Cleatis P., 84-0063M (2/84)
Hammer, Charles, 83-0254M (1/84)
Haron, Louis, 83-0348M etc. (1/84)
Hash, Stephen L., 84-0094M (3/84)
Hawkins, Floyd E., 83-0382M (2/84)
Heth, John W., 82-0290M (1, 2/84)
Hinzman, Bernie, 83-0097M (1/84)
Hoff, Harley, 84-0032M (2/84)
Holland, Judith, 84-0034M (2/84)
Hoskins, Charles E., 84-0100M (3/84)
Hudson, Ronald J., 84-0017M (1/84)
Hunter, Jeffery K., 84-0066M (3/84)
Hutchins, Francis, 83-0331M (3/84)
Hutchison, Joseph, 83-0393M (1/84)
Imdahl, Herbert M., 84-0026M (1/84)
Johnson, Douglas, 84-0003M (1/84)
Johnson, Vernon, 84-0087M (3/84)
Jones, Danny J., 84-0016M (2/84)
Kephart, Archie, 81-0173M (3/84)
Kerekes, Karen L., 84-0057M (2/84)
Kutch, Gerald, 82-0322m (2/84)
Kyle, Steve, 84-0008M (1/84)
Lakey, John, 84-0010M (2/84)
Lee, Dwight L., 84-0096M (3/84)
Lopez, Alex, 81-0315M (2/84)
Lundsten, Betty, 83-0319M (1/84)
Maddox, Gary, 83-0321M (1, 1/84)
Manwill, Moyle C., 83-0140M (1/84)
Martin, James, 82-0054M (1,2,3/84)
McTimmonds, Rodney, 83-0384M (3/84)
Mercer, Joan, 83-0342M (3/84)
Moore, Robert L., 84-0112M (3/84)
Mortensen, Lewis, 84-0022M (1/84)
Morton, William, 83-0111M (1/84)
Mosier, Marion R., 84-0095M (3/84)
Moyer, Phillip Sr., 84-0083M (3/84)
Mustoe, Erwin R., 83-0388M (1/84)
Neault, Marjie M., 83-0329M (3/84)
Nelson, Margie, 84-0027M (2/84)
Nichols, Samuel L., 83-0385M (1/84)
Nicks, Edward, 83-0158M (1/84)
Norton, Alberta M., 81-0129M (3/84)
Pacheco, Willadeane, 84-0006M (1/84)
Park, Thomas D., 84-0092M (3/84)
Parker, Donald, 84-0002M (1/84)
Parker, Lee Roy, 84-0074M (3/84)
Paulsen, John A., 83-0048M (1/84)
Peyton, Gary, 82-0253M (2/84)
Poelwijk, James, 83-0340M (1/84)
Purdy, Charles A., 83-0374M (1/84)
Rampenthal, Marquita, 84-0058M (2/84)
Rathman, Robert D., 82-0219M (2/84)
Rauschert, John, 83-0353M (1/84)
Rice, Mary Jane, 83-0314M (2/84)
Roelle, Walter D., 84-0015M (1/84)
Ross, Max J., 84-0067M (3/84)
Roth, Vernon L., 83-0386M (2/84)
Roush, Richard L., 84-0018M (2/84)
Salisbury, Jan L., 84-0025M (1/84)
Sevey, Gene, 84-0007M (2/84)
Sikes, Billie, 81-0086M (1/84)
Sizemore, Addie Mae, 83-0368M (1/84)
Slinger, Edward, 84-0126M (3/84)
Surratt, Kenneth, 83-0206M etc. (2/84)
Tipsword, Phyllis, 83-0184M (2/84)
Vering, John, 84-0043M (3/84)
Vineyard, Dennis L., 84-0070M (3/84)
Waldron, Donald L., 84-0082M (3/84)
Warner, June, 84-0071M (3/84)
Weber, Frank C., 84-0060M (2/84)
Williams, Robert H., 84-0044M (2/84)
Winkler, Gloria, 84-0059M (2/84)
Woody, Ulyess L., 83-0064M (1/84)
Wright, James E., 83-0248M (3/84)
Wright, Ronald, 81-0174M (2/84)

CLAIMANTS INDEX

CLAIMANTS INDEX

CLAIMANTS INDEX

CLAIMANTS INDEX