VAN NATTA'S WORKERS' COMPENSATION REPORTER

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

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37 Van Natta ___ (1985)

PAUL M. FORD, Claimant
Willner, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-09898
July 11, 1985
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Ford v. SAIF, 71 Or App 825, rev den, 299 Or 118 (1985). We have been instructed to order acceptance of claimant's occupational disease claim for hearing loss.

Now, therefore, the SAIF Corporation's denial dated October 5, 1982 is hereby set aside, and this matter is remanded to the SAIF Corporation for claim acceptance and processing according to law.

IT IS SO ORDERED.

WILLIAM R. GILL, Claimant
Evohl F. Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorney

WCB 84-08645
July 11, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of that portion of Referee Quillinan's order which assessed a penalty and accompanying attorney fees for its alleged unilateral offset of an overpayment from one claim against time loss payments made on a subsequent claim. Claimant cross-requests review contending his claim was prematurely closed or, alternatively, that the Referee's increase of his unscheduled permanent disability award for a low back injury from 10% (32°), as awarded by a July 26, 1984 Determination Order, to 15% (48°) was inadequate.

The Board reverses that portion of the Referee's order which assessed the employer penalties and accompanying attorney fees. Following our de novo review of the record, we are not persuaded that the employer unilaterally offset the prior claim's overpayment as it had initially threatened. To the contrary, the preponderance of the evidence suggests that claimant received his time loss payments at the full weekly rate, without any deduction. Consequently, we do not consider the employer's conduct unreasonable. Moreover, since there apparently was no loss of payment or delayed payment of compensation that was due claimant, there were no "amounts then due" upon which to base a penalty and attorney fees. Ray A. Whitman, 36 Van Natta 160 (1984) modified, Whitman v. Industrial Indemnity, 73 Or App 73 (1985); Darrell W. Carr, 36 Van Natta 16 (1984); EBI Companies v. Thomas, 66 Or App 105 (1983); ORS 656.262(10).

The Board affirms the remainder of the Referee's order.

ORDER

The Referee's order dated October 22, 1984 is affirmed in part and reversed in part. That portion which assessed the self-insured employer penalties and attorney fees is reversed. The remainder of the Referee's order is affirmed.

ERICA E. MORENO, Claimant
Evohl F. Malagon, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-00367
July 11, 1985
Order Denying Motion for Expedited Review and Stay

The self-insured employer has moved the Board for an order expediting review of the captioned claim and staying the effect of Referee Foster's order dated June 17, 1985, pending Board review. Board review was requested June 25, 1985, simultaneously with the filing of the employer's motion. There is no mechanism for expediting Board review, other than the parties' own diligence in meeting briefing schedules. Board policy is to review cases as expeditiously as possible, consistent with considerations of fairness to the parties and due process.

As to the employer's motion to stay the effect of the Referee's order, ORS 656.313(1) specifically provides that payment of compensation to a claimant shall not be stayed pending Board or court review at an employer's request. We are without authority to even consider such a motion.

The employer's motions are denied.

IT IS SO ORDERED.

SALLY M. TURPIN, Claimant
Svoboda & Associates, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 83-01963
July 11, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests, and the self-insured employer cross-requests, review of Referee Brown's order that: (1) affirmed the Determination Orders awarding claimant a total of 15° for 10% scheduled disability for the right wrist; (2) allowed the employer to recompute claimant's temporary total disability compensation rate on the basis of a 31.125 hour average work week and recover from claimant any resulting overpayment; and (3) granted the employer's request for recovery of an overpayment in the amount of $727.80 that accrued after the first Determination Order. On review claimant asserts entitlement to additional scheduled disability compensation. On cross-request, the employer argues that the Referee improperly recalculated claimant's average work week. The $727.80 overpayment has not been appealed.

Claimant developed right wrist pain in May of 1981 while working as a tree planter. Her symptoms resolved with lighter work. They later returned, however, and claimant visited Dr. Freeman, who ultimately diagnosed right carpal tunnel syndrome. A release of the right median nerve was performed on May 10, 1982. Claimant was found to be medically stationary on October 20, 1982 by Dr. Teal.

Claimant attempted a return to work in January of 1983, but her right wrist symptoms immediately returned. A second right median nerve release was performed, along with a flexor synovectomy, and tenovaginotomy of the right index and middle fingers on January 27, 1983. A Determination Order issued the same day granting claimant 10% scheduled disability.

The claim was soon reopened and claimant entered an authorized training program in bookkeeping and tax preparation. She was able to physically handle her classwork, although she experienced increasing right hand problems at the end of the training program. At the time of the hearing, claimant was enrolled in a second training program that also required use of the right hand. Claimant testified that she was successfully completing the program, but was continuing to experience pain and stiffness of the right hand when writing or using office machines.

Dr. Teal performed the closing examination in September of 1983. He found no permanent impairment at that time, but later indicated that claimant suffered disability in the form of pain upon rigorous use of the hands. A second Determination Order gave no additional permanent partial disability.

Claimant was examined twice in August of 1984 by Dr. Nathan, whose objective test results proved normal. He found no permanent impairment. Claimant was also examined by Dr. Karasek, who rated the loss of use in the right hand and wrist at between 10% and 20%.

After reviewing the record, we find that claimant has been adequately compensated by the 10% scheduled disability already awarded. Although she suffers some permanent impairment as a result of her surgeries, claimant has retained most of her right hand function. This is evidenced by her successful completion of a bookkeeping course and her entry into a second program. It is also evidenced by the medical record, which at times suggests that no impairment exists, and at other times suggests a 10% to 20% impairment.

The remaining issue is the computation of claimant's average work week. When claimant initially filed her claim, an employer representative calculated her benefits on the erroneous assumption that she was a full-time, regular employe. In fact, claimant was an "on-call" employe in that she worked only when work was available. The parties agree that the erroneous calculation resulted in an overpayment. They disagree, however, on how the average work week should be computed in order to effect a proper recalculation.

OAR 436-54-212(4)(a), formerly 436-54-212(3)(a), governs the calculation of time loss benefits for on-call employees. The rule provides:

> "Employed on call basis: Use average weekly earnings for past 26 weeks, if available, unless periods of extended gaps exist, then use no less than the last four weeks of employment to arrive at average. For workers employed less than four weeks use intent at time of hire comfirmed by employer and worker."

The rule does not define "extended gaps," nor have we found case law that sheds light on the meaning of the phrase.

The Referee found that in order to fairly compensate claimant, her benefits should be calculated so as to approximate her historical earnings. For several years prior to the claim, claimant had averaged approximately 23 hours per week. For the 26

weeks preceding the claim, she worked a total of 407 hours, an average of 15.65 hours per week. For the four weeks immediately preceding the claim, however, claimant worked extensively, averaging 31.125 hours per week. The Referee used only the last four-week period to calculate claimant's time loss. He found that although this method of calculation resulted in a "windfall" for claimant, it was most consistent with ORS 656.012(2)(a), which states that the workers' compensation law is to provide "fair, adequate, and reasonable income benefits" to the injured worker.

Although the Referee did not specifically find that there had been "extended gaps" in claimant's employment, that finding is inherent in his holding. The rule provides that only when there have been "extended gaps" is the on-call time loss calculation to be based on "no less than the last four weeks of employment. If no extended gaps exist, the calculation is to be based on the full 26 weeks preceding the claim.

After reviewing claimant's work record, we conclude that no "extended gaps" existed in her employment, and that her time loss should have been calculated using the 26-week period preceding her claim. During the 26 weeks there were two periods in which claimant did not work. One was a two-week period in June of 1981; the other was a four-week period in October of 1981. For the remaining 20 weeks, claimant worked between 8 and 80 hours during each two-week period. Although the four weeks of layoff in October, 1981 could conceivably be termed an "extended gap," we find that it is not, considering the seasonal nature of claimant's tree planting employment.

Whether extended gaps in a claimant's employment exist should be determined on a case-by-case basis, taking into consideration such factors as the length of the "gaps," and whether or not the work is seasonal. If the work is seasonal, periods of layoff are to be expected, and unless they are particularly lengthy, they should not be considered to be "extended" as that term is used in the rule. On the other hand, if the on-call employment has historically involved relatively steady work, any layoff might be considered a significant event, so as to represent an "extended gap" in the employment.

In the present case, we find that claimant's two layoff periods were not "extended". Because they were not, the rule requires that claimant's time loss be computed using the entire 26-week period preceding her claim. When the entire period is used, claimant's average work week is 15.65 hours per week.

ORDER

The Referee's order is affirmed in part and modified in part. That portion of the order that affirmed the August 17, 1984 Determination Order is affirmed. That portion of the order that calculated claimant's average work week to be 31.125 hours per week is modified. The claim is remanded to the employer for a calculation of claimant's work week at 15.65 hours per week, and the employer shall be allowed to recover any resulting overpayment consistent with this order and ORS 656.313(2).

KENNETH E. CHOQUETTE, Claimant
Burt, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-07556
July 15, 1985
Order on Reconsideration

Claimant requests reconsideration of our Order on Review dated June 18, 1985. The SAIF Corporation requested review of the Referee's order that granted claimant an award for permanent total disability. Our Order on Review was a memorandum order in which we affirmed the Referee's order. Claimant contends that our award of $550 as a reasonable attorney fee for services on Board review was inadequate.

Claimant's attorney is entitled to a reasonable fee to be paid by the SAIF Corporation by virtue of ORS 656.382(2) and OAR 438-47-055. In determining the amount of a reasonable attorney fee, we consider "the efforts of the attorney and the results obtained . . . ." OAR 438-47-010(2). See also Muncy v. SAIF, 19 Or App 783, 787-88 (1974); Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). In its Order of Adoption of the adminstrative rules pertaining to attorney fees in workers' compensation cases, the Board said, "It is incumbent on all parties that each case be evaluated on its own merits . . . ." WCB Admin. Order 1-1979, January 9, 1979. In concert with this case-by-case evaluation, there are few Board cases that purport to establish "rules" for determining attorney fees. See e.g. Robert Heilman, 34 Van Natta 1487 (1982) ("active and meaningful" participation in responsibility cases).

The only issue raised by claimant at this stage of the proceeding is the adequacy of the attorney fee awarded for services on Board review. Claimant was separately compensated by fees awarded and allowed by the Referee at the hearing level. The Referee allowed claimant's attorney a fee of 25% of the increased compensation obtained, not to exceed $2,000, and awarded an additional fee of $900 to be paid by the insurer for having successfully overcome two partial denials. ORS 656.386; OAR 438-47-020(1)(a); OAR 438-47-025. We take administrative notice of the fact that the attorney fee allowed out of compensation will almost certainly be paid in full out of claimant's permanent total disability award.

The attorney fee calculus is fundamentally two-part: result obtained and effort expended. As to the result obtained, claimant's attorney was instrumental at this level in defending against SAIF's effort to have the Board reduce an award for permanent total disability. Claimant, thus, kept the maximum award possible under the Workers' Compensation Law. That this was a good result for claimant is beyond cavil. We turn, then, to effort expended.

Attorneys in workers' compensation cases are not required to practice within the constraints of technical or formal rules of evidence or procedure. ORS 656.283(6). Board review is on the record developed by the parties and the Referee at the hearing. ORS 656.295(5). The Board normally does not entertain oral argument, and there is no particular form required for briefs or argument to the Board. OAR 438-11-010. Cf. ORAP 7.05 through 7.40. Although this case was one in which claimant sought to retain the maximum possible award, the only issue before the Board was whether claimant had made reasonable efforts to become employed at a suitable occupation. SAIF's appellant's brief was five pages and claimant's respondent's brief six pages. No

extraordinarily complex or unique factual or legal issues were presented by either party or the record. Given the nature of the practice in general and the facts and circumstances of this case in particular, we conclude that $550 is a reasonable award for claimant's attorney's services on Board review in this case.

We will ordinarily discuss in our orders only those facts relevant to a decision whether to award an extraordinary attorney fee. Our failure to discuss or analyze an attorney fee award or allowance in most cases should not be taken to mean that all of the factors discussed above are not carefully considered in each and every case where the issue is relevant. See John B. Bruce, 37 Van Natta 135 (1985) (discussion of Board's use of memorandum orders).

Claimant's request for reconsideration is granted. On reconsideration, we adhere to and republish our former order effective this date.

IT IS SO ORDERED.

NANCY BOWLIN, Beneficiary
CORDIS E. BOWLIN (Deceased), Claimant
Emmons, et al., Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-05982
July 16, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of Referee Podnar's order setting aside its denial of survivor's benefits to Nancy Bowlin. The issue is whether Ms. Bowlin and claimant cohabited in this state as husband and wife for over one year prior to the date claimant was killed on the job.

Ms. Bowlin relies on lay testimony to prove that she cohabited with claimant in this state as husband and wife for over one year before claimant was killed. The testimony can be briefly summarized as follows. Claimant had been married and fathered four children in Tennessee. Apparently that marriage was lawfully terminated, and claimant began living with Millie Ramo in about 1951. Claimant fathered five children by her, then in about 1961, began living with Nancy Bowlin, the woman now seeking benefits. Ms. Bowlin already had seven children and claimant fathered three more by her. Millie Ramo married Mr. Ramo and bore three more children. Mr. Ramo died in 1977. Claimant maintained a close relationship with both women. Mrs. Ramo cooked for him, laundered his clothes, provided him lodging on a more or less frequent basis and helped support claimant financially. The testimony is unanimous, however, that claimant's sexual relationship was exclusively with Ms. Bowlin.

Approximately five months before claimant was killed, Ms. Bowlin moved into low income housing. She could not have qualified for this assistance had claimant been declared as living with her. Ms. Bowlin, Mrs. Ramo, Ms. Bowlin and claimant's daughter, and Mrs. Ramo and claimant's daughter all testified that claimant was surreptitiously staying with Ms. Bowlin. Mrs. Ramo explained:

> "Q. Okay. How much did he stay at your house during that year prior to his death? I'm talking about how many nights a week average would he have stayed at your house?

"Mrs. Ramo: Well, he usually stayed till -- you know -- he'd -- he'd sneak over to Nancy's at night, because I mean, the Welfare makes people sneak. We all know that. You have to be a thief and liar -- you know -- or starve to death, so -- I mean if you get Welfare, and but Gene would stay and then most of the time Nancy would come to my house.

"Q. Okay. I guess I need to know how many nights he didn't sneak. How many nights a week did he stay at your house?

"A. Not too many. Not all -- not all night long. He'd sometimes get up at 2:00 or 3:00 and go to Nancy's house -- you know -- I mean, me and Gene were just friends, and he usually slept on my sofa, because I had a small, little two-bedroom apartment, and two teenage kids living at home, so there wasn't much privacy for anybody.

"Q. So I'm still having a hard time getting down to the nitty gritty here. Did he ever stay the night at your house during the last year and one-half?

"A. Well, of course, he stayed a lot of nights at my house, but so did -- so did -- so did Nancy -- you know -- and I -- and then I'd go to sleep on the couch, and they'd have my room. * * *

"Q. Okay. Who -- how did -- where did he keep his clothes?

"A. Well, he had to take his clothes out of Nancy's house because of the Welfare and Housing Authority -- you know --."

Mrs. Ramo did not deny that she had told an investigator that claimant lived with her 20 nights a month. She explained that at that time she was mad at Ms. Bowlin. We note, however, that Mrs. Ramo herself also filed a claim for survivor's benefits.

The Referee made no explicit demeanor based on credibility findings. On de novo review we have struggled to determine the pertinent facts and sort out the conflicting testimony. Based on our careful reading of the transcript and the report of SAIF's investigator, we have no confidence in the veracity of any of the four principal witnesses. We find Ms. Bowlin's testimony particularly untrustworthy. For her claim to succeed we must accept that she was less than candid with those responsible for her housing assistance. Her testimony similarly demonstrates a lack of candor. As but one example, when asked where she lived immediately before moving into low income housing about five months before claimant's death, she testified that she did not remember.

Mary Fraley testified that she had known Ms. Bowlin and Mrs. Ramo for about ten years and that she visited Mrs. Ramo's home two

or three times a week. She testified that claimant lived with Mrs. Ramo 80 percent of the time and that Mrs. Ramo cooked and washed for him, although Mrs. Fraley did not know about their sleeping arrangements. At the conclusion of her testimony, she volunteered that she thought Mrs. Ramo was first in line for the money.

ORS 656.226 provides:

> "In case an unmarried man and an unmarried woman have cohabited in this state as husband and wife for over one year prior to the date of an accidental injury received by one or the other as a subject worker, and children are living as a result of that relationship, the surviving cohabitant and the children are entitled to compensation under ORS 656.001 to 656.794 the same as if the man and woman had been legally married."

The burden of proof rests with Ms. Bowlin, the petitioner. She must prove by a preponderance of the evidence that she cohabited with the deceased worker for the year immediately before the accident. See Amos v. SAIF, 72 Or App 145, 152 (1985); Gormley v. SAIF, 52 Or App 1055, 1059 (1981). Precisely what she must show to demonstrate cohabitation under the statute is not entirely clear. The litigants have cited no authority construing that portion of the statute and our research has discovered none, although we note that similar language in an unrelated statute was construed in Wadsworth v. Brigham, 125 Or 428 (1928). See generally 2A Sutherland, Statutory Construction §53.03 - 53.05 (4th ed. Sands 1984) (discussing the relevance and limitations of interpretations of unrelated statutes).

The Board, as fact-finder, must review the evidence objectively and determine if it preponderates in favor of the petitioner. If it does not, the burden of proof has not been met. See Gormley v. SAIF, supra. We find very little reliable evidence in the record upon which to base a decision. When the evidence is inconclusive, we necessarily have to recall where the burden of proof lies. See e.g. Daniel R. Hill, 35 Van Natta 1217, 1220 (1983). We hold that Ms. Bowlin has not carried her burden.

ORDER

The Referee's order dated December 31, 1984 is reversed. The SAIF Corporation's denial of September 30, 1984 is reinstated and affirmed.

DEE A. ERICKSON, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-04406 & 84-04934
July 16, 1985
Order on Reconsideration

The Board issued its Order on Review herein May 31, 1985. 37 Van Natta 619 (1985). That order affirms those portions of the Referee's order challenged by claimant and stated as follows:

> "Claimant requests review of those portions of Referee Danner's order which upheld the SAIF Corporation's aggravation claim denial, failed to award interim

compensation and declined to impose a penalty/attorney's fee. Claimant contends that SAIF's denial should be set aside, that she is entitled to interim compensation, and that a penalty and associated attorney's fee is warranted for SAIF's failure to properly process her claim(s)."

On May 30, 1985, claimant's attorney sent a letter to the Board requesting clarification of a portion of the Referee's order not challenged by claimant. This letter was received the same date that the Order on Review herein was entered and was not considered in the Board's review. Claimant has requested reconsideration in order to obtain the clarification originally sought. SAIF is content to "let sleeping dogs lie." We abated our Order on Review by order dated June 25, 1985.

At hearing claimant contended that the April 11, 1984 Determination Order, which closed her November 23, 1983 left upper extremity claim, "prematurely closed" that claim. The Determination Order awarded temporary total disability, less time worked, through March 1, 1984. Claimant contended that she was entitled to temporary total disability until March 26, 1984, claiming that she was not medically stationary until that later date. In the body of his order, the Referee agreed with claimant's contention, concluding that March 26, 1984, "would be a proper date to find that claimant became medically stationary." In the "order" portion of his Opinion and Order, however, the Referee neglected to modify the Determination Order accordingly.

SAIF did not cross-request review of any portion of the Referee's order; however, in its respondent's brief, SAIF addressed this "premature closure" issue and argued that the Determination Order correctly terminated temporary disability as of March 1, 1984. Thus, SAIF sought reversal of that portion of the Referee's order. See generally Jimmie Parkerson, 35 Van Natta 1247 (1983). In her reply brief, claimant again addressed the issues she raised on review without addressing the additional issue raised in SAIF's respondent's brief.

Although the nomenclature is incorrect, SAIF raised an issue by way of its respondent's brief, and we failed to consider it in the course of our original review of this case. Although claimant now seeks a clarification of the ambiguity arising from the Referee's order, having now considered the time loss question raised by SAIF's respondent's brief, we find that the relevant portion of the Referee's order must be reversed and not merely clarified.

We first note that the issue raised by claimant at hearing and by SAIF on review is not a premature closure issue. An issue of premature closure arises when there is evidence that a claimant was not medically stationary at the time of claim closure. The Determination Order in this case closed the claim on April 11, 1984 with an award for temporary total disability through March 1, 1984. Claimant contended, and the Referee found, she was entitled to temporary total disability through March 26, 1984. This is a question of entitlement to additional temporary total disability under this Determination Order. It is not an issue of premature claim closure since claimant admits that her condition was stationary at least as of March 26, 1984, which is prior to claim closure.

The Evaluation Division obviously assigned March 1, 1984 as the date for termination of temporary disability because on that date claimant was examined by the Orthopaedic Consultants and considered stationary. The Referee found March 26, 1984 the appropriate date for termination of time loss based on the following reasoning:

> "Although Dr. Freeman [claimant's attending physician] tends to agree with the Orthopaedic Consultants' opinions, only a few days later he stated that he wanted her to continue her current routine, and that if her symptoms did not change significantly within the next month, she would be considered at a plateau. Then, a month later, he stated that although claimant was seen by Orthopaedic Consultants on March 14 (sic) that she still discussed various discomforts, etc., and on that date, Dr. Freeman said 'the patient appears to be at a plateau, and I think that claim closure can be initiated.' He was the treating physician, and this would be a proper date to find that claimant became medically stationary."

We are unable to find any indication that Dr. Freeman examined claimant "a few days" after the Orthopaedic Consultants' examination. The Referee's reference apparently is to Dr. Freeman's chart note preceding the chart note entered on March 26, 1984, in which Dr. Freeman notes:

> "The patient is advised to continue her current routine and if her symptoms do not change significantly by the next visit in one month she can probably be considered at a plateau. In the meantime she will be evaluated at Orthopaedic Consultants on 1 March 1984."

This chart note is dated February 27, 1984, which was a few days before the Orthopaedic Consultants examination, not a few days after. Dr. Freeman's chart note dated March 26, 1984, reflects that since claimant's last visit, i.e., February 27, 1984, her symptoms had not changed significantly. This indicates to us that claimant probably was medically stationary when examined by the Orthopaedic Consultants on March 1, 1984. At least there is no persuasive evidence to the contrary. Therefore, we must reverse that portion of the Referee's order which purported to modify the Determination Order by awarding claimant additional temporary total disability.

ORDER

On reconsideration of the Order on Review entered herein and dated May 31, 1985, the Board modifies that order as follows. That portion of the Referee's order dated November 6, 1984, which purportedly modified the Determination Order dated April 11, 1984 by awarding additional temporary total disability through March 26, 1984, is reversed, and that portion of the Determination Order which awarded temporary total disability, less time worked, through March 1, 1984, is affirmed. Except as modified herein, the Board adheres to its prior order, which hereby is republished effective this date.

JOHN A. GRAHAM, Claimant
Noreen Saltveit, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Lindsay, et al., Defense Attorneys

WCB 84-01383 & 84-03399
July 16, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Shebley's order which: (1) upheld the SAIF Corporation's denial of his aggravation claim for a 1980 neck, right shoulder, and trapezius injury; and (2) upheld United Pacific Insurance Company's so-called "de facto" denial of his low back claim. On review, the issues are compensability and responsibility.

On May 28, 1985 we remanded this matter to the Referee with instructions to determine the effect, if any, the inclusion of an omitted exhibit, a copy of a March 1984 denial letter from United Pacific/Reliance Insurance Company, had upon his original order. John A. Graham, 37 Van Natta 574 (1985). By Order dated June 25, 1985 the Referee advised the Board that the exhibit had been identified and admitted at the previous hearing. Furthermore, the Referee found that the exhibit's inclusion did "absolutely nothing to alter the conclusions expressed" in his original order.

Following our de novo review of the medical and lay evidence, which includes an appraisal of claimant's noncredible testimony, we agree with the Referee's conclusion that claimant failed to prove the compensability of his claims against either insurer. Accordingly, we affirm the order of the Referee with the following modification. Inasmuch as United Pacific issued a March 21, 1984 denial letter, we uphold that formal denial rather than a "de facto denial" as phrased by the Referee.

ORDER

The Referee's orders dated September 17, 1984 and June 25, 1985, as modified herein, are affirmed.

MARIA G. IBARRA, Claimant
Olson Law Firm, Attorneys
Marion-Polk Legal Aid Service, Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-04137
July 16, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Wilson's order which: (1) upheld the SAIF Corporation's March 8, 1984 preclosure partial denial; (2) upheld Determination Orders awarding temporary total and temporary partial disability and 7.5° for 5% scheduled permanent partial disability for loss of use of the right leg; (3) upheld SAIF's August 7, 1984 partial denial and denial of aggravation; and (4) denied claimant's request for an award of penalties and attorney fees.

Claimant has submitted additional medical chart notes, some generated since the hearing, and has mentioned subsequent interaction with Dr. Wilson. Such new evidence may not be considered by the Board. ORS 656.295(5). We treat claimant's submission as a request for remand. We find that the case was not improperly, incompletely or otherwise insufficiently developed or heard by the Referee. Even were that the case, however, we are not convinced that remand for the admission of the additional

medical evidence would here be appropriate. See Bailey v. SAIF, 296 Or 41 (1983); Casimer Witkowski, 35 Van Natta 1661 (1983); ORS 656.295(5).

On de novo review of the record we agree with the findings and conclusions of the Referee. Accordingly, we affirm.

ORDER

The Referee's order dated October 23, 1984 is affirmed.

ALONZO M. LOVELESS, Claimant
Haugh & Foote, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-11185 & 84-00171
July 16, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Galton's order which affirmed the SAIF Corporation's denial of claimant's bilateral carpal tunnel syndrome. The issues on review are the compensability of the carpal tunnel syndrome and penalties and attorney's fees for SAIF's alleged unreasonable denial. We review de novo and find that claimant's carpal tunnel syndrome is compensable.

For a period of two months in mid 1984, claimant worked as an inspector for Precision Castparts. On June 6, 1984 he compensably injured his right middle finger on the rough surface of a part he was handling. The injury was treated with first aid at the job site, and claimant was able to return to work immediately. He continued to work for approximately a month until he was terminated for poor job performance.

As claimant's finger was healing, he began to feel increasing numbness in his right hand and wrist. He first sought medical attention from Dr. Goodstein, who diagnosed nerve regeneration pain. Claimant was next seen by Dr. Nye, who suspected the presence of carpal tunnel syndrome because of the history of complaints related by claimant. Subsequent nerve conduction studies confirmed the diagnosis. Claimant was then examined by Dr. Layman, who also confirmed the presence of carpal tunnel syndrome, severe on the right. Dr. Layman attributed claimant's condition to his work because of the history given by claimant that his job involved repetitive use of the hands and forearms.

The Referee found claimant "to have been a credible and reliable witness in material part and not to have been credible or reliable in material part as well." The Referee apparently found claimant credible with regard to the loss of use of his right middle finger, but not credible with regard to the circumstances surrounding the onset of his carpal tunnel symptoms. He found claimant's testimony regarding the onset of symptoms prior to the compensable injury to conflict with what claimant told his physicians. The Referee also accepted the testimony of two of claimant's supervisors that claimant's job did not require extensive use of the hands or forearms. He, therefore, found the history of extensive use that claimant gave to his physicians to be inaccurate, thereby rendering the causal opinions generated by those doctors unpersuasive.

After reviewing the record, we disagree with the findings of

the Referee. While it is true that claimant experienced tiredness in his arms before the compensable injury, the carpal tunnel symptoms he later perceived were of a new and different variety. We, therefore, do not find it surprising nor inconsistent that claimant represented to his physicians that he was not experiencing symptoms prior to the compensable finger injury. Claimant understandably attributed the feelings of tiredness to his having not worked for some time before beginning work with this employer. He did not believe the tiredness to be related to his finger injury and, therefore, did not mention it to his treating doctors.

We also find that claimant's employment did, in fact, entail extensive use of the hands and arms and that his description of his work activity to his physicians was accurate. He testified that the work entailed manipulating and pushing parts of various sizes along a roller belt, and positioning them so that they could be sprayed with die and inspected under a black light. The volume of work varied from between 20 and 50 parts per hour. While claimant's supervisors testified that, in their opinion, the work was not particularly repetitive, the remainder of their testimony indicates that it was. Both supervisors stated that the work did, in fact, involve primarily the use of the hands. They further agreed that the time period during the summer in which claimant was employed was a particularly busy time for the company, and that in order to keep up, claimant had to keep quite busy.

We are satisfied that the substance of claimant's testimony did not appreciably vary from that of the other witnesses. We are also satisfied that the minor discrepancies between claimant's testimony regarding preexisting symptoms and the information he provided to his physicians were understandable, given that the carpal tunnel symptoms differed from those that claimant attributed to tiredness. Finally, we find that the record supports claimant's assertions regarding the repetitive nature of his work. Dr. Layman specifically found claimant's carpal tunnel syndrome to be related to the work activity accurately described by claimant. The condition, therefore, is compensable and the Referee's holding to the contrary must be reversed.

The remaining issue is penalties and attorney fees for SAIF's alleged unreasonable denial. While we agree with claimant that SAIF's denial may have been unreasonable, there is no amount "then due" upon which to calculate a penalty. Claimant missed no work as a result of his compensable finger injury, nor did his carpal tunnel condition precipitate time loss. By the time the condition was positively diagnosed, claimant had been terminated from his job for reasons unrelated to his physical condition. Because there are no amounts "due," a penalty cannot be calculated thereon. EBI v. Thomas, 66 Or App 105 (1983); Mary J. Spontak, 37 Van Natta 230 (1985).

ORDER

The Referee's order dated January 11, 1985 is reversed in part and affirmed in part. That portion of the order that upheld SAIF's denial of claimant's bilateral carpal tunnel syndrome is reversed and the claim is remanded to SAIF for acceptance and payment of compensation according to law. The remainder of the order is affirmed. For services at hearing, claimant's attorney is awarded $1,200. For services before the Board, claimant's attorney is awarded $600, to be paid by the SAIF Corporation.

TILLMAN E. PRICE (Deceased), Claimant
David Blunt, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-00515
July 16, 1985
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Price v. SAIF, 73 Or App 123 (1985). We have been instructed to determine a penalty to be assessed against the SAIF Corporation for unreasonably denying claimant's low back aggravation claim.

Now, therefore, the SAIF Corporation shall pay additional compensation in an amount equal to 25% of the temporary total disability compensation due claimant from the first day of compensable time loss arising out of this aggravation claim, being on or about November 13, 1982, through and including May 26, 1983.

IT IS SO ORDERED.

RENE VANWOESIK, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-09431
July 16, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Knapp's order which upheld the insurer's denial of the claim of aggravation of claimant's low back injury. In its response brief, the insurer argued the issues of the date of the last arrangement of compensation and the application of the doctrine of res judicata to findings in a previous hearing on a prior claim of aggravation. In his reply brief, claimant objected to consideration of issues argued by the insurer and requested an attorney's fee on Board review if the Referee's finding on the date of the last arrangement of compensation is affirmed. The issues on review are aggravation, jurisdiction to consider issues raised in a response brief, and an attorney's fee for prevailing on a collateral issue on Board review.

The Board affirms and adopts the order of the Referee.

Claimant's argument that the Board has no jurisdiction to consider issues raised by the insurer in its response brief disregards longstanding case law to the contrary. Neely v. SAIF, 43 Or App 319 (1979); Ronald L. Reedy, 36 Van Natta 1633 (1984); Jimmie Parkerson, 35 Van Natta 1247 (1983).

Claimant's attorney is not awarded a fee on Board review for prevailing on the issue of the date of the last arrangement of compensation because "'prevailing' in technical issues while losing on the claim itself should not allow an award." Korter v. EBI Companies, Inc., 46 Or App 43 (1980).

ORDER

The Referee's order dated December 4, 1984 is affirmed.

DONALD W. WILKINSON, Claimant
Roll, et al., Claimant's Attorneys
Macdonald, et al., Defense Attorneys

WCB 83-09551
July 16, 1985
Order on Reconsideration

The SAIF Corporation has requested reconsideration of our Order on Review issued February 27, 1985. We abated our order so that we could fully consider the issues raised by the parties on reconsideration. The basis of SAIF's request for reconsideration was that our Order on Review granted claimant an award for permanent total disability, and SAIF requested authorization to offset permanent partial disability compensation paid during the time claimant was also entitled to permanent total disability benefits. Claimant argues that SAIF is precluded from requesting the authority to deduct the overpayment because it did not raise the issue of offset until after our Order on Review was issued.

In Pacific Motor Trucking Co. v. Yeager, 64 Or App 28, 32 (1983), the court held that a claimant cannot receive permanent partial disability benefits in addition to permanent total disability benefits, reasoning that loss of earning capacity cannot be greater than total. Under the rationale of Yeager, SAIF should be authorized to deduct from the permanent total disability benefits due claimant any permanent partial disability benefits paid subsequent to the effective date of the permanent total disability award. The question, now, is whether SAIF waived its right to seek offset authorization by not raising the issue until after our Order on Review was published.

In Russell v. A & D Terminals, 50 Or App 27, 31 (1981), the court recognized in theory the Board's authority to fashion an appropriate disposition of each case by exercise of our de novo review, whether or not specific issues were raised by the parties. In Russell, the court recognized that the Board has the authority sua sponte to reduce a permanent partial disability award, although the court ultimately reinstated the award based upon its resolution of the facts of the case. We have subsequently admonished the Hearings Division (and ourselves), however, that ordinarily issues not raised by the parties will not be decided. Michael R. Petkovich, 34 Van Natta 98 (1982). Even prior to Russell and Petkovich, the Court of Appeals established a "raise or waive" rule with regard to claims for penalties in denied claim cases. Mavis v. SAIF, 45 Or App 1059, 1062 (1980). Nevertheless, the court in Hicks v. Fred Meyer, Inc., 57 Or App 68, 71 (1982), approved a procedure in which a request for offset was raised after the Referee had entered his order. We have recognized an exception to the "raise or waive" concept where a party merely advances a different legal theory to resolve an issue already raised. Anita A. Bade, 36 Van Natta 1093 (1984).

The issue posed by Pacific Motor Trucking Co. v. Yeager, supra, is potentially present in every case in which permanent total disability is an issue. The Court of Appeals in Mavis v. SAIF, supra, considered the argument that a penalty is potentially an issue present in every denied claim case, concluding:

> "Under these circumstances, we see two possible approaches. First, we could hold that a claimant in a denied-claim context need not specifically articulate that he claims entitlement to a penalty because as

> a matter of law the possibility of imposing a penalty is always an issue in a hearing on a denied claim. Second, we could apply a raise-or-waive rule and hold that a claimant must articulate claimed entitlement to a penalty or that issue is waived."

The court adopted the second approach, reasoning that because proof of unreasonableness of a denial is a condition precedent to the assessment of a penalty, in at least some cases no penalty could or would be claimed.

In Hicks v. Fred Meyer, Inc., supra, after the Referee issued his order, the employer requested reconsideration, requesting the authority to offset overpaid compensation against the permanent disability award granted by the Referee. The Referee allowed reconsideration and authorized the requested offset. The court stated:

> "[W]e conclude that the referee's action was not improper. Although the employer did not raise the issue at the hearing, neither did it act unilaterally. Employer brought the issue to the referee's attention; and had claimant contested the issue, the referee could have reopened the hearing. The procedure was not unfair to claimant, and the policy favoring an orderly compensation process was satisified."

We believe that the present case is more like Hicks than Mavis. In this case, the Referee increased claimant's unscheduled permanent partial disability award by 40% to a total of 95%. After review, we increased claimant's award to one for permanent total disability. Although the Yeager issue was a potential all along, it was not a reality until our order was issued. SAIF promptly called it to our attention once it arose. Further, SAIF could only have speculated as to our resolution of the time period involved, because until we awarded permanent total disability, the effective date of the award was unknown. We believe the result we reach is not unfair to claimant and satisfies the policy of an orderly system of compensation. The offset will be allowed.

ORDER

The request for reconsideration is granted. On reconsideration our Order on Review dated February 27, 1985 is modified to authorize the SAIF Corporation to offset against permanent total disability benefits due any permanent partial disability benefits paid subsequent to September 15, 1983. As modified, we adhere to and republish our previous order effective this date.

CHARLES L. WILLIAMS, SR., Claimant
Stunz, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-11189, 84-00087 & 84-02456
July 16, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

INA Insurance Company (Aetna) requests review of Referee Fink's order which set aside its denial of claimant's new injury claim, issued in behalf of the employer Primo Mussi. This "injury" claim has been processed with an assigned date of August 29, 1983. The only issue is employer/insurer responsibility for claimant's current low back condition. INA contends that claimant's work activity for its insured did not independently contribute to claimant's low back condition, presently diagnosed as a herniated disc.

We find that claimant's low back condition worsened during the summer of 1983. There was no "injury" in the sense of there having been an identifiable traumatic episode. We find, however, that the rigorous work activity in which claimant engaged independently contributed to this worsening of his preexisting back condition. Therefore, the Referee properly assigned responsibility to INA as the insurer for claimant's employer during this period. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Bill B. Dameron, 36 Van Natta 592 (1984); see also Wayland A. Porter, 36 Van Natta 560 (1984).

ORDER

The Referee's order dated July 19, 1984 is affirmed.

BERT G. HARR, Claimant
Aitchison, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 82-03306
July 17, 1985
Order on Remand

This case is before us on remand from the Supreme Court. ASC Contractors v. Harr, 298 Or 552 (1985) (Per Curiam). The Supreme Court reversed the Court of Appeals' decision affirming our Order on Review that found claimant's carpal tunnel syndrome compensable and remanded the case to us for reconsideration in light of Wheeler v. Boise Cascade, 298 Or 452 (1985).

Claimant was 32 years old at the time of the hearing and was employed as a carpenter. Prior to the occupational exposure at issue here, claimant had experienced numbness in the fingers of both hands, but had not sought medical attention. Within three weeks of beginning work for the present employer, claimant began experiencing increased numbness in the first three fingers of each hand and, for the first time, pain in his hands.

Claimant's treating physician, Dr. Altrocchi, diagnosed carpal tunnel syndrome. He also stated that, based upon claimant's history, the carpal tunnel syndrome definitely preexisted the occupational exposure with this employer. Dr. Altrocchi is the only physician whose opinion appears in the record. He rendered two opinions. In the first, written June 22, 1982, he said:

> "[Claimant's] work activities during the three months he worked at ASC did not cause his carpal tunnel syndrome.
>
> "The work activity as a carpenter for ASC caused his carpal tunnel syndrome to become symptomatic during the third or fourth week of working but did not materially worsen his underlying carpal tunnel problem."

In his second written opinion, dated July 12, 1982, Dr. Altrocchi said:

> "[Claimant's] work for three months at ASC certainly made his symptoms worse but did not cause the condition, i.e. they aggravated a pre-existing problem. It is my best recollection that he did have some minor symptoms of the carpal tunnel syndrome at the time he went to work for ASC Corp. but they rapidly became worse because of heavy requirements for using his hands. Certainly, his work activities were the major contributing cause for the relapse of his bilateral carpal tunnel syndrome.
>
> "When I most recently saw him on June 22, 1982, he was entirely asymptomatic and had been so since early December, 1981, since he has not been working."

The Referee found that claimant had failed to prove that his work exposure worsened his preexisting condition, as required by Weller v. Union Carbide, 288 Or 27 (1979), and upheld the insurer's denial. We concluded that Weller did not apply to this case, reasoning that where a claimant had never sought medical treatment for a preexisting condition, it would be impossible to prove a worsening because there could no "baseline" from which to measure. The Court of Appeals affirmed our order; however, it did so based upon its decision in Wheeler v. Boise Cascade, 66 Or App 620 (1984). The court held that where a claimant's preexisting condition is asymptomatic when he or she begins employment, a "Weller worsening" was not required to establish the compensability of an occupational disease claim. In reversing the Court of Appeals, the Supreme Court stated, "We hold that the Weller analysis is the appropriate analysis whether the conditions are symptomatic or asymptomatic at the time of employment." Wheeler v. Boise Cascade, supra, 298 Or at 457-58.

Because we previously found that the Weller analysis did not apply, we did not discuss whether claimant's evidence was sufficient to show a worsening of his underlying, preexisting carpal tunnel syndrome. Having now considered the evidence in light of Wheeler v. Boise Cascade, supra, we conclude that it is not. Dr. Altrocchi's first opinion unequivocally states that the work exposure in issue did not cause a worsening of the underlying condition. The second opinion appears to state that claimant's work exposure caused his preexisting carpal tunnel syndrome to

become symptomatic, but did not worsen the condition itself. This interpretation, while certainly not made unequivocal, is bolstered by the fact that claimant became totally asymptomatic when he stopped working. Taken together, the statements persuade us that this work exposure did not cause a worsening of the underlying condition. Accordingly, the insurer's denial will be upheld.

ORDER

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

N.M. CALKINS, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-02109
July 22, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of that portion of Referee Gemmell's order which found that claimant was entitled to $5 per week for each of his children who enrolled as a full-time student in an accredited institution of higher education within six months of the date he or she left high school, until he or she became 23 years of age or graduated from the institution, whichever was later. On review, SAIF contends the weekly benefit should have terminated once each child reached 18 years of age.

Following our de novo review of the record and after a thorough analysis of the applicable statutes, including ORS 656.206(2), and legislative history, the Board affirms and adopts the order of the Referee with the following modification. Claimant should be entitled to his weekly benefits until each child who is pursuing an education beyond high school becomes 23 years of age or graduates from an institution of higher education, whichever is earlier, not later as the Referee's order presently provides.

ORDER

The Referee's order dated November 28, 1984, as modified herein, is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

TOMMY L. COMBS, Claimant
Robert Chapman, Claimant's Attorney
John Snarskis, Defense Attorney

WCB 83-09055 & 83-09056
July 22, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Fink's order which set aside its denial of claimant's "aggravation" claim and upheld Industrial Indemnity's denial of claimant's "new injury" claim for his low back condition. On review, the issue is responsibility.

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

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, 244 (1984). If the evidence shows that a disability is caused solely by an injury occurring during an earlier employment, there is no reason to apply the last injurious exposure rule. Starbuck, supra., 296 OR at 243.

Following our de novo review of the medical and lay evidence, we are persuaded that claimant's current disability was caused solely by his May 1981 injury, for which SAIF is responsible. Consequently, we need not apply the last injurious exposure rule. However, had we employed the rule our decision would not change since we are persuaded that claimant's activities in August 1983, while employed by Industrial Indemnity's insured, did not contribute to his disability.

ORDER

The Referee's order dated October 29, 1984 is affirmed.

JAMES R. LeCLAIR, JR., Claimant
Hayner, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 84-07449
July 22, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Leahy's order that found the insurer's termination of claimant's temporary total disability benefits proper. On review, claimant asserts that the insurer's action constituted an improper unilateral termination of benefits. Claimant requests penalties and attorney's fees for the alleged improper termination. We review de novo and reverse.

Claimant had worked for three years as a lumber dryer/grader at employer's Gold Beach mill when, on April 19, 1984, a wood sliver entered the base of the ring finger of claimant's left hand. This compensable injury was accepted. On May 9, 1984 claimant underwent exploratory surgery in an effort to determine the cause of his ongoing left hand problems. The recovery process included hand soakings three times daily and the application of sterile dressings.

Claimant's hand failed to heal properly and on June 11, 1984 his treating physician, Dr. Mann, took him off work. Claimant was told to remain off work until July 9, when he was to return for a check-up.

During the time claimant was off work, he was told by his employer to call in on a weekly basis to receive employment information. Claimant called on June 18. He was told by an employer representative that on June 14, the employer had contacted Dr. Mann and had secured an oral work release for claimant to return to a light duty "putty patching" job. Claimant apparently believed that all jobs at the mill required the use of gloves. He also believed that because his left hand had swollen, he would be unable to get a glove over it. He did not feel that his physician would want him exposing the hand to dirt and particles at work. He, therefore, told his employer that he wanted to contact Dr. Mann. According to the employer, claimant also inquired as to what would happen if he did not report to work as ordered, and that he was told that he would be considered absent without authorization.

Claimant contacted Dr. Mann's office but was told that Dr. Mann would be out of the office for six weeks. Claimant's case had been referred to Dr. Mann's associate, Dr. Smith. Claimant apparently spoke to Dr. Smith and explained that he did not feel he could do the job offered by the employer. After hearing claimant's explanation, Dr. Smith directed claimant to stay off work. Claimant then informed Dr. Smith's secretary that he would be leaving town for approximately a week. He also asked the secretary to contact his employer and to explain that Dr. Smith had taken him off work.

Claimant went to California the same day, June 19. Later that day, the employer contacted Dr. Smith and explained that claimant would not need gloves to perform the patch job. Upon hearing this explanation, Dr. Smith orally released claimant for work and directed the employer to work out the details of claimant's reemployment with claimant himself.

Relying on this release, the employer sent a registered letter to claimant's address, informing him that he had been released for work and that he was expected to report. The letter was dated June 20, 1984. Claimant did not receive the letter because he was on his way to California on the day it arrived at his home. In fact, claimant did not become aware of the letter until he made his next weekly phone call to the employer on June 26. At that time, he was informed that he had been terminated from his job and that his time loss benefits had been terminated because he had refused employment.

Claimant stayed in California for another week. Upon his return, he tried to get his job back but the employer refused to rehire him. Claimant ultimately requested a hearing in an attempt to recoup the time loss benefits that had been terminated on or about June 20, 1984.

The Referee found that although claimant had been warned about what would happen if he failed to report to work, he "recklessly defied the order to return to work" and thereby interfered with the employer's efforts to return him to gainful employment. The Referee found that the employer's June 20 letter offering employment to claimant complied with the administrative rule governing termination of time loss benefits.

After reviewing the evidence, we disagree with the Referee. As he correctly noted, the controlling administrative rule is OAR 436-54-222(5) and (7), which read:

> "(5) An insurer or self-insured employer shall cease paying temporary total disability compensation and start making payment of temporary partial disability compensation *** 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 the 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 employment which states the beginning time, date and place; the duration of the job, if known; 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. ***

"(7) An insurer or self-insured employer shall provide a written explanation to the injured worker of the reasons for the changes in the compensation rate and the method of computation whenever temporary total disability compensation is terminated *** A copy of the letter to the worker shall be sent to the Compliance Division in cases where the worker has refused wage earning employment."

We read the rule as requiring that there be a "refusal" of employment by the worker before a termination of benefits is warranted. Presumably, the refusal may be actual or constructive, so long as there is conduct by the worker constituting a rejection of the employer's offer. We find no "refusal" in this case. Rather, we find a hopelessly confused situation in which claimant's physicians changed their minds several times regarding whether claimant was indeed released for work. We find it reasonable that claimant relied on first Dr. Mann's and later Dr. Smith's directives that he remain off work until he could be rechecked in early July. Although we think that claimant could have reduced the confusion somewhat by personally contacting his employer before going to California, we do not find that he purposefully circumvented the employer's efforts to reemploy him. We also note that the employer sent its offer of employment to claimant's home even though it knew he had left town. Claimant could not respond to a letter of which he had no knowledge, but the employer terminated him anyway when he did not respond.

The administrative rule requires that the attending physician agree that the job offered by the employer is within claimant's capabilities. We have earlier held that this doctor's release must be "clear and unambiguous." Neva W. Brehmer, 36 Van Natta 1603 (1984). The release in this case was not clear. In fact, in one report, Dr. Mann stated that when Dr. Smith released claimant the second time, the release was specifically conditioned on claimant's being able to personally assess whether he would be able to satisfactorily perform the offered employment. A conditional release of this nature is not clear and unambiguous. See Volk v. SAIF, 73 Or App 643 (1985).

Finally, we note that the employer failed to comply with the procedural requirements of OAR 436-54-222(7). The employer neither provided a written explanation to claimant regarding the reasons for the change in benefits, nor provided a copy to the

Compliance Division. Because the process for terminating benefits was not followed, procedurally or substantively, we find the unilateral termination of benefits to have been improper. However, we do not feel that penalties and attorney's fees are warranted. This case is characterized by a great deal of confusion. Because the employer did secure what it may have felt was a proper release from Drs. Mann and Smith, it was not unreasonable for it to take steps toward terminating the time loss benefits at issue.

ORDER

The Referee's order dated November 30, 1984 is reversed. The insurer is ordered to pay claimant temporary total disability compensation beginning as of the date benefits were unilaterally terminated and continuously until a determination of claimant's claim is made according to law. Claimant's attorney is allowed a reasonable attorney fee of 25% of the compensation awarded by this order, not to exceed $1,500, payable out of and not in addition to compensation.

MARTHA O. OSORIO, Claimant
SAIF Corp Legal, Defense Attorney

WCB 84-10631
July 22, 1985
Order of Dismissal

The claimant has requested review of Referee's order dated June 13, 1985. The request for review was filed with the Board on July 16, 1985, 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.

RICHARD M. DESKINS, Claimant
Evohl F. Malagon, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 84-02010
July 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of Referee McCullough's order that set aside its low back aggravation denials. Claimant cross-requests review of that portion of the Referee's order that awarded a $1,200 employer paid attorney fee for services at hearing in procuring the overturning of the denials, contending that the fee is inadequate. The issues are compensability and attorney fees.

On the issue of the compensability of the aggravation claim, the Board affirms and adopts the relevant portions of the Referee's order.

The Board also affirms the Referee's order with respect to the amount of the employer paid attorney fee awarded, with the following comments. As noted above, the Referee awarded a fee of $1,200 for claimant's attorney's services through the hearing. Claimant has submitted affidavits in which a total time of 25.25 hours of work is averred to, which claimant urges should be compensated at the rate of $100 per hour. The basis for the

employer paid attorney fee in this case is ORS 656.386(1), which in relevant part provides:

> "In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. . . ."

In determining a reasonable attorney fee, among other things, we look to the efforts expended and result obtained for the claimant. See Muncy v. SAIF, 19 Or App 783, 787-88 (1974); Barbara A. Wheeler, 37 Van Natta 122 (1985). The actual time invested by the attorney is relevant, but not determinative. In Clara M. Peoples, 31 Van Natta 134 (1981), we noted that an average attorney fee in a denied claim case was in the $800 to $1,200 range. See also Daryl W. Sell, 37 Van Natta 649 (1985); John C. Roop, 35 Van Natta 1652 (1983). By making that observation, we did not and do not mean to say that, as a matter of law, a specific range is "reasonable" for every case. What is reasonable must be, and is, determined on a case by case basis.

Although the record in this case consists of 129 exhibits, the record contains evidence relating to claimant's entire claim history since his October 1979 injury. The only issue was whether claimant's condition had worsened since September 1983, when a Referee's order established claimant's level of permanent partial disability for the last time. On that issue, there was evidence from three physicians and some lay testimony. Thus, the thickness of the file belies the relative simplicity of the case. We note that apparently claimant's attorney agreed, because his written closing argument begins with the statement, "This is a simple case."

While it is no doubt true that no case that reaches this level of litigation is "simple" in the ordinary sense of the word, relative to cases presenting the same or similar issues, this case is not extraordinary. Claimant has not asserted that it is. We think that, in terms of the issues presented, effort apparently expended and result obtained, claimant's attorneys have requested an above average fee. There being no reason to award such a fee, we decline to do so. We believe that the fee awarded by the Referee was reasonable.

ORDER

The Referee's order dated November 26, 1984 is affirmed. Claimant's attorney is awarded $500 for services on Board review in connection with the employer's request for review, to be paid by the self-insured employer.

LONA L. EMERY, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-03674
July 23, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of that portion of Referee T. Lavere Johnson's order which set aside the Determination Orders dated March 14 and April 3, 1984, had determined that claimant was medically stationary on February 22, 1984, and awarded temporary disability compensation. In her brief on review, claimant requests review of those portions of the order which: (1) denied temporary total disability compensation from June 27, 1983 through January 3, 1984; and (2) denied temporary total disability compensation as interim compensation on her aggravation claim from May 16 through July 20, 1984. Claimant further requests that if the Board finds that claimant was medically stationary on February 22, 1984, then the Board should find that the insurer's aggravation denial was unreasonable and penalties and attorney's fees should be awarded. The issues on review are premature closure, temporary total disability, aggravation, and penalties and attorney fees for unreasonable denial.

Claimant suffered a compensable cervical and dorsal muscle strain on October 5, 1982. She has obtained chiropractic treatment from two chiropractors and conservative treatment recommendations from five different physicians. She has been examined by two surgeons who concurred in the conservative treatment recommendations. She underwent myelography in May 1983 which showed small bulges in the discs at C2-3, C5-6, and C6-7; a notch defect at C5-6 on the right; and mild degenerative disease of the cervical spine. An electromyogram in January 1984 was within normal limits. Drs. Lawton, Tiley, Duff, Rosenbaum and Collada had all found that claimant was medically stationary by February 22, 1984, based on numerous examinations and comparisons of claimant's complaints. The first Determination Order, dated March 14, 1984, determined claimant was medically stationary on February 22, 1984 and awarded temporary disability compensation. An amended Determination Order dated April 3, 1984 changed the dates of temporary partial disability but otherwise affirmed the first Determination Order.

Dr. Boyer, chiropractor, first examined claimant on February 21, 1984. His history and examination findings were the same as previously reported. He suggested that 30 more days of chiropractic treatment might help claimant. He obtained thermograms on March 10, 1984 through Dr. Nelson, chiropractor, that showed diagnostic indications of C-6 right nerve root irritation.

In April 1984 Dr. Collada opined that claimant's cervical spondylosis was a gradual degenerative process which had been aggravated only one time for a short period by her work.

In May 1984 Dr. Altrocchi examined claimant. He found that claimant had initially improved after her first symptomatic period, but had remained at the same plateau for one and one-half years. He noted that claimant had never followed the conservative treatment regimen repeatedly prescribed. He opined that claimant must follow the medical advice she had been given because it was the only medical treatment available for her condition. In June and August 1984 Dr. Altrocchi further noted that claimant was

still not following medical advice to effect reduction of symptomatology. In his opinion, because claimant had not yet achieved that point of recovery beyond which no further improvement could be expected by time or further treatment, claimant was not medically stationary.

We find that the opinions of Drs. Lawton, Tiley, Duff, Rosenbaum and Collada, based on examinations and comparisons over a 16 month period, are more persuasive than Dr. Boyer's opinion on his first examination that claimant was medically stationary on February 22, 1984. "The reasonableness of medical expectations at the time of claim closure must be judged by the evidence available at the time, not by the subsequent development of the case." Alvarez v. GAB Business Services, 72 Or App 524, 527 (1985). Although we almost always defer to the treating physician's opinion regarding the need for treatment, we are not bound by it. Brad T. Gribble, 37 Van Natta 92 (1985). Dr. Altrocchi's opinion in May 1984 does not affect our finding because it has no bearing on claimant's condition in February 1984. Therefore, we find that claimant was medically stationary on February 22, 1984.

On the aggravation issue, claimant had to show that her back condition had worsened due to her industrial injury since February 22, 1984. Claimant first made her claim on either May 16 or May 25, 1984. Dr. Boyer reported that claimant's symptomatology had improved between February and July and Dr. Altrocchi reported in August that claimant's symptoms continued since her 1982 work injury. Claimant testified that her pain increased in February 1984 because she was "trying to do everything" around the consignment resale shop she had opened. Claimant's symptomatology was exacerbated by activity associated with her consignment shop and by dune buggy trips. Claimant admitted that she improved when she followed her doctors' instructions. The exacerbations of pain were predicted by her doctors based on the severity of the unrelated underlying spondylosis and unrelated C5-6 defect that claimant might suffer due to activity. We find that claimant failed to carry her burden of proof that her condition worsened due to her industrial injury after February 22, 1984 and, therefore, we affirm the insurer's denial of her aggravation claim. See Maarefi v. SAIF, 69 Or App 527 (1984).

On the issues of temporary total disability compensation from June 27, 1983 through January 4, 1984, and interim compensation on her aggravation claim pending denial while working, we affirm the Referee's order.

ORDER

The Referee's order dated October 9, 1984 is reversed in part and affirmed in part. That portion which set aside the Determination Orders of March 14 and April 3, 1984 is reversed. The attorney fee allowed out of the temporary disability compensation resulting from the reopening of the claim due to premature closure is reversed. The Determination Orders of March 14 and April 3, 1984 are reinstated. The insurer's denial of claimant's back aggravation claim dated July 20, 1984 is approved. The remainder of the Referee's order is affirmed.

BRUCE A. PHILLIPS, Claimant
Emmons, et al., Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 84-06676
July 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of those portions of Referee Howell's order which upheld the insurer's denial of claimant's low back condition, diagnosed as a herniated L4-5 disc, and imposed a penalty equal to five percent of unpaid interim compensation. Claimant contends that his back condition is compensable, and that the penalty imposed by the Referee is inadequate. It is unclear whether claimant is proceeding on an injury theory or occupational disease theory. The Referee made alternative findings and holdings. We agree that whether claimant contends his back condition is compensable as an industrial injury or an occupational disease, he has failed to satisfy his burden of proof in either regard. The penalty imposed is appropriate considering the fact that on the 18th day after notice or knowledge of the claim, the insurer issued its denial.

For the foregoing reasons, we affirm and adopt the Referee's order.

ORDER

The Referee's order dated October 19, 1984 is affirmed.

PAUL ROGERS, Claimant
David C. Force, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 84-04530
July 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of Referee Howell's order which set aside its denial of claimant's low back injury claim and awarded a penalty and attorney fees for unreasonableness of that denial. The issue on review is compensability.

Claimant has a long history of back injuries. His first industrial injury was in June 1976, for which he underwent a laminectomy in 1977. He compensably re-injured his back in January 1978 and underwent surgery in August 1978. In October 1981 claimant slipped and fell at home and aggravated his back condition and had to be hospitalized for ten days of conservative treatment. On July 15, 1982 claimant was injured in a motor vehicle accident and was hospitalized for lumbar strain, cervical strain, and bilateral sciatic irritation. Cervical fusion was performed in October 1982. Cervical discectomy and additional fusion was performed in January 1983. Claimant returned to work in July 1983 and worked until the date of the alleged injury, February 13, 1984.

By Opinion and Order of November 19, 1982, the employer was found responsible for the worsening of claimant's condition in October 1981 due to the slip-and-fall accident at home. By Opinion and Order of September 22, 1983, the employer was found not responsible for the worsening of claimant's condition in October 1982 because the worsening of claimant's condition was due to the intervening noncompensable motor vehicle accident. The Board affirmed that order by memorandum opinion in May 1984 and the Board's Order on Review was affirmed by the Court of Appeals without opinion. 74 Or App 366 (1985).

Claimant alleges that he suffered a slip-and-fall accident on February 13, 1984 at the workplace and suffered a back injury as a direct result of that fall. Claimant contends that injuries suffered on February 13, 1984 materially contributed to his need for medical treatment and disability after that date. The employer alleges that there was no accident and that claimant suffered no injuries at work on February 13, 1984, and that any need for treatment and disability after that date was attributable solely to the injuries suffered in the motor vehicle accident of July 1982.

The Referee found claimant sufficiently credible on the issue of whether there was a slip-and-fall accident that claimant proved the accident happened. The Referee relied on the record to explain inconsistencies between the testimony of claimant and the testimony of the witnesses and the reports and testimony of the doctors. The Referee is in no better position than are we to evaluate credibility, reliability and persuasiveness of witnesses based on the record. Davies v. Hanel Lbr. Co., 67 Or App 35 (1984). If there was a credible and reliable witness, including claimant, at the hearing, it cannot be inferred from the record. Each witness effectively impeached himself on relevant issues. We find that claimant did not prove by a preponderance of the evidence that he suffered an accident at work on February 13, 1984 that caused injuries that contributed to his need for medical treatment and disability after that date.

Claimant's cousin was not listed as a witness on the claim form but testified in great detail about an accident which differed from the one described by claimant. The cousin's recollection of the events immediately following the accident were vivid and radically different from and totally incompatible with claimant's testimony. Claimant's friend, whose testimony was entirely incompetent and irrelevant, was certain that he worked the same shift as claimant on the date of the alleged accident when in fact they worked different shifts. Claimant repeatedly contradicted his own testimony about the basic facts of the accident and the events that followed. The alleged injury happened on a Monday morning, after a weekend off work, and claimant had no memory of the weekend, but otherwise he had an excellent memory for details. Even if the testimony of his two witnesses were disregarded, claimant's own testimony is insufficiently persuasive to carry his burden of proof that he fell at work as alleged.

The attending physician related claimant's surgery and disability to conditions resulting from the 1982 motor vehicle accident and could relate them only as possibilities with claimant's February 13, 1984, alleged accident. Claimant is required to prove compensability of his claim by a preponderance of the evidence, and a possibility of causation is insufficient. We find that claimant has failed to establish that his disability and surgery after February 13, 1984 was work related. See Robert D. Tuttle, 36 Van Natta 1687 (1984).

ORDER

The Referee's order dated August 29, 1984 is reversed and the self-insured employer's denial of April 16, 1984 is reinstated and affirmed.

DERONDO PETER SHOUP, Claimant
Bottini & Bottini, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-07171
July 23, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of that portion of Referee Menashe's order that awarded claimant's attorney a $1,500 insurer paid fee for services at hearing in securing a penalty for delay in payment of temporary disability compensation. The issue presented by SAIF is the reasonableness of the amount of the attorney fee. SAIF concedes that claimant's attorney is entitled to a reasonable fee for having secured the penalty. ORS 656.382(1). It is the amount of the fee awarded that SAIF protests. Claimant requests that an additional attorney fee be awarded on Board review for defending the Referee's attorney fee award.

Attorney fees awarded or allowed by Referees or the Board are in all cases based upon the efforts of the attorney and the results obtained for the claimant. OAR 438-47-010(2). The distinction between allowing a fee and awarding a fee is that the former is paid out of claimant's increased compensation, while the latter is paid by the employer/insurer in addition to claimant's compensation. In this case, claimant's attorney was allowed a fee of 25% of claimant's increased permanent partial disability compensation, not to exceed $2,000, as well as having been awarded the $1,500 insurer paid fee for securing the penalty. The amount of the penalty was $1,335.27.

Having reviewed the record and arguments, we conclude that a reasonable attorney fee, based upon the effort expended and result obtained on the penalty issue, is $1,100, and claimant's attorney fee will be adjusted accordingly. See Mobley v. SAIF, 58 Or App 394, 396 (1982); Andrew Simer, 37 Van Natta 118, 120-21 (1985).

Claimant asserts that the Board should award an additional insurer paid attorney fee for services on Board review. Claimant has not called our attention to any statutory or other authority upon which such an award can be based, and we have found none. See Harold L. Dotson, 37 Van Natta 759 (1985). An insurer paid attorney fee may only be awarded in a case in a procedural posture such as this one, i.e. a request by the employer/insurer for Board review, if the Board "finds that the compensation awarded to a claimant should not be disallowed or reduced . . . ." ORS 656.382(2). Claimant's compensation has never been an issue on Board review in this case, and claimant has not argued that the attorney fee in issue is "compensation." SAIF has expressly argued that the fee is not compensation. We hold that an insurer paid attorney fee associated with a penalty under ORS 656.382(1) is not compensation. Mobley v. SAIF, supra. See also Candy J. Hess, 37 Van Natta 12 (1985); Robert G. Perkins, 36 Van Natta 1050 (1984).

ORDER

The Referee's orders dated August 1, 1983 and August 17, 1983 are modified to award claimant's attorney a reasonable attorney fee of $1,100 for securing a 25% penalty on unpaid temporary total disability benefits, to be paid by the SAIF Corporation in addition to and not out of claimant's compensation. In all other respects, the Referee's order is affirmed.

ROBERT TUCKER, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-07215
July 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Pferdner's order that affirmed the most recent Determination Order that awarded claimant 5% (16°) unscheduled permanent partial disability for injury to the low back and 10% (15°) scheduled permanent partial disability for loss of use of the left leg (thigh). Claimant's disability awards of record are 105% (336°) unscheduled (50% for a compensable heart condition and 55% for his low back and neck) and 10% (15°) scheduled for the left leg. Claimant argues that he is permanently and totally disabled. The insurer urges us to affirm the Referee's order.

Claimant was age 54 at the time of the hearing and had an eighth grade education with a GED obtained during vocational retraining. Claimant's various injuries and surgeries are well documented in the record. Claimant first injured his back and neck in February 1977. Dr. Danielson performed a foraminotomy and nerve root exploration at L5 in April 1977, at the time ruling out fusion. Claimant was found to have a grade I spondylolysthesis of L5-S1.

In November of 1977 Dr. Danielson had released claimant to attempt to perform his regular truck driving duties, although he apparently had doubts as to whether claimant was medically stationary. Physicians employed by claimant's employer would not permit claimant to return to his regular duties, however, because they felt he had an unstable back. In February 1978 Dr. Danielson diagnosed a herniated disc at C6-7, related to the earlier injury. Disagreement among treating and consulting physicians resulted in postponement of cervical spine surgery. Claimant still had not had cervical spine surgery when his claim was closed by a September 5, 1978 Determination Order that granted an award of 160° for 50% unscheduled permanent partial disability for injury to the low back and neck. On September 26, 1978 Dr. Kaesche released claimant for modified work. Dr. Danielson still maintained that claimant had not yet become medically stationary, on the basis of his untreated cervical spine condition, but was willing to allow claimant to attempt to return to work. Claimant's employer, however, refused to permit claimant to resume his normal duties. Claimant has not been able to obtain a driving job since.

Dr. Danielson performed an anterior cervical discectomy and fusion with bilateral foraminotomies at C6-7 in February 1979. He declared claimant to be medically stationary in July 1979, and estimated that claimant had impairment as a result of his neck condition in addition to that compensated by the earlier Determination Order. This particular claim was not again closed until July 22, 1983, however. In November 1979 claimant obtained employment as a concrete core tester with another employer. On November 28, 1979 claimant sustained an on-the-job myocardial infarction, which was accepted by a different insurer. Claimant received vocational assistance under the heart claim during 1980 and 1981 and was retrained in typewriter repair. Claimant did not, however, complete that portion of the program that would enable him to repair electric typewriters. The heart claim was

closed by an April 1981 Determination Order that awarded no permanent disability. In March 1982, after a hearing, Referee Pferdner awarded claimant 160° for 50% unscheduled permanent partial disability for his cardiovascular condition. At that point, claimant had received combined awards of unscheduled permanent partial disability equal to 100% of the "maximum" award.

Pending closure of the heart claim, claimant had additional problems with his back indicating a worsening of the low back condition. In November 1981 claimant underwent a complete laminectomy of the posterior arch of L5 and a lumbosacral, posterolateral sacral transverse process spinal fusion performed by Drs. Todd and Smith. In spite of this rather extensive surgery, claimant continued to experience significant low back and left leg radicular pain, largely unrelieved by various therapy and mechanical back braces. In August 1982 the Orthopaedic Consultants examined claimant, noting evidence of a possible pseudarthrosis at the L4-5 level, and rating claimant's impairment as a result of loss of lumbosacral function in the moderately severe category. The panel suspected some functional aspect to claimant's disability, but specifically noted that there was no functional disturbance present during the examination. In September 1982 Dr. Todd, one of claimant's treating surgeons, opined that claimant's condition had deteriorated. He referred claimant to Dr. Smith, who found claimant's fusion to be solid, but recommended physical therapy. Dr. Todd then referred claimant to the William A. Callahan Center for Disability Prevention.

Claimant's experience at the Callahan Center was checkered. He entered the center December 2, 1982 and was discharged January 25, 1983 for medical reasons which the record indicates was a Morton's neuroma in his right foot, apparently not connected to his compensable condition. He returned to the center February 22, 1983 and was again discharged February 24, 1983. During this second stay, claimant evidently refused to cooperate with what he viewed as useless procedures and testing. Claimant felt that he was being counseled to lie about his physical condition so that he could get work and that he was being tested to beyond his ability to physically perform. Claimant, however, refused to decline services, according to Dr. Wise. It is apparent that claimant did not want to be at the Callahan Center, and felt that there was little or nothing the center could do for him. The center's occupational therapist furnished a list of several light duty jobs that he thought claimant should be able to perform.

Claimant again was examined by Orthopaedic Consultants in June 1983. The panel concluded that claimant's spondylolysthesis had probably progressed to grade III and that his impairment continued to be moderately severe, but that he should be able to work as a typewriter repairer. Dr. Todd agreed with the Consultants' diagnoses and impairment estimate, but disagreed that claimant could work in typewriter repair, stating that lifting a typewriter would "put [claimant] out of commission." Dr. Todd felt that claimant could do sedentary work only. On July 22, 1983 claimant's back claim was finally reclosed by a Determination Order that granted an additional 16° for 5% unscheduled permanent partial disability for injury to his back and 15° for 10% loss of use of the left leg.

Claimant appealed from that Determination Order, contending in the alternative that he is entitled to an award for permanent

total disability or that his unscheduled permanent partial disability should be increased substantially. Because we conclude that claimant is permanently and totally disabled, we do not address the question raised by claimant's alternate argument, i.e. whether a claimant can or should be compensated for loss of more than 100% of earning capacity. But see American Building Maintenance v. McLees, 296 Or 772 (1984).

ORS 656.206(1)(a) defines permanent total disability as:

> "[T]he loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a suitable occupation is one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation."

ORS 656.206(3) provides that:

> "The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

Total physical incapacity is not required in order to prove permanent total disability status. A combination of physical impairment and social and vocational factors can result in permanent total disability. Wilson v. Weyerhaeuser Co., 30 Or App 403, 409 (1977). Where the evidence as a whole indicates that it would be futile for a claimant to seek employment, the requirements of ORS 656.206(3) will be deemed satisfied. Butcher v. SAIF, 45 Or App 313, 318 (1980). The Board recently thoroughly analyzed the case law on the so-called "seek work" requirement in George M. Turner, 37 Van Natta 531 (1985). There we concluded:

> "Based upon our review of the [case law], we conclude that the insurer is mistaken in its assertion that a claimant who is not permanently and totally disabled on the basis of medical factors alone is required, as a matter of law, to satisfy the seek-work requirement of ORS 656.206(3). We believe that the scope of the futility exception to the seek-work requirement must necessarily be defined on a case-by-case basis. As we previously held in Dock A. Perkins, [31 Van Natta 180 (1980)], a claimant may be so 'incapacitated,' in terms of the claimant's inability to sell his or her services in a competitive labor market, as a result of medical factors and social/vocational factors, as to be excused from the seek-work requirement.

> "Even if a claimant is not completely excused from the statutory requirement, it is nevertheless possible, given the evidence of the claimant's medical condition and relevant social/vocational factors, that very minimal efforts to seek and obtain employment satisfy the statutory requirement. Pournelle v. SAIF, 70 Or App 56 (1984); Petersen v. SAIF, 52 Or App 731 (1981); see also Livesay v. SAIF, 55 Or App 390 (1981). In each case, the inquiry is what constitutes 'reasonable efforts' to obtain suitable employment, considering the evidence of claimant's disability.
>
> "In this case, we find that claimant is not so severely disabled, as a result of his medical condition and pertinent social/vocational factors, to justify the conclusion that he is completely excused from the statutory seek-work requirement. We do find, however, that claimant has exhibited motivation to return to the labor force since his industrial injury, and that the efforts he has made to do so have been thwarted by his medical condition." 37 Van Natta at 537-38, emphasis in original.

In this case, we find that claimant suffers from moderately severe physical impairment based upon his back condition alone, and that he suffers, also, from impairment based upon his heart condition and other, preexisting, physical problems. However, even given claimant's substantial physical impairment, he is not physically helpless. He has attended every examination, assessment and training program offered him and he has, in fact, been retrained, but into a field where he is unable to sell his services. We conclude that, notwithstanding the Referee having found claimant guilty of having a "bad attitude," he has adequately demonstrated his willingness and motivation to reenter the work force, but has been unable to do so because of his "incapacitation," as we clarified the term in George M. Turner, supra. We do not find claimant excused from the requirements of ORS 656.206(3), but that his efforts have been sufficient, as a matter of fact, to satisfy them. We find that claimant is entitled to an award of permanent total disability.

The standard for determining the effective date of a retroactive permanent total disability award is "the earliest date that claimant's permanent total disability is proved to have existed." Morris v. Denny's, 53 Or App 863, 867 (1981). See also Wilke v. SAIF, 49 Or App 427, 431 (1980). Although that date is frequently found to be the date on which a claimant was declared to be medically stationary, see, e.g., William B. Johnson, 36 Van Natta 98, 104 (1984), there is no rule of law that requires such a finding, see Michael R. Harman, 37 Van Natta 418 (1985); Albert D. Richey, 36 Van Natta 1580, 1583 (1984). A finding of the appropriate effective date is based upon all of the relevant medical, social and vocational factors. Morris v. Denny's, supra.

We conclude that all of the relevant medical and

social/vocational factors combined to allow the legal conclusion of permanent total disability as of the time that claimant left the Callahan Center for the last time. As of then, claimant's vocational status was finally established as having no training or experience to perform any employment that he had been trained or retrained for or that he had the experience to perform. We do not speculate as to what future efforts may hold for claimant. Gettman v. SAIF, 289 Or 609 (1980). Claimant's award will be effective February 24, 1983. The insurer shall be authorized to offset all permanent partial disability benefits paid subsequent to February 24, 1983 against this award. See Pacific Motor Trucking v. Yeager, 64 Or App 28, 32 (1983).

ORDER

The Referee's order dated February 13, 1984 is modified to grant claimant an award for permanent total disability effective February 24, 1983. The insurer is authorized to offset all permanent partial disability benefits paid subsequent to that date against the benefits made payable by this order. Claimant's attorney is allowed a reasonable attorney fee of 25% of the increased compensation awarded by this order, not to exceed $3,000, to be paid out of claimant's compensation and not in addition thereto.

MARY K. TURNER, Claimant
Ackerman, et al., Claimant's Attorneys
Daniel DeNorch, Defense Attorney

WCB 83-04146
July 23, 1985
Order Denying Request to Dismiss

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

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

IT IS SO ORDERED.

ANTHONY A. BONO, Claimant
Greco & Escobar, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-11418
July 24, 1985
Order on Remand

This matter is before the Board again after having been remanded to us by the Supreme Court, Bono v. SAIF, 298 Or 405 (1984), to determine whether claimant "left work during the period from the date the claim was filed until the date [claimant] was notified of its acceptance by employer." 298 Or at 410. Because we were unable to answer the question on the record before us, we remanded the case to the Hearings Division to take additional evidence.

A hearing was convened June 19, 1985 before Referee Lipton. At that hearing, claimant stipulated that "he had no evidence to present on this issue and was therefore unable to prove that he had left work on account of his compensable injury during the period August 26, 1980 through November 14, 1980." The question

whether claimant is entitled to "interim" compensation under the rule announced in Bono v. SAIF, supra, is, therefore, answered in the negative.

There remains the matter of a penalty and attorney fee to be assessed against the SAIF Corporation for having not accepted or denied claimant's claim within 60 days. ORS 656.262(6), (10); 656.382. The Court of Appeals found that a penalty should be assessed, Bono v. SAIF, 66 Or App 138, 143 (1983), and the Supreme Court left undisturbed that portion of the court's decision, 298 Or at 411. In Harold A. Lester, 37 Van Natta 745 (1985), we recently concluded that when an appellate court's mandate orders us in general terms to determine a penalty, we will do so in light of existing law governing the actual assessment of penalties. Existing law, as interpreted by our decision in Lester, supra, is that in order for a penalty to actually be assessed, there must have been an amount due and unpaid, either at the time the conduct being penalized occurred or at the time of the hearing. See also EBI Companies v. Thomas, 66 Or App 105, 111 (1983).

Although claimant concedes that he is unable to prove that there was ever any "interim" compensation due and unpaid, he asserts that there were medical bills that were not paid, and that these unpaid medical bills are "amounts then due" upon which to assess a penalty. At the time of the offending conduct in this case, August through November, 1980, ORS 656.262(6) did not exempt medical benefits from payment during the interval between the submission of a claim and its acceptance or denial. In Whitman v. Industrial Indemnity, 73 Or App 73, 76-77 (1985), the court concluded that, even after the amendment of ORS 656.262(6) in 1981 to exempt medical benefits from payment during that interval, failure to pay medical benefits after the expiration of 60 days was part and parcel of "unreasonable delay" for the purposes of ORS 656.262(10), and were "amounts then due" upon which a penalty could be quantified.

Claimant asserts that the issue of the unpaid medical bill was raised at each level of litigation in this claim. Claimant has not, however, pointed out to us where in the record the issue was raised. We have found a brief reference in the transcript of the January 12, 1982 hearing to a bill submitted to SAIF by Dr. Wolansky. From the context of the statements of counsel, it appears to us that the bill had not been paid as of the day of the hearing. SAIF's attorney represented that information had been sought from Dr. Wolansky as to the nature and times of treatments so that the bill could be audited for payment, and that as of the hearing, Dr. Wolansky had not responded. Neither party appeared, from what is reflected by the transcript, to have attached much significance to the bill or the fact, if it was a fact, that the bill had not been paid. We have searched the record thoroughly and have found no other reference to Dr. Wolansky's bill between the time of the first hearing and the hearing before Referee Lipton on June 19, 1985.

Claimant now urges us to demand that SAIF produce its copy of the bill for us to consider. We assume that SAIF would not object to producing the bill, however, we are without authority to consider it. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 (1983); Muffett v. SAIF, 58 Or App 684, 687 (1982). In the alternative, claimant asks us to again remand this matter to the Hearings Division to take evidence relating to the unpaid medical bill. ORS 656.295(5) authorizes us to remand a matter, "[I]f the

board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee . . . ."

In Robert A. Barnett, 31 Van Natta 172, 173 (1981), aff'd mem, Barnett v. Tillamook Co. Cremery Assoc., 59 Or App 133 (1982), we stated that, "To merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing." See also Delfina P. Lopez, 37 Van Natta 164, 170-71 (1985); Myrtle E. York, 36 Van Natta 23, 24 (1984). Virtually the only thing we know for certain about the phantom medical bill is that it was certainly in existence and almost certainly easily obtainable with due diligence before the hearing. Claimant's request for a further remand is denied.

There is insufficient evidence to preponderate in favor of a finding of fact that there were "amounts then due" at any relevant time to allow us to quantify a penalty. We are mindful of the fact that both appellate courts have concluded that a penalty is appropriate, however, ORS 656.262(10) only permits the actual imposition of a penalty as a percentage of "amounts then due." See Whitman v. Industrial Indemnity, supra; EBI Companies v. Thomas, supra. Cf. ORS 656.268(3); 656.382(3). It follows that, since no penalty may be assessed, no attorney fee may be awarded. Whitman v. Industrial Indemnity, supra; Darrel W. Carr, 36 Van Natta 16, 17 (1984).

Claimant being entitled to no affirmative relief, this case is dismissed,

IT IS SO ORDERED.

KENNETH L. BOORAS, Claimant
Evohl F. Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys
Marcus K. Ward, Attorney
Beers, et al., Defense Attorneys

WCB 83-11009, 83-11008 & 82-09693
July 24, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Foster's order which set aside its denial of claimant's back injury aggravation claim. In the alternative, SAIF asks the Board to find that claimant was medically stationary on June 9, 1983 and authorize an offset of interim compensation paid pending denial as an overpayment of temporary time loss compensation. The issues on review are aggravation and allowing an offset for overpaid interim compensation.

Claimant was first injured on November 25, 1977 when he lifted a garbage can. He suffered a lumbosacral strain. He improved under conservative treatment and returned to work. On January 19, 1978 he suffered a new injury to the same part of his body in the same way. His doctor continued conservative treatment and claimant was referred to the Callahan Center for evaluation and rehabilitation. It was recommended that claimant limit his lifting to 50 pounds and that he be referred for vocational rehabilitation in a less strenuous occupation. His claim was closed by Determination Order dated September 12, 1978 which awarded 16° for 5% unscheduled permanent partial disability.

Claimant was examined by Dr. Chiapuzio in October 1978 and February 1979. Dr. Chiapuzio found questionable weakness of the

dorsiflexor muscles to the toes of the left foot as compared to the right foot. At the October 1978 examination, he found that the extensor hallucis longus muscle was within normal limits, but it was questionably weak at the February 1979 exam. In November 1978 Dr. Serbu examined claimant and recommended a myelogram, which claimant declined.

In December 1978 Dr. Tsai examined claimant and found weakness of the extensor hallucis longus muscle on the left and no weakened dorsiflexion of the toes of the left foot. He diagnosed a probable disc protrusion at L4-5 as the cause of claimant's complaints and recommended no further testing and that claimant continue conservative treatment.

By stipulation dated January 24, 1979 claimant was awarded 56° for 17.5% unscheduled permanent partial disability in addition to the Determination Order award.

Claimant worked as a car salesman and a security guard in the years that followed the stipulation. While working as a security guard he noticed pain, weakness, and numbness that he attributed to his original back injury. He claimed aggravation of his back injury on October 21, 1982.

Dr. Tsai examined claimant on February 8, 1983. He observed weakness of the extensor hallucis longus muscle and dorsiflexor muscles on the left side and diagnosed radicular irritation of the L5 nerve root. He obtained a CT scan which showed a central bulge of the L4-5 disc. Dr. Tsai reported that claimant was pleased to have his problem diagnosed but that claimant had no desire for treatment. On June 9, 1983 Dr. Tsai opined that claimant was medically stationary and that no treatment was offered to claimant other than palliative care to enable him to continue with his activities.

Claimant testified that his pain stayed about the same while walking extensively as a security guard, although there were better and worse days. He developed numbness in his left leg that he had not had before. He was working more than full time as a painter at the time of hearing and twisting or turning caused his back to hurt.

SAIF concedes that claimant is entitled to continuing medical treatment for his back condition pursuant to ORS 656.245, but argues that claimant's condition has not worsened since the last arrangement of compensation in January 1979.

We note that claimant has no desire for curative treatment and none has been recommended. We find that claimant's condition fluctuates somewhat, as illustrated by his testimony and the examination findings between October 1978 and February 1979, and that the physical examinations are consistent with claimant's awards for 22.5% unscheduled disability. Claimant's condition was diagnosed in 1978 as a protruded disc at L4-5 and the same condition was diagnosed with more certainty in 1983. Claimant had the same symptom complex in 1983 that he did in 1978. Dr. Tsai concluded that claimant's condition had worsened, but his examination findings and claimant's description of his problems do not support that conclusion. Claimant believed that his condition had worsened, but his complaints had not changed nor did he desire treatment. We find that claimant, who has a history of a

protruded disc condition causing chronic pain characterized by periodic temporary exacerbations and remissions, has not shown by a preponderance of the evidence that his condition has worsened. Hutchinson v. Louisiana-Pacific, 67 Or App 577, rev. den. (1984); Billy Joe Jones, 36 Van Natta 1230 (1984).

The claim was still in deferred status when Dr. Tsai opined that claimant was medically stationary on June 9, 1983. SAIF paid temporary disability compensation to claimant through June 23, 1983, when it denied the claim. SAIF requested authorization to offset disability compensation paid after the medically stationary date. We find that the disability compensation paid to claimant was interim compensation paid pending denial. SAIF delayed its denial decision long past the 60 days allowed by statute, but paid interim compensation, therefore, there are no penalties due claimant for unreasonable delay. EBI Companies v. Thomas, 66 Or App 105 (1983); cf. Harold A. Lester, 36 Van Natta 745 (June 27, 1985) (amount reasonably due claimant unreasonably delayed merits penalty in spite of cure at time of hearing). Interim compensation was due until the date of the denial and no offset of any amount due as interim compensaton is allowed. Jones v. Emanuel Hospital, 280 Or 147 (1977); cf. Anna M. Scheidemantel, 35 Van Natta 740 (1983), rev'd on other grounds, 70 Or App 552 (1984) (disability compensation awarded from date of notice of claim until released to return to regular work before date of denial). Therefore, no offset of compensation paid after the date when Dr. Tsai reported claimant was medically stationary will be allowed.

ORDER

The Referee's order dated September 19, 1984 is reversed. SAIF's denial dated June 23, 1983 is reinstated. For prevailing on the issue of an offset for overpaid interim compensation, claimant's attorney is awarded $300 for services on Board review, to be paid by the SAIF Corporation.

JAMES T. HARVEY, Claimant
Peter O. Hansen, Claimant's Attorney
Mitchell, et al., Defense Attorneys

WCB 84-03508
July 24, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Nichols' order which, in effect, upheld the self-insured employer's de facto denial of claimant's aggravation claim; found that claimant had failed to present the employer with medical verification of inability to work as a result of a worsened injury-related condition and, therefore, held that interim compensation was not due and a penalty/attorney's fee was neither warranted nor authorized; and failed to award claimant compensation for an unscheduled disability in connection with his compensable hand/arm injury. In addition, the Referee refused to impose a penalty/attorney's fee for the employer's alleged failure to provide claimant with vocational assistance, specifically an authorized training program, in a timely manner. In this regard, the Referee concluded that neither the employer's actions nor the conduct of the Field Services Division of the Workers' Compensation Department warranted imposition of a penalty/attorney's fee. The issues raised by claimant on review relate to the compensability of his aggravation claim; entitlement to interim compensation,

claim; penalties and attorney fees relative to the vocational assistance issue; and entitlement to an award for unscheduled disability.

We affirm and adopt the portions of the Referee's order relative to the issues of interim compensation, penalties and attorney fees in connection with the aggravation claim. We affirm the remaining portions of the Referee's order with the following additional comments.

The evidence does not support the conclusion that claimant's orthopedic problem worsened any time subsequent to the last award or arrangement of compensation in this case, a November 1983 stipulation. Claimant contends that he suffers a psychological condition which has worsened and which warrants claim reopening pursuant to the aggravation statute. In support of this contention, claimant relies on the Orthopaedic Consultants June 1, 1984 report, which states a diagnosis (one of four) of severe functional overlay, and a subsequent statement from Dr. Grewe, claimant's attending neurosurgeon, that, "Psychologically I think [claimant] is worse . . . . "

Dr. Grewe's statement is obviously a reference to claimant's frustration, which he was experiencing as a result of his inability to obtain gainful employment either through his own efforts or with vocational assistance. This is not a physician's statement of a worsened condition in the sense contemplated by ORS 656.273. Although the Consultants diagnosed severe functional overlay, their report also states:

> "It is [our] feeling that he has a psychophysiological musculoskeletal reaction of a conversion type and has become ingrained since the original injury and will be most difficult to treat. This, however, would have to be confirmed by a psychiatrist, since [we] did not have the advantage of seeing him prior to this one time.
>
> "In any event, from a neurological/orthopedic standpoint, his symptom complex cannot be explained from his subjective complaints."

Claimant subsequently was examined and evaluated by Dr. Parvaresh, a psychiatrist. It was his opinion that, "[U]sing DSM III guidelines, this is a typical case of psychological factor affecting physical condition." Dr. Parvaresh also observed, "a good deal of inconsistency in what he really does and what he states in terms of limitation and inability to do." He found no objective psychiatric permanent disability attributable to claimant's accepted injury. Furthermore, Dr. Parvaresh stated:

> "He may have had anxiety tension, periods of depression in the past but these as a rule are basically neurotic in nature called at the Pain Center 'dysthymic reaction' and do not appear at this time to be of that nature or gravity to cause any permanent disability."

Dr. Parvaresh was of the opinion that if claimant's condition was "orthopedically stationary," then claim closure was in order.

Dr. Parvaresh's impression that "this is a typical case of psychological factor affecting physical condition" is consistent with the Consultants' secondary diagnosis of a post-traumatic chronic pain syndrome of claimant's right arm and hand. The Consultants believed that this condition might be amenable to psychiatric treatment but deferred this judgment to a psychiatrist. We understand Dr. Parvaresh's opinion to be that psychological/psychiatric intervention is not presently warranted. We are unable to conclude that claimant's injury-related condition has worsened since the last award or arrangement of compensation herein. ORS 656.273(7).

With regard to the issues concerning unscheduled disability, claimant contends that he is entitled to such an award because he suffers either shoulder impairment or a disabling psychological condition. Concerning the latter, there is a paucity of evidence to support an award for psychological disability. There may be a psychological component to claimant's chronic pain syndrome; however, claimant's disability is limited to his right upper extremity. There is no evidence to support a separate, unscheduled award for a psychological disability. Carl L. Smith, 35 Van Natta 1294 (1983); Julia I. Hicks, 33 Van Natta 497 (1981), aff'd mem 57 Or App 838 (1982); Joseph Needham, 32 Van Natta 63 (1981).

Claimant contends that he is entitled to an unscheduled award based upon alleged right shoulder impairment. The Referee found "no medical evidence to support the claimant's contention that his shoulder is involved in this injury," which was an injury to the hand. Claimant presently has a permanent disability award for loss of use of his entire arm, and he contends that the disability has spread into his shoulder. In support of this contention, claimant relies upon his and other lay testimony concerning limitations and pain of his right shoulder. In addition, Dr. Grewe, claimant's attending physician, indicated in a July 1983 office note that claimant's shoulder, "is a little stiff as a result of his arm symptoms and some associated disuse of the shoulder," but that, "the measurable function is nearly normal." Dr. Grewe later indicated in a report to claimant's attorney that claimant suffered minimal (1 to 10%) shoulder impairment as a result of his industrial injury.

Assuming that claimant, in fact, presently suffers impairment of his right shoulder as a result of his industrial injury, we find that the record fails to establish entitlement to a separate award for unscheduled disability under the criteria established by Woodman v. Georgia-Pacific, 289 Or 551 (1980). See also Donald Woodman, 34 Van Natta 178 (1982).

The only remaining issue that warrants discussion is claimant's argument that a penalty/attorney's fee should be imposed for the employer's failure to provide claimant with appropriate vocational assistance in a more timely fashion. If we were to rule on the merits of this issue, we would agree with the Referee's finding, which is contrary to claimant's position. However, as we held in Joel I. Harris, 36 Van Natta 829, 840 (1984), aff'd mem. 72 Or App 591 (1985), this Board lacks jurisdiction to impose a penalty even in instances where it

appears that an employer/insurer unreasonably delayed an injured worker's referral for vocational assistance. That reasoning applies equally to situations in which the employer/insurer is directly responsible for provision of vocational assistance. The authority to impose a penalty in such situations is vested in the Director of the Workers' Compensation Department. ORS 656.745; OAR 436-61-981; see ORS 656.728(1) (eff. July 1, 1984).

ORDER

The Referee's order dated October 15, 1984 is affirmed.

MICHAEL J. MOBLEY, Claimant
Bischoff & Strooband, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 84-05293
July 24, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of Referee Daron's order which awarded claimant interim compensation from October 17, 1983 through and including April 19, 1984; imposed a penalty equal to 25% of the interim compensation for the employer's unreasonable claims processing, and an associated attorney's fee of $500; and awarded claimant's attorney $1,250 as a reasonable attorney's fee for prevailing on this denied claim. The employer protests the Referee's imposition of a penalty/attorney's fee and takes issue with the amount of interim compensation awarded, as well as the attorney's fee for prevailing on this denied claim.

With regard to the period for which the Referee awarded interim compensation, claimant essentially concedes that he is entitled to interim compensation only for the days that he actually did not work as a result of his industrial injury. Bono v. SAIF, 298 Or 405 (1984) (decided subsequent to the Referee's order). Thus we modify this portion of the Referee's order.

With regard to the issue of penalties/attorney fees and the employer's allegedly unreasonable claims processing, we agree with the Referee's rationale and imposition of the maximum penalty allowable. Thus, we affirm that portion of his order imposing a penalty equal to 25% of the interim compensation "then due." However, having reduced the amount of compensation "then due," which results in a substantial reduction in the penalty payable to claimant, we deem it appropriate to reduce the corresponding attorney's fee. Attorney fees associated with a penalty are imposed, in significant part, as a measure of the relative unreasonableness of an employer/insurer's claims processing action. William H. McCall, 35 Van Natta 1200 (1983). The benefit which accrues to the claimant as a result of his attorney's efforts, however, is also a factor to be considered in assessing the amount of the attorney's fee. In consideration of these factors, we believe that $200 is an appropriate fee pursuant to ORS 656.382(1).

On the question of the amount of the fee awarded for prevailing on a denied claim, ORS 656.386(1), we agree with the employer that the Referee's award is excessive. Approximately one week before the hearing, counsel for the employer indicated to one of claimant's attorneys that the compensability of claimant's injury would probably be conceded at the hearing. Understandably, in the absence of any written confirmation of this tentative

agreement, claimant's attorney came to the hearing prepared to present evidence on the compensability issues raised by the employer's denial. At the hearing, the parties stipulated to the compensability of claimant's injury, which stipulation was incorporated in the Referee's order. Claimant's attorney testified to the efforts expended in claimant's behalf prior to the hearing. He was not, however, able to detail the number of hours spent in representing claimant. Considering counsel's sworn testimony and the circumstances leading up to the employer's voluntary acceptance of this claim, we find that $600 is a reasonable attorney's fee.

ORDER

The Referee's order dated October 25, 1984 is modified. In lieu of the Referee's award of interim compensation, claimant is awarded temporary total disability from October 17, 1983, through and including October 28, 1983. In lieu of the penalty and associated attorney's fee imposed by the Referee, the employer shall pay claimant a sum equal to 25% of the aforesaid temporary total disability, and claimant's attorney shall be paid $200. In lieu of the attorney's fee awarded by the Referee for services rendered in prevailing on the employer's denial, claimant's attorney shall be paid $600 as a reasonable attorney's fee.

TIMOTHY R. PUDERBAUGH, Claimant
Pozzi, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 84-07461
July 24, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Tuhy's order which set aside its denial of claimant's injury claim. The issue is whether claimant's right knee injury, which he sustained during a softball game while playing on the employer-sponsored team, arose out of and in the course of his employment as a hospital orderly. We reverse.

The facts are essentially undisputed. Claimant worked as a transport orderly for Woodland Park Hospital, a job he had performed for five years preceding this injury. His regular work hours were between 8:00 o'clock a.m. and approximately 11:30 a.m. He was on call, however, for approximately 67 hours per week on the average. While on call, he was paid $1.50 per hour.

On the evening of May 8, 1984, somewhere between 6:15 and 7:15 p.m., while playing softball on the company-sponsored team, claimant injured his right knee when he jumped onto second base and his leg gave way. The following day he was treated at the Woodland Park emergency room, where a right knee sprain was diagnosed. He filed a workers' compensation claim with the employer, and the employer's insurer promptly denied on the basis that his injury did not arise out of and in the course of his employment.

The game was the first in a series of 15 scheduled weekly games. Claimant was on call during the game, and he was wearing a paging device to respond in the event he was called to work. Claimant testified that his actual working hours during April and May of 1984 averaged approximately 15 hours per week, and that he was on call seven-and-a-half hours per day after his regularly scheduled hours. The softball game was not being played during claimant's regularly scheduled work hours for that day.

The hospital had sponsored a softball team for approximately six years. It paid the sponsorship or entry fee, which for the 1984 season was approximately $400. The hospital also supplied five or six bats and softballs. The players purchased their own hats, jerseys, pants and gloves. The name of the hospital was printed on the jerseys, which was at the hospital's request. In previous years the hospital had provided uniforms; however, the expense eventually became too substantial. The team was part of a county league. The team had previously been part of a city league, during which time the hospital had allowed the team players to use a van in order to travel to the games. The players were responsible for providing their own transportation to and from the games.

The team was composed not only of employes of the hospital, but other individuals as well, such as friends of the employes. Claimant testified that approximately 60 percent of the team was composed of employes, and 40 percent were non-employes.

Employe participation was not required in any of the games. Claimant had assumed the responsibility of coaching the team; therefore, he felt that he should be in attendance at games. Employes generally were allowed to leave work early, if requested, to go play softball; however, as with absences for other personal reasons, they were expected to make up the time.

Supervisory personnel were known to play on the team. Attendance records for the softball games and practices were never taken. Neither the games nor the practices ever took place on the employer's premises.

The bulletin board in the hospital cafeteria was used to post the softball team schedule, and sign-up sheets for the games were posted around the hospital. The hospital newsletter usually mentioned something about signing up for the games or score results. Claimant used the hospital copy machine for softball-related needs, such as schedules for the players. There was no regulation or control of the use of the employer's copy machines, and they were frequently and commonly used by the employes for various personal reasons.

Claimant testified that softball was a prominent topic of discussion at work during working hours. The players would sometimes have "back room meetings" in order to plan the lineup. During the games, the players frequently conversed about current events at work.

If a new employe seemed to be a prospective softball player, the new employe would be referred to team personnel such as claimant. Non-employes were also recruited for participation.

Claimant testified that he understood the purpose of the softball team to be for public relations and to boost employe morale. He testified that he felt entitled, as an employe, to play on the team, that he was playing for the hospital, and that playing on the team was a benefit he derived as a hospital employe.

There was evidence that employes occasionally changed into their softball uniforms at the hospital, and that they would then return to work to resume their work shift after the game was completed. There was also evidence that, in the past when the employer's workers' compensation insurance was provided by another

insurer, softball injuries had been accepted and processed as compensable industrial injuries. The specifics of these "softball injuries," of which there were three, were not detailed.

The Referee concluded that claimant's injury was sufficiently work-connected to be considered as arising out of and in the course of his employment, pursuant to the standard enunciated in Rogers v. SAIF, 289 Or 663 (1980). He utilized the seven factors outlined in Jordan v. Western Electric, 1 Or App 441 (1970): benefit to the the employer; contemplation of the activity by the employer and employe; whether the injury-producing activity is an ordinary risk of, and incidental to, the employment; whether claimant was being paid for engaging in the activity; whether the activity took place on the employer's premises; acquiescence or direction by the employer; and whether claimant was on a personal mission at the time of the injury.

The Referee mentioned Richmond v. SAIF, 59 Or App 354 (1982), but found that case factually distinguishable and, therefore, not controlling.

In Richmond v. SAIF, supra, the court cited with approval, finding it "helpful," Professor Larson's analysis concerning the compensability of recreational or social activities. Professor Larson's black letter law states that 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 employe, 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 employe health and morale that is common to all kinds of recreation and social life." 1A Larson, Workmen's Compensation Law, 5-82, Section 22.00 (1985); quoted in Richmond v. SAIF, supra, 58 Or App at 357.

As we stated in Leslie Colvin, 36 Van Natta 315, 317 (1984), the seven factors enumerated in Jordan v. Western Electric, supra, appear to be integral parts of Larson's analysis.

Because it is undisputed that the softball activity in general, and this game in particular, did not occur on the employer's premises, the only relevant portions of Larson's analysis are parts (2) and (3).

The evidence simply does not establish that the employer, either expressly or impliedly, required participation in the softball games. Playing softball certainly was not part of claimant's job description; nor was there any understanding at the time claimant was hired or thereafter that claimant would play softball or coach the team. The fact that claimant felt obligated to attend the games because he was the coach does not constitute

required participation in the sense discussed by Larson. At most, the evidence supports a finding that the employer encouraged participation by employes who were interested in playing softball by making the activity available. This was accomplished by payment of the sponsorship or entry fee, as well as contributing to the cost of equipment, such as bats and softballs. This amounts to something more than the evidence in Richmond v. SAIF, supra, in which the court found that, "* * * [T]he chiefs of the departments acquiesced in the games and participated as players." 58 Or App at 358. Encouragement amounts to something more than acquiescence, but it is not equivalent to requiring that an employe participate. The fact that players were allowed to leave work early in order to play softball is counterbalanced by the evidence indicating that employes were not totally excused from their regular working hours in order to play softball, and that they were expected to compensate for the hours missed by working at other times.

Nor do we find that the employer made the softball activity part of claimant's or other employes' services, thereby bringing the softball games within the "orbit of employment." A case in which we made such a finding was Rasool Bambechi, 35 Van Natta 1060 (1983). In that case, a fry cook for one of Burgerville USA's Portland stores drowned while he was at a company picnic. We concluded that the decedent's death arose out of and in the course of his employment. We found persuasive the facts that the employer felt the annual company picnics were sufficiently important in its business to finance them to a certain extent, and to discuss and plan them at mandatory staff meetings; the employer exercised control over the picnic in question; and the picnics had become an institutional event centered around an incentive contest to improve store cleanliness, quality and service. In this case, by contrast, the softball games were not in any way related to the services performed for the employer by claimant. Nor is there any similar evidence regarding other employes who played on the team.

The fact that claimant was being paid for being on call while he was playing softball and when he was injured is, in this particular case, inconsequential. The Referee correctly noted that Wallace v. Green Thumb, Inc., 296 Or 79 (1983), has no application in this case. Claimant could have been performing any activity at all during the time he was on call. He was being paid to be available, which is the nature of on-call employment; he was not being paid to play softball. This fact does not serve to bring claimant's softball activity within the orbit of his employment. The fact that claimant wore a beeper while playing softball is reminiscent of the security patrolman in Allen v. SAIF, 29 Or App 631 (1977), who sustained a fatal injury in a motor vehicle accident while driving on his way to perform a personal errand during an early lunch hour. The claimant in Allen was on call during his lunch hour/personal errand in the sense that he was required to carry his walkie-talkie with him and stay within radio range so that he could return for any emergency requiring his presence. With regard to the claimant's being on call and carrying the radio, the court had this to say:

> "The fact that the decedent was on call is not persuasive unless the workman is actually called or his activity is significantly restricted. * * *

> "The radio is significant as a tool of the decedent's on-call status. It is conceptually similar, though technologically more effective, to leaving one's phone number with one's employer or checking in periodically." 29 Or App at 634.

As in Allen, claimant's "encumbrance by the . . . impedimenta of his employment was coincidental rather than related to the demands of the job." 29 Or App at 635.

Concerning the direct benefit that an employer may derive from employes' recreational or social activities, the Richmond court had this to say about the benefit softball game which gave rise to that claimant's injury:

> "Claimant argues that the city was benefited by the game, because it helped contribute to a positive image of the police department within the community. While acknowledging that public relations may be improved by worthwhile charitable activities such as the one here, we do not find that the benefit to the city was sufficiently substantial or of such a direct nature to establish the necessary beneficial relationship between the recreational activity and the employment." 58 Or App at 358.

The evidence of benefit to the employer in this case consisted of claimant's testimony that softball games improved employe morale. This is clearly insufficient to establish a sufficient work connection between the softball activity and employment. Richmond v. SAIF, supra; 1A Larson, Workmen's Compensation Law, supra. The only other evidence in this regard consists of the testimony of one of claimant's co-workers, a Mr. Hess, who was employed by the hospital for seven-and-a-half years as an orderly, had played softball for the team for approximately five years and performed in the capacity of coach during that period of time. Mr. Hess testified:

> "* * * I believe the primary benefit the hospital would get would be the advertising from the shirts and the way the league is set up where the different sponsors are cross-referenced. I know, personally, from players who have taken advantage of the things offered by other teams. I assume the advertisement and publicity we give. (sic) Four hundred other people, at least, come in contact with our name."

The Referee apparently considered this persuasive evidence of a significant benefit to the employer beyond improvement in employe health and morale, namely, promotion of the hospital during the games. We believe, however, that Mr. Hess' testimony is insufficient to establish that, as a result of the public exposure the hospital received by having its name on the players' jerseys, it derived a substantial direct benefit of the nature required to

establish "the necessary beneficial relationship between the recreational activity and the employment." Mr. Hess' assumption concerning the possible advertisement and good publicity resulting from the employer's sponsorship of the team is very much like the potential improvement in the city's public image, as discussed in Richmond v. SAIF, supra.

There are indicia of work connection in this case. The facts that tend to establish work connection are that the team was regularly organized for the past five years in the county and, formerly, the city leagues; some equipment was supplied by the employer; the sponsorship fee was paid by the employer; the employes were allowed to leave early to play softball, subject to the time being made up at a later time; that the employer formerly provided transportation to more distant games when the team was part of the city league; and the apparent fact that the employer did not merely acquiesce in employe participation but encouraged it, at least to the extent of making new employes aware of the softball team in case they were interested in playing.

Countervailing considerations which mitigate against work-connection are that the employes clearly were not required to play softball, either by express statement of the employer or by implication; that the games and practices were never conducted on the employer's premises; that the employer derived no substantial direct benefit from the softball games beyond the value of improved employe health and morale; that playing softball had absolutely nothing to do with the services rendered by the hospital or any of its individual employes; and that a substantial portion of the team was composed of non-employes who, like the employe team members, were not required to reimburse the hospital for any portion of the sponsorship or entry fee that was paid by the hospital.

The fact that the employer previously accepted and paid benefits for "softball injuries" could have the effect of weighing in a claimant's favor if there was evidence of any established policy on the part of the employer that any and all injuries sustained while playing on the company team would be accepted and processed as compensable industrial injuries, and that this policy had been conveyed to the employes. The evidence in this case, however, establishes only that three other employes, including Mr. Hess, previously were injured while playing softball, and that these injuries were accepted as compensable by the employer at a time that its worker's compensation coverage was provided by another insurer. There is no evidence of the facts and circumstances surrounding these softball injuries, or that, as a result of the employer's prior actions in this regard, claimant expected that if he was injured playing softball, such an injury would be accepted as an industrial claim. Considering the fact that an employer/insurer may pay workers' compensation benefits without admitting liability for a claim, or may pay more compensation than is required by law, ORS 656.262(9); 656.018(4), the fact that the employer, through a prior industrial insurer, accepted and processed prior softball injuries does not serve to bring the softball activity within the course of claimant's employment.

When the issue is whether an injury arose out of and in the course of employment, the peculiar facts and circumstances of each case are controlling. Therefore, other, similar cases offer

little precedential value and are useful only for purposes of comparison. After considering all of the relevant factors in this case, we are unable to conclude that there are sufficient indicia of a work connection between claimant's softball activities and his employment to enable us to find his injury compensable.

ORDER

The Referee's order dated November 9, 1984 is reversed, and the insurer's denial dated May 18, 1984 is reinstated and affirmed.

MARVIN D. REYNOLDS, Claimant
Welch, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-04011 & 83-06927
July 24, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of those portions of Referee St. Martin's order that: (1) set aside a denial of the compensability of claimant's alleged left carpal tunnel syndrome; (2) awarded claimant 48° for 15% unscheduled permanent partial disability for the left shoulder; and (3) awarded claimant's attorney a fee of $1,750 for obtaining a reversal of the denial of the carpal tunnel syndrome condition.

On review, the insurer argues that there is insufficient evidence that claimant suffers from carpal tunnel syndrome in the first instance, and that even if he does, the condition is not related to his compensable shoulder injury. The insurer further argues that the Referee's award of unscheduled permanent partial disability was excessive. We review de novo and reverse that portion of the Referee's order that found claimant's alleged carpal tunnel syndrome compensable. We affirm the Referee's award of unscheduled permanent partial disability.

Claimant is a utility worker for the Port of Portland. He was injured on March 25, 1982 when he pulled hard on a fire hose and experienced left shoulder pain. He was initially treated for thoracoscapular muscle strain by an orthopedist, Dr. Duff, who became and remained claimant's treating physician. Claimant's symptoms consisted of left shoulder pain on abduction, decreased left grip strength and mild weakness of the first three fingers of the left hand. Initial EMG studies suggested a left brachial plexopathy. Dr. Duff and Dr. Rosenbaum, who examined claimant numerous times throughout the claim on behalf of the insurer, initially concluded that this plexus stretch injury was the cause of claimant's symptoms. Dr. Duff released claimant for a return to work on June 4, 1982.

Claimant was apparently symptom-free for approximately a year. He then experienced a sudden recurrence of shoulder pain and numbness of the left extremity. Claimant was again examined by Dr. Rosenbaum, who again attributed claimant's symptoms to the original plexus stretch injury.

It was not until August of 1983 that the possibility of carpal tunnel syndrome surfaced. This was nearly one and a half years after the original injury. Dr. Duff found claimant's symptoms and physical findings "confusing," but he suggested that claimant might now be exhibiting median nerve compression. Dr. Rosenbaum disagreed, noting that claimant did not have a clinical history typical of carpal tunnel syndrome.

Claimant was then examined by hand surgeon, Dr. Nye. Although Dr. Nye found claimant's median and ulnar nerves to be operating normally, he suggested that claimant might indeed be experiencing mild carpal tunnel syndrome. Claimant's symptoms improved, and on reexamination Dr. Rosenbaum again asserted that the existence of carpal tunnel syndrome was only a remote possibility. Dr. Rosenbaum continued to believe that the initial plexopathy was the cause of claimant's symptoms. Dr. Duff then altered his prior opinion regarding claimant's left hand symptoms by stating, "I do believe this man's present problem is a recurrence of his brachial plexus neuropathy . . . ." Dr. Duff found claimant to be medically stationary on November 7, 1983 and rated claimant's permanent impairment as mild due to persistent left shoulder pain and reduced use of the left arm.

In December of 1983 Dr. Long completed an electrodiagnostic study of claimant's nerve conduction responses and found that they were abnormal not only on the left side, but the right, as well. In fact, claimant's responses were more abnormal on the asymptomatic right side than on the left. After reading Dr. Long's report, Dr. Nye found it "worrisome" that claimant's asymptomatic right hand was more abnormal than the left. He further stated that the relationship between claimant's symptoms and his work was "difficult to assess." When Dr. Duff was asked whether he felt claimant's carpal tunnel syndrome, if any, was job related, he stated that it "could be."

On March 16, 1984 claimant was examined by yet another orthopedic surgeon, Dr. Soot. Claimant complained of continuously dropping things with his left hand. Dr. Soot was unable to develop a specific objective diagnosis. He stated:

> "The question of the carpal tunnels being a potential cause of the patient's symptomatology is . . . very suspect. Certainly there is no indication that his potential carpal tunnel syndromes may have been caused by his work exposure. I use the term potential carpal tunnel syndromes because I find no real objective evidence that a significant part of the patient's symptomatology is related to median nerve entrapment at the wrist. The clinical findings are too diffuse at this time and nonspecific to indicate that there is a significant median nerve entrapment. The studies of nerve conduction velocities also indicate a more marked sensory conduction latency on the right side than the left. In conclusion, I find no evidence of any significant nature to indication [sic] that the patient's symptoms are related to medial nerve compromise within the carpal tunnels and find even less indication that this may have been caused by his work."

After reading Dr. Soot's report, Dr. Duff specifically concurred with Dr. Soot's analysis on March 27, 1984. Based on these medical reports, the insurer denied the compensability of medical treatment for claimant's alleged carpal tunnel syndrome.

The Referee found that claimant indeed suffered from left carpal tunnel syndrome, and that it was work-related. In reaching his decision, the Referee relied on the opinions of Drs. Duff and Rosenbaum. We find this surprising, for while it is clear that the opinions of these physicians are the most persuasive, neither doctor concluded that claimant has left carpal tunnel syndrome. Dr. Rosenbaum repeatedly suggested that claimant does not have it, and Dr. Duff ultimately concurred with the opinion of Dr. Soot that it was unlikely that claimant has the condition. Drs. Long and Nye did find evidence of left carpal tunnel syndrome, but neither of them could explain why claimant's nerve conduction studies were more abnormal on the right, which was uninjured.

Even if we were to find that claimant has carpal tunnel syndrome, there is no persuasive evidence in this record that the condition is related to claimant's compensable injury.

ORDER

The Referee's order dated December 13, 1984 is reversed in part and affirmed in part. That portion of the order that held claimant's alleged left carpal tunnel syndrome compensable is reversed. That portion of the order that awarded claimant 15% (48°) unscheduled permanent partial disability is affirmed. For successfully defending the unscheduled disability award on Board review, claimant's attorney is entitled to an attorney's fee of $550, to be paid by the insurer.

REBECCA A. SCHARN, Claimant
Michael B. Dye, Claimant's Attorney
Brian R. Whitehead, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-06420
July 24, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Quillinan's order that approved the insurer's denial of claimant's aggravation claim for the low back, and denied claimant's request for penalties and attorney's fees for the insurer's alleged late payment of physical therapy billings. The issues on review are the compensability of claimant's aggravation claim and penalties and attorney's fees.

On the issue of penalties and fees, we affirm. We also affirm on the aggravation issue, with the following comment. In affirming the denial, the Referee found that claimant had experienced a symptomatic worsening at most. The Referee then held that under Wheeler v. Boise Cascade, 298 Or 452 (1985), a symptomatic worsening without a worsening of the underlying condition is not compensable. Wheeler, however, involved the purported worsening of a preexisting disease, and was not a case involving an alleged aggravation. By contrast, the present claim involves the purported aggravation of a compensable industrial injury. Wheeler, therefore, does not control.

In Billy Joe Jones, 36 Van Natta 1230 (1984), we held that a mere worsening of symptoms may or may not be sufficient to establish a compensable aggravation, depending on the facts of the case. The facts of the present case do not establish a compensable aggravation. Therefore, although we do not agree with the legal standard set forth by the Referee, we agree with the result.

ORDER

The Referee's order dated January 15, 1985 is affirmed.

DAVID C. SCOTT, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-08558
July 24, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Thye's order which: (1) set aside its denial of aggravation of claimant's neck and low back condition; (2) awarded interim compensation for the period September 17, 1983 through October 21, 1983; (3) awarded a sum equal to 25% of interim compensation payable for that period as a penalty, plus a $250 attorney fee; and (4) awarded a sum equal to 10% of the amount of compensation paid for the period August 17, 1983 through August 31, 1983 as a penalty for late payment, plus an additional $100 attorney fee.

The treating doctor authorized time loss only for the period August 8, 1983 through September 16, 1983. In order to receive interim compensation a subject worker must have left work as a result of the compensable condition. Bono v. SAIF, 298 Or 405, 410 (1984). After being released to work claimant was no longer entitled to interim compensation. Accordingly, we reverse the award of interim compensation for the period after September 16, 1983, and the awards of associated penalties and attorney fees.

The Board affirms and adopts the order of the Referee in all other respects.

ORDER

The Referee's order dated August 21, 1984 is affirmed in part and reversed in part. Those portions of the Referee's order awarding interim compensation for the period September 17, 1983 through October 21, 1983 together with a sum equal to 25% of that interim compensation as a penalty and a $250 attorney fee are reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

SUSAN WAGAMAN, Claimant
Minturn, et al., Claimant's Attorneys
John Snarskis, Defense Attorney
Rankin, et al., Defense Attorneys

WCB 84-01198
July 24, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of that portion of Referee T. Lavere Johnson's order which found that claimant was entitled to interim compensation while she was working. Claimant cross-requests review, contending the insurer should be assessed penalties and accompanying attorney fees for unreasonable conduct.

We reverse that portion of the Referee's order which awarded interim compensation between December 1, 1983 and January 11, 1984. Subsequent to the Referee's order the Supreme Court issued its opinion in Bono v. SAIF, 298 Or 405 (1984). The court held that in order to receive interim compensation a subject worker must have "left work" as that phrase is used in ORS 656.210(3).

In the present case, the employer had notice of the claim on December 1, 1983, but claimant did not leave work until January 11, 1984. On January 27, 1984 the insurer accepted the claim and paid temporary disability benefits retroactively from January 11. Pursuant to the Bono holding, since claimant had not left work until January 11, she was not entitled to interim compensation prior to that date.

Claimant argues that the insurer's 16-day delay in paying benefits represents unreasonable resistance to the payment of compensation. We do not agree that the insurer's conduct was unreasonable. The insurer had 14 days within which to pay the first installment of compensation. ORS 656.262(4). Therefore, the delay was approximately two days. Delay of a day or two is too inconsequential to justify any penalty. Zelda M. Bahler, 33 Van Natta 478, 479 (1981), reversed on other grounds, 60 Or App 90 (1982). Consequently, no penalty and accompanying attorney fees shall be assessed.

We affirm the remainder of the Referee's order.

ORDER

The Referee's orders dated August 27, 1984 and September 27, 1984 are reversed in part and affirmed in part. That portion which awarded interim compensation is reversed. The remainder of the orders are affirmed.

W. CRAIG WALKER, Claimant
Carney, et al., Claimant's Attorneys
Horne & Meserow, Defense Attorneys
Tooze, et al., Defense Attorneys

WCB 84-00767 & 84-03849
July 24, 1985
Order on Reconsideration

The attorney for the Hartford Insurance Companies has written to the Board requesting certain clarifications regarding the issuance of our Own Motion Order and Determination in WCB Case No. 84-0128M issued June 28, 1985. In his letter, Hartford's attorney also requests clarification of the Board's Order on Review in these cases, specifically our implicit approval of that portion of the Referee's order that required Hartford to bear the cost of Dr. Struckman's deposition. We construe Hartford's request as a request for reconsideration of our order.

Hartford contends that Wausau Insurance Company should bear the cost of Dr. Struckman's deposition, under the rule of Michael N. McGarry, 34 Van Natta 1520 (1982). McGarry was decided in accordance with Hanna v. McGrew Bros. Sawmill, 44 Or App 189, 195, aff'd as modified, 45 Or App 757 (1980). Hanna states that a medical witness "remains the witness of the party offering the medical reports and that party is responsible for paying the fees and expenses incident to his appearance as a witness for cross-examination." In this case, Dr. Struckman was claimant's treating physician and his reports were offered into evidence by claimant. Under a strict application of the Hanna/McGrew rule, claimant would be responsible for the costs of the deposition. However, OAR 438-07-005(5) shifts the burden of that cost in the case of a claimant's doctor to the insurer or employer demanding the right to cross-examine, in this case Hartford. Whether or not Dr. Struckman's opinions were helpful to Wausau's position, Dr. Struckman was not Wausua's witness nor were his reports offered into evidence by Wausau.

The request for reconsideration is granted. On reconsideration, the Board adheres to and republishes its Order on Review dated June 28, 1985.

IT IS SO ORDERED.

JOHNNY B. WILLIAMS, Claimant
Don G. Swink, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 83-04134
July 24, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Pferdner's order which upheld the self insured employer's denial of compensability of his pararectal abscess and fistula. As a preliminary matter, claimant contends that the Referee erred in allowing the record to be held open to permit the post-hearing deposition of claimant's doctor.

Claimant alleges that the insurer failed to file its documents and index with the Referee at least 20 days before the hearing as required by OAR 438-07-005(3)(a). He also points out that the insurer did not subpoena claimant's doctor for cross-examination, as provided for by OAR 438-07-005(5). He contends that by allowing the record to remain open for the deposition of claimant's doctor, the Referee rewarded the employer for its alleged failure to comply with the rules of the Board.

We do not find claimant's contentions well founded. The Referee was obligated to conduct the hearing in a manner that would achieve substantial justice. See ORS 656.283(6). This included the responsibility to see that the parties were allowed the opportunity to completely and sufficiently develop the record. See ORS 656.295(5). Because we find that the Referee's actions were consistent with a reasonable effort to achieve substantial justice and not expressly prohibited by the Board's rules, we uphold his decision to accommodate the post-hearing deposition.

On the merits, considering all the evidence, including claimant's doctor's deposition and the reports of Drs. Wilson and Garnjobst, we find that the evidence does not preponderate in favor of compensability. Accordingly, we affirm.

ORDER

The Referee's order dated August 28, 1984 is affirmed.

CLIFFORD A. BETTIN, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 84-03445
July 26, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of Referee Daron's order which awarded claimant compensation for permanent total disability. Claimant previously has received awards for permanent partial disability totaling 208° for 65% unscheduled disability. The issue is whether, as a result of his seriously disabling industrial injury, claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a).

On our de novo review, we find and hold that claimant is not permanently and totally disabled. The record rather convincingly establishes that claimant's inability to obtain employment performing a "suitable occupation" is attributable, in significant part, to the poor economic conditions presently prevailing in the greater Coos Bay area. We also find that although claimant is not permanently and totally disabled as a result of his industrial injury, he is entitled to an additional unscheduled award for what we find to be a moderately severe low back injury.

Claimant went to work for Weyerhaeuser, the employer herein, in 1972. He initially worked in the mill and then worked on a road building crew in the woods, performing work such as drilling holes for dynamite charges. Thereafter he became a log truck driver, which was his job at the time he was injured. He sustained this injury in June 1976 when his log truck rolled over, and he was thrown against a metal tool box mounted where a passenger seat ordinarily would be. The ensuing medical treatment for his back injury was protracted, with results which generally would be considered less than satisfactory.

After a laminectomy and discectomy in early 1978, claimant returned to work as a log truck driver. He continued to suffer chronic pain and stiffness. His claim was closed initially with an award for 32° (10%) unscheduled disability. Claimant subsequently suffered a worsening of his low back condition, and his claim was reopened in late December of 1979. Claimant has not returned to work since.

In June of 1980 claimant's lumbar spine was fused at the L4-5 level, but a pseudorathrosis resulted, which necessitated further surgery the following year. Additional fusion surgery at the L4-5 level was performed in October of 1982. The pseudoarthrosis continued, as did claimant's chronic pain. Claimant's treating orthopedic surgeon, Dr. Berselli, recommended against any further surgical intervention, which he doubted would be curative.

In September of 1983 claimant was evaluated by Dr. Achterman, an orthopedic surgeon, who stated that claimant's condition was probably medically stationary. Dr. Achterman stated, "He is probably totally disabled as far as any form of manual labor is concerned, as a result of his back."

In October of 1983 the employer referred claimant for vocational assistance, at which time Mr. Wolf became claimant's vocational counselor. In response to Mr. Wolf's inquiry, Dr.

Berselli reported in December 1983 that claimant was precluded from engaging in any repetitious bending, stooping, twisting, squatting or heavy lifting of any nature. In addition, claimant was not to lift any weight in excess of 40 pounds.

On December 27, 1983 Mr. Wolf reported to the employer that in view of claimant's age, education and work history, it did not appear as though any type of formal retraining would be necessary or appropriate in order to provide for claimant's reentry into the labor market. He also stated that claimant possessed skills and abilities that were transferable to light work. Job search efforts were commenced as part of claimant's direct employment plan (DEP).

In January of 1984 Dr. Achterman submitted a belated report to the employer, based upon his September 1983 exam. In this letter, he stated:

> "As I indicated in the report, I feel that this patient is essentially totally disabled at the present time. I do however, feel that this could be salvaged to a certain extent by Pain Center treatment, and subsequent retraining into some type of a sedentary occupation. The sedentary occupation would have to be one which allowed the patient some flexibility as to position, so that when he becomes uncomfortable, he can switch from a sitting to a standing position and vice versa."

Mr. Wolf's reports to the employer during January and February of 1984 reflect that those months were difficult for claimant in terms of his ability to cope with his chronic low back pain. Claimant was having difficulty ambulating and was spending considerable portions of the day reclining in bed or on a couch. In a February 16, 1984 closing report, Mr. Wolf stated:

> "Because of his current alleged inability to even seek work, and the possibility of an impending referral to a pain center I am closing his case for vocational assistance until such time as the medical problems are resolved and the client is pronounced able and available for DEP job search."

Claimant was rehospitalized in late February of 1984 for a diagnostic myelogram. No new pathological developments were demonstrated.

A March 2, 1984 Determination Order reclosed the claim with an award for temporary total disability from December 21, 1979 through September 15, 1983, less time worked. In addition, claimant was awarded 176° (55%) unscheduled disability, for a total unscheduled disability award of 208° (65%).

Claimant was evaluated at the Northwest Pain Center on March 22, 1984, on referrral from his attending physician. The initial impression stated by Dr. Cramer was that claimant was demonstrating "a good deal of pain behavior." Dr. Cramer also commented that, "It would certainly seem that some definite

vocational direction would be a crucial issue." A psychological evaluation disclosed that claimant had indicated he was not particularly interested in Pain Center treatment at that time, "as he feels he is coping relatively well with his pain problem." The psychological evaluation concluded:

> "This man has no concrete plans with regard to work return and consequently, his financial security appears to rest on maintaining his disability status. His motivation for vocational rehabilitation and for return to work appears to be rather questionable."

The final conclusions of the pain center staff were stated in a multidisciplinary summary signed by Drs. Seres, Cramer, Wicher-Edwards and Newman. Their conclusions, in essence, were that although claimant was capable of performing a sedentary job, he had very little idea regarding exactly what he could do. The physicians felt that claimant probably was capable of more than a sedentary job if he possessed the motivation to improve his present situation. They suggested that he consider admission to the pain center as a future possibility once he found a type of work in which he would like to be involved. They felt that in claimant's case, admission to the pain center would be predicated upon a vocational plan that would be in place immediately following discharge.

The prognosis was stated as guarded because of claimant's "lack of interest in change." The pain center physicians believed that claimant would continue to use his physical complaints as a means of trying to establish financial security, which was felt to be "too bad because he is an honest man who has worked hard in his life and sees little options open to himself."

Sometime in April of 1984, claimant bid on a job with Weyerhaeuser as a warehouseman/order filler. This apparently reactivated claimant's vocational assistance file, and Mr. Wolf once again became involved with claimant in order to ascertain whether he would be capable of performing the warehouseman job. Mr. Wolf conducted a job analysis and reported his findings to Dr. Berselli. Dr. Berselli then informed the employer that claimant would not be capable of performing the demands of that job, since it involved lifting excessively heavy weights.

In a work restriction evaluation completed by Dr. Berselli in May of 1984, he reported that claimant was capable of intermittent standing/walking and sitting, but incapable of performing any lifting, bending, squatting, climbing, kneeling or twisting. In addition, he indicated that claimant would be capable of standing/walking one to three hours a day and sitting three to five hours a day. Lifting restriction was 10 to 20 pounds. No hand restrictions were noted; pushing and pulling were noted as being "okay," as were simple grasping and fine manipulation. Claimant was noted to be capable of working an eight hour day, and he was medically released to return to work as of July 1, 1984.

In a June 5, 1984 report to claimant's attorney, Dr. Berselli reiterated claimant's physical limitations and included the facts that claimant was not to climb ladders or drive heavy machinery which might subject his spine to frequent, repetitious bouncing and jarring motions.

At the hearing claimant testified to his belief that he was capable of performing the warehouseman job. He also felt he was capable of performing another job called "strap puller." As to this latter job, he had been informed by Weyerhaeuser that it no longer involved the same duties it once had, and the additional duties included physical demands beyond claimant's capabilities.

Claimant has a varied work history, including working in and managing auto service stations. He owned and operated a service station for eight years and was a service station attendant for six. He was a salesman for a car care products company, an ice cream company, Firestone Rubber Company and Uniroyal. As a result of this vocational background, Mr. Wolf believed that claimant would be able to obtain employment working in the parts department of a car dealership.

Claimant described his job contacts with a Chevrolet dealership and a Subaru dealership, which apparently included an inquiry concerning service work. Claimant was not hired. He applied for work at a school district, seeking any type of employment including driving a school bus. None of the job contacts made directly by claimant, or in his behalf by Mr. Wolf, resulted in employment.

Mr. Wolf described the nature of the job development efforts engaged in, the reasons for the lack of success, and the current plan to attempt an on the job training situation and job placement through that avenue. Mr. Wolf testified that claimant exhibited motivation to obtain employment and that his efforts to do so were diligent. In a nutshell, Mr. Wolf found that there simply were no job openings for a parts clerk -- a suitable occupation for claimant -- in the greater Coos Bay area. A possibility of an opening did appear with one car dealership; however, their position included doubling as a car jockey, which would include pushing dead cars in and out of the building. This latter function would be beyond claimant's physical abilities without doubt. In addition, Mr. Wolf found that a considerable number of parts clerk positions involved lifting 50 or more pounds on an occasional basis; however, several employers indicated that with a person they were interested in hiring, they would modify the job either by the use of hoists or by having another person perform the heavy lifting. However, not a single job opening of this nature, either modified or unmodified, was found. Although claimant had initially indicated to Mr. Wolf that he did not wish to relocate his residence in order to obtain gainful employment, after vocational assistance was resumed in April of 1984, claimant apparently stated that he would move if it became necessary.

Mr. Wolf testified that he had not been able to locate any job opportunities outside of the Coos Bay area. This would appear to be attributable not to the lack of suitable employment opportunities outside of the Coos Bay area but to the fact that Mr. Wolf's recent efforts in providing vocational assistance to claimant had been in the direction of on the job training, which necessitated appropriate vocational testing. Mr. Wolf testified that no on the job training situation had been located in the Coos Bay area.

On cross examination Mr. Wolf testified that the labor market in Coos County was "very poor," and that it was getting worse week by week.

Claimant is not permanently and totally disabled from a medical standpoint alone. His attending orthopedic physician believes that he is capable of working an eight hour day, subject to the limitations noted. Although Dr. Achterman, who examined claimant on one occasion, reported that claimant was "essentially totally disabled at the present time," reading his statement in context with his complete report of findings and conclusions indicates he is of the opinion that claimant is completely incapacitated from performing manual labor. This is consistent with the limitations stated by Dr. Berselli and the physicians at the Northwest Pain Center.

Nor do we find claimant permanently and totally disabled when considering his physical impairment in conjunction with relevant social/vocational factors. There is no doubt that claimant is significantly disabled as a result of his low back injury and ensuing back surgeries. It is equally apparent, however, that claimant is physically capable of regularly performing work in the sedentary to light category, and that he presently possesses the training and skills to perform such work, if it were available. Claimant has satisfied his burden of proving that he is willing to seek regular, gainful employment, and that he has made reasonable efforts to obtain such employment. ORS 656.206(3). Claimant has evidenced sufficient motivation to be gainfully employed; however, the fact that he is not yet employed does not translate into a finding of permanent total disability under the facts and circumstances of this case. The evidence of poor economic conditions in claimant's geographical area, which are largely accountable for his inability to obtain gainful, suitable employment, is reminiscent of the situation presented in Wesley Stiennon, 35 Van Natta 365, aff'd mem., 65 Or App 567 (1983), in which we stated:

> "Although the present economic turndown in the State of Oregon, and particularly in the locale in which claimant resides, makes it difficult for claimant to obtain employment, we are required to evaluate his assertion that he is permanently and totally disabled in the context of his ability to obtain and hold gainful employment in a hypothetically normal labor market, Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977), which is not necessarily limited to one finite geographical area, Raymond Orsborn, 34 Van Natta 574 (1982)." 35 Van Natta at 366.

As in Stiennon, we remain unconvinced that, as a consequence of his compensable injury, claimant has been rendered unable to sell his services on a regular basis in a hypothetically normal labor market.

Although claimant has failed to establish entitlement to an award for permanent total disability, we find he is entitled to an additional unscheduled award. Claimant was 49 years of age at the time of hearing. He has a tenth grade education. Although he was capable of performing heavy work prior to this injury, and he is now relegated to work in the sedentary to light category, his previous experience of working in and owning auto service stations, and his background in sales work, provide him with

specific transferable skills which lend themselves to employment in occupations suitable to his physical limitations, such as various counter sales and clerking jobs. Considering these social/vocational factors in conjunction with claimant's physical impairment, which is in the moderately severe category according to our review of the record, we find that claimant has suffered a loss of earning capacity equivalent to 256° (80%) unscheduled disability as a result of his low back injury. We modify the Determination Order accordingly.

ORDER

The Referee's order dated August 20, 1984 is reversed. In addition to the 176° (55%) unscheduled disability awarded by the Determination Order dated March 2, 1984, claimant is awarded 48° (15%) unscheduled disability, for a total award to date of 256° (80%) unscheduled disability for injury to the low back. In lieu of the attorney fee allowed by the Referee's order, claimant's attorney is allowed 25% of the additional compensation ordered herein, payable out of and not in addition to claimant's compensation.

STEVEN G. BOYER, Claimant
Ringle & Herndon, Claimant's Attorneys
Rankin, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-05820 & 84-04491
July 26, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Neal's order which declined to award him attorney fees because he took no position at the hearing concerning which of two employers/insurers was responsible for his low back condition. Argonaut Insurance Companies cross-requests review of that portion of the Referee's order which set aside its denial of claimant's "aggravation" claim and upheld Comstock Insurance Company's denial of claimant's "new injury" claim.

The Board affirms the order of the Referee with the following comment concerning the responsibility issue.

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, 244 (1984). If the evidence shows that a disability is caused solely by an injury occurring during an earlier employment, there is no reason to apply the last injurious exposure rule. Starbuck, supra., 296 Or at 243; CECO Corp. v. Bailey, 71 Or App 782, 786 (1985).

Following our de novo review of the medical and lay evidence, we are persuaded that claimant's current disability was caused solely by his November 1982 injury, for which Argonaut is responsible. Consequently, we need not apply the last injurious exposure rule. However, had we employed the rule our decision would not change since we are persuaded that claimant's activities in December 1983, while employed by Comstock's insured, did not contribute to his disability.

In a responsibility case claimant is entitled to attorney fees if the attorney actively and meaningfully participated. OAR 438-47-090(1). Active and meaningful participation has been

interpreted to mean that claimant advocated a position adverse to one of the employers/insurers and has prevailed. Erwin L. Bacon, 37 Van Natta 205, 208 (1985); Robert Heilman, 34 Van Natta 1487 (1982). Inasmuch as claimant did not advocate a position adverse to one of the employers/insurers he is not entitled to an attorney fee.

ORDER

The Referee's order dated November 16, 1984 is affirmed.

LEWIS J. COX, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Horne & Meserow, Defense Attorneys

WCB 84-03081 & 84-01790
July 26, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Wausau Insurance Company requests review of Referee Brown's order which set aside its denial of responsibility for claimant's medical services claim and upheld the SAIF Corporation's denial of responsibility for the aforementioned services. On review, the issues are compensability and responsibility.

The Board affirms the order of the Referee with the following comment. Wausau contends that SAIF's 1984 denial was improper because SAIF failed to close claimant's 1978 nondisabling back injury claim. We have recently held that the employer/insurer is under no obligation to formally close a nondisabling claim, regardless of whether the claim has been misclassified as nondisabling, provided no request for reclassification is made within one year from the date of injury. Garland Combs, 37 Van Natta 756 (1985). Accordingly, SAIF's denial was not improper.

ORDER

The Referee's order dated November 14, 1984 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by Wausau Insurance Company.

LUCILLE HOEFFT, Claimant
Black, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-03305 & 84-01626
July 26, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

EBI Companies requests review of those portions of Referee Mongrain's order which: (1) set aside its denial of responsibility for aggravation; (2) upheld Fireman's Fund's denial of responsibility for new injury for claimant's right shoulder condition; and (3) awarded claimant's attorney a fee of $800 for services before and at hearing. EBI argued that the amount of the fee was excessive and that the fee should be apportioned between the insurers according to the effort claimant's attorney expended. Claimant took no position on the issue of responsibility but did defend the amount of the attorney's fee and requested a fee for services on Board review. The issues on review are responsibility for claimant's condition and the amount and responsibility for claimant's attorney's fee.

The Board affirms and adopts the order of the Referee.

There is no authority for awarding a fee against an insurer against which claimant did not prevail, therefore, no apportionment of the fee between the two insurers can be made on the basis of claimant's attorney's efforts. See Ray A. Stern, 36 Van Natta 1328 (1984); David Petshow, 36 Van Natta 1323 (1984) (Order on Remand).

Claimant requests an attorney's fee on Board review for defending the attorney's fee at hearing. Because claimant's attorney's participation before the Board was limited to defending the amount of attorney fees awarded at hearing, no attorney fee will be awarded to claimant for services on Board review. Harold L. Dotson, 37 Van Natta 759 (1985).

ORDER

The Referee's order dated October 16, 1984 is affirmed.

EARL A. HUNTER, Claimant
Roll, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-05876
July 26, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Pferdner's order which awarded claimant 112° for 35% unscheduled permanent partial disability due to a low back injury in addition to the previous award of 48° for 15% unscheduled disability and which denied its claim for a $609.20 overpayment of time loss compensation. The issues on review are extent of unscheduled permanent partial disability and overpayment of time loss compensation.

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

On the issue of extent of disability we reverse. Claimant has found employment at three places since completing retraining.

We have considered the medical evidence and the lay testimony along with the guidelines in OAR 436-65-600 et seq. We find that claimant has been appropriately compensated for his unscheduled permanent partial disability by the previous award for 15% disability. We gave no consideration to the prior award for low back disability by the State of Alaska. American Bldg. Maint. v. McLees, 296 Or 772 (1984).

On the issue of the overpayment of time loss compensation between the time claimant finished his vocational rehabilitation program and the issuance of the Determination Order, we conclude that the SAIF Corporation has failed to show persuasive evidence that it has made any overpayment.

ORDER

The Referee's order dated October 9, 1984 is reversed in part and affirmed in part. That part of the order which awarded 112° for 35% additional unscheduled permanent partial disability is reversed. The remainder of the order is affirmed.

DARLA LUTZ, Claimant
Frederick L. Bennett, Jr., Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-05520
July 26, 1985
Order Deferring Motion to Strike Brief

Claimant has moved the Board for an order striking the employer/respondent/cross-appellant's brief on review on the ground that it was not timely filed. The motion will be deferred until the time of Board review and will be considered at that time.

IT IS SO ORDERED.

CLINTON L. MADDOCK, Claimant
Kenneth D. Peterson, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 81-07219
July 26, 1985
Order Denying Motion to Withdraw and Reconsider

Claimant has moved the Board for an order withdrawing its Order on Review dated February 25, 1985 and for reconsideration of the merits of the case. A petition for judicial review by the Court of Appeals is pending. Claimant maintains that we have the authority to withdraw our order at this time by virtue of the Administrative Procedures Act, specifically ORS 183.482(6), which provides:

> "At any time subsequent to the filing of the petition for [judicial] review and prior to the date set for hearing the agency may withdraw its order for purposes of reconsideration. If an agency withdraws an order for purposes of reconsideration, it shall, within such time as the court may allow, affirm, modify or reverse its order. If the petitioner is dissatisfied with the agency action after withdrawal for purposes of reconsideration, he [sic] may file an amended petition for review and the review shall proceed upon the revised order."

ORS 183.482 establishes the jurisdiction, procedure and scope of the court's authority to review orders of administrative agencies in contested cases. The right to judicial review of agency orders arises out of ORS 183.480, which states that "Judicial review of final orders of agencies shall be solely as provided by ORS 183.482, 183,484, 183.490 and 183.500." By virtue of ORS 183.315(1), ORS 183.480 does not apply to this agency. Neither do the procedures mandated by that statute apply to this agency. The jurisdiction, procedure and scope of the court's authority to review the orders of this Board are established by ORS 656.298. There is no counterpart to the "withdraw and reconsider" provision of ORS 183.482(6) in ORS 656.298. We conclude that, because there is no counterpart in the Workers' Compensation Act to ORS 183.482(6), the legislature did not intend that this Board be authorized to withdraw and reconsider its orders after the earlier of the filing of a petition for judicial review or the expiration of thirty days from the mailing date of an order. ORS 656.295(8); 656.298(1). See also ORS 656.704(1).

We are aware that this Board has previously referred to ORS 183.482(6) in connection with its authority to withdraw and

reconsider its orders. See Lewis Twist, 34 Van Natta 290, 293, (1982), aff'd, Tektronix Corp. v. Twist, 62 Or App 602, 604-05, rev den, 295 Or 259 (1983). We believe that Twist reached the correct result based on the facts of that case. In Twist the claimant objected in the Court of Appeals to the Board having abated and reconsidered its Order on Review, arguing that the court was without jurisdiction to consider our order because the petition for judicial review was filed more than thirty days after the date of our first order. We said, "If we can reconsider an order even after an appeal to the Court of Appeals, it is even more obvious that we can reconsider an order before an appeal to the Court of Appeals is filed." We conclude that the quoted language was unfortunate. In Twist, we abated our original order less than thirty days after it was mailed and before judicial review had been initiated. Twist did not involve the procedure described in ORS 183.482(6) at all. In Twist, our order was not final, ORS 656.295(8), when we withdrew it, nor had any party invoked the jurisdiction of the Court of Appeals. Our authority to do as we did was, in fact, based upon ORS 656.295(6) and (8).

Claimant's motion is denied.

IT IS SO ORDERED.

MARGIE B. McCASLAND, Claimant
Pozzi, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 83-01954
July 26, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of that portion of Referee Daron's order which upheld the insurer's denial of compensability of medical services performed in 1983 because they were not related to her 1971 back injury by a preponderance of the evidence. The insurer cross-requests review of those portions of the order which found medical services performed in 1981 were compensably related to the 1971 injury and 1972 surgery and which awarded an attorney fee for overturning its denial. The issues on review are compensability of 1981 and 1983 medical services and attorney fees for overturning a denial.

The Board affirms and adopts the order of the Referee.

The Referee awarded a fee to claimant's attorney for overturning the insurer's denial of compensability of the 1981 medical services. The insurer argues that claimant's attorney is not entitled to a fee because claimant obtained no compensation as a result of the attorney's representation. ORS 656.386 provides for payment by the insurer of a reasonable attorney fee to claimant's attorney for overturning a denial and does not tie the award to any compensation to claimant, therefore, the Referee's award of attorney's fees was correct. Claimant's attorney is entitled to an insurer paid fee for defending the finding of compensability on Board review. OAR 438-47-055.

ORDER

The Referee's order dated August 31, 1984 is affirmed. Claimant's attorney is awarded a fee of $250 for services on Board review, to be paid by the insurer.

RAYMOND C. NORGAARD, Claimant
Pozzi, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 83-09014
July 26, 1985
Republished Order on Review

We issued our Order on Review on March 18, 1985 in which we affirmed Referee Shebley's order dated July 9, 1984. At the request of the self-insured employer, we withdrew our Order on Review prior to its having become final. We did so in order to permit the parties to complete further litigation relating to this claim. We have now been informed that the other litigation has been completed.

Now, therefore, we hereby republish our Order on Review dated March 18, 1985 effective this date.

IT IS SO ORDERED.

BETTY L. OYLER, Claimant
John C. O'Brien, Jr., Claimant's Attorney
Beers, Zimmerman & Rice, Defense Attorneys
Bottini & Bottini, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-09858, 83-09859 & 83-09860
July 26, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

EBI Companies requests review of Referee Menashe's order which: (1) set aside its denial of claimant's "new injury" claim for a left arm and shoulder condition; and (2) upheld the SAIF Corporation and Mission Insurance Company's denials of claimant's "aggravation" claims. On review, the sole issue is responsibility.

Following our de novo review of the lay and medical evidence, we conclude that claimant's 1982 work exposure, while EBI was on the risk, independently contributed to claimant's condition. Furthermore, we are not persuaded that claimant's disability is solely attributable to an earlier employment incident or a cause unrelated to his employment. Accordingly, we affirm and adopt the Referee's order which found that EBI was the responsible party.

ORDER

The Referee's order dated December 14, 1984 is affirmed.

NORMAN D. WALKER, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-04028
July 26, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of Referee Pferdner's order which awarded 224° for 70% unscheduled permanent partial disability in lieu of a Determination Order award of 80° for 25% unscheduled permanent partial disability for claimant's low back condition. The insurer requests remand for further development of the record or, in the alternative, reversal of the Referee's award of additional permanent disability compensation.

Neither the employer nor its insurer appeared or were represented at hearing. The record indicates, however, that all the appropriate notices were sent. At the outset of the hearing, claimant's attorney made an unsworn representation that he had

telephoned the insurer that morning and that a claims representative indicated that there was a hearing set for that day and she thought their attorneys had been notified.

OAR 438-06-070 in relevant part provides:

> "Failure of a party to appear at a hearing without good cause constitutes a waiver of appearance."

On review the insurer contends that through no fault of claimant and despite apparently sufficient notice, it was "unable" to appear at the hearing. It does not explain why it was "unable" to appear or assert that it has evidence showing good cause for its nonappearance. Indeed, it makes no specific mention of any evidence to be introduced on remand. It states in general terms that it was afforded no cross-examination, no opportunity to object to testimony or evidence and no opportunity to present argument to the Referee.

Where we determine that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee, we have discretion to remand for further evidence taking. ORS 656.295(5). On de novo review of the record we find that the insurer was properly notified of the hearing and had a reasonable opportunity to appear and be heard. We find the Referee's decision to hear the case in the insurer's absence to have been totally proper. We find nothing to suggest that the case was improperly, incompletely or insufficiently developed or heard.

Considering the merits, claimant is a 61 year old high school graduate who was employed as a furniture and appliance delivery person. He injured his back lifting a queen size mattress on October 27, 1983. Dr. Howell, an osteopath, provided conservative treatment.

Dr. Howell reported in his January 20, 1984 closing evaluation that claimant indicated that he experienced low back pain whenever lifting 25 pounds or more. Standing in one place for ten minutes was also reported to accentuate the pain. Dr. Howell reported 80° of thoracolumbar flexion, lateral flexion reduced by approximately 33% and rotation reduced by about half. Tenderness and abnormal muscle spasm was still evident at L2-3. Dr. Howell stated his impression as follows:

> "1. Somatic dysfunction, lumbar, apparently the result of the 10/27/83 incident, unresolved in response to intensive conservative therapy. Some permanent partial disability anticipated and the patient will be unable to lift on a regular basis more than 25 pounds, and may experience ongoing pain.
>
> "2. Pre-existing osteoarthritis of the lumbar spine, asymptomatic prior to the event of 10/27/83. Symptoms now primarily in the area of arthritic change. The presence of the pre-existing arthritic condition is considered to have resulted in

a substantially greater resultant disability than the patient would have incurred had this condition not been present."

Dr. Howell characterized claimant's permanent disability as mild to moderate, attributable to reduced lumbar range of motion and the requirement that he adapt to less strenuous physical activity.

Claimant testified that he could not return to his old job, but that he felt he could work as a dispatcher, making use of his delivery experience. He testified of constant pain three inches above his belt, sometimes getting so bad as to make him sick to his stomach. He stated that he can lift 25 pounds at most, but does not attempt to do so often. Too much lifting puts him in bed the next day. Long standing or sitting causes pain. Changing positions provides relief. After walking three or four blocks he experiences difficulty. With difficulty he is able to climb three stories of stairs. Claimant closed his second-hand appliance and furniture business in January 1984 because he was unable to make his own pick-ups and deliveries.

Considering claimant's physical impairment and the pertinent social/vocational considerations, see OAR 436-65-600 et seq., we find that an award of 128° for 40% unscheduled permanent partial disability will most appropriately compensate claimant for his permanent loss of earning capacity due to the compensable injuries.

ORDER

The Referee's order dated November 20, 1984 is modified. Claimant is awarded 128° for 40% unscheduled permanent partial disability for his low back condition in lieu of all prior awards on this claim. Claimant's attorney's fee is adjusted accordingly.

EDWARD J. ALFORD, Claimant
Myrick, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
Brian Pocock, Defense Attorney

WCB 84-02162 & 84-02163
July 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Aetna Technical requests review of Referee Brown's order that set aside its denial of claimant's aggravation claim and approved Crawford and Company's new injury denial. The issue on review is responsibility.

While we agree with the result reached by the Referee, we find that he applied the wrong legal standard in reaching it. We, therefore, set forth the following essential facts and apply the appropriate standard of Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984), in affirming the Referee's order.

Claimant was compensably injured on December 6, 1979 while Aetna was on the risk. The initial diagnosis was probable disc herniation. Claimant's symptoms gradually resolved, although he continued to experience periodic flare-ups in 1980 and throughout 1983, when Crawford, the second insurer, was on the risk.

Sometime in 1981 claimant's job duties changed from the fairly rigorous telephone lineman work he had been doing to lighter equipment repair work. He continued in this lighter capacity through late 1983, when he noticed that the frequency and

severity of his symptoms were increasing. He returned to Dr. Strukel, the orthopedist who had treated claimant following the 1979 injury. Dr. Strukel performed a myelogram which revealed a large L4-5 disc herniation. Surgery was performed the next day for removal of the disc, along with a laminectomy and foraminotomy. Claimant submitted the billings for the surgery first to Crawford, which denied responsibility, and then to Aetna, which also denied.

The most significant medical evidence is a deposition of Dr. Strukel. It was his opinion that claimant's 1979 injury precipitated the disc herniation, and that while claimant's later employment could have contributed to further disc herniation, it probably did not. In fact, Dr. Strukel opined that the 1979 injury was the sole cause of the ultimate need for surgery.

In finding Aetna responsible, the Referee stated:

> "With regard to responsibility, in the case of successive insurers, the 'could have' test establishes both compensability and responsibility. The burden is on the second employer to show the first exposure was either the sole cause or that it was impossible for the second exposure to have caused an independent worsening of the underlying condition."

The Referee cited FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), in support of his holding, and found that the second insurer had indeed met its burden of proving that the first employment was the sole cause of claimant's need for surgery.

FMC v. Liberty Mutual Ins. Co., supra, is a responsibility case involving an occupational disease. In such a case, the "could have" test is the appropriate standard. Cf. Bracke v. Baza'r, 293 Or 239 (1982). The present claim, however, involves successive injuries for which the standard set forth in Boise Cascade v. Starbuck, 296 Or 238 (1984) is to be used. Under that standard, the first employer remains liable for a claimant's condition where the first employment contributes to a disability occurring during the later employment, but the later employment does not, in fact, contribute to claimant's ultimate disability. That is the situation presented by the present claim. Aetna remains the responsible insurer.

ORDER

The Referee's order dated December 13, 1984 is affirmed.

LYNWOOD G. BRYAN, Claimant
Evohl F. Malagon, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-07306
July 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of Referee Foster's order that granted claimant 128° for 40% unscheduled permanent partial disability in lieu of the 96° for 30% awarded by prior Determination Orders and a May 1981 Stipulated Settlement. On review, the self-insured employer asserts that the Referee's award was excessive. We agree and, therefore, modify the Referee's order.

Claimant was compensably injured on October 12, 1978 when he fell off of an incline while working on the green chain. Claimant landed on his back, and the fall resulted in an unstable lumbar spine condition. After conservative treatment, claimant returned to the green chain but found the work too strenuous. He was assigned to lighter duty in which he essentially performed the same work, but with lighter and drier wood products. He performed this lighter work successfully. Unfortunately, economic conditions forced termination of the light work, and claimant was once again assigned to the green chain. He could not perform the heavier work and he resigned.

Claimant then obtained vocational assistance in the form of a two-year program in court reporting. He began training at a Eugene training site, but when it became apparent that this training would be insufficient to qualify claimant as a certified court reporter, he quit the school and entered a court reporting school in Portland. In the interim, claimant's two years of vocational assistance eligibility expired. He is presently continuing his training program at his own expense. Although he had not completed training at the time of the hearing, evidence was introduced suggesting that claimant is qualified to be employed as a transcriber or hearings reporter. At the time of the hearing, claimant was expected to complete his training program sometime in 1985.

The first Determination Order awarded claimant 10%. An additional 10% was granted by way of a May 1981 Stipulated Settlement. The claim was later reopened, and a July 2, 1984 Determination Order granted another 10%, bringing claimant's total award to 30% at the time of the hearing. Finding claimant's loss of earning capacity "difficult to determine" because of claimant's inadequate training, the Referee granted 40% in lieu of the prior awards. The Referee provided no further analysis of the reasons for the increased award.

After reviewing the record, we find that claimant was adequately compensated by the 30% unscheduled award arranged prior to the hearing. At the time of the hearing, claimant was 37 years of age. He had a high school education. His impairment was not substantial and he had had no surgeries. He had engaged in a number of light and medium jobs in the past, and he does not appear to be precluded by his current disability from doing them now. Although claimant had not completed court reporter school at the the time of the hearing, a vocational consultant reported that with claimant's current training, he is qualified to serve as a transcriber or a hearings reporter.

We find that even when the record is viewed in a way most favorable to claimant, an award of 30% is adequate. The Referee's award of 40% was excessive.

ORDER

The Referee's order dated December 28, 1984 is reversed.

MARK D. BRYANT, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-09276
July 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Mulder's order which affirmed: (1) a February 25, 1980 Determination Order that did not award scheduled permanent disability for loss of use of his hands/wrists; and (2) an April 8, 1983 Determination Order that did not award additional unscheduled permanent disability for a low back injury in excess of the 15% (48°) award he had received by virtue of a prior Referee's order. On review, the issues are extent of scheduled and unscheduled permanent disability.

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

Following our de novo review of the medical and lay evidence, we find that claimant has not established that: (1) he is entitled to an award of scheduled permanent disability; or (2) he is entitled to an award of unscheduled permanent disability in excess of that which he has previously received. In evaluating the extent of claimant's unscheduled permanent disability we did not consider claimant's inability to lose weight as an unreasonable failure to follow needed medical advice or to otherwise mitigate damages. See Nelson v. EBI, 296 Or 246, 252 (1984). Thus, claimant's obesity did not cause us to reduce the extent of his unscheduled permanent disability.

ORDER

The Referee's order dated December 13, 1984, as modified herein, is affirmed.

GARY C. CUNNINGHAM, Claimant
Allen & Vick, Claimant's Attorneys
Cheney & Kelley, Defense Attorneys
Beers & Zimmerman, Defense Attorneys

WCB 83-11140 & 84-01382
July 30, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

EBI Companies requests review of that portion of Referee Mike Johnson's order that awarded claimant's attorney a $900 insurer paid fee. EBI does not request review of that portion of the Referee's order that set aside it denial of a new injury to the back and approved Safeco Insurance Company's denial of claimant's low back aggravation claim, thereby holding EBI responsible for claimant's current low back condition.

Claimant's attorney was required to appear at the hearing because Safeco's denial precluded an order designating a paying agent pursuant to ORS 656.307. Safeco withdrew its contention as to the compensability of claimant's claim immediately prior to the hearing. Claimant's attorney took a position at the hearing that was consistent with the Referee's decision on employer/insurer responsibility. Because the Referee ordered EBI to accept a previously denied claim, claimant's attorney is entitled to a reasonable attorney fee not to exceed $3,000. OAR 438-47-020(1). The fee awarded by the Referee is not unreasonable. See Robert Heilman, 34 Van Natta 1487 (1982). There is no statutory or regulatory basis upon which to apportion the fee award between EBI and Safeco.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated June 14, 1984 is affirmed.

SALLY A. DAVIS, Claimant
Pozzi, et al., Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 84-06555
July 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Wilson's order which upheld the insurer's denial of aggravation of claimant's low back injury. The issue on review is whether claimant carried her burden of proof that the worsening of her condition was due to her industrial injury rather than to her non-compensable degenerative disc disease.

The Board affirms the order of the Referee with the following comment. Claimant did not need a medical opinion of worsening or of compensable causation to prevail on her claim. Garbutt v. SAIF, 297 Or 148 (1984). Claimant has had at least two conditions that cause pain in her back, of which only one is compensable. Claimant must prove that the current condition for which she desires medical treatment was caused by her industrial injury. See Poole v. SAIF, 69 Or App 503 (1984). The medical opinions offered do not ascribe the worsening of her condition to the industrial injury portion of her back problems. We find claimant's testimony in this case insufficiently persuasive to carry her burden of proof that she has suffered a worsening of her industrial injury as opposed to a worsening of her non-compensable degenerative disc disease. Therefore, we affirm the Referee's order.

ORDER

The Referee's order dated January 4, 1985 is affirmed.

LAWRENCE W. DIGBY (Deceased), Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-01667
July 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of Referee McCullough's order which set aside its denial of claimant's myocardial infarction at work as not arising out of his employment. The issue on review is compensability.

Claimant was working as a log truck driver when he suffered a myocardial infarction on the morning of October 24, 1983. At the time, he was 62 years old, stood 6'2", and weighed about 180 pounds. He had been a two to three pack per day cigarette smoker for about forty years. He had had untreated angina for about six years. Claimant's wife credibly testified that he had felt fine when he left the house to go to work. The symptoms began shortly after claimant finished wrapping his first log load of the day. Claimant drove his load down the mountain as his symptoms became increasing distressful. After an hour, he pulled his truck to the

side of the road and his boss picked him up and transported him to the employer's shop. Claimant's wife met the men there and transported claimant to a hospital. At the hospital, the myocardial infarction was diagnosed and an angiogram revealed that there had been a recent occlusion of the anterior descending coronary artery with a remaining 80-90% stenosis of the artery distal to the first diagonal or intermediate branch and proximal to the second diagonal. Claimant was discharged from hospital care on November 10, 1983, with final diagnoses of: "(1) large anteroseptal myocardial infarction with resultant left ventricular aneurysm; (2) recurrent chest discomfort post-myocardial infarction; and (3) coronary artery disease." Claimant died on December 4, 1983, without returning to work.

SAIF does not contest the finding of legal causation. It is undisputed that claimant's myocardial infarction happened while claimant was at work. The issue is whether claimant proved medical causation: whether it has been established that work activity materially contributed to the onset of claimant's myocardial infarction. Two doctors, a cardiologist and an internist, claimant's attending physician, expressed opinions by letter and deposition on the issue of medical causation.

Dr. Kelley, claimant's attending physician, first reported that, in his opinion, the cause of claimant's myocardial infarction was totally due to his history of cigarette smoking. He stated, "it is impossible to quantify any relationship of belated stress or physical activity etc. in the function of the heart attack." His deposition testimony eroded the certainty of that opinion, but did not necessarily reject it altogether:

> "Q: Okay. What kind of physical exertion would be necessary, in your opinion, to spark myocardial infarction such as [claimant] had?
>
> "A: I don't think that you can quantitate that because that depends on how severe the arteries are narrowed. With someone who has moderately severe narrowing it might take quite a bit of physical activity, with somebody with severe narrowing it might take minimal, or as you mentioned earlier, no physical activity. I think it's hard to quantitate that and the example is why didn't it happen the day before or the next day in [claimant's] case and that's what makes it hard to put a number on it.
>
> "Q: So would it be fair to say that you are not positive or even -- are you within a reasonable medical probability when you say you think this exertion sparked the myocardial infarction?
>
> "A: I think that it may have been a contributing factor.
>
> "Q: It may have been. Are you dealing in possibilities or probabilities?

"A: Maybe I don't understand the difference. I think that it's likely that physical activity was a contributing factor to his heart attack.

"Q: Okay. I guess that leads me back to my previous question. Maybe I can rephrase it and add in some of the facts you gave. With regard to a person who has a preexisting coronary artery disease, maybe with the little stenosis that [claimant] had, what kind of physical exertion, in your opinion, would be necessary for a myocardial infarction?

"A: The reason I have difficulty quantitating that is that with his degree of physical activity maybe that could have occurred -- or with his degree of coronary disease maybe that could have occurred at rest in another month, and it's hard for me to put a number on -- well, if he walked one block he wouldn't have had a heart attack, if he walked five blocks he would have, and I just don't know how to answer that honestly."

In contrast, Dr. Kloster reported by letter that he could "not exclude the possibility that [claimant's] work activity at that time may have contributed to the development of the myocardial infarction at that time rather than some time later." He based his opinion partly on an investigative report which characterized the work of chaining down a log load as "'a physically strenuous operation of moderate nature.'" In his deposition, Dr. Kloster expounded on the theories about myocardial infarctions and concluded:

"A: No, I don't think his physical activity was a contributing factor to his development of coronary atherosclerosis, and, in fact, regular physical activity is thought to be beneficial.

"As far as the myocardial infarction, no, I don't think that his physical activity that morning was a major contributing factor to his infarction.

"Q: I know you don't feel it was a major one, was it a material one?

"A: No.

"Q: Was it significant in any respect at all?

"A: I don't think it was a significant issue. I think the stage was set for a myocardial infarction with severe narrowing of the artery, and that that was the reason he had the infarction.

"Q: I believe you've already said that it

was at the point of being precipitated just by being at home during that day, as well as going to work.

"A: Yes. And why the vessel becomes occluded right at that point is conjectural, it can be due to smoking a cigarette, provoking spasm or sticking of platelets together, which obstructs the artery. I think it's more likely to be that than to be due to mild or modest physical exertion, because we understand the mechanisms with cigarette smoking, and we don't understand -- we don't know of any mechanisms that we can relate to physical exertion."

Considering the relative expertise of the two doctors and their familiarity with claimant and the exertion involved in wrapping his log load, we find that their opinions are not persuasive that claimant's work activities on the morning of October 24, 1983 were a material contributing cause of his myocardial infarction. Dr. Kelley's conclusion that he could not honestly quantify the contribution of the morning's exertions and that he had no way of proving that there was a contribution in conjunction with Dr. Kloster's explanation of the mechanism of infarction and his opinion that claimant's activity the day of the infarction was not sufficiently strenuous nor sufficiently prolonged to contribute made the evidence in this case insufficient to carry claimant's burden of proof that his work activity was a material contributing cause of his myocardial infarction. Coday v. Willamette Tug & Barge, 250 Or 39 (1968); cf. Rogers v. SAIF, 289 Or 633 (1980); Adams v. Gilbert Tow Service, 69 Or App 318 (1984); Batdorf v. SAIF, 54 Or App 496 (1981).

ORDER

The Referee's order dated November 26, 1984 is reversed and the denial by the SAIF Corporation is reinstated.

RICHARD L. HENLEY, Claimant
Barnes, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Ass't. Attorney General

WCB 84-05335
July 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of that portion of Referee Peterson's order that awarded claimant's attorney fees in the amount of $8,432 for services at hearing. On review, SAIF argues that the Referee's award was excessive. We agree and modify the Referee's award.

The sole issue before the Referee in this case was compensability. Claimant asserted that he was the subject worker of one of two non-complying employers at the time he was severely injured in January of 1984. His claims were processed through the Workers' Compensation Department, which referred them to SAIF for denials on behalf of both employers.

The Referee affirmed SAIF's denial as to one of the employers but overturned the other. Therefore, as a result of the efforts

of his attorney, claimant was found to be entitled to medical services and other compensation which, at the time of the hearing, had reached a value of approximately $250,000. In his Opinion and Order, the Referee awarded claimant's attorney a fee in the amount of $3,000 for services at hearing.

Approximately three weeks after the order was issued, claimant's counsel filed an Application for Attorney's Fees for Extraordinary Services, along with a supporting affidavit. The Referee then issued an order suspending the previous order so as to allow opposing counsel an opportunity to respond to the application. Claimant's counsel's affidavit established that 81.7 hours had been expended in the preparation of claimant's case. In addition, counsel claimed 2.6 hours of staff time and two-to-three hours of time expended by a second attorney. At $100 per hour, counsel claimed fees in the amount of $8,432.00.

After considering the arguments of counsel, the Referee issued a second order, reinstating the previous one and granting counsel's request for the full amount of the fees requested. The Referee was impressed with counsel's high degree of skill and with the significance of the result obtained for claimant. He considered the fact that a portion of the time claimant's counsel spent on this workers' compensation proceeding will likely benefit counsel in the preparation of a third-party proceeding arising out of the same accident to be irrelevant to the determination of fees in the compensation forum.

On review, SAIF argues that claimant's counsel was adequately compensated by the $3,000 originally awarded by the Referee. SAIF points to the fact that the hearing involved only one issue, that the case was not overly complex, and that there were no significant medical issues presented.

In determining the reasonableness of attorney's fees, several factors must be considered: (1) time devoted to the case; (2) complexity of the issues involved; (3) value of the interest involved; (4) skill and standing of counsel; (5) nature of the proceedings; and (6) results secured. Muncy v. SAIF, 19 Or App 783 (1974); Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). In the present case, the time devoted was clearly extensive. The value of the interest and the results obtained for claimant were substantial. We do not find, however, that an extraordinary fee is warranted. While we have no reason to doubt counsel's affidavit, it must be considered in the context of the usual range of attorney's fees awarded for prevailing on denied claims. Bill M. Sturtevant, 37 Van Natta 294, 295 (1985). Because this claim generated only 11 exhibits, and because there was only one issue presented before the Referee, we conclude that claimant's attorney was adequately compensated by the award of $3,000 in the Opinion and Order of October 30, 1984.

ORDER

The Referee's order dated January 2, 1985 is modified. In lieu of the Referee's award, claimant's attorney is awarded a reasonable attorney fee in the amount of $3,000, to be paid by the SAIF Corporation. The remainder of the order is affirmed as modified.

ROBERT C. HOOD, Claimant
Bottini & Bottini, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-00427
July 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Leahy's order that affirmed the Determination Order granting claimant 48° for 15% unscheduled permanent partial disability for the upper and mid-back. The issue on review is extent of unscheduled disability.

Claimant was compensably injured in February of 1982 when a tractor-trailer rig in which he was riding ran off the road. Claimant incurred injury primarily to the cervical spine. He has experienced pain, stiffness and occasional blackout spells since the accident.

Claimant attempted to return to work twice in late 1982, but continuing symptoms resulted in his being taken off work in January of 1983. A May 1982 Determination Order awarded temporary disability compensation but no permanent partial disability. A second Determination Order issued December 14, 1983 granted 15% unscheduled disability for the upper and mid-back. Claimant was off work for about eighteen months. Then, because of the wages he could make driving a truck, claimant made another attempt at returning to his old job in June of 1984. This attempt was made against the advice of claimant's physicians, who felt that he should be retrained for lighter work.

After returning to work, claimant lasted only two months before his cervical pain forced him to quit once more. Claimant's treating chiropractor issued a report in which he stated that he asked claimant to stop driving on August 10, 1984. Claimant remained off work as of the date of the hearing. He was 44 years of age at that time and had completed the eighth grade. He has been a truck driver for most of his working life, and the evidence suggests that he is now precluded from that occupation.

The Referee found that claimant failed to prove entitlement to a greater award than that given by the December 1983 Determination Order. It appears that the Referee's conclusion was based partially on the fact that claimant returned to work in June of 1984 and made six long-haul runs in seven weeks. The Referee's conclusion, however, did not appear to be influenced by the fact that as of the time of the hearing, claimant was once again off work at the request of his treating physician.

After reviewing the record, we find that claimant is entitled to an increased award. Despite his several attempts at returning to his old job, it appears that claimant is now precluded from doing so by his cervical condition. Because claimant's career has consisted almost exclusively of truck driving, he does not have substantial transferable skills. Considering claimant's impairment, age, education and other social/vocational factors, we find that he is entitled to an award of 30% unscheduled permanent partial disability.

ORDER

The Referee's order dated December 4, 1984 is modified. In lieu of the Referee's award, claimant is awarded 96° for 30% unscheduled permanent partial disability. Claimant's attorney is allowed a fee in the amount of 25% of claimant's increased compensation, not to exceed $3,000.

HOWARD E. HUGHES, Claimant
Olson Law Firm, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 83-04319
July 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests, and the self-insured employer cross-requests, review of Referee Podnar's order which: (1) upheld the employer's denial of claimant's occupational disease claim for emotional stress; (2) awarded claimant interim compensation from April 16, 1982, the date claimant completed an 801 claim form, through July 8, 1983, the date of the employer's denial; (3) awarded claimant's attorney $2,000 as a reasonable attorney's fee for "procuring interim compensation"; (4) imposed a penalty equal to 25% of the interim compensation awarded for unreasonable resistance and delay in processing the claim; (5) and, in association with the penalty, awarded claimant's attorney an additional $1,000 attorney's fee for services in "the procurement of the penalties."

The employer makes the following contentions: that the claim was not timely filed, that it has established prejudice and that the claim, therefore, is barred and void, ORS 656.807(1); that, because the claim is void, it had no obligation to initiate interim compensation payments or otherwise process the claim; that the Referee's award of interim compensation, penalties and associated attorney fees is, therefore, erroneous; alternatively, that the Referee erred in awarding interim compensation from the date of the 801 form until the date of the denial; that there is no evidentiary basis for concluding that its delay was unreasonable; and that the employer-paid attorney fees awarded are improper and excessive.

Claimant contends that his claim is compensable and that the Referee's finding and holding to the contrary should be reversed. Claimant concedes that he is not entitled to interim compensation beyond the date that he "returned to work" in November of 1982, and that the portion of the Referee's order awarding interim compensation should be modified accordingly.

On the issues concerning the denial, including the timeliness of the claim, employer prejudice and compensability, we affirm. We agree with the Referee's conclusion that the employer has failed to establish prejudice; therefore, the claim is not barred for untimeliness. Although the claim was not barred, we agree with the Referee's finding that a preponderance of the persuasive evidence fails to establish that claimant's emotional stress arose out of and in the scope of his employment.

On the issue of interim compensation, we find that the employer had the requisite notice or knowledge of the claim on the date claimant completed and signed the 801 form. Claimant's testimony that he completed the form in the employer's personnel office and left it with one J. D. Wade, together with the signed 801 form, is sufficient to establish the employer's notice or knowledge of the claim. Thus, the employer's claims processing obligations, including payment of interim compensation, were triggered as of that date. Although the employer did not deny the claim until July 8, 1983, claimant started his own business on November 29, 1982, and he concedes that the Referee's award of interim compensation should be adjusted to reflect that he "returned to work in November 1982." We will, therefore, modify

the Referee's award of interim compensation by terminating the period of entitlement as of November 28, 1982.

The employer's delay in processing the claim is lengthy and unexplained. The Referee correctly imposed the maximum penalty allowable under the law.

The Referee's award of an employer-paid attorney's fee for "procuring the interim compensation" is legally erroneous. Attorney fees can be awarded only when authorized by statute. Forney v. Western States Plywood, 297 Or 628, 632 (1984); Brown v. EBI Companies, 289 Or 905 (1980); EBI Companies v. Thomas, 66 Or App 105, 112 (1983); SAIF v. Paresi, 62 Or App 139, 142 (1983). Obtaining interim compensation in a claimant's behalf does not entitle counsel to an insurer-paid fee in the absence of a finding that the failure to pay or delay in payment was unreasonable, in which case, an employer-paid fee is authorized pursuant to ORS 656.382(1). Clara E. Stewart, 37 Van Natta 181, 183 (1985). Obtaining an award of interim compensation entitles claimant's attorney to a fee payable out of claimant's award. Thus, the Referee should have allowed counsel a fee payable out of the interim compensation for prevailing on that issue and, in this case, an additional fee to be paid by the employer in association with the penalty for unreasonable claims processing. Cf. Mary Stone, 36 Van Natta 206 (1984); Charles E. Murray, 34 Van Natta 249, 251 (1982). Because interim compensation is in the nature of temporary disability benefits, the maximum fee allowable out of this compensation is $750. See OAR 438-47-030(1).

Contrary to the employer's assertion, the employer-paid fee awarded by the Referee "in the procurement of the penalties" is authorized by statute. ORS 656.382(1). Attorney fees associated with a penalty are imposed, in sigificant part, as a measure of the relative unreasonableness of the employer/insurer's claims processing action; however, it is appropriate to take into consideration efforts expended and results obtained in relation to the penalty issue. Michael J. Mobley, 37 Van Natta 963 (July 24, 1985); Carl W. Andrews, 35 Van Natta 1685, 1686-87 (1983). Although we have reduced the period of interim compensation awarded by the Referee, claimant still is entitled to receive approximately seven months of interim compensation under the terms of our order. Claimant will receive 25% of this interim compensation as a penalty. This is a significant result in terms of the additional sum payable to claimant as a penalty; however, counsel did not expend much effort in marshaling the evidence necessary to establish that a penalty is warranted. The unexplained delay in the employer's denial and the failure to pay interim compensation evidenced a disregard of the employer's claims processing obligations. In consideration of these factors, we believe that the $1,000 employer-paid attorney's fee for failure to pay interim compensation and unreasonable delay in acceptance/denial is appropriate.

ORDER

The Referee's order dated October 23, 1984 is modified in part. In lieu of the Referee's award of interim compensation for the period April 16, 1982 through July 8, 1983, claimant is awarded interim compensation from April 16, 1982 through November 28, 1982. The penalty imposed by the Referee is modified accordingly; i.e., the employer shall pay to claimant as and for penalty a sum equal to 25% of the interim compensation awarded

herein. In lieu of the $2,000 employer-paid attorney's fee awarded by the Referee for "procuring interim compensation," claimant's attorney is allowed 25% of the interim compensation awarded herein, not to exceed $750, as a reasonable attorney's fee for obtaining interim compensation. The remainder of the Referee's order is affirmed.

MARIA G. IBARRA, Claimant
SAIF Corp Legal, Defense Attorney

WCB 84-04137
July 30, 1985
Order on Reconsideration

On July 22, 1985 claimant submitted an English translation of her brief, previously submitted in Spanish. We treat this submission as a request for reconsideration of the Board's Order on Review dated July 16, 1985.

The request is granted. Claimant was provided a reasonable opportunity to submit an English translation of her brief before we reviewed this matter. She failed to do so. After carefully reviewing the record, we affirmed the order of the Referee.

On reconsideration, the Board adheres to and republishes its former order.

IT IS SO ORDERED.

GARY F. MILNE, Claimant
Emmons, et al., Claimant's Attorneys
John E. Snarskis, Defense Attorney

WCB 84-00140 & 84-04515
July 30, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of that portion of Referee Daron's order which awarded claimant 45% (144°) unscheduled permanent disability for two low back injuries, whereas December 28, 1983 and April 18, 1984 Determination Orders had awarded no permanent disability. On review, the insurer contends claimant's award of permanent disability is excessive. We agree and modify.

Claimant was 44 years of age at the time of the hearing. In March 1983, while working as a truck driver, he sustained a low back injury when he attempted to lift a tarp. Dr. Origer, claimant's treating physician, diagnosed a lumbar strain. Treatment was conservative and claimant returned to work within approximately six weeks. Dr. Origer placed claimant under permanent work restrictions. Claimant could lift a maximum of 50 pounds occasionally and 35 pounds repetitively, but he was admonished to refrain from any repeated bending, pushing, or pulling activities. This claim was closed in December 1983 without a permanent disability award.

Claimant initially returned to work as a truck driver. The truck driver job entailed rolling and lifting tarps which weighed 150 to 350 pounds, depending upon whether the tarps were dry or wet. A truck driver was also required to lift gang nail boxes weighing anywhere from 10 to 80 pounds and could involve sitting in a cab for six hours a day. Claimant subsequently transferred to a forklift driver position with the same employer, stating that truck driving was "getting real old" and "real boring." The forklift driver's duties primarily involved banding trusses into bundles which measured three feet by fourteen feet and weighed from 20 to 100 pounds.

In December 1983, while performing his duties as a forklift driver, claimant slipped and fell on the ice, sustaining a second injury to his low back. Dr. Origer diagnosed a muscle strain. After approximately five weeks of conservative treatment, Dr. Origer found claimant medically stationary and released him to return to work subject to his previous work restrictions. Although he felt claimant was employable within these restrictions, Dr. Origer suggested that claimant be referred for vocational rehabilitation. This claim was closed in April 1984 without an award of permanent disability.

Claimant attempted to return to work with his employer, but was advised that there were no positions available within his physical limitations. Other than a brief stint as a car salesman, claimant has not returned to work since his December 1983 injury.

Dr. Origer opined that claimant could anticipate frequent pain symptoms from his injuries. The doctor recommended home physical therapy, exercise, heat, and nonprescription analgesics as a means to relieve the pain. Dr. Origer expected claimant's normal aging degenerative spine changes to progress at a more rapid rate because of the injuries.

Dr. Origer did not discuss the effect, if any, a so-called "compression fracture of the spine 6 or 8 years ago" had upon claimant's current condition. The doctor had referred to this problem in a November 1982 chart note, prior to claimant's compensable injuries. Claimant conceded that he had sustained two prior back injuries while working in California. However, the injuries had occurred approximately three and ten years prior to the hearing and had not resulted in an award of permanent disability.

Since the December 1983 injury claimant has experienced an ongoing "toothache-like" pain in his back. He agreed that Dr. Origer's work restrictions accurately described his physical limitations. Prolonged sitting or standing increases his pain. He engages in little, if any, activities which require bending, pushing, or pulling motions. Claimant's symptoms have forced him to eliminate or curtail many of his recreational activities, such as hiking, fishing, cross-country skiing, running, woodworking, and gardening. At the time of hearing claimant had been taking prescribed antidepressant medication for approximately seven weeks.

Claimant has an eighth grade education and no GED. He admitted that he had previously untruthfully advised a rehabilitation counselor that he had a high school degree with one year of junior college. He stated that he had falsified his education because he was fearful that given his age and limited schooling the system was "really going to shut the door on me."

In addition to his experience as a truck and forklift driver, claimant has worked as a fence builder for approximately 24 years. For seven of those years he operated his own business. Furthermore, he has experience as a carpenter, a fry cook and as a manager for a doughnut shop. Claimant also worked a few months in a cannery's quality control division. Other than this experience in quality control, claimant felt that his past work experiences were now beyond his physical capabilities.

We are persuaded that claimant is entitled to an award of permanent disability. However, we find that a 45% award is excessive.

The criteria for rating a disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.215(5). Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, training, skills, and work experience. ORS 656.215(5). Although claimant is subject to permanent physical restrictions, we are not persuaded that these limitations are so severe that claimant is foreclosed from transferring the skills and training derived from his previous work experiences to future opportunities in the broad field of general occupations.

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 claimant's permanent disability. However, we do not apply these rules as rigid mechanical calculations that are determinative of the final result. Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). After completing our de novo review and considering the above guidelines, we conclude that an award of 20% unscheduled permanent disability would more appropriately compensate claimant.

ORDER

The Referee's order dated December 31, 1984 is modified in part. In lieu of the Referee's award, claimant is awarded 20% (64°) unscheduled permanent disability for his two low back injuries, which is his total award of permanent disability to date. Claimant's attorney's fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed.

JEANNIE M. MOCK, Claimant
Robert L. Chapman, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 81-09800
July 30, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Mongrain's order that: (1) affirmed the insurer's denial of claimant's low back aggravation claim; and (2) affirmed the Determination Order of January 4, 1984 that awarded 32° for 10% unscheduled permanent partial disability for the low back in addition to the 32° for 10% unscheduled disability awarded by a previous Determination Order.

On the issue of extent of disability, we affirm the Referee's order. We also affirm on the issue of aggravation, with the following comment. The Referee affirmed the insurer's denial because claimant had proved a mere increase in symptoms. The Referee found that he was bound by Scheidemantel v. SAIF, 68 Or App 822 (1984), to affirm the denial, for Scheidemantel requires proof of a worsened underlying condition in order to establish a compensable aggravation.

The Court of Appeals withdrew its opinion in Scheidemantel approximately four months after it was initially issued. Scheidemantel v. SAIF, 70 Or App 552 (1984). Therefore, the original opinion no longer controls.

In Billy Joe Jones, 36 Van Natta 1230 (1984), we found that a mere worsening of symptoms may or may not represent a compensable

aggravation, depending on the facts of the case. See also James W. Foushee, 36 Van Natta 901 (1984). An essential factor in determining whether worsened symptoms alone constitute an aggravation is whether the claimant has received an award of disability that takes into account periodic flare-ups. Richard A. Scharbach, 37 Van Natta 598 (1985). If the Board finds that claimant's worsening is greater than that reflected by the prior award, reopening may be warranted. Jimmy B. Hill, 37 Van Natta 728 (1985).

In the present case, claimant has received awards totalling 20% unscheduled disability for the low back. We are satisfied that these awards contemplated the possibility that claimant's symptoms would wax and wane, at least to the extent they have, subsequent to the last award. Reopening is not warranted.

ORDER

The Referee's order dated October 19, 1984 is affirmed.

EARL H. NORBY, Claimant
David C. Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-06365
July 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of Referee Baker's order which awarded 112° (35%) unscheduled disability for injury to claimant's low back on review of a Determination Order which awarded no compensation for permanent disability in connection with this November 1983 injury, and ordered that claimant be reimbursed in the amount of $600 incurred as moving expenses. SAIF contends that the Referee's permanent disability award is excessive and that claimant has failed to establish his entitlement to reimbursement for moving expenses.

Claimant initially injured his back while working for this employer in December of 1981. He was off work a few weeks, received some chiropractic care and then returned to his regular work as a pressline operator in the employer's rubber mill. Claimant reinjured his back in August of 1982, at which time he was off work from four to six weeks. He again received chiropractic care and returned to his regular work. Thereafter, claimant continued to experience low back symptoms, and he continued to receive monthly chiropractic treatments. Claimant testified that his symptoms were almost resolved when he sustained this injury in November of 1983, which prompted increased chiropractic care and resulted in approximately three weeks time loss. Claimant's attending physician, Dr. Carlstrom, released him to perform modified work; however, after making the attempt on two separate occasions, claimant found he was unable to perform his work activity. It was ultimately determined that, as a result of (or at least as indicated by) claimant's successive injuries, he should not return to his work as a pressline operator.

While this November 1983 injury claim was in open status and claimant was undergoing treatment, the parties entered into a stipulation in connection with the August 1982 injury claim, whereby claimant was awarded 32° (10%) unscheduled disability for that injury to claimant's low back. This stipulation does not appear in the record as an exhibit but apparently was executed in April of 1984.

The medical evidence concerning the permanent impairment resulting from this 1983 injury is conflicting. Claimant has a congenital anomaly in the form of a transitional last (sixth) lumbar vertebra, which predisposes that area of the spine to injury. Claimant had no back problems before these injuries; however, now he experiences pain and limitations, and at least one medical doctor, Dr. Wong with the Injured Workers' Program, has diagnosed a chronic lumbosacral strain. Dr. Carlstrom, claimant's chiropractic physician, has opined that the impairment resulting from claimant's successive injuries is "mild to moderate."

On the other hand, Dr. Degge, an orthopedic surgeon who examined claimant on referral by SAIF in late December of 1983 (approximately six weeks post-injury), expressed the opinion that claimant's "strain episodes" were transitory and that, on the date of his examination, claimant had returned to his pre-injury status. He indicated that claimant's ongoing complaints were postural in nature, secondary to the congenital deformity of his last lumbar vertebra. Dr. Degge also recommended a job change, since claimant's back is peculiarly vulnerable to heavy stress, thus causing repetitive strain injuries when he exceeds his "structural limitations." Dr. Degge found no loss of function due to claimant's injury, and he considered the total loss of function of the low back to be minimal and resulting from claimant's congenital problem.

On April 9, 1984 claimant was examined by a panel of three physicians with BBV Medical Services. Dr. Fry, the orthopedist who authored the report for the panel, apparently agreed with Dr. Degge's earlier assessment that the lumbar strain claimant had experienced as his November 1983 injury had resolved. With regard to claimant's sixth lumbar vertebra, however, Dr. Fry reported:

> "It is characteristic with a sixth lumbar vertebra to have narrowing of the intervertebral disk between the sixth lumbar vertebra and the sacrum. I am unable to determine whether the congenital anomalies are a cause of his discomfort or whether they are mainly an X-ray finding, and strain was due to the face [sic] that, with his height, he had an increased lever arm with doing any heavy work which is transmitted to the lumbar-sacral articulation."

These physicians concurred that claimant needed a job change, and they found no impairment of claimant's back in relation to his November 1983 injury.

The parties subsequently deposed Dr. Fry in order to clarify his opinion. He was unable to state whether claimant's sixth lumbar vertebra actually contributed to his continuing discomfort. He affirmatively stated that claimant's sixth vertebra probably did not prolong recovery from the back strain. He admitted that there was very slight impairment of claimant's back based on his complaints of pain and the medical recommendations concerning physical limitations. The report that claimant experienced no back impairment as a result of his November 1983 injury was based upon the total absence of objective findings to substantiate claimant's continuing complaints of pain. The recommendation for a job change was based upon Dr.

Fry's opinion that as a result of his long torso, claimant was likely to experience repeated injuries if he engaged in heavy work of the nature demanded by claimant's job at the rubber mill.

Thus, claimant is a thin, tall worker who has a congenital anomaly of the lumbosacral spine, who is obviously prone to straining his back when engaging in heavy labor, but who was able to perform this type of work for years before he found it necessary to change employment. The medical opinion is divided on the question of whether claimant's ongoing symptomatology is attributable to any of claimant's industrial injuries, or whether it results solely from congenital factors. We believe it is more likely than not that claimant, in fact, has sustained permanent impairment as a result of his successive industrial injuries. Overall, however, the extent of this impairment is very minimal.

We are required to award permanent disability which is due to this November 1983 industrial injury. ORS 656.214(5). We are also required, however, in determining an appropriate award for this injury, to take into consideration claimant's previous injuries and "his past receipt of money for such disabilities." ORS 656.222. The Referee considered the latter statutory provision, although it is unclear exactly what effect he thought the stipulated award of 10% unscheduled disability should have in determining claimant's possible entitlement to an additional unscheduled award. A significant factor which he did take into account is the fact that after claimant's two prior injuries, he was able to continue his employment, but after his third injury, he was medically advised to discontinue this line of work and, in fact, found it necessary to do so.

The Court of Appeals has recently said the methodology we employed in evaluating permanent disability attributable to an injury where the claimant had sustained prior injury to the same area of the body and received a permanent disability award in connection with that prior injury was faulty. Thomason v. SAIF, 73 Or App 319, 322 n. 4 (1985) ("The Board misapplied the guideline on 'impairment,' . . . when it assigned a value to 'impairment' [15 percent] after the 1977 injury which was the difference between claimant's 'impairment' after [30 percent] and before [15 percent] that injury. The effect of this error was to count 'impairment' before the 1977 injury twice -- once in determining the extent of disability from the 1970 injury and again in determining the extent of disability from the 1977 injury.").

The methodology apparently employed by the court was to evaluate the total extent of injury-related disability after the most recent injury; determine the extent of injury-related disability immediately preceding the most recent injury, and then determine how much additional permanent disability the claimant was entitled to receive as a result of the most recent injury. "Injury-related disability" is used in the sense of all disability related to all industrial injuries. By application of relevant factors, such as a return to work for a period of time reflective of some regained earning capacity, see, e.g. Cascade Steel Rolling Mills v. Madril, 62 Or App 598 (1983), 57 Or App 398, 402 (1982); Harris v. SAIF, 55 Or App 158 (1981), the trier of fact determines the claimant's possible entitlement to additional unscheduled disability for the most recent industrial injury.

In this case claimant received no permanent disability in connection with the December 1981 back injury, and apparently none

was awarded upon closure of the August 1982 claim. However, claimant eventually received the aforementioned 10% unscheduled award in connection with the August 1982 injury, but the stipulated award was made based upon facts and circumstances existing after claimant had already sustained his November 1983 reaggravation (i.e. facts and circumstances existing at the time of the stipulated award). This is a potentially complicating factor not present in any of the cases discussing proper application of ORS 656.222. Although it is of theoretical significance in this case, as a practical matter this factor is of limited consequence for the following reason.

Considering the permanent impairment resulting from all three industrial injuries, we find that claimant has persuasively demonstrated no more than impairment of a very minimal degree. Considering the relevant social/vocational factors, which include claimant's age of 26 at the time of hearing, the fact that he has obtained his GED, the fact that his residual functional capacity is for light work (whereas he previously was capable of performing heavy work), as well as his training, skills and work experience, we find that claimant is not, in any case, entitled to an unscheduled award in excess of 32° or 10%. Because claimant has already been awarded 10% unscheduled disability for his August 1982 injury, taking this prior award into consideration as we must, we find that claimant is not entitled to any additional unscheduled award as a result of his November 1983 injury. Therefore, we reverse the Referee's order and affirm the Determination Order awarding no permanent disability. In arriving at this conclusion, we have not applied a strict arithmetical offset; we have merely determined that, under the facts and circumstances of this particular case, claimant has failed to demonstrate his entitlement to an additional unscheduled award.

With regard to the question concerning reimbursement for moving expenses, we find and hold that claimant has failed to establish his entitlement to this compensation. We therefore reverse the relevant portion of the Referee's order.

After it was determined that claimant should not return to his pre-injury employment and that his employer had no suitable work for him, claimant was referred for vocational assistance. Although an authorized training program was recommended by the vocational counselor at the Injured Worker's Program, an authorized training program was not instituted. Instead, claimant received direct employment services, which commenced in May 1984. Claimant worked with the assigned rehabilitation consultant in attempting to locate suitable employment. Targeted jobs included work in warehouse shipping and receiving and auto parts counter help. It was understood that claimant would make efforts on his own to obtain suitable employment, in addition to receiving assistance from the vocational consultant.

In July claimant received an offer of employment in Seattle, Washington, working for his brother who owns a trucking school named Pacific Coast School of Trucking. There are other outlets of this institution located in Salem and Eugene, Oregon. Because claimant was not succeeding in obtaining employment locally in the Eugene/Willamette Valley area, and because he had been advised that his direct employment services would be terminating shortly, he decided to take the job offered by his brother in Seattle. He testified that he discussed with his vocational consultant his

intention of taking employment in Seattle; however, it is totally unclear whether claimant requested payment of his moving expenses prior to actually incurring these costs and moving to Seattle.

The Referee's findings and conclusions regarding the reimbursement issue were stated as follows:

> "Claimant moved to Seattle on July 29, 1984, at a cost of $600. He asked his rehabilitation counselor for moving expenses, but the money was not provided. Moving expenses clearly are contemplated by the rules governing direct employment plans. A worker should not be penalized for finding a job on his own or for being willing to move some distance to work. The $600 is a small additional cost for successful reemployment. I find that this claimant acted reasonably, that the expense is reasonable, and that he is entitled to reimbursement."

As indicated, the record simply does not answer the question of whether claimant requested that his moving expenses be paid before they were actually incurred, or whether, after incurring this expense and without receiving prior authorization therefor, claimant then sought reimbursement. We agree that $600 is a "small additional cost for successful reemployment"; however, we find that under the applicable administrative rules, claimant has failed to establish his entitlement to reimbursement.

OAR 436-61-161 does, indeed, contemplate payment of moving expenses that are necessarily incurred in meeting the requirements of obtained employment. That rule provides in pertinent part:

> "(1) Goods, services and allowances, called '<u>direct worker purchases</u>,' may be provided an eligible worker, by purchase, partial purchase, lease, rental or payment, as necessary elements of a vocational evaluation or of direct employment or training services, or as necessary to the worker's participation in those services, or as necessary to meet the requirements of obtained employment. <u>A direct worker purchase requires a determination by the vocational assistance server that the purchase is necessary, and requires prior approval by the server</u>. * * * The worker shall provide the information reasonably requested for the determination of necessity.
>
> "(2) * * *
>
> "(e) <u>Moving expenses</u>. Reimbursement requires that the worker has obtained employment outside commuting distance, or that moving is the most feasible and economical way for the worker to participate in training. Moving expenses shall be limited to covering the moving of household goods weighing in total not more

than 10,000 pounds. In determining the necessity of reimbursing moving expenses, the vocational assistance server shall consider the possible availability of employment which does not require moving, or which requires less than the proposed moving distance. * * * " (Emphasis supplied.)

It was not unreasonable for claimant to move to Seattle in order to obtain suitable, gainful employment. In fact, a worker's unwillingness to relocate geographically is a factor sometimes taken into consideration in determining appropriate compensation for permanent disability, including permanent total disability. It is much to claimant's credit that he was willing to relocate in order to pursue this job opportunity, particularly since it appeared as though his vocational assistance was coming to an end and no employment opportunities were presented in his local area. Claimant believed that there were no openings in the Salem or Eugene branches of the trucking school, although he testified that he did not actually contact these offices, with which his brother is not affiliated. We do not wish our order to be construed as penalizing claimant for his failure to make this extra effort. The reason we reach the result we do is that the record is utterly devoid of evidence to provide the basis for the conclusion that claimant actually sought prior approval of the anticipated moving expenses by his vocational assistance server. It is claimant's burden to prove his entitlement to the relief requested, and we are forced to conclude that claimant has failed to satisfy his burden in this regard.

ORDER

The Referee's order dated December 7, 1984 is reversed in its entirety. The Determination Order dated June 6, 1984, which awarded no compensation for permanent disability in connection with this injury, is affirmed.

JACK REEF, Claimant
Doblie & McSwain, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-07364
July 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of Referee Podnar's order which: (1) directed the employer to pay claimant temporary total disability benefits for the period from February 25, 1981 to August 28, 1981; (2) assessed a 25% penalty against the self-insured employer for unreasonable resistance to the payment of compensation; and (3) awarded claimant's attorney a $1,000 employer-paid fee for prevailing at hearing. On review, the issues are claimant's entitlement to the temporary total disability payments at issue, penalties and attorney fees, and the $1,000 attorney's fee awarded by the Referee.

Claimant was compensably injured on December 7, 1979. The employer paid temporary disability payments through 1980 and early 1981, until an Order of Suspension issued from the Workers' Compensation Department on March 10, 1981, terminating claimant's benefits as of February 25, 1981. The reason for the suspension was claimant's failure to submit to medical treatment in the form of a myelogram and surgery. Claimant requested a hearing on the suspension, which was upheld at both the Hearings Division and Board levels. Claimant appealed the Board's order to the Court of Appeals.

Shortly after the Order of Suspension, the employer requested that a determination of claimant's claim be made. On July 10, 1981 a Determination Order issued in which the Evaluation Division found that the information in claimant's file was inadequate at that time to make a finding as to the extent of his permanent partial disability. The order further stated that claimant was entitled to temporary total disability from the date of the injury through the effective date of the suspension. Claimant requested a hearing on this Determination Order three days later. However, the request for hearing raised only the issue of permanent partial disability, and made no mention of claimant's entitlement to temporary disability.

In October of 1981 the parties entered into a stipulation in which it was agreed that claimant would withdraw his request for hearing and ask the Evaluation Division to reconsider the July 1981 Determination Order. It was further agreed that a subsequent Determination Order would issue, setting forth a medically stationary date and a determination of the extent of claimant's permanent partial disability. On November 17, 1981 the second Determination Order issued. It awarded claimant 128° for 45% unscheduled disability and temporary total disability from August 28, 1981 through November 13, 1981 pursuant to the earlier stipulation. Claimant requested a hearing on the November Determination Order, but again raised only the issue of permanent partial disability. The issue of entitlement to additional temporary total disability was not raised. A subsequent Opinion and Order awarded claimant additional unscheduled disability.

The Court of Appeals then issued its decision regarding the earlier Order of Suspension. Reef v. Willamette Industries, 65 Or App 366 (1983). The court held that claimant's reasons for refusing to submit to medical treatment were reasonable, thereby reversing the Board's order regarding the Order of Suspension. The effect of the Court of Appeals' decision was to entitle claimant to temporary disability payments from February 25, 1981 (the effective date of the suspension) through August 28, 1981, the date the employer resumed paying time loss pursuant to the October 1981 stipulation. Despite the Court of Appeals' decision, the self-insured employer made no subsequent temporary disability payments to claimant. Claimant requested a hearing, arguing that the Court of Appeals' decision mandated payment of temporary disability benefits for the period in which the erroneous suspension was in effect.

The Referee agreed with claimant, holding that by appealing the Department's Order of Suspension, claimant kept the temporary total disability issue alive. He found that a separate appeal of the temporary disability portion of the July 10, 1981 Determination Order would have been unnecessarily duplicative. The Referee awarded claimant temporary disability for the time period from the date of suspension through August 28, 1981. He also found that the employer's failure to pay the temporary disability at issue constituted unreasonable resistance to the payment of compensation, and he assessed a 25% penalty against the self-insured employer.

On review, the employer argues that because claimant's request for hearing on the July 10, 1981 Determination Order raised only the issue of permanent partial disability, claimant failed to preserve an argument on temporary total disability in

the event his appeal of the Suspension Order was successful. The employer argues that because claimant failed to timely challenge the temporary disability portion of the Determination Order, the Referee was without jurisdiction to overturn or modify that order. Alternatively, the employer argues that the temporary disability determination made in that order is now res judicata.

After considering the parties' arguments on review, we agree with the Referee's analysis and affirm. When claimant requested a hearing on the Department's Order of Suspension, he thereby preserved the issue of entitlement to the temporary total disability payments for the time period in which the Order of Suspension, which was later determined to be erroneous, was in effect. It would have been unnecessarily duplicative for claimant to have been required to request a hearing on the Determination Order as it pertained to temporary total disability payments for the same time period covered by the Order of Suspension. The Court of Appeals' decision in Reef v. Willamette Industries, supra, which effectively granted claimant temporary disability for the time period at issue, cannot be overturned by this Board.

With regard to penalties and attorney fees, we affirm the order of the Referee. The Court of Appeals' decision regarding the Order of Suspension provided a clear directive that claimant be paid temporary disability for the period at issue. The employer's failure to pay the temporary disability benefits ordered by the court was unreasonable, and the Referee's assessment of a penalty in that regard was proper.

With regard to the $1,000 attorney's fee awarded by the Referee, we affirm.

ORDER

The Referee's order dated February 25, 1985 is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the self-insured employer.

HOWARD R. ROE, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03880
July 30, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee McCullough's order that: (1) approved the SAIF Corporation's denial of claimant's occupational disease claim for the left leg; and (2) ordered SAIF to pay interim compensation from October 18, 1983 to February 10, 1984, less amounts previously paid. Claimant has not filed a brief on review. The SAIF Corporation cross-requests review of that portion of the Referee's order that awarded interim compensation.

We affirm that portion of the Referee's order that upheld SAIF's denial. On the interim compensation issue, we reverse.

Claimant gave notice of his claim to his employer on October 18, 1983. SAIF paid interim compensation beginning October 18 and continuing through October 22, 1983. SAIF paid no further interim compensation through the date of its denial on February 10, 1984. Claimant returned to work on October 24, 1983. The Referee held that under the Court of Appeals decision

in Bono v. SAIF, 66 Or App 138 (1983), claimant was entitled to interim compensation from the date of notice through the date of denial, even though claimant had returned to work.

Under the Court of Appeals decision in Bono, the Referee was correct. However, subsequent to the issuance of the Referee's order, the Supreme Court reversed the Court of Appeals decision, holding that a worker is entitled to interim compensation only during periods in which he has left work. Bono v. SAIF, 298 Or 405 (1984). In the present case, claimant returned to work on October 24, 1983 and continued to work through the date of the denial. Under the Supreme Court's Bono decision, no interim compensation was due during this period in which claimant worked.

ORDER

The Referee's order dated November 7, 1984 is affirmed in part and reversed in part. That portion of the order that affirmed SAIF's denial of claimant's occupational disease claim is affirmed. That portion of the order that ordered SAIF to pay interim compensation from October 18, 1983 through February 10, 1984 is reversed.

JAMES C. WELCH, Claimant
Burt, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 84-03571
July 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Seymour's order that directed it to pay for a medical examination and that awarded claimant's attorney a $500 fee for prevailing on a denial. The issue is compensability of a medical examination and attorney fees.

The detailed history of this claim is set forth in James C. Welch, 35 Van Natta 1794 (1983), reversed and remanded, Welch v. Bannister Pipeline, 70 Or App 699 (1984), on remand, 37 Van Natta 271 (1985), and will not be repeated here. We find the following facts to be relevant to our resolution of the present dispute.

Claimant was injured in an industrial explosion in 1980. He was awarded permanent total disability by a Referee's order in August 1982. In October 1983 claimant was working with the Field Services Division of the Workers' Compensation Department (FSD), one of whose counselors sent him to his treating physician, Dr. Sulkosky, for an examination to determine his physical capabilities for the purposes of rehabilitation planning. Dr. Sulkosky's written report to FSD concluded that claimant was medically stationary and should be working.

On December 16, 1983 the Board reversed the Referee's order awarding claimant permanent total disability and, instead, granted claimant an award of 60% unscheduled permanent partial disability. In late February 1984 claimant went to his attorney and asked to be referred to a physician other than Dr. Sulkosky for another medical opinion. Claimant testified that he had become dissatisfied with Dr. Sulkosky. Claimant's attorney gave him a list of four physicians and from that list claimant picked Dr. Berkeley, a Portland neurologist. Claimant saw Dr. Berkeley on March 2, 1984. After his examination of claimant, Dr. Berkeley reported that any treatment of claimant would be supportive and preventative. Dr. Berkeley's report was entitled "Neurological

evaluation" and notes that the referral was from claimant's attorney. The report was not addressed to any party. It is this examination and report with associated radiological charges that are in issue.

In Clara M. Peoples, 31 Van Natta 134, 135 (1981), we stated that, "A doctor's fee for writing a report is the responsibility of the carrier if the report is written in connection with compensable treatment." There is no persuasive evidence that claimant sought any treatment. Dr. Sulkosky, claimant's treating physician, said claimant did not need any treatment, and Dr. Berkeley, the consultant, said that any treatment claimant received would be palliative. Claimant is certainly entitled to seek a second, third, fourth or twelfth opinion as to his condition, but not at the insurer's expense if no compensable purpose is involved. We find that Dr. Berkeley's report was more in the nature of a litigation report than anything else and, as such, it is not the insurer's responsibility. The Referee's order is reversed.

ORDER

The Referee's order dated November 14, 1984 is reversed. The insurer's denial of payment for Dr. Berkeley's report and associated charges is approved.

VICTOR C. GREGORY, Claimant
Hayner, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-08393
July 31, 1985
Order of Dismissal

The SAIF Corporation seeks Board review of the Opinion and Order in the above-referenced matter which was issued June 25, 1985. The thirty days for filing a Request for Review expired July 25, 1985, and the request was dated July 25, 1985 and received by the Board July 26, 1985. Therefore, the order of the Referee is final by operation of law, and the SAIF Corporation's Request for Review is hereby dismissed as being untimely filed.

IT IS SO ORDERED.

EDWARD J. NICKS, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-12247
July 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of Referee Quillinan's order which set aside its denial of aggravation of claimant's low back injury. The issue on review is whether claimant proved worsening of his low back condition since the last arrangement of compensation.

Claimant had a previous industrial injury to his cervical spine. In April 1980 Dr. Tsai diagnosed radiculopathy of the L5 nerve root by physical examination. In May 1980 Dr. LaFrance diagnosed a possible L4-5 disc herniation and thoracic outlet syndrome by physical examination. Also in May 1980, Dr. Buza examined claimant and reported that he had been treating claimant for multiple back complaints for several months and that claimant had a new complaint every time one complaint was resolved.

Claimant injured his low back on July 16, 1980 when he jumped from a crawler tractor he was operating on a logging job. A

myelogram confirmed a herniated disc at L5-S1, and Dr. Erkkila performed a laminectomy and partial discectomy on July 30, 1980. A myelogram in June 1981 showed that claimant continued to have evidence of some root impingement at C6-7 and L4-5. Dr. Erkkila's discharge notes reported that claimant's thoracic outlet and carpal tunnel syndromes fluctuated symptomatically. His low back claim was closed by Determination Order dated October 1, 1981, which awarded claimant 32° for 10% unscheduled permanent partial disability due to the low back injury and surgery. At the time of that Determination Order, Dr. Erkkila limited claimant to sedentary jobs without sitting or lifting and with very little standing or walking, and recommended another program of vocational rehabilitation for claimant. Dr. LaFrance agreed with Dr. Erkkila's findings and recommendations and added that claimant should not be considered for further medical treatment other than symptomatic pain relief.

By June 1982, Dr. Erkkila opined that claimant was significantly disabled and needed vocational rehabilitation but could perform heavy work for short periods of time. A March 1982 assessment of claimant at the Callahan Center showed that claimant's primary problem was the condition of his arms which was not related to his low back injury, but that claimant's back condition fluctuated and he said his back always hurt. On June 29, 1982 claimant was awarded by stipulation 48° for 15% permanent disability due to his low back injury and surgery in addition to the Determination Order award.

Near the time of the stipulation in June 1982, claimant began working as a farm hand for a neighbor. He worked the summers of 1982 and 1983 haying. He drove tractor, unloaded and loaded hay trailers by hand, and delivered hay to farms along the coast two to three times a week. He also obtained a contract to provide and deliver straw and hay to a horse racing facility in the fall of 1982 which he did until spring 1983 and then did again from February to April 1984. Some of the lifting and dragging in the hay operation involved weights around 100 pounds, but most of the hay bales weighed about 50 pounds. The hay deliveries to the coast were loads of 150 bales per trip which claimant unloaded himself.

In January 1983 Dr. Gallagher examined claimant and recommended more investigation of claimant's thoracic outlet syndrome. In March 1983 Dr. Erkkila reported that an EMG showed claimant had thoracic outlet syndrome and carpal tunnel syndrome and needed surgery because his condition had worsened. X-rays taken in April 1983 were compared to claimant's July 1980 x-rays and found to show no change in claimant's lumbar spine.

On November 7, 1983 Dr. Erkkila examined claimant and reported that claimant continued to have arm and leg pain, that he was totally disabled and that he was unable to return to the kinds of work he had done before his low back injury. On December 22, 1983 Dr. Siegel, neurology resident at Oregon Health Sciences University, examined claimant and reported that claimant had been doing heavy lifting and tractor driving work until November 7, 1983, and he recommended a pain center approach to claimant's condition.

On April 12, 1984 Dr. Tsai examined claimant and reported that claimant was progressively deteriorating, was not medically stationary, and was not employable. He recommended that no vocational rehabilitation nor further medical treatment be

attempted. On June 4, 1984 claimant requested reopening of his claim for aggravation of his low back injury.

Claimant changed his attending physician to Dr. Buell, D.O., whose office was closer to claimant's home, in September 1984. Dr. Buell agreed with Dr. Erkkila's assessment that claimant was totally disabled from performing the jobs he had performed or been trained for before his injury and recommended a new back brace and symptomatic treatment of his complaints. Claimant was in the hospital for ten days of traction under Dr. Buell's care, and at discharge the doctor opined that claimant's current condition was worse than in June 1982 and that claimant was not medically stationary and had been totally disabled since at least July 1984.

In October 1984 claimant was examined by Orthopaedic Consultants who reported that there were inconsistencies between claimant's complaints and symptoms, and that he was medically stationary. They recommended that no further medical treatment should be considered for claimant's condition. They related his current condition to degenerative disc disease not related to his industrial injury.

On October 23, 1984 SAIF denied the claim of aggravation of the low back injury because claimant's condition was not worse than it had been at the time of the last arrangement of compensation but reiterated that claimant was entitled to continued medical treatment.

Before the low back injury, claimant's prior work history was in the fields of heavy construction, logging, truck driving, and rodeo cowboy. Claimant was 48 years old at the time of hearing, and had completed two community college programs: animal husbandry and small engine repair. Drs. Erkkila, LaFrance, Tsai, and Buell have opined that claimant was totally disabled due to his industrial injuries, unless he obtained vocational training within his physical limitations.

It is clear from the medical and lay evidence that claimant felt worse and was less able to work actively in the summer and fall of 1984 as compared to the previous two years. However, claimant must show that his condition worsened in relation to his condition at the time of his last arrangement of compensation in June 1982. John E. Cain, 37 Van Natta 9 (1985). At that time, claimant's low back condition had fluctuated considerably, even before his compensable injury. April 1980 physical examination and x-rays showed positive straight leg raising tests at less than 40° bilaterally, active deep tendon reflexes in the lower extremities, limited forward flexion, degenerative changes at T11-12, and cervical osteoporosis. On April 30, 1980 Dr. Tsai's examination report indicated active deep tendon reflexes, positive straight leg raising at 80° and 60°, pain in the right leg to the foot, and that claimant's right buttock was flatter than the left. On May 1, 1980 Dr. LaFrance's examination report indicated active deep tendon reflexes in the knees but trace reflexes in the ankles, several weaknesses in the right leg, and complaints of right hip pain. In July Dr. LaFrance reported that the right hip pain improved when claimant stopped wearing a belt and began using suspenders on his pants.

Dr. Medved examined claimant at the Callahan Center on March 15, 1982. His report is exhaustive:

"[Claimant's] complaints at the present time are low back pain, more toward the right just outside the right sacroiliac area. He wears a brace almost every day. When he doesn't he can do very little without a lot of pain in his low back, and if he walks very much or does anything much like mow grass, he has pain in his leg. Driving bothers him a lot and he says his leg was hurting today and so is the hip. He says when he has this, he cannot sleep. He feels that there really has been very little change since early 1981 and he has not been doing anything except walking a little more at times.

"The second complaint, which he feels is his major complaint, is constant pain in both arms, from shoulder clear to his hands, and he says the muscles are sore, not the joints. On the right side it seems to have more of an ulnar nerve distribution discomfort in the hand, but on the left it is just his whole arm and hand. He says the muscles are sore to touch. He had an EMG done in January or February and those reults are not here, although Dr. Erkkila has said he would send it to me. He has been given a 10-pound lifting limitation. He does not know anything that makes it better, and he says he sleeps poorly because of his arms and hardly ever gets more than two hours of sleep. When talking to me, Dr. Erkkila said that maybe there was thoracic outlet syndrome and that he had mentioned to him that maybe surgery would help, but he could not guarantee him anything, that it was totally elective, and the patient would have to make up his own mind. The patient stated that he wondered if he could exercise and whether or not he would get better. He says his left hand and arm are wasting, and he says that they have been measuring less than they were, especially the left. I would imagine that since he has not been doing anything, they would get smaller by lack of use. His arms are his major symptoms. . . ."

"DORSOLUMBAR SPINE
He has normal range of motion, forward flexion, backward flexion, lateral bending and rotation. His straight-leg tests bilaterally supine and sitting are normal. Supine he has tight hamstrings bilaterally. Dorsiflexion of his foot does not cause symptoms. He has good dorsiflexion of both great toes. He walks normally. He can walk on his toes and on his heels. He can squat well. The deep

tendon reflexes in the lower extremities and the sensory changes are normal. He is slightly tender in the low back just to the right of the right sacroiliac joint and also directly over the incision at the lower end of the sacral area."

On April 20, 1982 Dr. Erkkila reported claimant's physical limitations:

"The restrictions that [claimant] should observe are that he should essentially have no overhead work or perform tasks at shoulder level. In addition, bending, stooping, squatting, flexing and crawling for any period of time should not be permitted. As I have said in the past, [claimant's] constellation of symptoms regarding his neck and back render him really unemployable to any regular type of occupation. A sedentary job might be feasible for [claimant] if somebody were to consider complete job retraining. In addition to the above mentioned restrictions, pushing and pulling should be extremely limited.

"As you can see from what I am saying, [claimant] is significantly disabled in a physical sense. I do believe that he could perform hard work at times if it were for only a short duration of time. But to have this gentleman, for instance, driving heavy equipment, logging on a daily basis, working at a mill, painting, doing carpentry, plumbing would truly be unreasonable."

And on June 9, 1982 Dr. Erkkila reported:

"Limitations necessitated by his current disabilities include the following: I do not believe that he should do any overhead work. His lifting should be minimal, i.e., approximal 15 to 20 lbs., and only on an infrequent basis. He should not be required to work in a forward-flexed posture for any prolonged period of time, and bending, squatting, stooping, in general, should be eliminated."

The next physical examination after the last arrangement of compensation was by Dr. Gallagher, orthopedic surgeon, on January 11, 1983. He reported:

"I did a brief examination today. As far as the low back is concerned, there is no muscle spasm in the lumbar paravertebral musculature. He shows me that he hurts in the upper thoracic region and he does have some dorsal kyphosis. Range of motion of the back is full but apparently does cause him some discomfort. Neurological

examination of the lower extremities shows no muscle atrophy in the calf to tape measure bilaterally. Deep tendon reflexes are 2+. Straight leg raising is negative. His strength and sensation are normal in both legs."

On April 12, 1984 Dr. Tsai examined claimant and reported claimant's work history since the last examination in 1980. He reported that claimant was taken off work by Dr. Erkkila in November 1983 and that since that time claimant's only work had been to feed his 15 cows and 10-15 sheep. Dr. Tsai appeared to be unaware of claimant's weekly trips of approximately 110 miles to deliver hay on contract to the horse racing track from February to April 1984. Dr. Tsai reported that claimant had a "flabby left buttock," straight leg raising tests positive at 50° on the right and 80° on the left, very active knee reflexes, mildly active ankle reflexes, several weaknesses in the right leg, pain in the left leg, and one-tenth of one inch atrophy in the right calf. His impression was progressive deterioration of claimant's condition, but he recommended that no further diagnostic nor therapeutic procedures be attempted. He felt claimant was not stationary.

Drs. Tsai and Buell opined that claimant was not stationary, but in the context of their opinions we find that there was no expectation of improvement by the passage of time nor by medical treatment and, therefore, by the legal definition, claimant was medically stationary. ORS 656.006(17).

Comparison of physical examinations by Drs. Mack, Tsai, LaFrance, Buza, Erkkila, and Medved and claimant's statements in 1980, 1981, and 1982 with physical examinations by Drs. Gallagher, Siegel, Tsai, Buell, and Orthopaedic Consultants and claimant's statements in 1983 and 1984 persuades us that, as a whole, claimant's condition due to his low back injury did not worsen since his last arrangement of compensation. See Hoke v. Libby, McNeil & Libby, 73 Or App 44 (1985); John E. Cain, 37 Van Natta 9 (1985); Charlotte A. Clemmer, 36 Van Natta 753 (1984). Claimant's doctors' assessments of his limitations are unpersuasive when compared to claimant's actual physical activities. That claimant feels less able to perform work that he could perform in 1982 and 1983 does not persuade us that he has suffered a worsening of his low back condition, either, because he believed in 1982 that he was permanently and totally disabled, even as he was working full-time cutting hay and delivering it around western Oregon. See Ace L. McElmurray, 37 Van Natta 199 (1985). Because we find that claimant has not proven by a preponderance of the evidence that his compensable low back condition has worsened since the last arrangement of compensation, the Referee's order is reversed and the SAIF Corporation's denial is reinstated.

ORDER

The Referee's order dated January 7, 1985 is reversed and the SAIF Corporation's denial dated October 23, 1984 is reinstated.

STEVE W. BURKE, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-07526
August 1, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Neal's order which held that a Stipulation and Order to Settle Disputed Claim entered into by and between the parties herein does not require that the SAIF Corporation pay the full amount of medical bills incurred by claimant for psychiatric treatment. Claimant contends that the disputed claim settlement agreement requires payment of the medical bills in full, and not merely to the 90th percentile, and furthermore that the mere partial payment of the medical bills constitutes an unreasonable refusal to pay compensation in accordance with the terms of the settlement agreement, warranting imposition of penalties/attorney fees.

Claimant sustained two injuries to his right hand in February and November of 1982. He alleged that, as a result of either one or both of these injuries, he suffered psychiatric effects requiring medical treatment. The parties entered into the disputed claim settlement agreement in issue, disposing of claimant's contention that his injuries produced "either temporary or permanent need for psychiatric intervention." With regard to the related medical bills incurred by claimant, the stipulation states:

> "Any payment of psychiatric benefits in the past that SAIF Corporation may have made were made on a diagnostic basis, and, therefore, in this spirit, Dr. John L. Carter's bills will be paid on a diagnostic basis up to the date of the approval of the settlement and not beyond."

SAIF paid Dr. Carter's billings for treatment, but only to the 90th percentile. ORS 656.248(2) states:

> "Medical fees equal to or less than the 75th percentile shall be paid when the vendor submits a billing for medical services. Medical fees greater than the 75th percentile but not greater than the 90th percentile shall be paid only when the vendor has provided satisfactory evidence that the fee is the usual and customary fee for the medical service. In no event shall that portion of a medical fee be paid that exceeds the 90th percentile."

See OAR 436-69-701.

Claimant contends that payment of medical services under the terms of the disputed claim settlement agreement is not the payment of compensation as defined by ORS 656.005, since the parties are in agreement that the "injury" for which treatment has been rendered shall remain in its denied status, and the "injury," therefore, is not a "compensable injury." Also, ORS 656.245, which grants the right to medical services, refers only to medical services for conditions resulting from a compensable injury. Therefore, claimant argues, none of the statutory provisions

applicable to compensable medical services apply to medical services payable under the terms of a disputed claim settlement agreement, and the Director of the Workers' Compensation Department lacks authority to regulate payment of these medical services as contemplated by ORS 656.248 and pertinent administrative rules. Thus, it necessarily follows that SAIF had no authority to reduce Dr. Carter's bills for psychiatric treatment to the 90th percentile, and it was required to pay the billings in full. This is an intriguing argument; however, we need not address its possible merit in order to resolve this case.

There was no evidence taken at the hearing. The only document appearing in the record is the stipulation. Arguments of counsel, however, were reported and transcribed. The Referee concluded that, at the time the stipulated order was entered into, SAIF had paid some of Dr. Carter's billings, and that the amount of payment had been to the 90th percentile in accordance with statutory and regulatory requirements. Thus, she concluded that the "plain language" of the stipulation contemplates that SAIF would continue to pay the psychiatric bills in the manner it had previously paid them, up until the date of the settlement. She found nothing in the stipulation to indicate that the amount of payment would be changed from the amount paid in the past. To the extent there was an ambiguity in the document, any such ambiguity would have to be construed against the drafter, who in this case was claimant.

Claimant objects to the Referee's "finding" that SAIF actually paid some billings for psychiatric treatment before the stipulation was entered into and approved, since there is no evidence to form the basis of such a conclusion. The Referee's only foundation for concluding as she did was the impression created by the statements of counsel in argument at the hearing. Claimant maintains that the language of the stipulation, indeed, is plain on its face and, therefore, requires application of no rule of construction such as that applied by the Referee. The plain language, argues claimant, contemplates payment of Dr. Carter's billings in full.

A disputed claim settlement agreement may be viewed as a private contractual agreement between the parties. Mary Lou Claypool, 34 Van Natta 943, 946 (1982). Viewing the parties' agreement as a written contract, certain principles are applicable in construing its terms. One such principle is that where a contract is definite and certain, it is to be construed according to the common meaning of the words used. Interior Warehouse Co. v. Dunn, 80 Or 528 (1916).

The settlement agreement provided that Dr. Carter's bills would be paid up until the date that the settlement was approved. This language is clear and unambiguous, and determining its meaning does not require resort to rules of construction. Therefore, SAIF was required to pay Dr. Carter's bills in full and not merely in part.

SAIF argues that requiring it to pay any amount in excess of the 90th percentile is in direct contravention of the portion of ORS 656.248(2) which states, "In no event shall that portion of a medical fee be paid that exceeds the 90th percentile." We disagree. The money paid to claimant under the terms of the settlement agreement, and the obligation to pay Dr. Carter of which claimant is relieved, are consideration for claimant's

agreement to waive his right to contest SAIF's denial. Both parties get the benefit of their bargain and, within the confines of their contractual agreement, they may limit or expand the rights and liabilities that might otherwise apply under the law. Thus, we conclude that ORS 656.248(2) does not govern the payment of Dr. Carter's bills in this case.

Although we conclude that SAIF's failure to pay Dr. Carter's bills in full was wrong, we do not find this conduct unreasonable. It is more likely than not that when the parties entered into their agreement, no thought was given to whether Dr. Carter's fees exceeded the 90th percentile. SAIF's claim that it is not obligated to pay beyond the 90th percentile is certainly colorable. We believe that SAIF could have a legitimate doubt, from a legal standpoint, as to its liability for full payment of Dr. Carter's outstanding billings. Therefore, SAIF's conduct was not unreasonable and a penalty is not warranted. Zwahlen v. Crown Zellerbach, 67 Or App 3 (1984); Norgard v. Rawlinsons, 34 Or App 999, 1003 (1977); Tillman E. Price, 36 Van Natta 1076 (1984).

Although SAIF is not liable for payment of a penalty, claimant's attorney is entitled to a reasonable attorney's fee under the rationale expressed in Mary Lou Claypool, 34 Van Natta 943, 948 (1982):

> "* * * Employer/insurer paid fees are intended in large part to promote the availablity of administrative and judicial remedies. If entitlement to employer/insurer paid fees depended on refusal to comply with an approved disputed claim settlement or agency order and the refusal had to be both wrong and unreasonable before attorney fees could be awarded, the additional burden of proving unreasonableness . . . could frustrate the availability of remedies. We conclude that an award of attorney fees under ORS 656.382(1) for noncompliance with an order or agreement to pay compensation depends only on establishing that the noncompliance was wrong."

Considering the fact that there was no evidentiary hearing, that claimant's attorney appeared briefly before the Referee for oral argument, and that, as a result of this proceeding, SAIF will be required to pay in excess of an additional $1,000 in medical fees, we find $650 to be a reasonable attorney's fee for services at hearing. An additional fee is warranted for services on Board review.

ORDER

The Referee's order dated January 2, 1985 is reversed. The SAIF Corporation shall pay in full the medical bills in question. Claimant's attorney is awarded $650 for services rendered at hearing and $500 for services on Board review.

MICHAEL E. DAVISON, Claimant
W. Daniel Bates, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-09422
August 1, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of that portion of Referee Seymour's order that granted claimant an award of interim compensation, a penalty and an attorney fee. Claimant cross-requests review of that portion of the Referee's order that denied claimant's request that his claim be remanded to the Evaluation Division for reclassification and closure. The issues are whether claimant's nondisabling injury claim may be reclassified more than one year after acceptance and "interim compensation," penalties and attorney fees.

Claimant suffered a traumatic amputation of the tip of his left little finger while on the job on January 15, 1982. The amputation resulted in the loss of the soft tissue from the base of the nail forward, including a small amount of bone (a portion of the end of the phalangeal tuft.) Claimant was treated in the emergency room where the remaining phalangeal tuft was trimmed and the tactile pad, which had been recovered, was thinned and reattached.

Claimant returned to work immediately, his finger protected by a large bandage. Except for the the time involved in his trip to the emergency room, claimant lost no time from work. Claimant did not complete Form 801 until February 24, 1982. On March 16, 1982 SAIF accepted the claim as one for a nondisabling injury. There was no further action on the claim until claimant requested a hearing on the extent of scheduled permanent disability, on December 6, 1983.

The major issue presented by this case was squarely faced in Garland Combs, 37 Van Natta 756 (1985), and Deborah L. Greene, 37 Van Natta 575 (1985). Combs and Greene both involved injuries originally classified as nondisabling. In both cases we held that ORS 656.262(12) required that, in order to obtain further compensation more than one year after initial claim acceptance, the claimants were required to prove a worsening of conditions under the aggravation statute, ORS 656.273(4)(b). We went further in Combs to hold that ORS 656.268(3) is permissive and does not require insurers to formally close nondisabling injury claims. Although it may be argued in this case that claimant's injury was never nondisabling, we conclude that the one year afforded by ORS 656.262(12) in which to correct such an error, if error it was, is all that is contemplated by the statute and is adequate. On de novo review of the evidence, we find that claimant has not proved that his condition worsened since claim acceptance.

The evidence further establishes that claimant never left work on account of his injury. He is, therefore, not entitled to temporary disability benefits as "interim compensation." Bono v. SAIF, 298 Or 405 (1984). Finally, we find no conduct warranting a penalty or insurer-paid attorney fee.

ORDER

The Referee's order dated June 14, 1984 is reversed in part and affirmed in part. Those portions of the Referee's order that

awarded a penalty and attorney fee for failure to close claimant's claim and awarded "interim compensation" are reversed. The remainder of the Referee's order is affirmed.

DELWIN A. DOUGHTY, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-09598
August 1, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of Referee Foster's order which awarded claimant: (1) additional temporary disability from that awarded by an August 26, 1983 Determination Order; and (2) an additional 5.2% (7.75°) scheduled permanent disability for loss of use of his left leg (knee), whereas the aforementioned Determination Order had awarded him 25% (37.5°). On review, SAIF contends that a prior stipulation prevented claimant from raising the temporary disability issue and that claimant's permanent disability award is excessive.

On May 28, 1985 we remanded this matter to the Referee to determine the effect, if any, the inclusion of some omitted exhibits into the record had upon his original order. On June 11, 1985 the Referee advised the Board that he had considered the exhibits in reaching his original decision, but that the exhibits had apparently been misplaced prior to reaching the Board. The Referee further advised the Board that he reaffirmed his previous order and that the parties agreed that the Board should proceed with its review.

Following our de novo review of the record, we affirm the order of the Referee with the following comment concerning the extent of disability issue. Claimant asserts that the Referee doubled claimant's scheduled permanent disability award for a left knee injury from 25% to 50%. Although we recited this assertion in our previous Order on Review (Remanding), claimant's assertion is incorrect. The Referee clearly concluded that "claimant is granted a total of 7.75 degrees additional permanent partial disability" which is "in addition to all previous awards received by claimant."

The Referee states that claimant has established 50% left leg permanent disability. However, the Referee goes on to conclude that this figure represents the total disability for the entire left leg. Therefore, the Referee's conclusion encompasses not only claimant's left knee disability, but his left foot disability as well. The left foot disability pertains to a May 1981 left ankle injury for which SAIF was not responsible. Claimant has received a total of 25% (33.75°) scheduled permanent disability for this left foot (ankle) injury.

Finding that claimant had already received 71.25° for his left leg injuries (37.5° for his left knee and 33.75° for his left foot), the Referee held that claimant was entitled to an additional permanent disability award of 7.75°. Thus, rather than doubling claimant's previous left leg (knee) disability award, the Referee increased the previous 37.5° award by 7.75°, giving claimant a total scheduled permanent disability award for his left leg (knee) injury of 45.25°.

ORDER

The Referee's orders dated September 25, 1984 and June 11, 1985 are affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the SAIF Corporation.

JACOB FUCHS, Claimant
Brian R. Whitehead, Claimant's Attorney
Michael B. Dye, Attorney
Schwabe, et al., Defense Attorney

WCB 84-07072
August 1, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of that portion of Referee Nichols' order that set aside the employer's denial of claimant's claim for carpal tunnel syndrome. On review the employer argues that claimant has failed to establish the compensability of his condition. We agree with the employer and reverse.

Claimant is a warehouseman. He suffered minor bumping injuries to his right hand in 1980 and 1982. Both injuries resolved without disability. Claimant testified that he incurred a third injury in 1983, but the employer's records show no evidence of it.

In July of 1983 claimant was seen by orthopedist Dr. Mayhall for increased right hand symptoms. Prior to this onset of symptoms, claimant's warehouse job had changed from a position in the loading area to one in receiving. Dr. Mayhall suspected the presence of carpal tunnel syndrome at the time of claimant's initial visit, and the diagnosis was confirmed in February of 1984. Dr. Mayhall opined that claimant's condition was probably related to his job.

The employer then sent claimant to Dr. Nathan for an independent medical examination. Dr. Nathan examined both claimant and a description of claimant's warehouseman job sent along by an employer representative. It was Dr. Nathan's conclusion that claimant indeed showed signs of carpal tunnel, but that it was unrelated to his work. After reviewing claimant's job description, Dr. Nathan felt that the job did not involve the type of wrist motion that precipitates median nerve compression.

Dr. Nathan's report and claimant's job description were sent to Dr. Mayhall. After reviewing both, Dr. Mayhall stated that it was "entirely possible" that claimant's change of jobs precipitated the onset of carpal tunnel symptoms. He further indicated, however, that he could not say with a "high degree of medical probability" that there was a relationship between claimant's work and the onset of symptoms. Based on Dr. Nathan's report and the follow-up response of Dr. Mayhall, the employer issued its denial on May 11, 1984.

Claimant's attorney contacted Dr. Mayhall seeking a clarification of his report. Dr. Mayhall then issued another report in which he stated that claimant's work was the major contributing cause of the carpal tunnel condition. This report, however, also contained the following: "He [claimant] reports to me that he did a lot of lifting and moving of boxes or crates that weighed 240 [lbs] apiece." In fact, claimant was required to lift objects weighing only three to 50 pounds, and much of the heavier

lifting was done with a forklift. Claimant himself testified that Dr. Mayhall's statement regarding the weight of objects lifted on the job was in error.

After receiving a copy of Dr. Mayhall's report, the employer contacted him and presented him with the correct facts regarding the weights lifted and claimant's job description. Dr. Mayhall refused to comment on the new information, however, stating: "...I cannot comment nor am I able to evaluate the information that you have given me as it is not a statistical study and certainly doesn't relate to the medical history of the patient that we have discussed." Dr. Mayhall then adhered to his prior statement regarding causation, and also apparently adhered to the prior history given him.

Seeking further clarification, the employer then showed Dr. Mayhall a videotape of the job activities done by claimant, both in the loading and receiving areas. The tape revealed that most of the work is done with a forklift, although there is some handstacking done of the various items in the warehouse. Very little of the overall activity, however, involves the actual flexion and extension of the wrist.

After reviewing the videotape, Dr. Mayhall issued a November 26, 1984 report in which he stated:

> "First, I would comment that it is hypothetically possible for someone to develop carpal tunnel syndrome doing the type of physical activity that you have described. Driving a lift truck and operating its controls could do this as well as the lifting. However, I find it quite significant that you have not had any cases on record of the development of carpal tunnel disease as an industrial or occupational disease or as an occupational injury. Therefore, although I would find it possible that someone could develop carpal tunnel from the activities of lifting and driving trucks, I would not say that it is highly probable that any one specific emplyee [sic] would get carpal tunnel from that situation. *** "

Dr. Mayhall further stated that for claimant's symptoms to be related to his work, the history "would have to be relatively clear cut. That is, a direct temporal relationship between the development of symptoms, possibly inciting events such as loading boxes, cartons or crates and an excessive number of times a day or an excessive number of hours per day such as in the overtime situation."

The record in this case does not suggest that claimant lifted objects an "excessive number of times a day or an excessive number of hours per day." Claimant worked 7.5 hour shifts, and the videotape reveals that much of the lifting was done by a forklift. The Referee, however, found the claim compensable. She was impressed that Dr. Mayhall adhered to his causation opinion even after being presented with new and more accurate facts regarding claimant's job activities. The Referee failed to note,

however, that Dr. Mayhall essentially refused to consider the new facts presented when adhering to his prior opinion. She also failed to note that when Dr. Mayhall was shown the videotape of claimant's job site, he appeared to back away from his prior opinion somewhat and to phrase his causation analysis in terms of "possibility" rather than "probability."

Carpal tunnel syndrome presents a sufficiently complex medical question to require competent medical evidence on the issue of causation. If the medical evidence demonstrates the mere possibility of a connection between claimant's work and his condition, rather than a probability, the evidence is insufficient to sustain claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055, 1060 (1981); Herbert E. Richards, 36 Van Natta 791, 796 (1984). We interpret the medical evidence in the present case to suggest a mere possible connection between claimant's work and his carpal tunnel condition. We view Dr. Mayhall's opinions, when read as a whole, to be based on what he believed to be a temporal connection between claimant's work and the onset of symptoms. As a general rule, a temporal connection alone is not enough to establish medical causation. Edwards v. SAIF, 30 Or App 21 (1977). We believe this to be particularly true in the present case, in which at least some of the facts relied upon by Dr. Mayhall in his early opinions were erroneous.

Claimant has failed to prove the compensability of his claim. The Referee's order as it pertains to compensability must, therefore, be reversed.

ORDER

That portion of the Referee's order dated January 9, 1985 that set aside the SAIF Corporation's denial is reversed. SAIF's denial is reinstated. The remainder of the order is affirmed.

CARY D. GENTRY, Claimant
Cash Perrine, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-08947
August 1, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests, and claimant cross-requests, review of Referee Nichols' order which set aside the employer's aggravation claim denial and declined to impose a penalty/attorney's fee for unreasonable denial and/or unreasonable refusal to provide claims information.

On our de novo review, we find that claimant has failed to establish the compensability of his aggravation claim by a preponderance of the persuasive evidence. Therefore, we reverse the relevant portions of the Referee's order and reinstate the employer's denial. On the penalty/attorney's fee issue raised by claimant, we affirm.

Claimant sustained a left shoulder injury in August of 1983 while pulling veneer in the employer's mill. A rotator cuff injury was diagnosed. Claimant filed a claim, which was accepted, and benefits were paid. Claimant had surgery by Dr. Carroll in September of 1983. Claimant returned to work the first week of December 1983 with restrictions of no lifting over 20 pounds and

no work above the shoulders. In early March he was released to full duty. Dr. Carroll considered claimant's condition stationary and reported that claimant had lingering subacromial bursitis, which left him with a mild disability. He suggested that claimant avoid working for long periods with his arms elevated above his shoulders. The claim was closed by Determination Order dated June 7, 1984, with an award for temporary total disability and 32° for 10% unscheduled disability for injury to the left shoulder.

Claimant was able to perform his regular job duties. He testified that he experienced pain in doing so, however. There was a general layoff at the employer's plant beginning on June 27, 1984. Claimant returned to work on July 9 and worked only one day. The following day his wife called in and reported that claimant was experiencing stomach problems or flu symptoms such as nauseau and vomiting. Claimant never returned to work. On July 18, 1984, claimant reported to Dr. Carroll with a great deal of pain in his shoulder. Dr. Carroll's chart note of that date indicates that claimant had a good deal of audible popping and snapping in the left shoulder. Dr. Carroll's note comments, "[Claimant] seems to have really lost a lot of ground and genuinely is having quite a bit of problem." Dr. Carroll recommended that claimant stop working and begin a course of physical therapy. He also indicated, "He is probably going to have to stay out of work."

A copy of this chart note was provided to the employer's adjusting company and was received August 10, 1984. On August 16, 1984 claimant's aggravation claim was denied on the ground that, "* * * [I]t does not appear your condition was worsened 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."

At the hearing the employer offered two documents which claimant found objectionable. These documents appear in the record as Exhibits 6A and 8. After claimant objected to admission of these proffered exhibits, the employer withdrew the offer. These documents, therefore, were not admitted to the evidentiary record. It appears from our reading of the Referee's order, however, that she considered these documents as part of the record. When claimant filed his cross-request for review, he specifically designated as an issue the propriety of the Referee's apparent reliance upon these documents. We conclude that these documents were not admitted as exhibits by the Referee, and we, therefore, have not considered them in our review.

The Referee apparently had some reservations about claimant's veracity, as indicated by her comment that she viewed claimant's testimony "with caution." We share those same concerns in view of internal inconsistencies in claimant's testimony and differences between his testimony and that of other witnesses. In additon, we believe the employer successfully impeached claimant, although only on collateral matters such as claimant's prevarication on his employment application. We might agree with the Referee that the unreliability of claimant's testimony is not detrimental to his case if we were able to find some persuasive medical evidence establishing the requisite causal connection between claimant's original industrial injury and his worsened condition. Finding none, however, we must conclude that claimant failed to satisfy his burden of proof.

The employer's theory of defense to the compensability of this aggravation claim is that, during the layoff in late June/early July of 1974, claimant somehow reinjured his shoulder by riding, moving or lifting a heavy motorcycle. The employer has not established that such an incident actually occurred or that, if it did, it constituted an intervening, superseding injury so as to relieve the employer of responsibility for claimant's current shoulder condition. The burden of proof, however, does not lie with the employer. It is claimant's burden to prove that his original injury is a material contributing cause of his current shoulder condition. Grable v. Weyerhaeuser Co., 291 Or 387, 400-401 (1981). Such a finding of medical causation generally requires competent medical evidence. William C. Myers, 36 Van Natta 851, 855 (1984). But see Gilbert v. SAIF, 63 Or App 320 (1983) (court found that all circumstantial evidence indicated claimant's 1981 condition resulted from 1977 compensable injury and there was nothing to suggest an alternative cause for claimant's complaints).

The only medical opinion in the record is from Dr. Carroll. Although claimant requested Dr. Carroll's opinion concerning the possibility that claimant's original injury materially contributed to his worsened shoulder condition, Dr. Carroll never answered this question. Instead, Dr. Carroll stated that it was "conceivable that the repetitive type of work that [claimant] was doing is the cause for this problem." This does not support an aggravation claim. It would lend support to a new claim for a new industrial exposure based upon protracted work activity, a claim in the nature of one for an occupational disease. Standing alone, however, this statement does not support the compensability of such a claim. Dr. Carroll also reported, "It is also possible that some outside factors, as suspected by his employer, could be involved, although the patient denies this vehemently." In addition, Dr. Carroll mentioned the possibility that some undiscovered element could be contributing to claimant's current shoulder problem.

Considering claimant's questionable credibility, the absence of any persuasive statement of medical causation between claimant's original injury and his worsened shoulder condition, and the evidence suggesting at least the possibility of another explanation for claimant's current condition, we find that the employer's denial must be upheld.

As to claimant's request for penalties and attorney fees, our conclusion that the employer's denial must be upheld dictates the conclusion that the denial was not unreasonable. As to the other basis for penalties/attorney fees, the employer's allegedly unreasonable failure or refusal to provide requested claims information, we find that the Referee correctly concluded that a penalty/attorney's fee is not warranted by the evidence of record.

Claimant raised an issue, in the alternative to the aggravation issue, concerning the permanent disability awarded by the Determination Order dated June 7, 1984. Because the Referee found the aggravation claim compensable and remanded it for acceptance and processing, she did not address the extent issue. Since we find the aggravation claim is not compensable, the extent issue is ripe for determination. There is sufficient evidence in the record to evaluate claimant's permanent disability on our de novo review.

Claimant was 32 years old at the time of hearing. He has a formal eighth grade education; however, when he was in the military service he obtained his GED. When Dr. Carroll found claimant's condition stationary on March 9, 1984, he indicated that claimant had "a mild disability" of the right shoulder as a result of lingering, chronic subacromial bursitis. Prior to working for this employer, claimant worked as a ranch hand, which included tractor driving; he did upholstery work on cars, boats, planes and furniture; he was a plant operator at a kitty litter plant, during which time he supervised other workers; he is, or has been, a musician playing the guitar; and he has performed other various types of manual labor. Claimant testified that he would be unable to perform some of these occupations as a result of limitations caused by his shoulder pain.

Dr. Carroll released claimant to return to "full duty" on or about March 9, 1984, although he advised that claimant avoid working for long periods with his arms elevated above his shoulders. Claimant, in fact, returned to his regular work for the employer, and continued to successfully perform in this capacity for well over three months before the general layoff in June of 1984.

Considering this evidence in light of the guidelines for evaluating unscheduled disability, OAR 436-65-600 et seq., we find that the Determination Order award of 32° for 10% unscheduled disability for injury to the left shoulder adequately compensates claimant for the loss of earning capacity attributable to this industrial injury. Therefore, we affirm the Determination Order.

ORDER

The Referee's order dated January 21, 1985 is reversed in part. That portion of the order which set aside the employer's aggravation claim denial is reversed, and that denial, dated August 16, 1984, is reinstated and affirmed. The remainder of the Referee's order is affirmed. The Determination Order dated June 7, 1984, which awarded 32° for 10% unscheduled disability for injury to claimant's left shoulder, is affirmed.

JOHNNIE E. JONES, Claimant
Doblie & McSwain, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-09077
August 1, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Knapp's order which affirmed the SAIF Corporation's denials of compensability of 1983 medical services for a condition found not materially related to his 1971 industrial injury. Claimant contends in the alternative that the Board should hold that these medical services are compensably related to his 1974 industrial injury. Claimant also contends that a penalty and attorney's fee should be awarded for SAIF's allegedly unreasonable delay in furnishing him copies of medical records and other documentation relating to the 1974 claim. The SAIF Corporation cross-requests review of that portion of the Referee's order finding that he was without jurisdiction to determine whether claimant's 1983 medical care was related to his 1974 industrial injury. SAIF contends that claimant's current condition is not related to the 1971 or 1974 injuries.

Claimant has separately requested that the Board exercise its own motion jurisdiction pursuant to ORS 656.278 and reopen his 1971 and 1974 claims. Those matters, 83-0284M and 85-0027M, are decided by separate order this date.

We first address the jurisdictional matter. The issue of the possible relationship of claimant's 1983 medical services to his 1974 injuries was first raised before the Referee in the closing arguments. Both parties agree that the record has been fully developed on that issue. SAIF has waived notice to the 1974 employer. Both parties want the issue resolved in this proceeding.

The Referee declined to rule, holding that jurisdiction cannot be initiated by the parties' consent, citing JoAnne E. Russell, 35 Van Natta 821, aff'd on reconsideration, 35 Van Natta 1082 (1983). Russell, however, turned not on a construction of our statutory jurisdiction but rather on concerns of procedural fairness. The Board held that the Referee erred in deciding whether Ms. Russell's claim was prematurely closed when the sole issue presented and litigated at hearing was extent of permanent disability. See also Dortha Lorraine Oyler, 34 Van Natta 1128 (1982). In Donald A. Hacker, 37 Van Natta 706 (1985), the Board recognized its authority to reach issues not raised by the parties, but held that fundamental fairness dictates that the parties have a reasonable opportunity to present evidence on an issue before it is decided. Here the particular issue in question has been raised by both parties, and they concede that the record is adequately developed.

The Workers' Compensation Law was enacted based in part on a finding that the common law method of compensating injured workers involved long and costly litigation without commensurate benefit, and with an objective of providing a fair and just system for the delivery of medical and financial benefits to injured workers that reduces litigation to the greatest extent practicable. ORS 656.012. Consistent with that objective, we find it appropriate to consider whether claimant's 1983 medical services are materially related to his 1974 injuries.

The Board adopts the Referee's findings of fact as its own. On de novo review of the record we hold that the evidence, viewed as a whole, does not preponderate in favor of a finding that claimant's 1983 medical services are materially related to either his 1971 or 1974 injuries.

Finally, claimant contends that a penalty and attorney's fee should be awarded for alleged unreasonable delay in furnishing copies of medical records and other documentation relating to his 1974 claim. Because we hold that no compensation is due claimant, neither a penalty nor associated attorney fee can be awarded. See EBI Companies v. Thomas, 66 Or App 105 (1983); Mary J. Spontak, 37 Van Natta 230 (1985). Hence we do not consider whether SAIF's conduct was, in fact, unreasonable.

ORDER

The Referee's order dated December 6, 1984 is affirmed in part and modified in part. That portion of the Referee's order upholding SAIF's September 26, 1983 and March 30, 1984 denials is affirmed. Claimant's 1983 medical services are held not to be compensably related to his 1974 industrial injuries.

SHERRY A. McLEAN, Claimant
McNutt, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 84-09943
August 1, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order that: (1) held claimant's optometrist's bill to be not compensable; and (2) denied claimant's request for penalties and attorney's fees for the insurer's failure to accept or deny the optometrist's bill within 60 days of its receipt. The issues on review are the compensability of medical services and penalties and attorney fees. In addition, claimant protests certain actions taken by the Referee following the hearing.

Claimant was a "fish scraper" at the employer's Charleston, Oregon plant. On August 20, 1984 she had a spontaneous black out spell. The cause of the black out has never been determined, although the medical evidence appears to attribute it to causes unrelated to claimant's work. In the process of falling, claimant incurred a cervical strain that resulted in left side neck and shoulder pain. The insurer denied responsibility for claimant's fainting spell, but accepted her cervical strain condition. The Referee found the fainting spell to be not compensable, and that ruling has not been appealed.

What has been appealed is the Referee's holding with regard to optometrist's services that claimant asserts are related to her accepted cervical condition. The Referee held that claimant had failed to prove the required causal connection between her injury and her subsequent need for corrective lenses. We agree.

Sometime after her initial fainting spell, claimant visited optometrist Dr. Haylor, complaining of headaches. Dr. Haylor diagnosed myopia and prescribed corrective lenses. Later, when asked by claimant's attorney of the possible relationship between claimant's cervical injury and her need for the lenses, Dr. Haylor reported: ". . .it is possible and probable that the disturbance of cervical vertebrae could induce or increase the severity of her visual problems." (Emphasis added.) The problem with Dr. Haylor's report is that it is based on a supposed "disturbance" of the cervical vertebrae that has never been shown to exist. The accepted condition is a "cervical strain" and no physician has ever suggested that claimant's cervical vertebrae are involved. Dr. Haylor's opinion is not persuasive.

With regard to penalties and attorney fees, claimant submitted a request for payment of Dr. Haylor's billings to the insurer on November 27, 1984. At the time of the February 14, 1985 hearing, the insurer had not paid, accepted or denied the billings. A physician's billing is a claim, which must be accepted or denied within 60 days of its receipt once the original claim has been accepted. Billy J. Eubanks, 35 Van Natta 131 (1983). Failure to make timely payment subjects the insurer to penalties and attorney's fees, ORS 656.262(10); 656.382, but only if there is compensation due upon which to calculate a penalty. EBI Companies v. Thomas, 66 Or App 105 (1983); Mary J. Spontak, 37 Van Natta 230 (1985). Because claimant's optometrist's services are not compensable, there is no compensation due. Therefore, no penalty can be assessed.

The remaining issue involves the Referee's handling of the hearing. At the conclusion of the hearing, both parties gave oral closing arguments. During the insurer's closing, a request was made to leave the record open so that the insurer could generate a medical report regarding claimant's myopia condition. The Referee agreed to leave the record open for one month, and indicated to claimant's counsel that once the insurer's medical report was received, counsel would "probably" have the opportunity to present additional closing remarks. Fourteen days later, the Referee issued his order, without having received the insurer's report or having entertained additional argument.

On review, claimant argues that the Referee's conduct was improper, although she does not request specific relief. Whether or not the Referee's conduct was proper, claimant was clearly not prejudiced by it. Any additional argument presented by claimant would necessarily have been in response to the insurer's medical report. Because that report was never offered, there was nothing to which claimant could respond. In the absence of prejudice to claimant, we can grant no relief.

ORDER

The Referee's order dated February 28, 1985 is affirmed.

STEVEN K. NAPIER, Claimant
Galton, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 84-02638 & 84-01220
August 1, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

EBI Companies requests review of Referee Thye's order that: (1) set aside its denial of claimant's new injury claim; (2) approved Aetna Insurance Company's denial of claimant's aggravation claim; and (3) awarded claimant's attorney a fee in the amount of $2,200 for services at hearing. On review, EBI asserts that Aetna's denial should be disallowed because it circumvents the claims closure process of ORS 656.268. EBI also asserts that Aetna is the insurer responsible for claimant's condition. Finally, EBI argues that claimant's attorney fee be reduced.

Claimant incurred a compensable low back injury on March 29, 1980 while Aetna was on the risk. A diskectomy, laminectomy and foraminotomy were performed in July of 1983. The claim was still open when claimant was again hospitalized after a fall on December 29, 1983 while claimant was employed by EBI's insured. Claimant filed claims against EBI and Aetna. Aetna issued its denial of responsibility on January 27, 1984, while the claim remained in an open status. EBI denied both compensability and responsibility on February 17, 1984. At hearing, EBI withdrew its compensability denial, and Aetna agreed to process the claim as paying agent under ORS 656.307.

From the outset, EBI asserts that Aetna should be estopped from denying responsibility for the claim, based on Safstrom v. Riedel International, Inc., 65 Or App 728 (1983), and Roller v. Weyerhaeuser Co., 67 Or App 583, aff'd on reconsideration, 68 Or

App 743 (1984). Those cases hold that an insurer may not deny future responsibility for medical services and/or time loss on a previously accepted claim that has not been closed pursuant to ORS 656.268. Safstrom, 65 Or App at 732; Roller, 67 Or App at 587. Neither Safstrom nor Roller, however, were responsibility cases.

This case is very similar to Jimmy C. Lay, 37 Van Natta 583 (1985), a responsibility case in which Industrial Indemnity made precisely the same argument against EBI that EBI now asserts against Aetna. In Lay, the claimant incurred two injuries, the first while EBI was on the risk, the second while Industrial Indemnity was the insurer of record. The claimant filed claims against both insurers, and EBI issued its denial while the claim remained open. Industrial Indemnity argued that Safstrom and Roller prohibited EBI's denial. We held:

> "We believe that it is the better policy to allow an employer/insurer to issue a preclosing denial of continued responsibility for an accepted condition where it appears that injuries or conditions attributable to a subsequent employment aggravate or exacerbate the condition such as to make a shift of employer/insurer responsibility appropriate. The practical effect of precluding responsibility denial in such a circumstance would be to make the first employer/insurer responsible for any and all effects of subsequent employments on the accepted condition between the time the claim is accepted and the time it is finally closed. We do not believe that such a result was intended." 36 Van Natta at 584.

Lay is directly applicable to the present case. Aetna's denial was proper.

On the issue of responsibility, EBI does not argue that the injury incurred while it was on the risk did not independently contribute to claimant's disability. Rather, it argues that the second injury was the direct result of the first, i.e., that claimant's surgery, which was necessitated by the first injury, caused claimant to experience right foot and leg numbness, which in turn caused claimant to lose his footing, resulting in the fall that worsened his condition. This "range of consequences" theory was first discussed and approved by the Court of Appeals in Calder v. Hughes and Ladd, 23 Or App 66 (1975).

There is evidence that claimant experienced right foot and leg numbness after his surgery. However, his testimony at hearing was vague regarding whether the numbness, in fact, caused him to fall the second time. He admitted that he was a bit fuzzy about the details of the fall, and that he may have merely slipped on ice and snow that covered the sidewalk on which he was standing at the time of the second accident. From this evidence we cannot conclude that the numbness resulting from claimant's surgery was in fact responsible for the second fall. Therefore, the second injury, which independently contributed to claimant's disability, and which was insured by EBI, is responsible for claimant's current condition.

The remaining issue is attorney fees. Claimant requested a fee of $2,900 for services at hearing. The Referee awarded $2,200. EBI argues that $2,200 is excessive. We agree. Although claimant's attorney did have cause to prepare this case on the issue of compensability, EBI withdrew its compensability denial at the start of the hearing. Therefore, that issue was not actually tried. We further note that of the 126 exhibits produced at hearing, many were generated by the insurer. After reviewing the proceeding, we hold that claimant's attorney would be adequately compensated by a fee of $1,200 for his services at hearing.

ORDER

The Referee's order dated December 17, 1984 is affirmed in part and modified in part. That portion of the order that set aside EBI's denial and affirmed Aetna's denial is affirmed. That portion of the order that awarded claimant's attorney $2,200 for services at hearing is modified. In lieu of the Referee's award, claimant's attorney is awarded a fee of $1,200, to be paid by EBI Companies. For participating in the responsibility issue before the Board, claimant's attorney is awarded a fee of $300, to be paid by EBI Companies.

LOUIS D. TRUDELL, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-04583
August 1, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Foster's order that approved the SAIF Corporation's denial of claimant's aggravation claim involving the neck and upper back. On review, claimant asserts that he has incurred a compensable aggravation of his neck and upper back condition.

Claimant was compensably injured on August 25, 1980 when a truck he was operating lost its brakes on a steep grade. In an attempt to bring the truck under control, claimant was bounced around in the cab. He hit his head on the cab ceiling, injuring his neck. Subsequent hospitalization and traction provided little relief of claimant's neck and upper back pain. A myelogram was performed, revealing defects at C5, C6 and C7.

Claimant was released to return to modified work, but he continued to experience significant shoulder and arm pain, as well as headaches. In November of 1980 he underwent surgery for an anterior fusion at C5-6 and 6-7. Claimant's condition improved and he was once again released for modified employment. The first Determination Order issued in August of 1981, awarding 20% unscheduled permanent partial disability for the neck and 5% scheduled disability for the left forearm. Claimant thereafter entered vocational rehabilitation. The rehabilitation program was terminated when claimant had to withdraw for reasons unrelated to his industrial injury.

In February of 1983 claimant experienced increasing pain and numbness in his right hand. X-rays revealed the need for further surgery at the C5-6 level, and a refusion was performed on May 20, 1983. Claimant's condition improved and by January of 1984 it was suggested that he reenter vocational rehabilitation. Soon thereafter, he began a training position with a trucking company as a safety supervisor.

After a short period of training, claimant began to experience neck spasms and other muscle symptoms apparently attributed to training-related stress. A final Determination Order was entered on April 5, 1984, awarding an additional 5% unscheduled disability. Claimant's stress-related symptoms continued into May of 1984. His subsequent aggravation claim was denied by SAIF on August 17, 1984. As of the time of the hearing, claimant continued to work as a safety supervisor, and was apparently getting along well, although he continues to experience symptoms.

The Referee found that claimant had experienced increased symptoms requiring treatment subsequent to the last Determination Order. He approved SAIF's denial, however, based on his finding that there had been no permanent worsening of claimant's underlying condition. On review, claimant argues that the legal standard by which this case is to be evaluated arises under the four-part test set forth in the Supreme Court's holding in Weller v. Union Carbide, 288 Or 27 (1979). He further argues that he has produced evidence sufficient to satisfy Weller. SAIF argues that claimant must show a worsening of his underlying condition, and cites Scheidemantel v. SAIF, 68 Or App 822 (1984), for that proposition. SAIF asserts that claimant has demonstrated at most an increase in symptoms which, under Scheidemantel, is insufficient to establish an aggravation.

On review, we find that neither the parties nor the Referee applied the correct legal standard in this case. First, Weller does not control, for Weller was an occupational disease case involving the purported worsening of an underlying, preexisting condition. In the present case, claimant's claim involves neither an occupational disease nor a preexisting condition. It involves the purported aggravation of a compensable condition. Weller does not apply to aggravation claims. James W. Foushee, 36 Van Natta 901, 902 (1984).

Neither is Scheidemantel v. SAIF controlling, for the Court of Appeals withdrew its opinion in that case approximately four months after it was initially issued. Scheidemantel v. SAIF, 70 Or App 552 (1984).

In Billy Joe Jones, 36 Van Natta 1230 (1984), we found that a mere worsening of symptoms may or may not be sufficient to establish a compensable aggravation, depending on the facts of the case. Therefore, the Referee's finding in the present case that claimant suffered a mere symptomatic worsening is not necessarily fatal to the claim. After a review of the record, however, we agree with the Referee that claimant has failed to establish a compensable aggravation.

The medical evidence is clear that claimant's underlying condition remains unchanged since the last arrangement of compensation. It is unclear, however, whether there has been any kind of worsening since the last award. Claimant's most recent flare-ups began at least two months prior to the award, and the evidence suggests that his overall condition and level of symptoms remained essentially the same up to the time of the hearing.

Even if there has been a worsening of symptoms in the present case, we find that it does not represent a compensable aggravation. An essential factor to be considered in determining whether worsened symptoms alone represent an aggravation is whether the claimant has received an award of disability which

takes into account periodic flare-ups. Richard A. Scharbach, 37 Van Natta 598 (1985); see also Kenneth L. Elliott, 36 Van Natta 1141 (1984). If the Board finds that claimant's worsening is greater than that reflected by the prior award, reopening may be warranted. Jimmy B. Hill, 37 Van Natta 728 (1985). In the present case, claimant had received unscheduled awards totalling 25% at the time of hearing. The last award was entered a mere month prior to claimant's last symptomatic flare-up. The Referee awarded an additional 25% unscheduled disability at hearing, and that award remains unchallenged. We are satisfied that claimant's prior awards contemplated the possibility that his symptoms would wax and wane subsequent to the last award. We, therefore, find that claimant has failed to establish a compensable aggravation.

ORDER

The Referee's order dated November 13, 1984 is affirmed.

MARY L. VAUGHN, Claimant
Harper, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Edward C. Olson, Defense Attorney

WCB 84-06187 & 84-07981
August 1, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests, and EBI Companies cross-requests, review of Referee Pferdner's order which upheld denials issued by EBI Companies and North Pacific Insurance Company, which denied the compensability of claimant's neck and back condition(s); and ordered the payment of interim compensation, and penalty-related attorney fees. Claimant contends that her claim for an occupational disease is compensable. EBI contends that the Referee's award of interim compensation and the imposition of a penalty/attorney's fee are error. The Referee also ordered that North Pacific Insurance Company pay interim compensation and a penalty-associated attorney's fee. That insurer, however, has not challenged these portions of the Referee's order; therefore, we will not disturb them.

On the compensability issue raised by claimant, we affirm. Claimant has worked for the employer, a retirement center, for approximately seven years. She has worked as an aide, a housekeeper and a cook. The physical demands of her employment are moderate in degree. These demands include lifting, bending, twisting and standing for long periods of time.

Claimant has a long history of medical treatment for rheumatoid arthritis, which manifests itself by generalized arthralgia and myalgia. She has received treatment for many years from Dr. Dobbes, an osteopathic physician. She has even received treatment in the form of gold injections.

On or about April 16, 1984 two co-administrators at the retirement center confronted claimant to discuss perceived problems in claimant's attitude and conduct. Claimant became irate. Her last day of work was April 17 or 18, 1984. On April 19, 1984 she consulted Dr. Buttler, a chiropractic physician, complaining of constant aching in her low back, thoracic and cervical spine, with pain radiating into the right leg, accentuated upon coughing and sneezing. Claimant also complained of right hip pain. Dr. Buttler diagnosed lumbosacral

sprain and strain syndrome with intervertebral disc derangement and concurrent right-sided sciatica, as well as thoracic and cervical strain. On an 827 form dated April 24, 1984, Dr. Buttler indicated that these conditions were work related, and that claimant was not released for work. In a subsequent report to claimant's attorney, signed by Dr. Buttler and another chiropractic physician, Dr. McMahon, the following was stated:

> "It is our opinion that [claimant] has had pre-existing problems in her cervical and thoracic spinal regions due to the history that we have taken on her. However, we feel that her activities at work are the major contributing cause to a material worsening of her cervical and thoracic condition. It is also our considered opinion that [claimant's] low back condition has as its primary edeology [sic], the activities performed in her occupation as a nursing home worker. * * * [Claimant's] pre-existing cervical and thoracic conditions were transient in nature and only bothered her periodically with activity. However, over the last six years, they have grown progressively worse to the point where recently, due to activities on her job, they have grown to be of a constant nature. In regards to her low back condition, her activities on the job caused her low back condition and symptoms."

Drs. Buttler and McMahon were subsequently provided a copy of a report dated November 10, 1967, authored by Dr. Hanford with regard to an August 5, 1967 motor vehicle accident in which claimant sustained a neck injury. Dr. Hanford prognosticated that claimant would always experience problems as a result of this neck injury, and that activities such as mopping and bending over to peel potatoes would "bring on trouble." After reviewing this report, Drs. Buttler and McMahon wrote to claimant's attorney: "We have noted that this report makes reference to a neck injury. [Claimant's] current on-the-job injury is her low back." (Emphasis in original.)

The Referee found the opinion of Drs. Buttler and McMahon unpersuasive. His apparent rationale was:

> "The relationship between the development of arthritis and other joint pains to physical activity is regularly debated by the medical profession, and Dr. Buttler appears to be one of those physicians who always asserts the affirmative of that proposition. His sole opinion is insufficient to carry the burden of proof."

The fact that a physician belongs to a particular school of thought is, by itself, an insufficient basis upon which to totally discount that physician's opinion. Bales v. SAIF, 294 Or 224 (1982). This opinion is to be evaluated in the context of this specific claim and this specific record. SAIF v. Carter, 73 Or App 416, 419 (1985).

Because the claim is for an occupational disease, claimant must establish that her work activity was the major contributing cause of the condition(s) diagnosed by Drs. Buttler and McMahon. Dethlefs v. Hyster Corp., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570 (1982). It is difficult to conceive of an occupational disease claim that could be established on the basis of lay testimony alone. Considering the nature and extent of claimant's preexisting medical problems, this certainly is not such a case. Therefore, competent expert evidence is required to establish the requisite connection between claimant's work activities and the condition(s) diagnosed by Drs. Buttler and McMahon. Uris v. Compensation Dept., 247 Or 420 (1967); see William C. Myers, 36 Van Natta 851, 855 (1984). For the following reasons, we do not find the opinion of Drs. Buttler and McMahon persuasive and, therefore, conclude that claimant has failed to establish the compensability of her claim for an occupational disease.

Nowhere in the reports of Drs. Buttler and McMahon is there a statement of their findings on examination of claimant. Generally, a diagnosis of sprain or strain is based upon some objective signs, such as palpable muscle spasm. The chiropractors' diagnosis apparently is based upon claimant's complaints of pain. Claimant, however, has been experiencing pain for a number of years as a result of her rheumatoid arthritis, and we find no evidence that the chiropractors were aware of the fact that claimant is a sufferer of this disease. Claimant has suffered low back problems for years, even before her employment with the retirement center. Although claimant may not recall the fact that she was treated for low back and lower extremity pain as long ago as March of 1975, medical records indicate that this is the case. The absence of any mention of claimant's preexisting low back problems in the reports of Drs. Buttler and McMahon, as well as the absence of any mention of claimant's rheumatoid arthritis condition, casts considerable doubt upon the chiropractors' diagnosis of a sprain or strain condition. If, in fact, claimant does suffer from a low back sprain or strain, we are not persuaded that it is causally related to her employment activities, and certainly not to a major extent.

We do not agree with the Referee's characterization of the claim as "too transparent to merit serious consideration." However, we must admit that the circumstances are somewhat suspicious. Furthermore, we cannot help but wonder why, if claimant's back pain increased to the point that she no longer was capable of working in mid April of 1984, her physician of many years, Dr. Dobbes, was not consulted for an opinion concerning the relationship between claimant's work activities and her ostensibly worsened back condition.

On the interim compensation issue raised by EBI's cross-request for review, we reverse. The 827 form completed by Dr. Buttler, dated April 24, 1984, is addressed to EBI Companies. There is no evidence to establish the date on which this report form was received by EBI. EBI issued its denial on May 18, 1984, stating that the coverage it provided the employer terminated April 1, 1984, and advising that the employer's current insurer was "Pacific Northwest Insurance Company."

At the hearing, EBI contended that since it did not provide coverage when the claim was filed, it had no responsibility to process the claim. The Referee rejected this argument. On review, EBI essentially renews the argument, but with an added

twist. EBI analogizes to Bell v. Hartman, 289 Or 447 (1980), in which the Supreme Court held that ORS 656.262 does not require payment of interim compensation to a claimant who proves not to be a subject worker. EBI contends that, because the claim form describes the onset of symptoms subsequent to the date it provided coverage and the claim also was filed after that date, it was "never the 'subject insurer,'" and, therefore, was not required o pay interim compensation.

The Referee awarded interim compensation from April 18, 1984 through May 17, 1984. April 18 is the date he determined claimant became disabled. Because the claim is not compensable, claimant's only entitlement to interim compensation is from the date of notice or knowledge of the claim. Stone v. SAIF, 57 Or App 808, 812 (1982); Donald Wischnofske, 32 Van Natta 136 (1981), 34 Van Natta 664 (1982). Interim compensation is payable within 14 days of the employer's notice or knowledge of a claim under the provisions of ORS 656.262(4). However, ORS 656.807(1) requires that a claim for occupa ional disease be filed with the insurer or self-insured employer. See also Inkley v. Forest Fiber Products Co., 288 Or 337, 347 (1980). But see ORS 656.807(5); Inkley v. Forest Fiber Products Co., supra, 288 Or at 347-48.

There is no evidence to establish the date on which EBI received notice or knowledge of the claim. The Referee substituted an impermissible inference or "presumption" for this essential element of claimant's proof on the issue of entitlement to interim compensation. After noting that the 827 form addressed to EBI Companies was dated April 24, 1984, he presumed that it was mailed "shortly thereafter." We do not know when Dr. Buttler's office mailed this form, nor do we know when it was received by EBI. We do know, however, that EBI issued its denial on May 18, 1984. If the claim form was received anytime within the 14 days prior to the date of the denial, EBI had no obligation to pay interim compensation. ORS 656.262(2).

EBI was obligated to deny the claim, once notified. Having done so, it discharged its claims processing duties. Because the evidence does not allow an inference that EBI was notified of the claim any earlier than 14 days before its denial, there is insufficient evi ence to conclude that interim compensation should have been paid.

ORDER

The Referee's order dated November 16, 1984 is reversed in part. Those portions of the order which directed that EBI Companies pay claimant interim compensation and a penalty-associated attorney's fee are reversed. The remainder of the Referee's order is affirmed.

PAUL D. WEISENBERGER, Claimant
Black, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-02060
August 1, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Mongrain's order that approved the SAIF Corporation's denial of claimant's medical services claim for an orthopedic mattress, box springs and bed frame. The issue on review is the compensability of the claimed medical services.

Claimant suffered a compensable low back injury in April of 1983. In October of 1983 claimant underwent a related low back

fusion. Prior to this surgery, claimant mentioned to his treating chiropractor, Dr. Wehinger, that his mattress at home was "uneven" and was providing poor support for his low back. Dr. Wehinger advised claimant to purchase a "standard, posturepedic firm mattress." A consulting orthopedist agreed with Dr. Wehinger and on October 24, 1983 claimant purchased a queen size mattress, along with a box springs and a bed frame. Claimant sent the bill for all three items to SAIF.

Dr. Wehinger submitted a report to SAIF on November 21, 1983, confirming that he had advised claimant to purchase the mattress and box springs to facilitate his recovery. The consulting orthopedist, Dr. Gilsdorf, prepared a prescription for a "good, firm mattress" about a month later.

SAIF asked its medical consultant, Dr. Norton, for an opinion regarding the necessity of an orthopedic mattress for claimant's condition. Dr. Norton stated that there is nothing medically prescriptive about an "orthopedic" bed, and that a sheet of plywood would be equally beneficial to a claimant needing a firmer surface on which to rest. At hearing, claimant testified that he had tried placing plywood under his mattress, but that it had provided no relief.

Based on Dr. Norton's report, SAIF issued its January 25, 1984 denial, suggesting that claimant purchase a piece of plywood and place it under his mattress for extra support.

OAR 436-69-201(7) governs the compensability of furniture as medical services. It provides:

> "Furniture is not a medical service. Articles such as beds, hot tubs, chairs, jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the 'nature of the injury and the process of recovery requires' that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments. . . ."

Shortly before the hearing, claimant's attorney contacted Dr. Wehinger and apparently asked him to issue an opinion regarding whether claimant's bed was necessary for his low back condition. On September 4, 1984 Dr. Wehinger responded:

> "In response to our telephone conversation this morning regarding [claimant] in which you asked the question: With particularity, tell me why this patient requires an item not usually considered necessary in the great majority of workers with a similar impairment.
>
> "My Answer is: Most workers with multi-spinal problems do require supportive sleeping appliances. Most industrial back injuries involve one region of the spine; however, in [claimant's] case his injury

has involved multiple spinal regions, cervical and lumbar, compromising spinal integrity to a far greater degree than in most industrial spinal injuries.

"Since the patient spends approximately one-third of his life in bed, this type of supportive care is, in my opinion, necessary for adequate support to maintain the patients [sic] present level of stability and prevent further worsening of his condition."

The Referee upheld SAIF's denial. In doing so, he did not comment on the efficacy of Dr. Wehinger's report. Rather, the Referee held that claimant failed to establish entitlement to the orthopedic bed because he did not produce evidence demonstrating that the plywood recommended by Dr. Norton would not be effective. Apparently, the Referee felt that because claimant did not prove that an alternative measure would not suffice, he had failed to prove that the bed was necessary.

We disagree with the Referee's analysis. He appears to require claimant to meet a burden of proof not envisioned by the administrative rule. We find nothing in the rule that requires a claimant to prove that alternative means of treatment are not satisfactory. Rather, claimant must prove that the claimed treatment is necessary and reasonable.

In the present case, the compensability of claimant's bed turns on the report of Dr. Wehinger. If the report satisfies the requirements of the administrative rule, the service is compensable. After reviewing both the report and the rule, we find the report to at least minimally satisfy the rule. The report states that claimant's mattress is necessary for his maintenance and recovery. In addition, it explains the special needs of this claimant arising from his multi-level spinal involvement. We are satisfied that the minimum requirements of the rule have been met.

We are not persuaded, however, that SAIF is responsible for claimant's box springs and bed frame, as well as his mattress. Claimant testified that his old bed was a queen size, as is the one for which he now seeks reimbursement. He further testified that although his old mattress was worn out, the box springs were not. Neither is there evidence that the old bed frame needed replacing. Under these circumstances, it is inappropriate to hold SAIF responsible for the purchase of a new box springs and bed frame, when the record reveals that they are not necessary or required.

ORDER

The Referee's order dated January 15, 1985 is reversed in part and affirmed in part. That portion of the order that approved the SAIF Corporation's denial as it pertains to claimant's orthopedic mattress is reversed. The remainder of the order is affirmed. For his participation in overturning a portion of the denial, claimant's attorney is awarded fees in the amount of $750 for services at hearing and $100 for services on Board review. Both fees shall be paid by the SAIF Corporation.

EUGENE A. PAGE, Claimant
Olson Law Firm, Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 84-01155 & 84-01936
August 8, 1985
Order on Reconsideration

Claimant has requested reconsideration of our Order on Review mailed July 16, 1985. The self-insured employer requested review of the Referee's order that set aside denials of claimant's medical services and aggravation claims. Our Order on Review was a memorandum order in which we affirmed the Referee's order. Claimant contends that our award of $500 as a reasonable employer-paid attorney fee for services on Board review was inadequate.

In Kenneth E. Choquette, 37 Van Natta 927 (WCB Case No. 83-07556, July 15, 1985) (Order on Reconsideration), we recently discussed our analysis in awarding attorney fees for services on Board review. We said:

> "Claimant's attorney is entitled to a reasonable fee to be paid by the [employer/insurer] by virtue of ORS 656.382(2) and OAR 438-47-055. In determining the amount of a reasonable attorney fee, we consider 'the efforts of the attorney and the results obtained . . . .' OAR 438-47-010 (2). See also Muncy v. SAIF, 19 Or App 783, 787-88 (1974); Barbara A Wheeler, 37 Van Natta 122, 123 (1985). In its Order of Adoption of the administrative rules pertaining to attorney fees in workers' compensation cases, the Board said, 'It is incumbent on all parties that each case be evaluated on its own merits . . . .' WCB Admin. Order 1-1979, January 9, 1979. In concert with this case-by-case evaluation, there are few Board cases that purport to establish 'rules' for determining attorney fees. See e.g. Robert Heilman, 34 Van Natta 1487 (1982) ('active and meaningful' participation in responsibility cases).
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> ". . . . .
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> "Attorneys in workers' compensation cases are not required to practice within the constraints of technical or formal rules of evidence or procedure. ORS 656.283(6). Board review is on the record developed by the parties and the Referee at the hearing. ORS 656.295(5). The Board normally does not entertain oral argument, and there is no particular form required for briefs or argument to the Board. OAR 438-11-010. Cf. ORAP 7.05 through 7.40. . . ."

In Choquette we adhered on reconsideration to our award of a reasonable attorney fee of $550 for services on Board review in a case involving an insurer appeal from a Referee's order that

awarded claimant permanent total disability, the maximum award possible in this forum. We did so because the facts of that case justified such an award. We also pointed out that our failure to discuss our detailed analysis of attorney fee awards in most cases should not be taken to mean that we do not subject each and every case in which an attorney fee is awarded to the same scrutiny. When we award attorney fees for services on Board review, we consider all relevant factors in light of the uniqueness of this forum, including the relative certainty of payment. We have done that in this case, as we do in all cases.

Claimant's request for reconsideration is granted. On reconsideration, we adhere to and republish our former order effective this date.

IT IS SO ORDERED.

SHARON L. ANDERSON, Claimant
Evohl F. Malagon, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 83-07816
August 12, 1985
Order on Review (Remanding)

Reviewed by Board Members Ferris and McMurdo.

Claimant requests, and the self-insured employer cross-requests, review of Referee T. Lavere Johnson's order which: (1) declined to set aside a Determination Order dated August 12, 1983 as premature; (2) upheld the employer's de facto denial of a claim for medical services in the form of surgery recommended by Dr. Donald T. Smith; (3) upheld the employer's February 10, 1984 aggravation claim denial; (4) declined to impose a penalty/attorney's fee for the employer's alleged unreasonable denial of the claim for medical services; and (5) awarded claimant an additional 64° (20%) unscheduled disability, thereby increasing the Determination Order award of 32° (10%) to 96° (30%) unscheduled disability for injury to claimant's neck, upper back and right shoulder. Late in the review process, claimant moved the Board to remand this case to the Referee for further evidence taking, together with supporting medical reports. The employer has not responded, although claimant's submission indicates that a copy was provided.

In her appellant's brief, claimant argued that the Referee erred in concluding that the surgery proposed by Dr. Smith, an anterior cervical discectomy and interbody fusion, is not a reasonable and necessary form of treatment for her injury-related condition; that unless and until this surgery is performed, her condition will not attain a medically stationary status; and that the employer's refusal to authorize surgery constitutes unreasonable resistance to the payment of compensation. The employer contends that the Referee's order is correct in all respects, except insofar as it granted claimant an additional award for permanent disability. The employer contends that the Referee's award is excessive.

Claimant's motion for remand, together with its appended documents, indicates that on May 23, 1985, more than eleven months after the hearing, claimant was referred by Dr. Misko, another neurosurgeon, for a diagnostic procedure known as "magnetic resonance imaging," or "MRI." This procedure purportedly shows intervertebral disc material itself, and thus verifies the presence or absence of disc protrusion through the anulus fibrosus. Dr. Misko's interpretation of the MRI is that claimant

has a disruption of the disc at the C5-6 level. He had previously indicated in a report to Dr. Smith that, if the MRI disclosed a disc disruption, he would recommend an anterior cervical discectomy. We have considered this proferred evidence solely for the purpose of determining whether remand is an appropriate disposition.

Thus, the threshold issue is whether this case has been improperly, incompletely or otherwise insufficiently developed and, if so, whether remand is an appropriate disposition. For the following reasons we find that this case should be remanded to the Referee for further evidence taking on the issue of the reasonableness and necessity of the proposed surgery.

In stating the background facts of this case, we borrow liberally from the Referee's findings. Claimant sustained this injury on April 9, 1980 while working as a lumber grader. She was pushing out a load of lumber and suddenly experienced pain in her upper back. Dr. Matheson, claimant's attending physician, diagnosed myositis of the right paravertebral muscles -- trigger area, T4-7. He prescribed medication and daily physical therapy. Claimant continued to work. Physical therapy was tapered off after about one month, and then completely discontinued. In late November of 1980, because of continuing difficulty, the trigger area in the region of T5 and 6 was injected. This afforded temporary relief of claimant's pain. Claimant continued to experience pain about her right scapula. On March 18, 1981 she was examined by a panel of three physicians with the Orthopaedic Consultants. They diagnosed right dorsal strain and found her condition stationary. The Consultants felt claimant could continue in her occupation, although with limitations. They stated that her total loss of function, which was due to the injury, was minimal. Dr. Matheson suggested that claimant continue her medication, and that the claim remain in open status for about another two or three months. He stated that claimant would require her medication on an indefinite basis. In July of 1981 Dr. Matheson recommended claim closure. He stated that claimant's "partial permanent disability" was minimal, and that she should continue with Flexeril and Motrin on an as-needed, indefinite basis. The claim was closed by Determination Order dated August 12, 1981, with no award for temporary or permanent disability. Claimant continued working.

In June of 1982 claimant returned to Dr. Matheson with increasing symptoms of neck pain with muscle spasm. Dr. Matheson subsequently reported that claimant's condition was slightly worse, and that his current treatment was intended to be curative, as opposed to merely palliative, in the sense that he anticipated claimant would eventually attain a point of stability through conservative measures. X-rays of the cervical spine disclosed no significant interval change.

Claimant was examined by Dr. Eckman, a neurologist, in late September of 1982. He performed electromyography (EMG) and nerve conduction studies, which were entirely normal. His impression was that most of claimant's pain was musculo-ligamentous. His only concern was "her complaint of the dysesthetic sensation into the right arm and the very marked reduced reflexes." He stated that if conservative measures failed to produce any response, claimant probably should submit to a myelogram, particularly in light of the fact that her reflexes were markedly depressed.

Claimant continued to treat with Dr. Matheson. She continued to work despite continuing symptoms. On October 19, 1982, she was hospitalized for a cervical myelogram. The myelogram was normal, as were additional EMG and nerve conduction studies. Claimant was discharged from the hospital with a prescription for physical therapy three times weekly and medication. She was advised to stop working for two weeks. Dr. Eckman assumed primary responsibility for her care. In late November of 1982 Dr. Eckman reported that, except for tenderness in and around the scapular muscles and the paracervical region, he could find absolutely no neurological deficit. Claimant had no weakness, no reflex alteration and no sensory deficit.

Claimant then began treatment with Dr. Williams, a chiropractor. At first, chiropractic manipulation seemed to help; however, after two months, she returned to Dr. Eckman stating that the chiropractic treatment was of no particular benefit. Claimant requested a release to return to work, and Dr. Eckman obliged by giving a modified work release with the restriction of no lifting in excess of 30 pounds. Dr. Eckman prescribed additional medication. In early March of 1983, Dr. Eckman took claimant off work again for two weeks and initiated a course of physical therapy. Claimant received vocational assistance through the Field Services Division. It was eventually determined that she should not return to work at the employer's mill due to her physical limitations. Through direct employment planning, she was assisted in establishing her own business as an insurance agent, beginning in May of 1983.

Claimant returned to treatment with Dr. Matheson. She was still experiencing significant pain and muscle spasms in the area of the right trapezius, into the right occiput and around the muscles near the scapula toward the right shoulder. Dr. Matheson reported to the Field Services Coordinator that desk work and direct sales work of the nature involved in selling insurance would work out quite well for claimant. A TNS unit was subsequently recommended for use on a permanent basis.

On June 22, 1983 claimant was examined by another panel of three physicians with the Orthopaedic Consultants. Dr. Reilly, neurologist, who had been part of the three-physician panel in 1981, conducted the reexamination and authored the report. As before, the Consultants found no interference in the examination from functional disturbances. Their diagnosis was "dorsal strain, rhomboid muscles." They stated that she had reached maximum improvement, and that she could return to work in a light category, defined as repetitious handling of ten pounds with only an occasional 20 pound lift. They recommended that claimant be instructed in resistant exercise. Their impression remained one of minimal permanent impairment.

On July 25, 1983 Dr. Matheson reported his essential agreement with the Consultants' findings, conclusions and recommendations. He stated that the claim could be closed, except for palliative treatment on an as-needed basis.

A Determination Order dated August 12, 1983 reclosed the claim with temporary partial and temporary total disability for various periods from October 19, 1982 through June 22, 1983. This Determination Order awarded claimant 32° for 10% unscheduled disability for injury to her "upper back." Claimant's condition was found to be medically stationary on June 22, 1983.

Exactly one month after claim closure, claimant returned to Dr. Matheson with increasing complaints of pain in her neck and upper back, headaches and pain in the area surrounding the scapula. Claimant stated that riding in a car and sitting for extended periods while performing desk work aggravated her symptoms.

Dr. Matheson, at claimant's request, referred claimant for examination by Dr. Smith, neurosurgeon. He examined claimant on October 25, 1983. He had available the myelographic studies of October 20, 1982. He interpreted these as suggesting a minimal slight bulge at the ventral aspect of the C5-6 level. He diagnosed claimant's condition as a possible cervical discopathy. He stated that it could not be determined whether this represented a minute midline annulus tear or posterolateral rupture, which could only be determined with specialized testing. He recommended "cinefluroradiography" and discography of the C5-6 level and possibly the C4-5 and/or C6-7 levels, to see if a discopathic lesion could be determined and verified. He believed there was a reasonable possibility, if not probability, that claimant's condition could be "characterized," and if localized, successfully treated.

Cinefluorography was conducted on December 6, 1983. Cinefluorography, or cineradiography, is the making of a motion picture record of successive images appearing on a fluoroscopic screen. Dorland's Illustrated Medical Dictionary (26th Ed. 1981). This diagnostic procedure apparently indicated a reasonably normal cervical spine. A cervical discogram performed on the same date, however, disclosed some contrast in the C5-6 interspace, as well as some contrast around the intervertebral area outside of the disc space. A subsequent discogram was performed on January 3, 1984. An anesthetic was injected into the centrum portion of the disc at the C5-6 level. An immediate pain response was noted. Claimant was put through a full range of manipulations, and her pain was nearly totally relieved, if not totally relieved. She had no complaints of residual pain in either the right or the left shoulder/scapular area, and full hyperextension of the neck did not bring about any particular discomfort. Dr. Smith reported that this was a positive and conclusive anesthetic discogram, establishing the pain source as the C5-6 disc, associated with probable traumatic spondylopathy.

Claimant was examined by Dr. Wilson, neurologist, on referral by the employer. He stated that, on the basis of claimant's history, "at best," she was suffering cervical, dorsal and shoulder strains. He found nothing in her history nor on his examination to suggest that claimant's pain was discogenic in origin due to cervical nerve root irritation. He concurred in the conclusions of the Orthopaedic Consultants. He stated his impression that surgery would not help claimant, and that before any type of surgery was contemplated, she should have a psychological evaluation. In his opinion, normal EMG studies and a normal myelogram ruled out a cervical disc problem. When Dr. Wilson had the opportunity to review Dr. Smith's discograms, he stated that the discogram is of questionable significance. He apparently believes that a myelogram is "a much better diagnostic study in diagnosing cervical disc problems." He remained of the opinion that claimant's neck pain was not due to discogenic disease and that cervical surgery was not indicated.

By and through Dr. Smith, claimant requested authorization for a third "confirmatory" discogram at the C5-6 level. Dr. Smith indicated that if this procedure was again positive, claimant should be allowed to have an anterior cervical discectomy and interbody fusion for relief of her chronic neck, shoulder and arm pain.

By letter dated February 10, 1984 the employer denied a request for claim reopening, on the stated grounds that the information submitted did not establish a worsening of her condition. In addition, the employer advised claimant that the request for authorization of a third discogram was under advisement.

Dr. Sayler, a radiologist, reviewed the discogram films at the request of the employer. That report states in part:

> "Apparently, the procedure was performed with a videofluoroscope. Therefore, the person observing the exam may have a better idea of the relationships. From this exam alone, I cannot tell whether it is an extruded disc."

The Medical Director of the Workers' Compensation Department communicated with Dr. Matheson, at the employer's request, in order to suggest the possibility of treatment at a pain center. Apparently as a result, claimant was referred for a multidisciplinary pain assessment at the Northwest Pain Center. Claimant attended the pain center program from April 23, 1984 to May 16, 1984. The pain center staff diagnosed claimant's condition as cervical pain without evidence of nerve root problems. It was their opinion that nerve root compression was not the cause of claimant's chronic pain syndrome. They felt that surgery was not warranted. It was their opinion that surgery would not positively contribute toward resolution of claimant's chronic pain.

At the hearing, claimant described her chronic complaints of upper back, neck, right shoulder and right arm pain, which caused limitations in her ability to move her neck, right shoulder and right arm. Because of her chronic, multiple symptoms, she wishes to have the surgery recommended by Dr. Smith. She believes that such surgery will relieve her chronic pain syndrome and enhance her ability to return to regular work.

Thus, until claimant was examined by Dr. Misko after the hearing, and the MRI was performed, Dr. Smith was the only physician who diagnosed a disc lesion and recommended surgery. Dr. Smith believed that there has been a misdiagnosis of claimant's condition, and that she had not been treated properly.

The Referee found compelling reasons not to defer to Dr. Smith's opinions concerning the proper diagnosis of claimant's condition and the recommendation for surgery, even assuming he is the treating physician in this case. See generally Linda L. Cates, 36 Van Natta 1696 (1984); Leland D. Owens, 36 Van Natta 1614 (1984); Everett E. Robinson, 36 Van Natta 1290 (1984); Earl Freeman, 34 Van Natta 1284 (1982), aff'd mem. 63 Or App 529 (1983); Lucine Schaffer, 33 Van Natta 511 (1981). On the basis of the evidence that the Referee had before him, we agree with his conclusion that claimant failed to establish that the surgery

proposed by Dr. Smith is reasonable and necessary. Claimant's motion to remand, and the supporting medical reports, however, establish a "compelling basis" for remand. Buster v. Chase Bag Co., 14 Or App 323, 328 (1973); Tanner v. P & C Tool Co., 9 Or App 463, 467 (1972).

In the interim since the hearing, claimant apparently has continued to experience the same symptoms of headaches, neck and right arm pain. Dr. Smith apparently referred her to Dr. Misko for further evaluation. Without the benefit of the MRI, and on the basis of claimant's history, diagnostic studies, including those conducted by Dr. Smith, and his examination, Dr. Misko formed the tentative conclusion that claimant had a disc disruption at the C5-6 level which probably was lying beneath the ligament and causing symptoms. In a report, dated May 23, 1985, addressed to Dr. Smith, Dr. Misko stated:

> "Cases in which there is chronic posterior cervical and interscapular pain and headaches resulting from cervical disc rupture without radicular symptoms are difficult to diagnose and treat. This woman must be made aware of the fact that the results of surgery for this type of complex is not as good as in the pure radicular complex. However, if the lesion can be accurately localized and if adequate conservative therapy had been given, I believe that after this many years . . . an attempt at definitive treatment of this patient is indicated."

As stated above, claimant submitted to an MRI on or about May 28, 1985. This procedure, according to Dr. Misko, confirms Dr. Smith's other diagnostic studies and indicates that claimant has a disc disruption at the C5-6 level with disc material underlying the ligament. Dr. Snodgrass, a neurologist in the same office as Dr. Misko, concurs in this interpretation of the MRI.

Claimant's motion alleges that the MRI procedure was not available to any person within the State of Oregon until January or February of 1985, i.e., six to seven months after the hearing. The MRI apparatus utilized by the laboratory to which claimant was referred opened for services in February of 1985. According to claimant, prior to this time, this procedure was only performed in "major medical centers," and nowhere in the State of Oregon.

This case is similar to those in which a claimant's chronic condition remains undiagnosed at the time of hearing or, although diagnosed, unsupported by objective medical evidence. See, e.g. Armstrong v. SAIF, 67 Or App 498 (1984); Egge v. Nu-Steel, 57 Or App 327 (1982); Ronald J. Gazeley, 36 Van Natta 212 (1984); Edith Grimshaw, 36 Van Natta 63 (1984); Casimer Witkowski, 35 Van Natta 1661 (1983). In these cases, the court and the Board have found remand appropriate.

The recent diagnostic study conducted by Dr. Misko and his report persuade us that there is a potential void in the record concerning the proper diagnosis of claimant's chronic cervical pain and the most appropriate treatment modality. In this sense, the record has been incompletely developed. We find remand

appropriate based upon claimant's unchallenged assertion that the MRI study was not available in the State of Oregon at the time of hearing. We believe that this medical evidence, as well as any other recently developed evidence, should be considered by the Referee as it bears upon the question of the reasonableness and necessity of the surgery proposed by Dr. Smith.

This disposition makes it necessary to consider the effect upon the remaining issues in the case: the issues of premature closure, aggravation, extent of permanent disability and penalties/attorney fees. We disagree with claimant's contention that her condition never attained a medically stationary status. The record reflects a gradually worsening condition since claimant's original injury, with periods during which claimant's condition stablized but then worsened. Thus, regardless of the ultimate outcome on the question of surgery, we reject claimant's contention that her condition was not medically stationary at the time of the August 12, 1983 claim closure. Whether claimant is entitled to claim reopening for a worsened condition, and, if so, as of what point in time, is a matter which should be determined in conjunction with the ultimate decision on the issue of surgery. Thus, the effect of our order is to leave the claim in closed status, with a denied, but pending, aggravation claim. Whether the employer's refusal to authorize the surgery proposed by Dr. Smith is ultimately found to be correct or incorrect, it certainly cannot be considered unreasonable.

We deem it appropriate to vacate the Referee's order in its entirety, with the exception of those portions which upheld the August 12, 1983 Determination Order as a proper closure of the claim and declined to impose a penalty/attorney's fee for an unreasonable denial of medical services. Those portions of the order are affirmed. In the event that the Referee ultimately determines that claimant has failed to establish the reasonableness and necessity of the surgery in issue, the Referee shall issue an Order on Remand, with the appropriate notice to parties, reinstating those portions of his original order which upheld the denial of medical services, upheld the employer's February 10, 1984 aggravation claim denial and awarded additional unscheduled disability. Our disposition makes it impractical to address the extent of disability issue raised by the employer's cross-request for review at the present time.

In the event that claimant ultimately prevails on the issue of surgery and the related issue of claim reopening for a worsened condition, claimant's attorney shall be awarded a reasonable attorney's fee for services rendered at all prior levels of this proceeding, including Board review. ORS 656.388(1).

ORDER

The Referee's order dated September 26, 1984 is affirmed in part, vacated and remanded in part. Those portions of the order which upheld the Determination Order dated August 12, 1983 as a proper closure of the claim, and which declined to impose a penalty/attorney's fee for an unreasonable denial of medical services, are affirmed. The remaining portions of the Referee's order are vacated, and this case is remanded to the Referee for further proceedings consistent with this order.

JAMES L. BRIGGS, Claimant
Peterson & Peterson, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-06263
August 12, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Pferdner's order that approved the insurer's partial denial of claimant's right shoulder condition. Claimant has filed no brief on review. The insurer cross-requests review and asks the Board to rule on the propriety of the Referee's refusal to reopen the record for the admission of evidence that was unavailable while the record was open, but became available after it was closed.

On the merits, we affirm the Referee's order. On the insurer's cross-request, we note that because of our holding on the merits, the issue of the Referee's refusal to reopen the claim is moot. We find, however, that the Referee's refusal was, in fact, error, albeit harmless error. The documentary evidence that the insurer sought to have included in the record was clearly relevant in that it tended to refute claimant's testimony regarding his prior medical history. The evidence was also clearly not available while the record remained open, and could not have been produced by the insurer's due diligence. After reviewing the record and the proceedings below, we conclude that the record was incompletely developed and should have been reopened for the receipt of additional evidence. OAR 438-07-025; Bailey v. SAIF, 296 Or 41 (1983). Because of our holding on the merits, however, we do not remand.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated January 18, 1985 is affirmed.

SHARON L. JAMES, Claimant
Steven C. Yates, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Noreen K. Saltveit, Defense Attorney

WCB 83-07472 & 83-08033
August 12, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Danner's order. The Referee's order upheld Liberty Northwest Insurance Corporation's denial of claimant's cervical spine and shoulder aggravation claim, set aside Kemper Insurance Company's denial of claimant's new injury claim for her cervical spine and shoulder, and ordered that claimant was not entitled to palliative chiropractic treatments in excess of those established as within the guidelines of OAR 436-69-201(2)(a). Claimant has filed no brief on Board review.

This case poses a somewhat unique issue, in addition to those issues fairly raised by the record. Although claimant filed no brief to the Board setting forth her argument regarding where the Referee may have erred in his decision, the responsible insurer, Kemper, filed its brief arguing that the Referee erred in finding it responsible for claimant's compensation. Kemper did not file a cross-request for Board review. Liberty Northwest urges that we not consider Kemper's "responsibility" arguments on Board review,

because of Kemper's failure to cross-request review. In the alternative, Liberty Northwest argues that the Referee's responsibility finding was correct.

Although the phrase "cross-request" is frequently encountered as a matter of practice in this forum, there is no statutory requirement that a party file such a request once another party has petitioned the Board to review a case. Compare ORS 656.295 with ORS 656.298(4). Our review is de novo, and once a party requests review, our statutory grant of authority is to "affirm, reverse, modify or supplement the order of the referee and make such disposition of the case as [we determine] to be appropriate." ORS 656.295(6). See Neely v. SAIF, 43 Or App 319, 323 (1979); Francoeur v. SAIF, 20 Or App 604, 606-07 (1975); Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983). We, therefore, have considered Kemper's arguments directed at the responsibility issue.

In 1980 claimant was involved in a nonwork related motor vehicle accident, in which she injured her cervical spine. She treated for a year with Dr. Buttler, a chiropractor. On July 17, 1982 claimant sustained an on-the-job strain injury to her cervical spine and right shoulder rotator cuff while employed by Liberty Northwest's insured. Her treating chiropractor, Dr. Buttler, declared claimant to be medically stationary in early March 1983 and on March 29, 1983 the claim was closed with no permanent disability award. Apparently in early June 1983 claimant and her employer/insurer stipulated to an award of 32° (10%) unscheduled disability for her cervical spine and right shoulder.

Shortly after entering into the stipulation, claimant, who was at the time working for Kemper's insured, filed an aggravation claim with Liberty Northwest, which was denied June 27, 1983. She then filed a new injury claim with Kemper on August 10, 1983. Kemper issued its responsibility denial August 12, 1983 and an order designating a paying agent under ORS 656.307 was entered August 24, 1983.

In this responsibility case, the issue is which employer should be responsible for claimant's compensation where there is persuasive evidence that the latest employment actually and independently contributed to claimant's current disability. Doctors Pasquesi, orthopedist, and Gatterman, chiropractic orthpedist, both unequivocally state that employment exposure at Kemper's insured actually and independently contributed to claimant's current disability and need for increased medical and chiropractic treatment. Dr. Buttler, claimant's treating chiropractor, characterized the June 1983 exacerbation as being caused by the kind of work claimant was doing at Kemper's insured. All of the medical and chiropractic opinions acknowledged that the injury at Liberty Northwest's insured and the noncompensable motor vehicle accident also contributed to claimant's current condition. Although we do not agree with the Referee's conclusion that claimant "did in fact suffer a new injury" at Kemper's insured, in that there was no identifiable incident that brought on symptoms, we are persuaded by the weight of the evidence that work exposure at Kemper's insured actually and independently contributed to claimant's increased disability.

Therefore, the Referee correctly assigned responsibility to Kemper. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-45 (1984).

On the issue of the frequency of chiropractic treatments, in the absence of an indication as to what error the Referee may have committed, we have searched the record and have found none.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated December 17, 1984 is affirmed.

ROXANNE D. KENNISON, Claimant
Olson Law Firm, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-05747
August 12, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Seymour's order which set aside the Determination Order dated April 6, 1984 because of lack of jurisdiction in the Evaluation Division of the Workers' Compensation Department and denied other requested relief because of lack of jurisdiction in the Hearings Division. The issue on review is subject matter jurisdiction.

Claimant was injured on June 29, 1976. The claim was accepted as a non-disabling claim and not closed. Claimant applied to the self-insured employer for reopening in 1983. Reopening was at first denied, then additional evidence established the need for further medical services and disability compensation. The self-insured employer voluntarily reopened the claim and reclassified the claim as disabling. Claimant obtained surgery for her condition and was compensated for temporary disability. When claimant's condition was medically stationary, the employer submitted the claim for closure to the Evaluation Division of the Workers' Compensation Department apparently pursuant to ORS 656.268(2).

Claimant was entitled under ORS 656.273(4)(b) to reopening of her claim and processing under ORS 656.262 through closing under ORS 656.268 if she filed her aggravation claim within five years of the date of injury. Claimant did not appeal the classification of her claim within one year of the date of injury and thus cannot now protest the original classification. Garland Combs, 37 Van Natta 756 (1985).

The claim in this case was reopened more than five years after the date of injury, therefore, the reopening of the claim was a voluntary reopening in Own Motion status under ORS 656.278(4). As such, the Referee was correct to find that the Evaluation Division of the Workers' Compensation Department had no jurisdiction to make determinations of closure and permanent disability and that the Hearings Division was without jurisdiction in the controversy. Proper closing of the claim, opened under ORS 656.278, would be by application to the Workers' Compensation Board under ORS 656.278.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated December 27, 1984 is affirmed.

RONALD D. NIELSON, Claimant
David C. Force, Claimant's Attorney
Coons, et al., Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-11744
August 12, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of that portion of Referee Seifert's order that set aside the SAIF Corporation's denial of claimant's request for surgery, but did not order payment of temporary disability compensation beginning on the date claimant left work. On review, claimant argues that because the surgery was found to be compensable, temporary disability should have been awarded beginning as of the date claimant left work, and continuing through the date of the next closure following surgery.

The SAIF Corporation cross-requests review, arguing that claimant has failed to establish the compensability of the surgery in the first instance. It argues in the alternative that if the surgery is compensable, claimant has impermissibly raised for the first time on review the issue of continuing temporary disability compensation from the date of SAIF's denial through the next claim closure, for the issue at hearing was limited to entitlement to temporary disability from November 4, 1983 through the date of the denial.

We review de novo and reverse on the compensability issue. Because of our compensability holding, we need not address claimant's entitlement to temporary disability compensation for the period claimed.

Claimant was compensably injured when he slipped off of a 60-foot cliff and bounced down a hillside. He was immediately hospitalized, complaining of low back and right leg injuries. The initial diagnosis was lower back and right lower leg contusions. Claimant did not initially complain of head or neck symptoms.

Five days after the injury, claimant returned to the hospital complaining of headaches that he related to his fall. The diagnosis was cervical muscle strain, and claimant was given a cervical collar. A subsequent CT scan was normal.

Claimant began treating with Dr. Patterson, a neurologist. X-rays taken a month after claimant's accident were normal, except for some disc space narrowing at the C5-6 level. Dr. Patterson's neurologic examination was also normal, as was an EEG conducted soon thereafter. Dr. Patterson ultimately diagnosed "post-concussion headaches" and referred claimant to Dr. Holmes, who found that he had nothing to offer claimant other than exercise and physical therapy. Dr. Holmes released claimant to return to work as a truck driver beginning June 14, 1983. A December 1, 1983 Determination Order granted temporary total disability through June 14, 1983 and temporary partial disability from June 15 through November 4, 1983.

Claimant was next examined on January 12, 1984 by a neurosurgeon, Dr. Berkeley, who diagnosed post-concussion

syndrome, cervical injury with possible C5-6 spondylopathy and tinnitus. Dr. Berkeley related all of claimant's symptoms to the 1983 industrial injury. He also stated that claimant could not work, and that a cervical myelogram was needed to determine the exact disease process present. The subsequent myelogram confirmed the presence of C5-6 and 6-7 spondylosis lesions, and Dr. Berkeley asked for authorization to perform surgery at those levels.

SAIF sent claimant to Orthopedic Consultants, who examined him and issued a report stating that surgery was not needed. Based on this report, SAIF issued a denial of reopening for surgery. Claimant has not worked since October of 1983.

The Referee set aside SAIF's denial, holding that the reports of Dr. Berkeley provided sufficient medical evidence of an injury-related need for cervical surgery. We agree with the Referee that the evidence supplied by Dr. Berkeley is the most probative. We do not agree, however, that it is persuasive.

In his deposition taken prior to the hearing, Dr. Berkeley stated that based on claimant's history, there was no question that claimant's need for surgery was necessitated by the 1983 industrial injury. The history upon which Dr. Berkeley relied was that claimant had no preexisting symptoms in the neck or shoulders, that he had had a mild concussion resulting from a trucking accident in 1980, and a military service-related low back and knee injury. In taking claimant's history, Dr. Berkeley specifically asked whether claimant had experienced other trauma prior to the industrial injury. Claimant answered in the negative.

In fact, claimant had suffered other trauma. His testimony revealed that he had had two or three high speed motorcycle accidents, one of which resulted in a broken nose and teeth. He had also been involved in "a few" bar room fights in which he likely sustained blows to the head. Dr. Berkeley was unaware of these additional trauma until they were brought to his attention at the time of his deposition. After being presented with these new facts, he answered in the affirmative when asked whether the new information "made it harder" for him to find a causal link between claimant's need for surgery and the industrial injury. He also stated that the types of injuries described could precipitate the symptoms of which claimant currently complained. He maintained, however, that the essential fact from which his causation opinion was made was that claimant was asymptomatic prior to the industrial injury. Dr. Berkeley was not asked whether, considering the new facts, he remained of the opinion that claimant's industrial injury was a material contributing cause of the need for surgery.

It is claimant's burden to prove entitlement to medical services. See e.g., Anita A. Bade, 36 Van Natta 1093, 1096 (1984). Because entitlement to medical services is inherently a medical question, proof generally must come by way of persuasive medical evidence. See Mark. J. Deller, 37 Van Natta 558 (1985); cf., Uris v. Compensation Department, 247 Or 420 (1967). In order to be persuasive, a physician's opinion must ordinarily be based on complete and accurate information. If the history given by claimant is inaccurate or incomplete, the persuasive impact of an opinion generated therefrom is substantially decreased. Miller v Granite Construction Co., 28 Or App 473 (1977); Mark T. Sturgis, 37 Van Natta 715, 718 (1985).

In the present case, claimant relies on the reports of Dr. Berkeley to establish the compensability of claimed medical services. After considering the record, we find that those reports, which were generated from an incomplete history, are insufficient to satisfy claimant's burden of proof. His medical services claim must, therefore, fail.

Because we find that claimant's claim is not compensable, the subsidiary issue of entitlement to temporary disability compensation is moot.

ORDER

The Referee's order dated August 27, 1984 is reversed in part and affirmed in part. That portion of the Referee's order that set aside the SAIF Corporation's denial of claimant's claim for medical services is reversed and the denial is reinstated and affirmed. The remainder of the order is affirmed.

BERNARD L. OSBORN, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-10645
August 12, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Seymour's order which upheld the SAIF Corporation's denial of aggravation of compensable injuries to claimant's upper back and upheld SAIF's partial denial of compensation for medical services related to a cervical spine condition. Claimant also requests remand to reopen the record to admit an opinion letter from claimant's former attending physician created after the issuance of the Referee's order. The issues on review are whether the case should be remanded to the Referee to reopen the record, aggravation, and compensability.

Opinions of three doctors were obtained at the time of the hearing: Dr. Stainsby, who had performed surgery on claimant's cervical spine many years before the compensable injury; Dr. Davis, a chiropractor who examined and treated claimant; and Dr. Laubengayer, an orthopedic surgeon who was the attending physician. Dr. Stainsby reviewed his file and examined claimant and reported that claimant's work-related accident probably contributed to his current cervical spine condition. Dr. Davis did not know by history nor by reading radiographs that claimant had previously had extensive cervical spine surgery but believed claimant's symptomatology was due to the work-related accident. Dr. Laubengayer, who was aware of the previous surgery and who treated claimant from the time of injury through the date of hearing, believed that claimant's neck pain was secondary to the cervical spine surgery rather than to the compensable injury. The Referee relied on the attending physician's opinion that the strain injury sustained in the work-related accident was probably not contributory to claimant's current symptomatology and upheld the partial denial.

After the issuance of the Referee's order, claimant obtained a perfunctory report letter from Dr. Laubengayer that can be read to indicate that he may think that the work-related accident contributed to claimant's current condition. Dr. Laubengayer's reports in April and July 1983 clearly related claimant's symptomatology to residuals of his previous surgery as the sole

cause. The later of these reports was dated July 7, 1983. The hearing was held on November 28, 1984. In the interim, claimant apparently made no effort to contact his attending physician to clarify or modify his opinion. The Referee's order issued on December 26, 1984 and claimant had his opinion letter from Dr. Laubengayer on January 8, 1985 and requested reconsideration by the Referee on January 14.

Claimant had one and one-half years to obtain an opinion from Dr. Laubengayer before the hearing and did not. Two weeks after the Referee's order, claimant appeared with a "clarifying" opinion. As we said in Delfina P. Lopez, 37 Van Natta 164, 170 (1985), "to merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing." We find that claimant has not shown that Dr. Laubengayer's opinion could not have been obtained before the hearing if claimant had shown any diligence before the hearing and, therefore, deny the request to remand to consider new evidence.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated December 26, 1984 is affirmed.

TIMOTHY T. SPREADBOROUGH, Claimant
Peter O. Hansen, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-06956
August 12, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of that portion of Referee Gemmell's order that granted claimant an award of permanent total disability. On review, the insurer asserts that claimant has failed to prove that he is permanently and totally disabled. In addition, the insurer argues that it is entitled to an offset of 15% unscheduled permanent partial disability in the event that the Board finds claimant entitled to an unscheduled award exceeding 40%. In a 1984 stipulated settlement, the insurer granted claimant 15% unscheduled disability, in addition to the 25% awarded by a prior Determination Order and stipulated settlement, as an advance against future awards. The Referee did not address the offset in her order.

Claimant is a 43-year-old former funeral director and embalmer who compensably injured his low back while lifting a casket in April of 1976. His initial treatment was conservative, and his claim was closed with an award of temporary total disability compensation by a September 1976 Determination Order. Claimant returned to work, but experienced an immediate return of symptoms. After more conservative treatment, he again returned to the job, but a severe exacerbation on April 25, 1978 resulted in his being hospitalized. His treating physician thereafter recommended that claimant be retrained for lighter work. A second Determination Order awarded 5% unscheduled disability for the low back.

After a period of retraining, claimant found a job as an estimator for a construction company. The job ultimately proved too strenuous, however, and claimant resigned. A September 1979 stipulated agreement gave claimant an additional 20% unscheduled disability.

In March of 1980 claimant experienced another exacerbation, and a CT scan revealed the presence of a bulging L5-S1 disc. In addition, claimant began exhibiting a psychological reaction to the effects of his injury. In August of 1980 he came under the care of a psychiatrist, Dr. Ruminson. Dr. Ruminson opined that claimant was suffering from a depressive neurosis triggered by the sequelae of the compensable injury.

In late 1980 a 48-week training program in data processing was arranged for claimant. He completed it in December of 1981 and began looking for work. In March of 1982, however, he was hospitalized for surgical exploration and a foraminotomy at L5-S1 on the left, a left L4-5 medial foraminotomy and a bilateral discectomy at L3-4. Dr. Ruminson noted an increase in claimant's depression after the surgery. Claimant did return to work, however, in September of 1982 as a salesman. Dr. Ruminson rated claimant's psychological impairment as "mild to moderate," and later assigned a numerical value of 45% regarding the extent of claimant's psychological disability.

At the insurer's request, claimant was examined by two more psychiatrists. Dr. Hughes opined that claimant suffered from preexisting psychological problems and that a portion of his depression was due to the industrial injury. He also found, however, that none of claimant's psychological problems would preclude his returning to work. Dr. Parvaresh essentially agreed with those findings. Dr. Ruminson, however, disagreed, and in January of 1983 he suggested that claimant's condition had deteriorated to such a degree as to likely make him unemployable. He took claimant off of the sales job because he felt it was too stressful, and he recommended further training in data processing.

In September of 1983 a vocational evaluation report concluded that claimant could not be employed as a computer operator due to poor typing skills. His counselor felt, however, that with further training, claimant's chances of employment were "fair." In January of 1984 claimant's vocational file was closed until such time as he could participate to a greater degree in his own reemployment effort. Later that year, an interim stipulated settlement granted claimant an additional 15% unscheduled disability over the 25% already granted by the prior Determination Order and the earlier stipulated settlement.

In October of 1984 claimant was examined by a three-physician panel of Orthopedic Consultants. The panel concluded that claimant was capable of light work, and they estimated claimant's loss of lumbar spine function to be in the "mildly moderate" range. Three weeks later, claimant was again examined by Dr. Parvaresh, who concluded that there had been little change in claimant's clinical status since his January 1984 examination. He remained of the opinion that claimant was employable, and that an unscheduled award of 25% was "ample."

It is claimant's burden to prove entitlement to an award of permanent total disability. ORS 656.206(3). He may do so by demonstrating that he is permanently incapacitated from a physical standpoint alone, or by establishing that his less-than-total physical incapacity, when coupled with non-physical factors such as age, education and mental or emotional condition, makes it impossible for him to perform any work in a gainful and suitable occupation. Allison v. SAIF, 65 Or App 134 (1983); Wilson v.

Weyerhauser, 30 Or App 403 (1977); Darryl W. Bodle, 37 Van Natta 751 (1985). If his physical incapacity is less than total, claimant must evidence a willingness to be reemployed, and must demonstrate that he has, in fact, made a reasonable attempt to reenter the work force, ORS 656.206(3); Home Ins. Co. v. Hall, 60 Or App 750 (1982) rev den 294 Or 536 (1983), unless such an attempt would be futile. Butcher v. SAIF, 45 Or App 313 (1980).

In the present case, claimant is not totally physically incapacitated. The record evidences a physical impairment in the range of "mildly moderate." In fact, it appears that claimant's physical problems are secondary to the psychological reaction he has experienced as a result of the compensable injury. This compensable psychological reaction, of course, is to be considered along with claimant's physical problems when rating his extent of disability. See e.g., Allen v. Fireman's Fund Ins. Co., 71 Or App 40 (1984).

After reviewing the medical record, we are not persuaded that claimant has been rendered unemployable, either by his physical problems, the psychological reaction, or a combination of the two. As has been noted, claimant's physical impairment is not substantial. And, while we recognize that the psychological component is disabling, we note that no psychiatrist has stated that claimant has been rendered permanently or totally unemployable thereby. At one point, Dr. Ruminson did express doubts regarding claimant's employability, but he later suggested that, "getting the claimant back into the employment market will aid considerably in his recovery." Neither Dr. Hughes nor Dr. Parvaresh ever suggested that claimant was unemployable. In fact, both stated that he was not precluded from gainful employment by his psychological impairment.

Because we find that claimant is capable of employment, we must examine whether he has made a reasonable effort to return to work. We note that claimant has cooperated with his vocational personnel in that he has undergone recommended training and has followed prescribed vocational plans. We also note, however, that he has been markedly intolerant of his counselor's suggestions that he accept employment paying less than the wages he earned at the time of his injury (approximately $2,000 per month). The vocational personnel have indicated to him that returning to a similar wage level is unrealistic, but claimant has continued to be rather fixated on returning to employment with wage potential similar to that of his previous job.

At one point, claimant's vocational counselor arranged a job interview involving a position for which claimant was well-qualified and which paid approximately $1,200 per month. According to the counselor's report, however, claimant "talked himself out of [the] job" because he considered the position to be beneath his capabilities. On another occasion, claimant frankly stated that he would not accept commission sales positions. Although his attitude improved somewhat near the time of the hearing, it appears to us that historically, claimant's relationship with the vocational personnel has been marred by his inflexibility and an unrealistic attitude. We are simply not persuaded that claimant has made a reasonable effort to reenter the workforce. Accordingly, we find that claimant has failed to establish entitlement to permanent total disability compensation.

We further find, however, that claimant is entitled to an increased award of unscheduled permanent partial disability. After considering his physical and emotional impairments, along with the pertinent social and vocational factors, OAR 436-65-600, et seq., we conclude that claimant is entitled to an unscheduled award totalling 75%, which is an increase of 35% over that previously awarded by the Determination Order and stipulated agreements between the parties.

The remaining issue is the insurer's entitlement to offset 15% unscheduled disability from our 75% award. As has been noted, a 1984 stipulated agreement granted claimant 15% unscheduled disability as an advance against any future awards that might arise. At hearing, the insurer brought the advance to the Referee's attention, but did not specifically request that the offset be allowed. The Referee made no mention of the offset in her order.

On review, claimant argues that because the insurer's entitlement to the offset was not specifically raised as an issue at hearing, the insurer has waived its right to request the offset before this Board. We disagree. A stipulated agreement is a contract between the parties. Steve W. Burke, 37 Van Natta 1018 (WCB Case No. 84-07526, July 30, 1985); Mary Lou Claypool, 34 Van Natta 943 (1982). The agreement in the present case was entered into the record in the form of an exhibit. Our de novo review is based on the entire record before us. ORS 656.295(5); Neely v. SAIF, 43 Or App 319, 321 (1979). The exhibit in the present case speaks for itself, and the issue involving it did not need to be specifically raised at hearing in order for us to consider it on review. After considering the record, we find that the insurer is entitled to an offset of 15% unscheduled disability pursuant to the stipulated agreement between the parties.

ORDER

The Referee's order dated December 24, 1984 is reversed in part and supplemented in part. In lieu of the Referee's award and all prior awards, claimant is granted 240° for 75% unscheduled permanent partial disability. The insurer is allowed an offset against this award equal to 48°, or 15% unscheduled disability. Claimant's attorney is allowed a fee in an amount equal to 25% of the increased compensation granted by this order, not to exceed $2,000, in lieu of the attorney fee allowed by the Referee.

APOLONIO ENRIQUEZ, JR., Claimant
Roberts, et al., Defense Attorneys

WCB 84-01547
August 14, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Quillinan's order which affirmed the Determination Order dated November 16, 1983 which awarded 15° for 10% scheduled permanent partial disability of claimant's right forearm and awarded 7.5° for 5% scheduled permanent partial disability of claimant's left forearm; and approved the stipulated agreement that allowed the insurer to offset overpaid temporary total disability against the permanent partial disability awarded. The issues on review are extent of scheduled permanent partial disability and offset of overpaid temporary disability compensation against the permanent disability award.

The Referee found that claimant testified credibly, and in reliance on the medical reports and claimant's testimony found that claimant was not entitled to an award for disability in addition to that awarded by the Determination Order. After our review of the medical records and claimant's testimony, we agree with the Referee and affirm the Referee's order.

Claimant and the insurer reached an agreement before the hearing about the existence and amount of an overpayment of temporary total disability compensation. The Referee was authorized to approve the offset which allowed the insurer to treat the payment of temporary disability compensation after claimant was determined to be medically stationary as an advance payment on his permanent disability award. See Forney v. Western States Plywood, 66 Or App 155 (1983). The Board affirms the Referee's order.

ORDER

The Referee's order dated December 13, 1984 is affirmed.

BERNIE HINZMAN, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 83-0097M
August 14, 1985
Own Motion Order

This matter is before the Board pursuant to ORS 656.278. Claimant has requested imposition of a penalty and associated attorney's fee for the SAIF Corporation's alleged withholding of compensation due under a prior Own Motion Order, and for otherwise unreasonably processing this claim, in which claimant's aggravation rights have expired. SAIF requests authorization to recover an alleged overpayment, which SAIF claims arose through a miscalculation of temporary disability benefits paid under the terms of a prior Own Motion Order. The Board previously denied claimant's request for an award of an insurer-paid attorney's fee in this own motion proceeding. 35 Van Natta 739, 35 Van Natta 1374 (1983). See generally OAR 438-47-070, 438-12-010(4) and (5) (formerly OAR 436-83-820(4) and (5)).

Claimant was injured in January of 1971 while working in a lumber mill. He suffered a crushing type injury to the right leg, resulting in comminuted fractures of the medial condyles of the right tibia and right femur. Claimant had extensive surgery on the right leg. The claim was eventually closed by Determination Order in June of 1974; thus, claimant's aggravation rights expired in June of 1979. As a result of his injury, claimant suffers permanent right leg and psychological disabilities.

Claimant was hospitalized in November of 1982 for exploratory arthroscopy of the right knee and partial adhesiolysis. SAIF agreed to pay claimant's medical expenses pursuant to ORS 656.245; however, SAIF apparently refused to voluntarily reopen the claim pursuant to ORS 656.278(4) and submitted the question of claimant's entitlement to payment of temporary total disability to the Board for consideration. By Own Motion Order and Own Motion Determination dated April 29, 1983, we awarded temporary total disability from November 26, 1982, the date of claimant's admission to the hospital, through January 10, 1983, the date claimant returned to work, less any additional time claimant may have worked. Claimant's attorney was allowed a fee equal to 25%

of the additional compensation (not to exceed $500) payable out of claimant's compensation and not in addition thereto.

Claimant requested reconsideration of the Board's order, contending that he was entitled to have his attorney's fee paid in addition to, rather than out of, his compensation. One of the arguments advanced by claimant in support of an insurer-paid attorney's fee was claimant's allegation that SAIF's refusal to voluntarily pay temporary total disability constituted unreasonable resistance to the payment of compensation. In response, we stated:

> "The 1981 legislature amended the own motion statute to provide in clear terms that the insurer or self-insured employer has authority to voluntarily pay own motion benefits without the need to obtain an order from the Board directing that such payment be made. ORS 656.278(4). * * * 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. There would appear to be no basis, therefore, for imposition of a penalty or an associated attorney's fee in an own motion proceeding. 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." 35 Van Natta at 1375.

Claimant was rehospitalized in October of 1983. SAIF voluntarily paid temporary disability benefits from October 14 through October 24, 1983. Claimant was scheduled to be hospitalized beginning January 12, 1984 for a total knee replacement. SAIF indicated its willingness to voluntarily reopen the claim for payment of temporary disability as of that time. Claimant sought payment of temporary partial disability between October 24, 1983 and January 12, 1984. Claimant's employer indicated that claimant was unable to perform his full duties, but that the employer was willing to continue to pay claimant half his salary, based upon his understanding that claimant would be capable of returning to full duty after recovering from his surgery. By order dated January 10, 1984, we awarded claimant temporary partial disability from October 25, 1983 through January 11, 1984, less time worked.

On the same date that the Board issued its Own Motion Order, a January 9, 1984 letter from claimant's attorney was received. Counsel stated claimant's dissatisfaction with the manner in which SAIF had processed his request for claim reopening, specifically

objecting to SAIF's referral of the time loss question to the Board for consideration. After receiving the Board's January 10, 1984 order, counsel requested that the Board amend its order to direct that SAIF pay a fee in addition to, rather than out of, the compensation awarded, stating, "It seems to me that this [is] a case where SAIF should be ordered to pay my attorney fee for its failure to process the claim, for its failure to send notice of acceptance or denial of the claim, failure to pay interim compensation, and unreasonable delay and refusal to pay."

By correspondence dated January 17, 1984, SAIF advised the Board that claimant was entitled to no compensation under the terms of the Board's January 10, 1984 order, because claimant's temporary partial disability rate was zero when calculated according to the formula provided by OAR 436-54-222. SAIF also advised the Board that, in paying temporary total disability "for the period of November 26th through January 11th, 1983," in accordance with the Board's April 29, 1983 order, SAIF had miscalculated the benefits due claimant, resulting in claimant's receipt of "double compensation for that time period." SAIF claimed an overpayment of $872.25, of which claimant and his attorney were advised by SAIF's letter of December 8, 1983. Since claimant had been hospitalized on January 12, 1984, and temporary total disability payments had been initiated, SAIF requested authorization to recover this overpayment from claimant's ongoing time loss benefits. See Forney v. Western States Plywood, 66 Or App 155 (1983), aff'd on other grounds 297 Or 628 (1984).

In response to SAIF's correspondence, claimant asserted that if the administrative rule governing calculation of temporary partial disability actually called for the result that claimant receive no compensation, then the rule was invalid and in contravention of ORS 656.212, the statute which states entitlement to temporary partial disability. Claimant asserted his entitlement to compensation under the terms of the Board's January 10, 1984 order and claimed that SAIF's failure to pay constituted grounds for imposition of a penalty as a percentage of the compensation withheld. Claimant also contended that SAIF's request for authorization to recover its alleged overpayment should be denied.

First we will address the issues raised by claimant; then we will consider SAIF's claim of an overpayment. As to claimant's expressed dissatisfaction with SAIF's claims processing vis-a-vis its refusal to voluntarily pay temporary disability benefits, the rationale expressed in our previous order, as quoted above, is dispositive. Claimant's request for an insurer-paid fee on this basis, therefore, is denied. If claimant is entitled to temporary partial disability under the terms of our January 10, 1984 order, however, and if that compensation has not been paid, then SAIF's failure or refusal to pay such compensation might be considered sufficient grounds for imposition of a penalty and associated attorney's fee. Bernie Hinzman, 35 Van Natta 1374, 1375 (1983).

Claimant's contention that OAR 436-54-222 is inconsistent with ORS 656.212 and, therefore, invalid is without merit. In Fink v. Metropolitan Public Defender, 67 Or App 79 (1984), the court held former OAR 436-54-225, the predecessor of the current administrative rule, consistent with its construction of ORS 656.212 and the legislative concept of "earning power." The method for computing entitlement to temporary partial disability provided by former OAR 436-54-225 is essentially identical to the method of calculation provided by the current rule.

Claimant's wage at the time of his 1971 injury was $3.35/hr. For a work week consisting of five eight-hour days, or a 40-hour work week, claimant was paid $134. Claimant's regular wage for the period between November 26, 1982 and January 10, 1983 was $500/week. His employer paid him $250 per week in partial wages. Even at half of his 1982/1983 salary, claimant was earning more than he was at the time of his 1971 injury. OAR 436-54-222(2) provides, "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." Since claimant was receiving $250 per week, and this exceeded his weekly wage at the time of injury, claimant's temporary partial disability rate for the period in question was zero. Therefore, although we ordered SAIF to pay temporary partial disability, claimant was not entitled to receive any compensation because of the disparity between his earnings at the time of injury and his current earnings. See Fink v. Metropolitan Public Defender, supra.

Within a week of our Own Motion Order awarding temporary partial disability, SAIF advised claimant, as well as the Board, that his temporary partial disability rate was zero and that, therefore, he was not entitled to receive any compensation under the terms of the order. Under the circumstances, SAIF's conduct cannot be considered unreasonable, and there is no basis for imposition of a penalty or attorney's fee.

The question of SAIF's overpayment is rather complicated. On December 8, 1983 SAIF advised claimant of an overpayment in the amount of $872.25. On December 14, 1983, by an amended notice, SAIF advised claimant of an overpayment in the amount of $195.05. In its submission to the Board requesting authorization to recover the overpaid benefits, SAIF stated the amount as $872.25. This was subsequently confirmed by SAIF as the correct amount of the overpayment. SAIF submitted its work sheets to document how claimant's temporary disability benefits were miscalculated for the period November 26, 1982 to January 11, 1983; how the benefits should have been properly calculated; and what the difference between the two calculations yields. SAIF has separate calculations for the overpayment of compensation to claimant, on the one hand, and the overpayment of attorney fees, which were paid out of claimant's compensation and directly to claimant's attorney, on the other hand. These calculations show an overpayment of $872.25 to claimant and an overpayment of $195.05 to claimant's attorney, for a total overpayment of $1,067.30. As stated, however, SAIF has recently confirmed that the total overpayment claimed is in the amount of $872.25.

Because claimant was injured in 1971, his current temporary disability rate is adjusted by the receipt of additional benefits from the Retroactive Reserve Fund. ORS 656.636(2)(b). In view of the technical nature of computing claimant's temporary total disability benefits for the period November 26, 1982 through January 10, 1983, and in consideration of the apparent fact that SAIF had previously miscalculated these benefits, we attempted to verify the correct rate of payment independently of SAIF's calculations. Claimant and his attorney rendered little or no assistance in this regard. Therefore, we took the liberty of consulting the Audit Section of the Compliance Division of the Workers' Compensation Department. We were informed that the correct rate of claimant's temporary total disability benefit for the period November 26, 1982 through January 10, 1983 was $190.59,

of which $65 was statutory and $125.59 was from the Retroactive Reserve Fund ("RR"). Thus, according to the Audit Section, the total benefits due for the 6.4 weeks between November 26, 1982 and January 10, 1983 was $1,219.78, $416 of which was the statutory benefit, $803.78 of which was RR. We provided this information from the Audit Section to SAIF and claimant's attorney. We received a response from claimant which does not appear to take issue with the Audit Section's figures. SAIF has not responded,

SAIF has provided copies of two checks dated May 17, 1983, made payable in the amounts of $1,787.08 and $500 respectively. The larger check is made payable directly to claimant; the other check is made payable to claimant's attorneys. This totals $2,287.08, and appears to have been SAIF's total payment to claimant and his attorneys in accordance with our April 29, 1983 order. Claimant does not contend that these funds were not received. Claimant simply contends, enigmatically, ". . . it is unclear on what basis SAIF continues to claim any alleged overpayment for compensation paid between November 1982 and January 1983."

We find and hold that SAIF miscalculated the benefits to which claimant was entitled under the terms of our April 29, 1983 Own Motion Order and Own Motion Determination, for the period November 26, 1982 through January 10, 1983. This resulted in an overpayment of compensation to claimant, which SAIF is entitled to recover. Based on the evidence of payment made to claimant and his attorney, and the information received from the Audit Section of the Compliance Division, which confirms SAIF's calculations, the total amount of the overpayment is $1,067.30. The latest information received from claimant and SAIF indicates that the claim remains in open status. We deem it appropriate to allow SAIF to reduce claimant's ongoing temporary total disability payments by 5% in order to recover all, or at least a portion of, its overpayment. When the claim is submitted for closure, SAIF shall advise whether any portion of the overpayment remains. SAIF is authorized to recover its overpayment from claimant only in the manner set forth herein, or in any future order of the Board. We recognize it is arguable whether or not statutory authority exists to generally allow recovery of overpaid benefits from ongoing temporary total disability. See ORS 656.268 (allowing a credit against permanent disability benefits); OAR 436-54-320. Since this case is now in own motion status, however, whether SAIF would otherwise be permitted to recover its overpayment in this manner, we believe it is within our discretionary authority to allow this form of relief. ORS 656.278.

In conclusion, claimant's request for an insurer-paid attorney's fee for unreasonable claims processing is denied, as is claimant's request for imposition of a penalty/attorney's fee for SAIF's nonpayment of compensation due under the terms of our prior Own Motion Order. SAIF's request that it be authorized to recover an overpayment of compensation is allowed. SAIF's overpayment is in the amount of $1,067.30 and may be recovered by reducing claimant's ongoing temporary total disability benefits in an amount equal to 5% of each periodic payment. SAIF may not recover its overpayment in any manner other than prescribed herein or by future order of the Board.

IT IS SO ORDERED.

JERRY W. McLARRIN, Claimant
Pozzi, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 84-06744
August 14, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of Referee T. Lavere Johnson's order which set aside its aggravation claim denial dated June 6, 1984 and remanded claimant's aggravation claim, or "aggravation claims," for acceptance and processing; awarded interim compensation from March 23, 1984 to June 6, 1984; and imposed a penalty and associated attorney's fee for failure to pay interim compensation.

The issues are the compensability of claimant's "aggravation claims"; whether claimant is barred from receiving workers' compensation benefits for his gastrointestinal disorder as a result of his application for and receipt of Nelson Trust Fund benefits, see Summit v. Weyerhaeuser Co., 25 Or App 851 (1976); whether the Referee correctly awarded claimant "interim compensation," and the related issue of penalties/attorney fees for failure to pay the same. In addition, the employer contends that the Referee decided an issue not raised by claimant and, therefore, one which was not properly before him.

There are three separate "claims" involved in this case. Two involve conditions which were not part of claimant's original injury claim, which was for an injury to his neck/shoulder/left arm. This injury occurred in September of 1979, was accepted and processed to closure in July of 1980 with an award for 5% unscheduled disability for injury to the neck. Claimant resumed his regular work as a log truck driver.

The first "claim" involved in this case arose in June of 1983 when claimant developed a rash on his hands and fingers and, as a result, was required to stop working for one week. Claimant's attending physician determined that this rash was an allergic reaction to medication that claimant was taking for his neck condition. Claimant's medication was changed, the rash dissipated, and claimant returned to work. The employer paid one week of temporary total disability, but the "claim" was not otherwise processed.

With regard to this "claim" the employer contends that there is no proof that a claim was ever filed, and the mere act of paying temporary total disability does not constitute acceptance within the meaning of Bauman v. SAIF, 295 Or 788 (1983). There is sufficient evidence to conclude that the employer was notified in writing of claimant's adverse reaction to the medication prescribed for treatment of his neck condition. Although the employer's payment of temporary total disability for the period that claimant was disabled does not, in and of itself establish "acceptance," it is at least evidence that the employer was aware of this "claim." Therefore, we affirm the portions of the Referee's order relevant to this aspect of the case.

The second "claim" involved in this case concerns a gastrointestinal disorder that claimant developed in the fall of 1983. It was initially thought that claimant was a cancer victim. Because of his symptoms of cramps, diarrhea, fatigue and weight loss, claimant stopped working on or about October 14,

1983. He applied for and received Nelton Trust Fund benefits. Claimant submitted to numerous diagnostic procedures intended to determine the nature and extent of his suspected cancer. All tests were negative. Thereafter, one of claimant's physicians suggested that claimant stop taking Clinoril, a medication that had been prescribed for treatment of his neck condition. When claimant stopped taking the Clinoril, his gastrointestinal symptoms subsided; however, his neck pain increased. This gradually increasing neck pain in late 1983/early 1984 gave rise to the third claim in this case, which is the only real "aggravation claim" within the meaning of ORS 656.273.

The second "claim," like the first "claim," is for the consequences of an adverse reaction to medication claimant was taking for his compensable injury. The employer argues that the evidence fails to establish this gastrointestinal disorder was a sequela of claimant's original injury; however, we agree with the Referee's finding and holding to the contrary. The employer also argues that the evidence fails to establish this "claim" was properly filed and that compensability should be decided adversely to claimant on this basis.

A claim can be presented to an employer/insurer for the first time at hearing, and this agency has jurisdiction to decide its merit in the absence of the employer/insurer's objection or request for continuance in order to decide whether to accept or deny. Thomas v. SAIF, 64 Or App 193 (1983). We find that no "claim" for a gastrointestinal disorder was submitted or filed by claimant directly to or with the employer; however, in light of Thomas, we find the employer's argument in this case unpersuasive.

We also disagree with the employer's assertion that the "claim" for compensation related to claimant's gastrointestinal disorder was not properly raised as an issue. Claimant was seeking interim compensation or temporary total disability from June of 1983 through and including the date of the employer's June 6, 1984 denial. The employer knew that claimant was seeking compensation for his gastrointestinal disorder, and that this medical problem had resulted in temporary disability. Claimant was cross-examined concerning the nature and extent of his gastrointestinal problems, as well as the circumstances which led him to believe that it might be related to his original industrial injury. Several physicians' reports in the employer's possession by the time of the hearing relate claimant's gastrointestinal symptomatology to his industrial injury, either as a direct or indirect consequence. Under these facts and circumstances, we find that the issue was raised by claimant and properly considered by the Referee.

As to the employer's argument that this claim is barred by claimant's application for and receipt of Nelson Trust Fund benefits, we affirm and adopt those portions of the Referee's order holding to the contrary.

We also agree with the Referee that claimant has established the compensability of his aggravation claim for a worsened neck condition. The evidence clearly preponderates in favor of concluding that claimant's current neck condition is related to his original injury. The employer argues that because there is no objective evidence to support a finding that claimant's condition

worsened, his aggravation claim is not compensable. The absence of objective medical evidence of a worsened condition is not necessarily fatal to a claim for aggravation pursuant to ORS 656.273. Richard A. Scharback, 37 Van Natta 598 (1985); James W. Foushee, 36 Van Natta 901 (1984); see Garbutt v. SAIF, 297 Or 148 (1984).

We find that when claimant stopped taking the Clinoril in order to alleviate his gastrointestinal symptomatology, he experienced increasing symptoms of neck pain, which prevented his return to work. Dr. Adams, claimant's attending orthopedic physician, confirmed that claimant's neck was more symptomatic after October of 1983, although he, like claimant's other physicians, was unable to objectively verify this worsening. Because of this increase in neck pain, a cervical disc problem was suspected. In April of 1984 a myelogram was performed but was negative. Claimant continued with conservative treatment, and in June of 1984 his neck pain improved to the point that he was able to return to light work for the employer. At the time of the hearing in October 1984 claimant was continuing to work regularly. The evidence preponderates in favor of concluding that claimant's neck condition worsened and that his aggravation claim, therefore, is compensable.

The Referee found that a February 23, 1984 report from Dr. Adams constituted an aggravation claim, and that this report, together with Dr. Bernstein's March 20, 1984 report, was sufficient to trigger the employer's duty to pay interim compensation. The only basis on which claimant sought a penalty and associated attorney's fee was the employer's allegedly unreasonable failure to pay interim compensation. Neither these reports, nor any others received by the employer prior to its denial, verify claimant's inability to work as a result of a worsened condition resulting from his original industrial injury. ORS 656.273(6). Therefore, claimant was not entitled to interim compensation pending the employer's denial, and the employer's failure to pay was not unreasonable.

The only period for which the Referee awarded interim compensation or temporary total disability was March 23, 1984 to June 6, 1984, the period for which he found claimant entitled to interim compensation pending denial. He declined to attempt to evaluate or assess the periods for which claimant might be entitled to temporary total disability for each of his separate "claims." He left this determination to the employer and the Evaluation Division pursuant to ORS 656.262 and 656.268, to be made in the course of processing these claims. In his respondent's brief, claimant states the issues as being compensability of time loss between June 19 and June 24, 1983; compensability of time loss between October 14, 1983 and February 21, 1984; and compensability of time loss between February 21, 1984 and June 25, 1984. The periods of entitlement to time loss in connection with each of these claims has not been decided in this proceeding. To the extent that any such issues remain, they will have to be resolved in a subsequent proceeding.

ORDER

The Referee's order dated December 12, 1984 is reversed in part. Those portions of the order which awarded interim

compensation from March 23, 1984 to June 6, 1984, and imposed a penalty and associated attorney's fee for failure to pay interim compensation, are reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $900 for services on Board review, to be paid by the self-insured employer.

RONALD A. NELSON, Claimant
Davis, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-05256
August 14, 1985
Order on Reconsideration

We mailed our Order on Review in this case on July 24, 1985. Claimant has requested information regarding the status of his alternative request that we reopen his claim as an aggravation of his original injury pursuant to our own motion authority under ORS 656.278. It is our policy in cases involving contemporaneous requests for review of a Referee's order and an own motion petition to issue orders resolving both matters at the same time. In this case, we did not do so. Pursuant to claimant's inquiry, we hereby withdraw our previous Order on Review for reconsideration. Having reconsidered the order, we adhere to and republish our former order effective this date. We have also this date issued our order in WCB Case No. 85-0020M, resolving claimant's petition for own motion relief.

IT IS SO ORDERED.

ITHA M. BARNETT, Claimant
Peter O. Hansen, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 83-04743
August 16, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of that portion of Referee Neal's order that awarded claimant 128° for 40% unscheduled permanent partial disability for the low back in lieu of the 32° for 10% unscheduled disability awarded by a May 1983 Determination Order. On review, claimant asserts entitlement to an award of permanent total disability or, in the alternative, an increased award of unscheduled disability. The insurer argues that the Referee's award was excessive.

After reviewing the record, we agree with the Referee's finding that claimant is not permanently and totally disabled. We disagree, however, that claimant is entitled to an award of 40% unscheduled disability.

The impairment resulting from claimant's compensable conditions has been rated, at most, as "mildly moderate." Her employment was classified as "light" prior to the compensable injury. It remained "light" as of the date of the hearing. After considering claimant's impairment and the relevant social and vocational factors, OAR 436-65-600, et seq., we conclude that claimant's permanent disability does not exceed 25%.

ORDER

The Referee's order dated February 7, 1985 is modified in part and affirmed in part. That portion of the Referee's order that awarded claimant 128° for 40% unscheduled permanent partial

disability is modified. In lieu of the Referee's award and all prior awards, claimant is awarded 80° for 25% unscheduled permanent partial disability compensation. Claimant's attorney's fee shall be adjusted consistent with the provisions of this order. The remainder of the Referee's order is affirmed.

JOHN R. BEEMAN, Claimant
Spears, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03601 & 84-04192
August 16, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of those portions of Referee Shebley's order which found that: (1) claimant's request for hearing, from the SAIF Corporation's denial of his back injury claim, was untimely; (2) claimant had failed to establish good cause for his delay in filing his request; and (3) SAIF's denial was not unreasonable. On review, claimant contends that: (1) SAIF waived its right to raise the timeliness issue; (2) the Referee erroneously received testimony concerning claimant's reception of SAIF's denial which was based upon inadmissable evidence; (3) in the alternative, claimant established good cause for any delay in filing his request for hearing; and (4) SAIF's denial was unreasonable.

Following our de novo review of the record, we affirm the order of the Referee with the following comment.

Claimant contends that the Referee erroneously based his finding, concerning the date claimant received SAIF's denial letter, upon the testimony from SAIF's legal examiner. Claimant asserts that this testimony was not based on personal knowledge, but was solely derived from inadmissable evidence.

We find that even without the disputed testimony there is sufficient evidence to establish the date claimant received the letter. Claimant testified on direct examination that he received the letter "Around the end of December, January -- some time period in there it was done. You know, I couldn't tell you the date or anything."

On cross examination claimant was asked several questions generally based on the assumption that if SAIF's file reflected that he had received the letter on January 16, 1984 would he disagree. Claimant testified as follows:

> "I'm unfamiliar as far as knowing when exactly I got it. If it was on the 16th or 15th, I don't know. *** Well, I can't positively say that I received it on the 16th because I don't know if it was the 16th and I don't know if it was the 15th. *** It could be some time in that time period, yes, but, you know, I can't tell you, yes, definitely I got it on the 16th because, you know, I don't know."

Although the evidence does not establish exactly what date claimant received the denial letter, the evidence does establish that he received the letter on or about January 16, 1984.

Moreover, there is no contention that he received SAIF's denial any later than January 16, 1984. Thus, his request for hearing, filed March 30, 1984, exceeded the 60-day filing requirement of ORS 656.319(1).

ORDER

The Referee's order dated November 20, 1984, as supplemented herein, is affirmed.

MARILYN J. CHRISTENSEN, Claimant
Peter O. Hansen, Claimant's Attorney
Lindsay, et al., Defense Attorneys
Scott M. Kelley & Assoc., Defense Attorneys

WCB 81-03090 & 81-09364
August 16, 1985
Order on Remand

This case is before us on remand from the Court of Appeals, Christensen v. Argonaut Ins. Co., 72 Or App 110, rev den, 299 Or 37 (1985), for determination of claimant's reasonable attorney fee. The court reversed that portion of our Order on Review that reversed the Referee's award of permanent total disability, thereby reinstating the permanent total disability award. Claimant's attorney is entitled to a reasonable attorney fee payable out of the increased compensation awarded to claimant. ORS 656.386(2); OAR 438-47-045. Claimant's attorney has also requested an attorney fee in addition to compensation for services before the Board on the previous Board review. Because claimant did not prevail before the Board on the issue of permanent total disability, there is no statutory basis for an insurer-paid attorney fee award. See ORS 656.382(2).

Claimant's attorney is allowed a reasonable fee of 25% of the increased compensation awarded to claimant by the Court of Appeals, not to exceed $3,000.

IT IS SO ORDERED.

HAROLD L. DOTSON, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-06463
August 16, 1985
Order on Reconsideration

Claimant has again requested that we reconsider our Order on Review dated June 28, 1985 and republished July 22, 1985. The issue under reconsideration is whether claimant's attorney is entitled to an employer/insurer paid attorney fee for services on Board review, where the only issue on Board review was the amount of an attorney fee awarded by the Referee. In our original order, we held that there is no statutory authority for the award of an attorney fee for services rendered solely to defend against an attack on the fee awarded by a Referee.

Claimant has pointed out that in Patrick Murphy, 37 Van Natta 667 (1985), we awarded an insurer-paid attorney fee to the claimant's attorney in a fact situation virtually indistinguishable from those of this case, and reasons that if the attorney in Murphy received a fee for services on Board review where the Board in fact reduced the Referee's fee award, he should receive a fee in this case, where the Board affirmed the Referee's fee award. This argument would be compelling, were it not for the fact that we now acknowledge that Murphy was wrong on the point, and that a fee should not have been awarded the claimant's attorney in

Murphy, for the same reason we do not award a fee in this case, i.e., there is no statutory authority for a fee award. The insurer in the Murphy case apparently acquiesed to our erroneous fee award, because the order became final without the insurer having requested that we reconsider it.

The request for reconsideration is allowed. On reconsideration, we adhere to and republish our former Order on Review dated June 28, 1985, effective this date.

IT IS SO ORDERED.

ARLO W. DUNBAR, Claimant
Cash Perrine, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-08807
August 16, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of that portion of Referee Daron's order which awarded 128° for 40% unscheduled permanent partial disability in addition to the Determination Order dated October 5, 1984 which awarded 48° for 15% unscheduled disability for injury to claimant's left shoulder. The issue on review is extent of unscheduled permanent partial disability.

Claimant was injured on October 12, 1983 when he was crushed between a door and its frame by a truck pushing a trash dumpster into the door. Claimant sustained a longitudinal fracture of his left clavicle. The fracture extended to the base of his neck. Arthrograms subsequent to treatment have found no cause for the continuing symptomatology in claimant's shoulders. Physical examinations have found full passive range of motion in both shoulders.

The attending physician and the Callahan Center found that claimant should be limited to lifting twenty pounds and should not lift above his shoulder level. Subsequently, the attending physician raised the limit to 40 pounds. Orthopaedic Consultants opined that claimant's impairment due to the injury was in the mild range and the attending physician concurred.

Claimant was 53 years old at the time of the hearing. He has a high school education. His job at the time of injury was commercial milk route sales and delivery. He had previously been self-employed in the same line of work and had been the assistant supervisor at a government fish hatchery. He has identified several types of sales positions as his reemployment goal, but has thus far been unable to obtain employment. However, there is no evidence that his inability to be employed at a less strenuous sales position is related in any way to his disability as opposed to the general availability of employment in his geographical area.

Considering claimant's mild impairment, his work history, and other relevant social and vocational factors, as well as the guidelines found at OAR 436-65-600, et seq., we find that claimant would be most appropriately compensated by an award of 64° for 20% unscheduled permanent partial disability.

ORDER

The Referee's order dated February 19, 1985 is modified to award claimant 64° for 20% unscheduled permanent partial disability for injury to his shoulders in lieu of all prior awards. Claimant's attorney fee shall be adjusted accordingly.

DAN W. HEDRICK, Claimant
Hayner, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 84-10652
August 16, 1985
Order Denying Request to Dismiss

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

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

Claimant is allowed 20 days from the date of this order to file his respondent's brief.

IT IS SO ORDERED.

DOYLE LAMBERT, Claimant
Ackerman, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-08504 & 81-02089
August 16, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of that portion of Referee Baker's order which awarded claimant's attorney $2,500 as a reasonable attorney's fee for prevailing on a denied aggravation claim. The employer contends that the attorney's fee is excessive. We agree and modify the Referee's order accordingly.

The only issue at hearing was whether claimant's "aggravation claim," which was the subject of the employer's August 7, 1984 denial letter, should have been processed under claimant's August 1980 injury claim, rather than his December 30, 1976 injury claim. The employer agreed to pay medical expenses pursuant to ORS 656.245; however, because claimant's aggravation rights had expired in the 1976 claim, which was initially closed in November of 1978, the employer declined to reopen the claim for payment of time loss and directed claimant to apply for own motion relief pursuant to ORS 656.278. Claimant successfully contended that the employer should have processed his aggravation claim under the more recent, 1980 claim, with its attendant right to the payment of temporary total disability and claim reclosure pursuant to ORS 656.268. Although there were other issues pending for resolution at the time the hearing convened, including issues of penalties/attorney fees, all such issues were expressly reserved by the parties for resolution at a later date.

There is a multitude of documentary exhibits; however, many of these are relevant to issues which were reserved for future resolution. Claimant's attorney was responsible for developing

some exhibits pertinent to the issues decided by the Referee. Claimant and his wife were the only witnesses to testify. The transcript is 45 pages. Claimant submitted written closing argument to the Referee.

Counsel's affidavit details 37.2 hours expended in representing claimant since he was retained as counsel in July of 1982. Presumably, the significant efforts expended for purposes of this proceeding have occurred since the August 7, 1984 denial. The affidavit details 21.2 hours since this date, and counsel states that his hourly rate at the time was $75 per hour.

The results obtained through this proceeding are significant. By establishing that his aggravation claim should be processed under the more recent claim, claimant is entitled to payment of temporary total disability as a matter of right, and not merely at the discretion of the Board pursuant to the own motion statute. Furthermore, when the claim is reclosed, claimant will have the right to appeal the Determination Order if he is dissatisfied with that order in any particular.

The Referee did not articulate his reasons for awarding a fee of $2,500. Although we can only speculate, he may have felt that an enhanced fee was justified by the procedural complexity of the case. He may also have intended to penalize the employer for what he may have considered unreasonable claims processing. With regard to the former possibility, although the history of claimant's two injuries is complicated by the employer's questionable claims processing, the question decided by the Referee nevertheless was rather straightforward and did not require extensive legal or factual research or analysis by claimant's attorney. As to the latter possibility, the question of claimant's possible entitlement to penalties/attorney fees for unreasonable claims processing was not one of the issues submitted for decision.

In Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), we considered the factors enumerated in Muncy v. SAIF, 19 Or App 783, 787-88 (1974), in evaluating the reasonableness of an attorney's fee. These factors (time devoted to the case, complexity of the issues, value of the interest, skill and standing of counsel, nature of the proceedings and results secured) are integral parts of the efforts expended/results obtained standard established by our administrative rules governing attorney fees. OAR 438-47-010(2).

The Referee has authority to award up to $3,000 as an attorney's fee for prevailing on a denied claim, absent a finding of extraordinary services, in which case the fee may exceed the maximum allowed by rule. OAR 438-47-020(1), 438-47-010(2). However, the fee awarded must bear reasonable relation to the efforts expended by counsel and results obtained in claimant's behalf. See also Daryl W. Sell, 37 Van Natta 649 (1985).

In consideration of the above, we find and hold that $1,500 is a reasonable attorney's fee for services rendered at hearing.

ORDER

The Referee's order dated December 21, 1984 is modified. In lieu of the Referee's award of attorney fees, claimant's attorney is awarded $1,500 as a reasonable attorney's fee for prevailing on a denied claim.

CHARLES LAVINDER, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 84-05169
August 16, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Mongrain's order which awarded claimant 160° for 50% unscheduled permanent partial disability in lieu of a Determination Order award of 64° for 20% unscheduled permanent partial disability for claimant's left shoulder.

In applying the guidelines for rating permanent disability, the Referee determined that claimant has medium residual functional capacity. The Referee found the guidelines to suggest an award of 35% unscheduled permanent partial disability, but considering claimant's functional illiteracy and poor learning capacity, awarded 50%. We find that claimant has but light residual functional capacity. On our de novo review of the record, considering claimant's impairment together with the pertinent social/vocational factors, see ORS 656.214 (5); OAR 436-65-600 et seq., we agree with the Referee that claimant should have an award of 160° for 50% unscheduled permanent partial disability. Accordingly, the Board affirms the order of the Referee.

ORDER

The Referee's order dated January 11, 1985 is affirmed. Claimant's attorney is awarded $450 for services on Board review, to be paid by the insurer.

DONALD MACKIN, Claimant
Steven C. Yates, Claimant's Attorney
Daniel J. DeNorch, Defense Attorney

WCB 84-08198
August 16, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Michael Johnson's order that affirmed the Determination Order granting claimant 160° for 50% unscheduled permanent partial disability for the left shoulder. On review, the insurer asserts that the 50% award was excessive. Claimant has submitted no brief on review.

Claimant is an auto mechanic who specializes in front end alignment and brake work. He sustained two compensable injuries to the left shoulder. The first occurred in 1980, the most recent in 1983. Surgery was twice performed on the shoulder. Subsequent to surgery, claimant was limited to lifting six to ten pounds on the left. Claimant is left-handed. He remains capable of working on autos, but it appears that he is now limited to light or sedentary work. His disability was rated "moderate" by his treating physician.

After reviewing claimant's file, the Evaluation Division rated claimant's unscheduled disability at 50%. The Referee approved the resulting Determination Order. On review, the insurer argues that the Evaluation Division improperly rated claimant's disability in that it used the wrong information from

the Dictionary of Occupational Titles in gauging claimant's work adaptability before and after the compensable injuries. Specifically, the insurer argues that the Division's evaluator utilized information from the "auto mechanic" category of the Dictionary, when in fact the "front end mechanic" or "brake drum lathe operator" categories should have been used. When one of these categories is used, the resulting values in the evaluation areas of "Work Experience," "Labor Market," and "Adaptability" are reduced, thereby reducing claimant's overall disability rating.

Whether or not we agree with the insurer's argument, we cannot consider the Dictionary of Occupational Titles materials it submits on review. This material was never entered into evidence at the hearing. It became a part of the record only when it was submitted to the Referee in the form of written closing argument. The same material was submitted for our consideration on Board review. Although closing arguments are part of the hearing record, they are not evidence. See Ramona A. Waits 36 Van Natta 1684 (1984). Because the materials submitted are not evidence, we cannot consider them. Groshong v Montgomery Ward Company, 73 Or App 403 (1985).

Although we cannot consider the materials submitted, we can remand the case to the Referee for the taking of additional evidence if we are convinced that the hearing record was incompletely or improperly developed. ORS 656. 295(5); see Bailey v. SAIF, 296 Or 41 (1983). In Robert Barnett, 31 Van Natta 172, 173, aff'd mem. (1981), 59 Or App 133 (1982), we held "* * * To merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing." See OAR 438-07-025. We find that the materials submitted on Board review were obtainable and could have been offered as evidence at hearing. Therefore, remand is not appropriate.

After reviewing those portions of the record that we can consider, we affirm the order of the Referee. Because claimant's attorney submitted no brief on review, no attorney's fee will be allowed on Board review.

ORDER

The Referee's order dated January 30, 1985 is affirmed.

ROBERT E. MARTELL, Claimant
Bischoff & Strooband, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-01811
August 16, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) found claimant's claim to have been properly closed by the Determination Order dated December 29, 1983; (2) affirmed the insurer's denial of claimant's neck and upper back aggravation claim; and (3) awarded claimant 48° for 15% unscheduled permanent partial disability for the neck and upper back. Following the issuance of the order, claimant filed a request for reconsideration, alleging that the Referee ruled on a matter that was not at issue. The insurer agreed with claimant and on December 24, 1984 an Order on Reconsideration issued amending the original Opinion and Order. The issues on review are whether claimant's claim was prematurely closed, aggravation and extent of unscheduled disability.

Claimant was compensably injured on August 31, 1983 when he fell from the window of a truck parked at a loading dock. Claimant fell about six feet to the ground, striking his neck and upper back. He was seen initially by his family doctor, who prescribed rest and analgesics.

Claimant was then referred to Dr. Jones, a neurologist. Claimant complained of pain over the spinous process of the seventh thoracic vertebra, as well as pain radiating from the neck to the right upper extremity. At hearing, claimant testified that he was completely symptom-free prior to his compensable injury. Despite claimant's subjective complaints, Dr. Jones could find no signs of abnormality in the upper extremity.

Claimant then began seeing Dr. Jones's associate, Dr. Englander, who became the treating physician. Dr. Englander noted that claimant's symptoms had remained essentially unchanged since the time of the injury, but he could find no objective evidence of radiculopathy or other abnormality. Dr. Englander found claimant medically stationary on November 29, 1983, based partly on claimant's statements that his condition had remained unchanged. No objective impairment was found at that time.

Dr. Englander's report was apparently the basis for the Determination Order issued on December 29, 1983. The Determination Order granted claimant time loss, but no award of unscheduled permanent partial disability. Claimant now asserts that his condition has worsened since the issuance of the Determination Order, although he admits that his symptoms are essentially the same in terms of location and overall character.

In March of 1984 claimant was examined by Dr. Nash, who is also a neurologist. Claimant presented Dr. Nash with X-rays that had been taken in September of 1983. They showed narrowed disc spaces with foramen encroachment at C5-6 and 6-7 bilaterally. The narrowing appeared to be caused by bulging discs at both sites. Dr. Nash found positive neurological signs that he felt were representative of neuroradiculopathy. He also found claimant's history compatible with a cervical myofacial injury, and he recommended additional testing. A subsequent CT scan and myelogram confirmed the X-ray evidence of the bulging discs. It was Dr. Nash's opinion that claimant had never been medically stationary since the injury.

Claimant was seen once again by Dr. Englander. The examination revealed normal motor function in the upper extremities, and the same reflex function findings that Dr. Englander had seen prior to the issuance of the December 1983 Determination Order. The only sign of possible cervical radiculopathy was a slightly reduced triceps reflex. In commenting on the possible causes of claimant's disc lesions, Dr. Englander stated that they preexisted claimant's fall and were unlikely the result of it. He indicated that evidence of claimant's preexisting condition surfaced with the September 1983 X-rays, and that the mechanism of claimant's fall was not compatible with his cervical disc lesions. Dr. Englander also doubted Dr. Nash's clinical findings.

The insurer next sent claimant to Dr. Rosenbaum, a third neurologist. Dr. Rosenbaum's August 1984 exam revealed a normal

range of cervical motion, a full range of motion of the shoulders, normal motor strength and no direct evidence of cervical radiculopathy. Dr. Rosenbaum had completed an examination in December of 1983, and he found no worsening since that time. It was also his opinion that claimant suffered from preexisting cervical osteoarthritis in addition to cervical strain. He rated claimant's loss of cervical function as "mild," apparently gauging the effects of the preexisting problems as well as the cervical strain.

I

On the issue of premature closure, the Referee found the claim to have been properly closed by the December 1983 Determination Order. The Referee relied on the report of Dr. Englander over that of Dr. Nash. We agree that the claim was properly closed, but find that it was unnecessary and inappropriate for the reports of Drs. Englander and Nash to have been compared. At the time of the Determination Order, Dr. Englander's report was the only one in existence. Dr. Nash's report issued several months after the Determination Order. Whether a claimant is medically stationary is to be judged by the evidence available at the time of closure, not by the subsequent development of the case. Alvarez v. GAB Business Services, 72 Or App 524 (1985); Maarefi v. SAIF, 69 Or App 527 (1984). Dr. Englander's report clearly stated that claimant was stationary. The resulting Determination Order to that effect was proper.

II.

On the aggravation issue, the Referee found the reports of Drs. Englander and Rosenbaum more persuasive than that of Dr. Nash and denied the claim. We agree. Although Dr. Nash was the last treating physician, Dr. Rosenbaum was the first, and he remained involved in the claim throughout. According to Dr. Englander, there has been no material worsening of claimant's condition since December of 1983, and even if there has, it is due to claimant's preexisting degenerative osteoarthritis. Dr. Rosenbaum agrees. We find these medical reports persuasive and the claim not compensable.

III.

On the issue of extent, the Referee found claimant entitled to 15% unscheduled disability, whereas the Determination Order gave none. In making that finding, the Referee found claimant to have disability resulting from a cervical injury, with probable radiculopathy. We find this conclusion to be inherently inconsistent with the Referee's holding regarding the aggravation claim. On that issue, the Referee accepted the reports of Drs. Englander and Rosenbaum, which effectively stated that claimant's condition was related to noncompensable osteoarthritis. If claimant's current condition is not compensable, any disability resulting therefrom should not be the basis of an unscheduled award. We believe claimant's current condition to be the result of noncompensable causes, and that no unscheduled award should have been made. However, on review the insurer does not ask for a reversal of the award, but rather asks that the award not be increased. It is the Board's policy not to reduce an award of permanent partial disability when a reduction has not been requested. Therefore, on the issue of extent, we affirm the order of the Referee.

ORDER

The Referee's order dated November 6, 1984, as amended on reconsideration, is affirmed.

MICHAEL J. MOBLEY, Claimant
Bischoff & Strooband, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 84-05293
August 16, 1985
Order on Reconsideration

The self-insured employer requests reconsideration of our Order on Review entered herein on July 24, 1985, in which we modified the Referee's award of interim compensation and award of attorney fees for prevailing on a denied claim, and modified the penalty/attorney's fee imposed for failure to pay interim compensation. The employer does not take issue with any portion of our order. The purpose of this request for reconsideration is to request "supplemental relief."

The Referee awarded interim compensation from the date of the employer's knowledge of claimant's injury, October 17, 1983, until the date of its denial, April 19, 1984. The Referee was aware that claimant had only missed approximately nine days of work as a result of his injury. The law governing payment of interim compensation at the time of the Referee's decision required payment of interim compensation to a claimant who continued to perform his or her regular work. Bono v. SAIF, 66 Or App 138 (1983). By the time this case was reviewed, the Supreme Court had reversed the Court of Appeals' decision, holding that in order to receive interim compensation, a subject worker must have left work as that phrase is used in ORS 656.210(3). 298 Or 405 (1984). Thus, on review claimant essentially conceded he was only entitled to interim compensation for the days that he actually did not work as a result of his industrial injury, i.e. from October 17, 1983, through and including October 28, 1983.

The employer now seeks an order directing that claimant reimburse any interim compensation paid between the date of his return to work in October of 1983 and the date of denial; i.e. the additional interim compensation erroneously awarded by the Referee in apparent reliance upon the Court of Appeals' Bono decision. The employer contends that the interim compensation analogous to time loss was payable pending review of the Referee's decision, pursuant to ORS 656.313(1); but that "the interim compensation that was not attributable to time loss was not . . . payable under ORS 656.313." It appears, however, that the employer paid all of the interim compensation awarded by the Referee pending Board review.

Under the circumstances of this case, we decline to allow the employer's request for relief. Therefore, we adhere to our Order on Review as originally published.

Claimant has submitted a response in opposition to the employer's Request for Reconsideration. We deem it appropriate to award claimant's attorney an additional fee for these supplemental services on Board review.

ORDER

On reconsideration of the Order on Review entered herein on July 24, 1985, the Board adheres to its prior order, which hereby is republished effective this date. In addition to the attorney's fee awarded by our Order on Review, claimant's attorney is awarded $350 for services on reconsideration.

TONYA M. REIDHEAD, Claimant
W. Daniel Bates, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-09421
August 16, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of those portions of Referee Howell's order which set aside the Determination Order dated January 24, 1983 which awarded temporary disability and found claimant medically stationary on January 5, 1983, and which set aside SAIF's denial of compensability of surgical procedures performed in July, August and December 1983. SAIF also requests that the Board review the extent of claimant's unscheduled permanent partial disability in the event the Board finds the Determination Order should be reinstated. The issues on review are premature closure, compensability, and extent of unscheduled permanent partial disability.

I

Claimant was compensably injured on November 11, 1982. She sustained a strain injury in her right lower abdominal quadrant. At the time of the injury she was approximately six months pregnant. Her attending physician, Dr. Furrer, opined that she probably would not have sustained the injury if she had not been pregnant. By December 21, 1982 Dr. Furrer reported that claimant had minimal symptoms and was doing well. On January 5, 1983 Dr. Furrer wrote SAIF the following letter: "In my opinion [claimant] has now reached her pre-injury status from the accident November 11, 1982." He reported on January 17, 1983 that claimant could return to work six weeks post-delivery and that she had "no apparent residuals from 11/11/82 accident." On January 20, he reported:

> "In my opinion, [claimant] has reached her pre-injury status as of 1/5/83 (from accident 11/11/82) and there is no limitation of activity or work or permanent residual resulting from that accident. She is now limited from work or lifting due only to her pregnancy which is due to reach confinement 2/5/83±."

The Determination Order issued on January 24, 1983. On March 9, 1983 Dr. Bianchini examined claimant and diagnosed a strained abdominal wall or round ligament related to claimant's industrial injury, and reported that claimant was not medically stationary, was not released to return to work, and needed no treatment because the problem was "self-limiting." On April 7, 1983 Dr. Furrer reported that claimant was released to return to work on March 4, 1983. On April 15, Dr. Bianchini concurred with the statements that he found no objective indications to support claimant's complaints of pain, that he recommended no treatment

nor follow-up care for the abdominal strain injury, and that he neither authorized time loss nor prohibited claimant's return to work due to her industrial injury.

Claimant was admitted to a hospital for exploratory laparoscopy and dilatation and curettage (D & C) in July 1983. No medical report or testimony described the findings of that surgery. Dr. Furrer testified that he performed the July surgery to satisfy himself that he had not missed something in evaluating the source of claimant's abdominal pain problem, although he conceded it was not indicated nor ordinarily performed for a muscle strain injury.

In August 1983 claimant submitted to a second laparoscopy and D & C. According to the surgical report, Dr. Furrer found a small hydatid cyst, and adhesions and other indications of chronic pelvic inflammatory disease.

Further examinations ruled out inguinal and femoral herniations or nerve root entrapments. In December 1983 claimant submitted to a third laparoscopy and D & C. According to the surgical report, Dr. Barbour found a hemorrhagic right tube with an old necrotic hydatid cyst, tubal occlusion, and left tube adhesions.

In February 1984 Dr. Furrer concurred with the statement that the August surgery was performed on a diagnostic basis to discover the cause of and solve claimant's continuing pain problem. He also concurred with the statement that the cause of claimant's pain was related to her pelvic inflammatory disease and that the industrial injury had no relationship to claimant's condition. Dr. Furrer further reported that Dr. Barbour's examination report indicated the same findings as his.

Dr. French, a general surgeon, examined claimant on March 10, 1984. He theorized that claimant's symptomatology was "more likely related to her reproductive organs and that she may have sustained some sort of a straining injury to one of the ligamentous structures of her uterus when she lifted and twisted at the time of her injury while being eight months pregnant." He concluded that her symptoms were not consistent with a hernia and that a pain center evaluation might be appropriate.

The hearing was held on September 13, 1984. The record was held open for the depositions of Dr. Furrer on September 25 and Dr. French on September 28, 1984. Dr. Furrer opined that claimant might not have returned to her pre-injury status in January 1983 because subsequent events indicated some possibly related problems. Dr. Furrer's testimony is confusing because it is phrased in so many qualifications for every possibility. At one point, his explanation becomes as clear and as relevant as it gets:

> "I think the pain probably is related gynecologically. And I think it's related to her straining in this area that already had a chronic pelvic inflammatory disease. And the pain on having intercourse is probably related also to the aggravation of the pelvic inflammatory disease, probably a pulling standpoint."

Dr. French deferred to the gynecologists on the question of

medical causation because his examination and his knowledge of the mechanisms involved in claimant's pelvic architecture were insufficient in his opinion to make a statement. He did say that adhesions do not cause pain in and of themselves, but they can be a source of pain if stretched or inflamed.

Claimant testified that before her injury she never had the kind of abdominal pain she has now. Before the second laparoscopy she had no knowledge that she had had pelvic inflammatory disease. Claimant's pain worsens with activity. She has done little if anything since the birth of her child to restore her abdominal muscle strength and tone.

II

We first consider whether the claim was prematurely closed. At the time of closure, the treating physician was certain that claimant was medically stationary, and he repeated his opinion after the birth of claimant's child. At the time of closure, there was no treatment recommended nor was any further improvement expected with the passage of time. Claimant is not entitled to look back after the passage of one and one-half years and have the Determination Order set aside. See Sullivan v. Argonaut, 73 Or App 694 (1985); Laurence E. Saxton, 37 Van Natta 692 (1985). We find that the claim was not prematurely closed based on the medical opinion evidence available at the time of closure.

Claimant obtained one examination from her family doctor in April 1983 regarding her continuing abdominal pain. He thought it was related by history to her industrial injury, but had no treatment recommendation. Claimant returned to Dr. Furrer in July 1983 because of her abdominal pain. Dr. Furrer performed the first laparoscopy on a diagnostic basis. We do not have the benefit of a surgical report nor of testimony relating the findings at that procedure, but Dr. Furrer found nothing to indicate the source of claimant's problems at that time according to his later testimony. The second laparoscopy was also done on a diagnostic basis and similarly revealed no cause for claimant's complaints, although the doctor admitted that the hydatid cyst could cause pain.

Diagnostic services related to discovery of the cause of complaints of pain can be reasonable and necessary expenses to be borne by the industrial insurer even if the results indicate that the condition requiring the test was unrelated to the compensable injury. Faught v. SAIF, 70 Or App 388 (1984); Brooks v. D & R Timber, 55 Or App 688 (1982); Waunita M. Walker, 36 Van Natta 44 (1984). We find that claimant was entitled to have one diagnostic laparoscopy but that the additional laparoscopies and related procedures were not related to claimant's industrial injury, having had a cause determinable by laparoscopy reasonably ruled out by the first laparoscopy. The subsequent laparoscopies merely confirmed the findings of the first laparoscopy, according to claimant's attending physician. Therefore, that portion of the Referee's order must be modified to award compensation for the first diagnostic laparoscopy only as a reasonably related medical expense.

Having found that the claim was properly closed by the Determination Order, and extent of disability having been an issue at hearing and having been raised on review, we consider the

extent of claimant's permanent partial disability due to her abdominal injury. Dr. Furrer originally opined that claimant had no permanent impairment due to her abdominal injury and released her to return to her regular work. Dr. Barbour has limited claimant to jobs that do not require lifting or prolonged standing but has not related the limits to claimant's industrial injury. Claimant has pain associated with activity. It is medically probable that the source of claimant's pain is adhesions that are stretched at the time of activity but the source of the adhesions is claimant's unrelated pelvic inflammatory disease. We find that claimant's limitations due to pain are not attributable to her industrial injury and, therefore, find that she is not entitled to an award for permanent partial disability. Cf. Barrett v. D & H Drywall, 73 Or App 184 (1985).

Claimant's attorney is awarded no fee on review because claimant's compensation was reduced on review. ORS 656.386(1), 656.382(2).

ORDER

The Referee's order dated January 17, 1985 is reversed in part and modified in part. That portion of the order that set aside the Determination Order dated January 24, 1983 is reversed and the Determination Order is reinstated. That portion of the order that set aside SAIF's denial is modified to award claimant compensation for the first laparoscopy performed as a diagnostic medical service only. The remainder of SAIF's denial is reinstated. Claimant's attorney fee is modified to award $250 for services through hearing related to overturning SAIF's denial of the first laparoscopy.

JOSEPH P. RETTLER, Claimant
Michael B. Dye, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 83-06794
August 16, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of that portion of Referee Foster's order which increased his unscheduled permanent disability award for a low back injury from 55% (176°), as awarded by a July 11, 1983 Determination Order, to 80% (256°). On review, claimant contends that he is entitled to an award of permanent total disability. The insurer contends that the Determination Order's permanent disability award is sufficient.

Following our de novo review of the medical and lay evidence, including claimant's testimony, we are not persuaded that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation. See ORS 656.206(1)(a). In addition, claimant has failed to establish that a combination of medical and non-medical conditions have effectively foreclosed him from gainful employment. See Livesay v. SAIF, 55 Or App 390 (1981). Thus, he is not entitled to an award of permanent total disability through the so-called "odd lot" doctrine.

Finally, we conclude that the Referee's award of permanent disability adequately reflects claimant's permanent loss of earning capacity as a result of his compensable injury. See ORS 656.214(5). Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated February 28, 1985 is affirmed.

RAYMOND D. TAYLOR, Claimant
Bick & Monte, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Norman Kelley, Ass't. Attorney General

WCB TP-85009
August 16, 1985
Third Party Distribution Order

The SAIF Corporation petitioned the Board to resolve a conflict regarding the final distribution of claimant's third-party settlement pursuant to ORS 656.593. Partial distribution pursuant to the agreement of the parties was previously made. There is now the sum of $11,097.77 held in trust by claimant's attorney. Initially, SAIF contended that the sum of $2,303.95 was due to it for reimbursement of costs in connection with claimant's vocational rehabilitation program, and that the remaining $8,793.82 could be distributed to claimant.

We have since determined that, if reimbursement of the vocational rehabilitation costs is statutorily authorized or required, the proper party to be ultimately reimbursed is the Workers' Compensation Department. The Department of Justice, on behalf of the Workers' Compensation Department, has acknowledged that, under current law, there is no statutory requirement or authorization for reimbursement of the costs involved in this case out of the proceeds of third-party recoveries. (We note that effective January 1, 1986 ORS 656.593 will be amended to add a new subsection including the Department within the term "paying agency" for the purpose of reimbursement of most vocational rehabilitation costs from third-party recoveries. 1985 Or Laws, Ch. 600, sec. 12.) That being the case, the Department has withdrawn and waived its claim to the funds previously claimed as a part of the SAIF Corporation's lien, and has asked that this proceeding be dismissed. For the sake of finality of agency action, rather than dismissing this matter, we issue this final order.

Now, therefore, claimant's attorney is authorized and directed to disburse the sum of $11,097.77, presently held in trust, directly to claimant as a complete and final distribution of the third-party settlement obtained in this case.

IT IS SO ORDERED.

WANENA D. TRUE, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03069
August 16, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of those portions of Referee Pferdner's order which awarded claimant interim compensation and assessed it penalties and accompanying attorney fees for failing to pay interim compensation and for an unreasonable delay in accepting or denying the claim. On review, SAIF contends that: (1) claimant was not entitled to interim compensation because she had retired from the work force at the time of her claim; and (2) penalties and accompanying attorney fees are not justified because there are no amounts "then due" upon which to base them. We agree and reverse.

Subsequent to the Referee's order the Supreme Court issued its opinion in Cutright v. Weyerhaeuser, 299 Or 290 (1985). In Cutright, the claimants, who had retired from the labor market at the time of their aggravation claims, sought temporary total disability. The Cutright court found that the retired claimants were not entitled to temporary disability benefits, reasoning that temporary disability was intended to provide support and help replace lost income during the healing or recovery process. The court concluded that a claim for temporary disability in the absence of wage loss seeks a remedy where there is no damage, in that non-workers can sustain medical expenses, but they cannot lose earnings. Cutright, 299 Or at 302.

As with the claimants in Cutright, claimant had retired at the time of her request for further medical services. Thus, pursuant to the Cutright holding, claimant is not entitled to interim compensation. Since no interim compensation was due, imposition of a penalty and accompanying attorney fees for failing to pay interim compensation would also be inappropriate.

Furthermore, no penalty and attorney fees are justified for SAIF's failure to accept or deny the claim. Claimant's attending physician requested authorization for surgery on November 14, 1983. SAIF authorized surgery on December 19, 1983. Although SAIF refused to pay interim compensation and never formally denied the claim, there is no contention that claimant's medical bills were left unpaid. Thus, inasmuch as all compensation to which claimant was entitled has apparently been paid, there are no amounts "then due," either at the time the conduct being penalized occurred or at the time of the hearing, upon which to base a penalty and attorney fees. ORS 656.262(10); EBI Companies v. Thomas, 66 Or App 105, 111 (1983); Harold A. Lester, 37 Van Natta 745 (1985).

Accordingly, those portions of the Referee's order which assessed SAIF a penalty and accompanying attorney fees for refusing to pay interim compensation and for failing to accept or deny claimant's aggravation claim are reversed.

ORDER

The Referee's orders dated October 2, 1984 and October 31, 1984 are reversed.

KENNETH E. BIRKBECK (Deceased), Claimant
Robert N. Ehmann, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-02480
August 19, 1985
Order on Review (Remanding)

Reviewed by Board Members Ferris and McMurdo.

Decedent's wife has filed a motion for a substitution of parties and for an order remanding this case to the Hearings Division for the receipt and consideration of evidence not available at the time of the hearing.

On January 17, 1985 Referee Fink issued an Opinion and Order affirming the SAIF Corporation's denials of claimant's occupational disease claims. A request for Board review of the Referee's order was thereafter timely filed. On March 22, 1985 claimant passed away. An autopsy has been ordered. Decedent's wife now moves the Board for an order remanding this case to the Hearings Division for the receipt and consideration of the autopsy report and any medical reports generated therefrom.

We have authority to remand a case for the taking of additional evidence if we find that the record below has been incompletely developed. ORS 656.295(5); Bailey v. SAIF, 296 Or 41 (1983). In the present case, the autopsy report, which was obviously not capable of being produced at the time of the hearing, may be relevant to the determination of causation. Therefore, we find remand to be appropriate. Remand, however, shall be limited to the receipt and consideration of the autopsy report and any medical reports directly generated therefrom.

ORDER

The Referee's order dated January 17, 1985 is vacated and this matter is remanded to the Hearings Division for further proceedings consistent with this order.

SALLY CARDER, Claimant
Jerry Gastineau, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-07474
August 19, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of that portion of Referee Mongrain's order that set aside its denial of claimant's claim for a left wrist ganglion condition. The issue on review is compensability.

Claimant was compensably injured in 1976 when her hand became entangled in a conveyor belt mechanism. She suffered a sprain and contusion of the left hand, along with an "indentation" on the dorsal surface of the left wrist. Claimant thereafter experienced varying levels of hand and wrist symptoms, depending on the level of activity in which she was engaged.

In May of 1978 claimant underwent surgery on the left wrist for what her orthopedist diagnosed as de Quervain's syndrome. Subsequent to the surgery, claimant's symptoms continued.

Despite claimant's ongoing symptoms, no ganglion condition was definitively diagnosed until January of 1984, when Dr. Gilsdorf determined that a ganglion was present at the dorsal aspect of claimant's left wrist. This diagnosis came more than seven years after claimant's 1976 injury. At the time of Dr. Gilsdorf's examination, he took a history from claimant that the ganglion had been present since the time of the accident. Because the prior medical record made no mention of a ganglion, however, Dr. Gilsdorf concluded that claimant had merely experienced wrist symptoms without the presence of a ganglion.

SAIF's medical consultant, Dr. Embick, reviewed claimant's records and stated that ganglia are normally the result of degenerative rather than traumatic causes. He felt it particularly significant that no definite diagnosis of a ganglion was made in this case until several years post-injury. In Dr. Embick's opinion, the extended time period between the injury and the diagnosis made it unlikely that there was a causal connection between the two.

After reviewing Dr. Embick's report, Dr. Gilsdorf agreed that

an absence of a ganglion diagnosis for more than seven years made it unlikely that claimant's injury caused her condition. He disagreed that ganglia were usually caused by degenerative changes, although he admitted that "many" ganglion cases are of degenerative origin. A few months later, however, Dr. Gilsdorf issued another report in which he altered his opinion. He stated that after reviewing "a copy of the complete medical file," it was probable that claimant's industrial accident precipitated symptoms that ultimately resulted in the development of a ganglion. His opinion was shared by Dr. Ross, who had examined claimant in 1980 and 1982.

At hearing, SAIF produced the testimony of neurological consultant Dr. Tennyson. Prior to the hearing he had reviewed claimant's medical record. He was also present throughout the hearing and heard claimant's testimony. It was Dr. Tennyson's opinion that ganglia can result from either trauma or degenerative changes. He stated, however, that a ganglion resulting from trauma is generally noticeable within three to six months after an injury, and that it is invariably present within one year. Because the present claimant's ganglion did not surface for more than seven years post-accident, Dr. Tennyson found it highly unlikely that it was related to the industrial injury.

Because Dr. Tennyson was present during claimant's testimony, he heard her describe the activities in which she had been engaged subsequent to the 1976 injury. The activities included periods of employment in which claimant kneaded bread, arranged flowers and engaged in other activity involving repetitive hand and wrist movements. Claimant also incurred minor "jamming" injuries to a thumb and finger subsequent to the 1976 injury. After hearing claimant's testimony, Dr. Tennyson stated that "microtrauma" such as that precipitated by claimant's many activities during the seven years since the injury could cause the degenerative type of ganglion to occur.

Of the several medical opinions present in this case, we find Dr. Tennyson's most persuasive. He had the benefit of not only claimant's medical file, but her testimony, as well. From the testimony, Dr. Tennyson was able to analyze the effects of claimant's post-injury activities which, in his opinion, may have resulted in the development of a degenerative ganglion. We note that Dr. Gilsdorf's opinion (upon which the Referee relied) does not discuss the potential effects of these activities, nor does it thoroughly analyze the mechanism by which a 1976 injury could lead to a 1984 ganglion. Without more from Dr. Gilsdorf or other physicians, we cannot agree with the Referee that claimant has produced sufficient evidence to sustain her claim.

ORDER

The Referee's order dated December 10, 1984 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's denial of claimant's left wrist claim is reversed and the denial is reinstated. The remainder of the order is affirmed.

JEANNE M. LORENZEN, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-01859
August 19, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of those portions of Referee Howell's order which: (1) awarded $5 per day child care costs as medical services under ORS 656.245 while claimant was hospitalized for treatment of her compensable low back injury; (2) awarded a penalty and attorney's fee for unreasonable delay in providing a formal notice of denial of child care costs; and (3) awarded a penalty and attorney's fee for unreasonable delay of payment to claimant's physician for compensable services. The issues on review are whether child care during hospitalization of a single parent is compensable as a medical service, penalties and attorney fees for unreasonable delay in providing a formal denial of services, and penalties and attorney fees for unreasonable delay of payment for accepted medical services.

Claimant was compensably injured on August 3, 1983. She was hospitalized seven times for approximately 71 days over the course of the next sixteen months. She arranged and paid for an adult to perform child care services while she was in the hospital and paid that adult $5 per day for the services in excess of those she would have paid for while working. Claimant was unmarried as a result of divorce, but had custody of three children, aged 10, 14 and 16. There had been two recently attempted burglaries of her home. Claimant's total monthly income during the period of her total disability was approximately $445, consisting of temporary disability compensation, child support, and welfare payments for two of the children.

SAIF argues on review that the purpose of claimant's temporary disability compensation was to replace wages that claimant would have been using to provide child care, among other things, and that child care is not "other related services" under the medical services statute in addition to the disability compensation. Claimant replies that it was necessary for her to provide responsible adult supervision of her minor children during her hospitalizations and that the process of recovery from her injury required the child care services as "other related services" under ORS 656.245(1). Each party cited Peggie Roberts, 15 Van Natta 76 (1975), apparently the only published decision in which the issue has been presented, in support of its contentions.

Roberts involved a mother with six children, one of whom had serious medical conditions requiring constant supervision. As the Board majority stated:

> "The question to be determined by the Referee was whether child care, when authorized or approved by the workman's treating physician, was a proper 'medical' or 'other related service' which would be the responsibility of the employer under the provisions of ORS 656.245(1). The referee concluded, after considering that the expense would not have been incurred but for the industrial injury, that it was

> authorized or approved by claimant's physician, that the physical state of claimant during the hospitalization and period of recovery precluded claimant from caring for her children herself, that the child care aided claimant in the recovery process, and, considering the unwritten adminstrative policy regarding child care expenses, that such expenses incurred by claimant were compensable 'medical' or 'other related services' under the provisions of ORS 656.245(1)." (Emphasis added.)

There are now administrative rules applicable to the provision of medical services. OAR 436-69-003, et seq. The rules applicable at the time of claimant's injury, and now, make no mention of child care services as either included or excluded services, nor of child care providers as included or excluded service providers. OAR 436-69-201 and -301 apply to provision of and providers of medical services. OAR 436-69-301(2) provides:

> "Attending physicians may prescribe treatment to be carried out by persons licensed to provide medical service, or by other persons who work under the direct supervision and control of the attending physician. If the attending physician prescribes services to be provided by persons not licensed to provide medical services for the relief of injury and not under the direct supervision and control of the attending physician, the physician shall state in writing that he or she assumes full responsiblity for the performance of those services."

It cannot be denied that claimant owed a high legal and moral duty to provide responsible supervision for her minor children during the period of her confinement in the hospital for treatment of her industrial injury. But for her industrial injury, claimant would have taken care of her children herself or by purchasing child care services out of her income. That the services were reasonable and necessary and related in circumstance to claimant's injury is not at issue. However, the question in this case is whether child care services were provided as a medical or other related service under ORS 656.245(1). There is no evidence in the record to indicate that any physician or practitioner of the healing arts ever authorized or discussed or considered claimant's need for child care services in connection with her hospitalizations or any other aspect of her recovery from her injuries. We find that claimant has failed to carry her burden of proof that the child care services she obtained during her hospitalizations in 1983 and 1984 were compensable as medical or other related services under ORS 656.245(1) and reverse the Referee's order.

On the issue of penalties and attorney fees for unreasonable delay in providing a formal notice of denial of child care services, we reverse the Referee's order because there are no amounts due upon which to base a penalty.

On the issue of penalties and attorney fees for unreasonable delay of payment for claimant's physician's compensable services, the Board affirms the Referee's order.

ORDER

The Referee's order dated January 25, 1985 is reversed in part and affirmed in part. Those portions of the order which awarded child care costs as medical services and penalties and attorney fees for unreasonable delay in providing a formal denial of the child care costs are reversed. All other portions of the Referee's order are affirmed. For prevailing on the issue of penalties and attorney fees associated with the claim for unreasonable delay of payment for medical services, claimant's attorney is awarded $350 for services on Board review, to be paid by the SAIF Corporation.

MARLENE W. RITCHIE, Claimant
Brian Whitehead, Claimant's Attorney
Merrily McCabe, Defense Attorney

WCB 84-07248
August 19, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Seymour's order that set its denial of claimant's occupational disease claim for rhinosinusitis and bronchitis. Claimant cross-requests review of that portion of the Referee's order that refused to award penalties and attorney fees for SAIF's failure to accept or deny the claim within 60 days, or penalties and attorney fees for SAIF's failure to pay interim compensation within 14 days of receipt of the claim. We review de novo and reverse the Referee's order, both as to compensability and penalties and attorney fees.

Claimant is a clerical worker employed by the Executive Department of the State of Oregon. She does not smoke and has never smoked. None of her family members are smokers. Claimant began working for the Department in October of 1976. At that time the Department was housed in the Public Service Building. Claimant testified that she experienced no respiratory symptoms while working in the Public Service Building, apparently because the building did not employ a "closed" ventilation system and windows could be opened to ventilate claimant's work area.

In 1979 the Executive Department moved to the Executive Building. Claimant's new work area consisted of a large room separated into cubicles by five-foot high partitions. The Executive Building employs a "closed" ventilation system in that air is conditioned and recirculated without the influx of outside air. Smoking was permitted in claimant's work area, and claimant testified that there were three smokers working within six feet of her desk.

In September of 1982, approximately three years after the Department moved to the Executive Building, claimant began experiencing symptoms in the form of a cough. She attributed her

symptoms to second-hand cigarette smoke, which she said was heavy enough to be seen and smelled. Claimant testified that at times, a "blue haze" of smoke was visible throughout the work area. She complained to her supervisors about her work environment, but was dissatisfied with what she felt was an inadequate response to her complaints. The situation grew heated, and claimant was ultimately reprimanded for insubordination when she allegedly went outside the chain of command in an attempt to be relocated to a less smoky environment. The reprimand led claimant to file a grievance, and the relationship between claimant and her supervisors remained strained.

Claimant apparently first sought medical attention in April of 1983, which was the same time period in which her reprimand and subsequent grievance arose. She saw Dr. Mahoney, who issued a note indicating that claimant was suffering from a cough brought on by exposure to cigarette smoke, and that she should be relocated to a less smoky environment. Claimant presented this note to her supervisor, and she was moved to a less smoky area of the Executive Building. She was also given an air purifier to place at her desk. According to claimant, neither of these measures were helpful, and she again requested a move to a different environment.

Claimant next saw a pulmonary specialist, Dr. Schultz. She described her symptoms as a cough precipitated by what she termed a "blue haze" of cigarette smoke on the job. She stated that the coughing had on occasion been so severe that she had coughed up blood and vomited. She also indicated that she would sometimes begin coughing even when she suspected that someone in the room had been smoking. Dr. Schultz found it difficult to obtain a clear history from claimant regarding what exactly precipitated her symptoms or when they developed. He also was unable to find objective signs of respiratory distress, nasal congestion or sinus problems. Chest X-rays were normal. Because claimant gave a history of coughing both on and off the job, Dr. Schultz recommended that claimant undergo an allergy test to determine whether she was reactive to substances outside the workplace. There is no evidence that an allergy test has ever been done.

Perhaps because of the lack of objective findings, Dr. Scultz was uncertain of claimant's ability to objectively relate her symptoms. He stated:

> "I am a little concerned about the impartiality of her symptom description, as she is obviously quite concerned that her symptoms are cigarette smoke related and expressed the view that she felt her office co-workers should be prohibited from smoking. . . . She rather strongly indicates that she does not feel that she should have to take medications for prevention of these symptoms when they are caused by others smoking. Obviously, this complicates her treatment, particularly in terms of assessing response to therapeutic approaches."

From claimant's history, Dr. Schultz did find an association between claimant's work environment and her cough, despite the lack of evidence of rhinitis or bronchitis.

Claimant testified that she first missed work in May of 1983, although the record is devoid of documented time lost during that month. She was verifiably absent from work from June 27 through July 4, 1983. On June 30, 1983 Dr. Young issued a return to work slip indicating that claimant had been under his care beginning on June 27, and that she could return to work on July 5. Claimant presented this slip to her employer and informed the employer that her absence had been due to her exposure to smoke on the job. Ultimately, at the request of Dr. Young, claimant was transferred from the Executive Building to a different State office building where the environment was relatively smoke free. Claimant testified that her symptoms began to resolve after the move. At the time of the hearing, however, claimant had resumed working at the Executive Building for approximately two hours per day and, according to her testimony, her symptoms had begun to return.

While claimant worked at the Executive Building, she regularly took breaks with two coworkers who smoked. Breaks were taken either at a break room in the Executive Building or at a coffee shop in the Marion County Courthouse. The environments in both the break room and the coffee shop were repeatedly characterized by various witnesses as very smoky. Claimant testified that she attempted to avoid smoke while in these rooms, and did not enter the rooms if too many smokers were present.

Following her initial time loss in mid-1983, claimant apparently missed no more work until March of 1984, when she was scheduled to undergo a breast biopsy. Her treating doctor stated that claimant was suffering from bronchitis, aggravated by cigarette smoke, and that she should remain in a smoke-free environment in order to prepare for the biopsy. She was authorized by Dr. Young to remain off work through April 6, 1984. Claimant subsequently filed a claim with her health care insurer for both the biopsy and the purported bronchitis condition.

In May and December of 1984 SAIF sent its industrial hygienist to evaluate the air quality of the Executive Building. Measurements were taken for particulate matter, formaldehyde and carbon monoxide, which are among the contaminants produced by burning tobacco. The hygienist found the Executive Building air quality to be in "good order" with particulate levels, formaldehyde and carbon monoxide all being at or well below average levels. By contrast, air quality at the Marion County coffee shop, which was also measured, was poor due to high levels of all three contaminants. Testimony at hearing revealed that although there is no specific test for cigarette smoke pollution, levels of the three contaminants tested by SAIF's hygienist are a good indicator of general air quality.

In addition to taking specific test measurements, SAIF's hygienist personally observed the general environment near claimant's former work station and found it to be clean. Interestingly, test measurements taken at claimant's former worksite evidenced contaminant levels even lower than in other areas of the work floor.

Five more witnesses testified regarding claimant's general work environment at the Executive Building. All of them worked with claimant in the same building and on the same floor. One witness directly corroborated claimant's testimony regarding the

high levels of cigarette smoke present, at least during the last few months that the witness worked for the Executive Department in 1984. Two witnesses testified that they regularly went to breaks with claimant and smoked in her presence. One witness testified that she [the witness] has a verified allergy to cigarette smoke and is very sensitive to its effects. She was able to work in claimant's general work area without experiencing difficulty with second-hand smoke. Claimant's current supervisor testified that while claimant worked in the Executive Building, she was approximately 15 feet away from the nearest smoking coworker.

Two physicians also testified. One was Dr. Parosa, a pulmonary specialist, who examined claimant ten days before the hearing. Dr. Parosa testified that claimant is not allergic to tobacco, but is more sensitive to cigarette smoke than most persons. In Dr. Parosa's opinion, claimant primarily suffers from rhinosinusitis, an inflammatory condition which affects the upper respiratory tract and triggers coughing. Dr. Parosa also initially suggested a secondary diagnosis of bronchitis, but further testimony revealed that in the absence of positive sputum sample testing, this diagnosis was tentative at best. The documentary evidence revealed that sputum samples taken earlier were essentially negative.

Dr. Parosa testified that at the time he examined claimant she exhibited objective signs of rhinosinusitis, namely a reddening and swelling of the nasal passages. He admitted that it is possible to develop those symptoms over a period of days as well as over an extended period, and that except for the objective symptoms, he was relying exclusively on claimant's history to render his diagnosis. Using those factors, however, he opined that claimant's work environment was the major contributing cause of the onset of claimant's symptoms.

Dr. Parosa is an outspoken advocate of banning smoking in public places. He testified in this case free of charge on behalf of claimant, and has done so for another claimant in at least one other workers' compensation case. When asked the reasons for his testifying in the present case, he answered in part "...frankly, because I believe in her cause."

Dr. Girod, an internist and infectious disease specialist, testified on behalf of SAIF. Dr. Girod reviewed claimant's medical records but did not examine her. When asked to explain the various test results generated in 1983 and 1984, Dr. Girod essentially found them all negative for signs of either rhinosinusitis or bronchitis. He noted that a sputum sample was negative for signs of bronchitis, and that a methacholine test revealed no evidence of asthma. Pulmonary function tests were normal as were claimant's chest X-rays. Dr. Girod noted that none of the medical reports generated throughout the period of the claim revealed evidence of a chronic pulmonary condition. Neither did the reports mention abnormal breath sounds, red eyes, throat pathology, pale nasal passages, or other objective signs of disease. In response to questioning regarding the presence of disease, he stated:

> "The only evidence [is] . . . the complaints themselves, and that may be significant, but it's based, I think, primarily on the credibility of the person

> who makes the complaints. If . . . those complaints are, indeed, valid, then there could certainly be some illness here, although not severe illness, but it's solely in a subjective question which can't be supported by any objective findings whatsoever."

Dr. Girod personally visited the Executive Building and found the general environment to be consistent with the description given by SAIF's industrial hygienist. He testified that under the conditions he observed, it would have been "unimaginable" that claimant would develop symptoms in the work place.

The remaining medical evidence consists of several reports generated by Drs. Schultz, Young and Lonigan in 1983 and 1984. All three physicians took a history from claimant that she had worked in an environment characterized by heavy smoke. Her claim form, filed in July of 1984, indicated that she had developed symptoms due to "heavy" smoke on the job. As was noted earlier, Dr. Schultz was unable to objectively verify the presence of disease in May of 1983.

A few days after claimant filed her claim, she was examined by Dr. Lonigan. As did Dr. Schultz, Dr. Lonigan noted that claimant was "very concerned about being an innocent bystander to smoke exposure...." Dr. Lonigan could find no specific evidence of disease, but based on claimant's history he found a "clear relationship" between claimant's work and the development of symptoms.

In November of 1984 Dr. Young issued a report in which he indicated that while he had no reason to doubt claimant's subjective complaints, he could find no objective evidence of disease. He stated:

> "Unfortunately, there has been a paucity of objective findings during her visits to my office. Aside from a croupy sounding cough which cannot be manufactured, the lungs have sounded uniformly clear to auscultation. Chest xrays of February 1983 showed no radiographic changes to explain her cough. However, in March 1984 lowgrade perihilar bronchial wall thickening was noted on xray bilaterally, suggesting a slight bronchitis."

Dr. Young went on to state that chronic exposure to cigarette smoke can be a major contributing cause of the development or aggravation of bronchitis. The X-rays from which he apparently drew his conclusion regarding bronchitis were later reviewed by a second radiologist, who found them to be normal, apparently with no evidence of the bronchial wall thickening earlier suggested. The lack of productive sputum also suggests the absence of bronchitis, according to Drs. Parosa and Girod.

After reviewing the evidence regarding the compensability issue, the Referee set aside SAIF's denial, holding that claimant had proven the requisite elements of a compensable occupational disease. The Referee found, however, that claimant's alleged

hypersensitivity was not an "underlying disease process" that preexisted her employment. Therefore, he found Weller v. Union Carbide, 288 Or 27 (1979) and its progeny (most specifically Wheeler v. Boise Cascade, 298 Or 452 (1984)) to be inapplicable. Rather, he held that claimant did, in fact, suffer from a disease process in the form of rhinosinusitis and bronchitis, and that the process developed for the first time after claimant began work. The Referee also found that claimant's disease process required medical treatment and that the conditions of her employment were the major contributing cause of the development of her disease. In reaching his conclusion, the Referee accepted the opinion of Dr. Parosa over that of Dr. Girod. The Referee did not discuss the remainder of the medical record.

From the outset, we disagree with the Referee regarding the applicability of Weller and Wheeler. While no physician in this case has specifically stated that claimant's alleged hypersensitivity to cigarette smoke preexisted her employment, we are satisfied, on the basis of Dr. Parosa's testimony as a whole, that if claimant indeed has an underlying hypersensitivity, it was preexisting. See, e.g., Mary A. Downey, 37 Van Natta 455 (1985). Therefore, if claimant establishes the existence of an underlying disease, she must prove that it was worsened by the conditions of her employment, Weller, 288 Or at 35, whether or not she was asymptomatic at the time she began work. Wheeler, 298 Or at 457-58.

Regardless of whether claimant's disease was preexisting, she must prove from the outset that a disease or infection in fact exists, ORS 656.802(1)(a), and that the conditions of her employment were the major contributing cause thereof. Dethlefs v. Hyster Co., 295 Or 298 (1983). After reviewing the evidence, we are not satisfied that claimant has established the existence of disease. In reaching our decision, we note that except for Dr. Parosa's examination ten days before the hearing, there has been a consistent lack of objective findings throughout the long history of the claim. Dr. Schultz could find none in 1983. Dr. Lonigan could find little or none in 1984. Dr. Young could find little or none. Dr. Parosa's objective findings consisted of reddened and swollen nasal passages that may or may not have developed over a lengthy period. There has never been persuasive evidence of bronchitis.

We also note that claimant apparently worked at the Executive Building for approximately three years before developing symptoms in September of 1982. If indeed claimant is hypersensitive to cigarette smoke, it remains unexplained why she did not react for the first three years of her employment in the new building.

It is clear from the record that claimant represented to the physicians who examined her that her working environment was very smoky. The resulting opinions from those physicians, we believe, were generated primarily from that history. After reviewing the air quality test results, as well as the testimony of several witnesses who either worked in or visited the Executive Building, we conclude that claimant's working environment was not as she represented it to her physicians. To the extent that the medical opinions were based on claimant's history, therefore, they are not persuasive. Miller v. Granite Const. Co., 28 Or App 473 (1977).

We do not find claimant's testimony persuasive either, for

the record reveals that her testimony may be fueled by reasons other than the desire for compensation. Since she first complained to her supervisor about her working environment, there has been a great deal of tension and bad feelings between claimant and Executive Department management personnel. We share Dr. Schultz's concern that this intra-agency conflict has affected claimant's ability to objectively, or even accurately, relate the factual elements of this claim.

Finally, we find the testimony of Dr. Girod more persuasive than that of Dr. Parosa, for several reasons. First, unlike Dr. Parosa, Dr. Girod had the benefit of actually visiting claimant's worksite. He had the opportunity to view firsthand the conditions about which claimant complained. After seeing those conditions for himself, he stated that it would be "unimaginable" that claimant would experience symptoms in that environment. Second, we note that Dr. Parosa's opinion, like that of the other physicians, is based primarily on the history given by claimant. In addition, it is possible that his opinion was affected by the active role he has assumed in what he terms the "cause", i.e., preventing smoking in public places.

Claimant has failed to prove that she suffers from a disease or infection, as is required by the statute. Therefore, we need not consider whether her working conditions were the major cause of the disease, or whether the disease was worsened by her employment. We note that this case is factually similar to Mary A. Downey, supra. In Downey, the claimant was a State employe who alleged that her underlying irritative rhinosinusitis was worsened by exposure to cigarette smoke in the workplace. Unlike the present case, however, the greater weight of the evidence established that the claimant, in fact, worked in a very smoky environment. The claimant also produced the opinions of three doctors who stated that her work environment, in fact, worsened her underlying condition. As we have noted, claimant's evidence in the present case is simply not persuasive, either as to her working conditions nor her alleged disease. This claim is not compensable.

The remaining issue is claimant's entitlement to penalties and attorneys fees. She seeks penalties both for SAIF's alleged failure to accept or deny claimant's claim within 60 days, and for its alleged failure to pay interim compensation within 14 days of the employer's notice or knowledge of the claim. Claimant asserts that the employer had notice or knowledge on April 18, 1983, when Dr. Mahoney issued a note indicating that claimant was experiencing symptoms as a result of cigarette smoke, and that she should be moved to a new work environment. In the alternative, claimant argues that the employer was notified of the claim either by Dr. Young's note of June 30, 1983, in which he stated that claimant had been under his care and that she had verified time loss, or by his note of March 22, 1984, authorizing time loss at that time. SAIF argues that the employer did not obtain notice of the claim until claimant filed her Form 801 on July 13, 1984.

The Referee held that neither Dr. Mahoney's nor Dr. Young's notes satisfied the elements of a claim for compensation. He found that because the notes did not state that claimant's work was the major contributing cause of her disability, the employer was not apprised of a claim for occupational disease. We

disagree. First, there is no requirement that a claim for compensation contain a description of the degree of contribution alleged to exist between the work and the disability. Rather, a claim for compensation is a communication, oral or written, see Robert L. Fowler, 36 Van Natta 1222, 1223 (1984), from the claimant or his representative, which serves to advise the employer of a potential compensable claim. Stanley Siler, 35 Van Natta 196 (1983).

The question in this case involves when the employer can be said to have gained knowledge of claimant's claim. From the outset, we note that, for purposes of the penalties issue involving interim compensation, the question of whether the April 18, 1983 note from Dr. Young constitutes a claim is moot. Claimant did not have a verified time loss until June 27, 1983. A claimant is not entitled to interim compensation for a period in which he or she has not left work. Bono v. SAIF, 298 Or 405 (1984). Therefore, even if SAIF unreasonably failed to respond to Dr. Mahoney's April 18 note, there was no compensation "then due" upon which to calculate a penalty. EBI Companies v Thomas, 66 Or App 105 (1983). We are convinced, however, that claimant's employer was sufficiently apprised of claimant's potential compensable claim when it obtained knowledge of her verified time loss on June 30, 1983. Dr. Young's note verified time loss and notified the employer that claimant was receiving medical services. Although the note did not specifically state that services were being provided for conditions related to claimant's work, we are satisfied that the note, coupled with claimant's explanation to her employer of the alleged relationship between the time loss and her work, was sufficient to put the employer on notice that a potentially compensable claim was present. This is particularly true considering the strained relationship that existed between claimant and her employer at the time the purported claim was made. The employer knew or should have known that claimant was claiming injury or disease related to cigarette smoke at work. Therefore, interim compensation was payable no later than 14 days after June 30, 1983, the date the employer obtained knowledge of the claim. Claimant was entitled to interim compensation for the periods in which she was verifiably off work, beginning June 27, 1983, and running through the date of the denial on September 24, 1984. We find that SAIF's failure to pay it was unreasonable, and that penalties are warranted.

In order to resolve the penalties issue as it pertains to SAIF's alleged failure to accept or deny within 60 days, we must address whether the April 18, 1983 note of Dr. Mahoney in fact constituted a claim. The text of that note was as follows:

> "TO WHOM IT MAY CONCERN:
>
> "RE: MARLENE W. RITCHIE
>
> "Dear Sirs:
>
> "Marlene Ritchie has had a persistent cough now for the past 1 1/2 years. This cough is brought on by exposure to cigarette smoke. This patient is bothered with a distracting and somewhat disabling cough and this has not responded successfully to medication.

"I recommend that she be placed in an environment with as little exposure to cigarette smoke as possible.

"I think it is unfortunate that any employee has to work in such an environment. I am particularly concerned with an employee with known sensitivity to cigarette smoke is expected to work effectively in an environment where there is constant smoke exposure.

"If I can be of further help, please let me know."

ORS 656.005(7) provides that a "claim" is alternatively a request for compensation from the worker or his representative, or any compensable injury of which a subject employer has notice or knowledge. "Notice" need not be in any particular form. ORS 656.265(2). A report from the worker's doctor concerning an accident which may involve a compensable injury is considered "notice." Id.

After reviewing the circumstances surrounding this case, we find that we need not specifically determine whether the April 1983 report constituted a claim. In reaching this finding, we conclude that whether or not the report was a claim in and of itself, the report, when coupled with the circumstances surrounding it, made out a claim for compensation. Claimant's complaints to her employer regarding her work environment began before Dr. Mahoney's April report issued. This is best evidenced by the fact that, by the time the report was made, claimant had been reprimanded for alleged insubordination arising from her complaints. We are satisfied that the combination of claimant's complaints, which were quite direct, and Dr. Mahoney's report were sufficient to constitute a claim, as that term is used in the statutes.

In order to assess penalties and attorney's fees for failure to accept or deny within the statutory period, however, we must first find that the insurer's failure was unreasonable. Mt. Mazama Plywood v. Beattie, 62 Or App 355 (1983). Although we find that the aforementioned circumstances were sufficient to constitute a claim, we do not find SAIF's conduct in April of 1983 to have been unreasonable. Dr. Mahoney's report did not affirmatively state that a claim was being made on claimant's behalf. Claimant did not specifically advise the employer that a claim was being made. In the absence of more affirmative conduct, SAIF's failure to act was not unreasonable.

It was unreasonable, however, for SAIF to fail to respond to Dr. Young's June 30, 1983 return to work slip. This note clearly advised the employer that claimant was under a physician's care and that she had verified time loss. Claimant presented the note to her employer and asserted that she had been off work as a result of her work environment. The employer's knowledge of claimant's time loss, medical treatment and the circumstances alleged to be the cause thereof were such that there should have been little question that a potentially compensable claim was being presented. It was, therefore, unreasonable that the claim was not accepted nor denied within the 60-day period provided by the

statute. Penalties and a resulting attorney's fee are warranted. We note that although there are two penalty issues in this case, we are constrained by statute to assess a single penalty consisting of 25% of the compensation due. ORS 656.262(10).

ORDER

The Referee's order dated February 7, 1985 is reversed. The SAIF Corporation's denial of claimant's claim for occupational disease is reinstated. Claimant is entitled to interim compensation for periods of verified time loss between June 27, 1983 and September 24, 1984, the date of the denial. The SAIF Corporation is assessed a penalty in the amount of 25% of the compensation due. Claimant's attorney is awarded a fee of $250, payable by SAIF Corporation, for prevailing on the penalty issue.

ROBERT E. STAM, JR., Claimant
John Unwin, Attorney, Dept. of Justice

WCB CV-85001
August 19, 1985
Crime Victim Order

Claimant requests review of the final order of the Department of Justice Crime Victim Compensation Fund that denied claimant compensation pursuant to ORS 147.005 to 147.365 arising out of an alleged criminal incident on December 31, 1984. We are the final reviewing tribunal pursuant to ORS 147.155(5). By statute, the only constraint placed upon our review is that we acheive substantial justice. We have previously held that to do so we review de novo on the record as a whole. Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

The parties have waived a hearing. Based upon our de novo review of the documentary evidence submitted, we make the following findings of fact:

1. Claimant was assaulted by being struck in the face by one Toby Shaver on the night of December 31, 1984, while in a tavern in Baker, Oregon.

2. Claimant promptly reported the crime to the Baker, Oregon police.

3. It is more probable than not that claimant did not substantially provoke the assault.

4. As a result of the assault, claimant sought medical services of a reasonable value and cost of $146.65.

5. Claimant cooperated with the prosecuting authority and, in fact, urged that his assailant be prosecuted.

6. As a matter of prosecutorial discretion, the City Attorney of Baker, Oregon declined to prosecute claimant's assailant.

Based upon these findings of fact, we reach the following conclusions:

The Department of Justice denied claimant compensation as the victim of a crime for two reasons. In its first order, the Department denied compensation on the ground that claimant had substantially provoked his assailant. ORS 147.015(5). In its

second and final order, the Department denied compensation on the ground that claimant had not cooperated in the prosecution of his assailant. ORS 147.015(3). The evidence is very persuasive that, contrary to not cooperating in prosecution, claimant insisted that his assailant be prosecuted, which insistence was disregarded, for whatever reason, by the person empowered to prosecute. While the other ground, substantial provocation, is a closer question, we conclude that the evidence does not persuade us that claimant substantially provoked the assault, which is the level required by ORS 147.015(5).

We nevertheless affirm the Department's order. Claimant has documented a compensable loss of $146.65. In order to receive compensation under this statutory scheme, a claimant must comply with all relevant portions of ORS 147.015. which begins:

> "A person is entitled to an award of compensation under ORS 147.005 to 147.365 if:
>
> "(1) He is a victim, or is a dependent of a deceased victim of a compensable crime that resulted in a compensable loss of more than $250 . . . ."

Because claimant's compensable loss is less than the statutory minimum, he is not entitled to compensation under ORS 147.005 to 147.365.

ORDER

The final order of the Department of Justice Crime Victim Compensation Fund dated May 24, 1985 is affirmed.

MICHELLE R. BIDEGARY, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-00434
August 22, 1985
Order of Dismissal

The claimant has requested review of Referee's order dated July 17, 1985. The request for review was filed with the Board on August 19, 1985, 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.

ALVIN H. CANELL, Claimant
Dave Frohnmayer, Dept. of Justice

WCB 84-03347
August 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Presiding Referee Daughtry's order dismissing claimant's request for hearing for want of prosecution. The issue on review is whether the dismissal was proper. Claimant has filed no brief on review.

Claimant is an inmate at the Oregon State Penitentiary. He filed notice of an injury with the Inmate Injury Fund in December

of 1983. The Fund denied the claim approximately two months later. Claimant, through his attorney, requested a hearing on March 12, 1984. On June 12, 1984 the attorney requested that a hearing be scheduled. On or about July 1, 1984 claimant escaped from the penitentiary.

On August 21, 1984, the Deputy Administrator of the Inmate Injury Fund requested that the Hearings Division issue an Order to Show Cause why the request for hearing should not be dismissed. On October 31, 1984, claimant's attorney notified the Hearings Division that he was withdrawing from the case because of his client's failure to maintain contact. He also advised the Board of claimant's escape. The Board made inquiry of the Injury Fund regarding claimant's status, and on November 5, 1984, the Fund confirmed that claimant had escaped. The Board thereafter acquired claimant's last known address and, based on the information received, the Presiding Referee issued an Order to Show Cause on December 13, 1984. The order advised claimant that the previously-filed application to schedule a hearing was not a sufficient response to the order. It further advised that claimant's failure to respond would result in the dismissal of his request for hearing. Claimant did not respond, and on February 1, 1985, the Presiding Referee issued an Order of Dismissal.

In the interim, claimant had been recaptured and transported to California to testify as a material witness in a murder trial. Claimant was apparently not in Oregon during most of February 1985.

Subsequent to his receipt of the Order of Dismissal, claimant submitted various correspondence to the Board, which we have construed as both a request for Board review and a request for remand. Claimant argues that the claim should not have been dismissed because at the time the Order to Show Cause issued, he was not at his last known address. The reason claimant was not at his last known address, of course, is that he was on escape status.

OAR 438-06-085 provides that a request for hearing may be dismissed for want of prosecution where the party requesting the hearing causes a delay of more than 90 days without good cause. Based on the information the Presiding Referee had received at the time he issued the Order of Dismissal, the Presiding Referee found that claimant had failed to show good cause for the delay. On review, we have considered the information that was made available to the Presiding Referee and we find that Order of Dismissal was proper. After reviewing the correspondence submitted by claimant on review, we find remand to be unnecessary, for the Presiding Referee's consideration of these materials would not affect the result.

ORDER

The Presiding Referee's Order of Dismissal dated February 1, 1985 is affirmed.

ELIZABETH V. FOWLER, Claimant
David C. Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-01589
August 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Mongrain's order which found claimant had not proven she was permanently and totally disabled as a result of her compensable back injury and disability preexisting her work-related accident, awarded 320° for 100% unscheduled permanent partial disability due to her low back injury in lieu of prior awards totalling 192° for 60% permanent disability and affirmed the prior award of 7.5° for 5% scheduled permanent partial disability of her left leg. In its response brief, the SAIF Corporation cross-requests review of the extent of claimant's permanent disability and requests reduction of the unscheduled disability award. The issues on review are whether claimant is permanently and totally disabled and, if not permanently and totally disabled, the extent of claimant's unscheduled permanent disability. The award for scheduled disability is not an issue on review.

Claimant was compensably injured on May 13, 1977. She has undergone two surgeries on her low back and a third surgery was suggested but reasonably rejected. She returned to her regular work with some modifications for approximately three years, but she quit working because her back and leg pain continued to increase. Vocational rehabilitation assistance was offered and claimant seemed highly motivated to return to work, but the development of unrelated cardiovascular conditions prevented commencement of a meaningful rehabilitation or training program. Claimant has a psychogenic pain disorder caused in part by her industrial injury that is disabling in addition to the physical effects of her injury.

Claimant argues for an interpretation of that phrase in ORS 656.206(1)(a) referring to "preexisting disability" as including impairments and disabilities that result from conditions that first become symptomatic or diagnosed after the date of injury but before a subsequent reopening of an aggravation claim. We can only consider those unrelated impairments and disabilities that preexisted the date of the compensable injury when determining whether a claimant is permanently and totally disabled. Arndt v. National Appliance Co., 74 Or App 20 (1985); John D. Kreutzer, 36 Van Natta 284, aff'd mem., 71 Or App 355 (1984). It is very unclear, as the Referee noted, how to quantify the contribution of the post-injury unrelated conditions to claimant's present disability situation, but it is also clear that before the unrelated conditions interfered with vocational rehabilitation, claimant was physically and psychologically capable of working or of completing a retraining program.

The independent medical examination of Dr. Luce led to the latest reopening of the claim. Dr. Luce opined that claimant was unable to engage in a gainful occupation primarily due to the condition of her back and its associated pain state. His assessment of her physical disability was "in the category of moderately severe impairment of function." At the time of his examination in August 1983, before an aggravation due to rough handling by a Josephine County Sheriff's deputy, he found evidence of radiculopathy and suggested that a pain center would be the appropriate course of treatment.

Claimant was referred to the Northwest Pain Center. Their evaluation was that claimant would not be an appropriate candidate for their program because she had a hearing impending. They reported that their program might be considered after her claim was settled and "contingent upon a significant change in attitude and motivation." They felt claimant and her husband had already decided that she was permanently and totally disabled and that no program of rehabilitation would change that. Her claim was closed upon their recommendation that no further treatment be considered.

Claimant was then examined by Dr. Holland, a psychiatrist, in June 1984. He found that claimant was caught in a medical dilemma in that she needed to exercise strenuously to improve her cardiovascular condition but her leg pain resulting from her back injury prevented extensive exercise. He recommended referral to Western Pain Center for her pain disorder. He also recommended that she participate in the program with her workers' compensation claim closed because the major contribution to her psychological need for the pain center services was unrelated to her industrial injury, although he felt that there was a material contribution to the psychological condition by the compensable injury and its sequelae. Claimant participated in the Western Pain Center's program for the full three weeks, and showed improvement. The pain center reported at her discharge that there was "no increase in her level of permanent partial disability." Unfortunately, the report does not provide information that can be utilized to compare claimant's condition in terms of "no increase," especially in light of the examiner's preconceived belief that only objective physical worsening of claimant's discs or vertebrae could be considered a compensable worsening of her condition despite the element of compensability of her psychological condition.

We find that claimant's disability due to her compensable and preexisting disabilities is less than total. She is probably permanently and totally disabled now because she does not have the capacity to complete a training program or perform work at a gainful and suitable occupation, but she is prevented by unrelated disabling factors subsequent to her industrial injury.

Dr. Luce's independent medical assessment, that claimant was moderately severely disabled due to her industrial injury, is the latest assessment that guides us to the determination of claimant's compensable physical impairment. Considering some portion of claimant's psychological impairment as caused by her compensable injury, her age of 56, her high school education, her employment history as a grocery store clerk, and the labor market findings that there are few if any job profiles that fit claimant's compensable limitations, and considering the guidelines contained at OAR 436-65-600, et seq., we find that claimant would be appropriately awarded 272° for 85% unscheduled permanent partial disability in lieu of the Referee's award of 320° for 100% unscheduled disability.

ORDER

The Referee's order dated January 8, 1985 is modified. Claimant is awarded 272° for 85% unscheduled permanent partial disability due to her low back injury in lieu of the Referee's award of 320° for 100% unscheduled disability. Claimant's attorney's fee shall be adjusted accordingly. The remainder of the order is affirmed.

CHARLES E. MARTIN, Claimant
Pozzi, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-07396 & 83-07397
August 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

EBI Companies request review of that portion of Referee Galton's order which: (1) set aside its denials of claimant's "new injury" claim for a low back condition; and (2) upheld the SAIF Corporation's denial of claimant's "aggravation" claim. On review, EBI contends the Referee was without jurisdiction to overturn its first denial because claimant's appeal was untimely, or, alternatively, that SAIF is the responsible party.

Claimant was 49 years of age at the time of hearing. He has a history of low back problems beginning in approximately 1965. In March 1977, while working for SAIF's insured as a carpenter, claimant slipped while carrying lumber, twisting his back. His condition was diagnosed as low back strain with degenerative disc disease. Dr. Langston, orthopedist, rated claimant's disability attributable to his injury as mildly moderate. Following conservative treatment and vocational rehabilitation, the claim was closed in October 1979. Claimant was awarded 5% permanent disability. This award was apparently not appealed.

In September 1979 claimant was hired by EBI's insured as a forklift and crane operator. His duties were relatively sedentary, allowing claimant to refrain from heavy lifting, kneeling, pulling or stooping, activities which his physicians had recommended claimant avoid. From September 1979 through February 1982 claimant performed these activities on a variety of projects in Oregon and Washington. His back symptoms continued on an intermittent basis, dependent upon his activities, but he did not seek medical treatment during this time. In early February 1982 EBI's insured assigned claimant to work on a circle saw which required significant bending, stooping, standing, and lifting. Claimant's symptoms soon increased to the point that he sought medical treatment, describing the location of his back pain as higher than that which he suffered in 1977.

Claimant was taken off work for approximately one week. Thereafter, he was released for work, but was promptly laid off due to economic conditions. Claimant has not returned to work since. Dr. Jawurek, the physician who initially treated claimant in February 1982, ultimately opined that it was medically probable that claimant's condition was an aggravation of his preexisting condition.

Claimant filed his claim with EBI's insured in June 1982. The claim was accepted as nondisabling. After further investigation, EBI learned that claimant's injury occurred while he was working at a Washington job site. Moreover, EBI was advised by its insured that approximately 80% of claimant's wages were derived from Washington projects. In October 1982, apparently based on this new found information, EBI denied the claim, contending claimant was not an Oregon subject worker. The denial letter further instructed claimant to "[P]lease file a claim for workers' compensation benefits in the State of Washington." There is no indication that claimant ever filed a request for hearing specifically appealing this denial.

Claimant pursued a workers' compensation claim in Washington. His request for Washington benefits was denied in March 1983 and again, on reconsideration, in April 1983.

In July 1983 claimant was examined by Dr. Butler, orthopedist. Dr. Butler opined that any continued treatment claimant received since February 1982 was related to his degenerative disc disease and not to any February 1982 exposure while working for EBI's insured. Dr. Butler rated claimant's total impairment to be 15%, 10% attributable to claimant's ongoing degenerative disease and 5% to his 1977 injury while working for SAIF's insured. Soon after receiving Dr. Butler's report, SAIF denied claimant's request for reopening.

In August 1983 claimant filed his request for hearing concerning SAIF's denial of his aggravation claim for his 1977 injury. In addition, claimant filed a request for hearing regarding EBI's so-called "de facto" denial of his February 1982 incident.

In October 1983 EBI filed its response to claimant's request for hearing. EBI contested compensability and responsibility. In addition, EBI asserted the claim was untimely and should fall within the jurisdiction of the State of Washington.

In December 1983 EBI issued another denial letter. EBI contended that claimant's medical treatment from February 1982 through July 1982 was either attributable to claimant's underlying degenerative disc disease or as a result of his previous work activities with SAIF's insured. Claimant timely appealed this denial.

In May 1984 Dr. Butler opined that claimant's condition was not permanently and/or independently worsened by the February 1982 incident. Dr. Duckler, claimant's most recent attending physician, agreed with Dr. Jawurek that it was medically probable that claimant suffered an aggravation of his preexisting condition.

The Referee found that EBI was prohibited by the holding of Bauman v. SAIF, 295 Or 788 (1983), from issuing its October 1982 back-up denial. The Referee reasoned that EBI had failed to rescind its acceptance within 60 days from the date of notice and thus was barred from subsequently denying the claim. Addressing the responsibility question, the Referee concluded that claimant had sustained an identifiable new injury while working for EBI's insured which had contributed at least slightly to his disability. Consequently, EBI was adjudged responsible for claimant's current low back condition.

EBI contends that the Referee lacked jurisdiction to decide the merits of claimant's new injury claim because he failed to timely request a hearing from EBI's October 1982 denial. We agree and reverse the Referee's order.

A request for hearing from a denial of a claim for compensation should be filed within 60 days after the claimant was notified of the denial. ORS 656.319(1)(a). A request filed later than 60 days, but within 180 days after notification, is acceptable if the claimant establishes good cause for failing to file the request within 60 days. ORS 656.319(1)(b). If these filing requirements are not followed, a hearing shall not be granted and the claim shall not be enforceable. ORS 656.319(1).

In John E. Russell, 36 Van Natta 678 (1984), we stated that partial denials are subject to the time limitations prescribed in ORS 656.319(1), regardless of the prohibition against back-up denials contained in Bauman v. SAIF, 295 Or 788 (1983). We were not persuaded that the Bauman court intended to create another exception to the statutory and jurisdictional requirement that a hearing be requested within 60 days. Russell, supra., at page 679. This rationale is no less relevant in the present case. After initially accepting the claim as nondisabling, EBI issued its denial in October 1982. Claimant's request for hearing was not filed until August 1983, long after the 60 and 180 day filing deadlines had elapsed. Consequently, the Referee was without jurisdiction.

Claimant asserts that the October 1982 denial was a nullity inasmuch as EBI had accepted the claim and not issued its denial within 60 days of notice or knowledge of the claim. Furthermore, he argues that to allow the denial to stand circumvents the clear intent of Bauman. These arguments raise interesting and perplexing issues. However, to address them presupposes that we have jurisdiction. As we stated in Russell, such a presumption would be erroneous where the claimant fails to timely file a request for hearing.

Claimant also asserts that EBI failed to raise this issue at the hearing. Moreover, claimant contends that EBI's late raising of the jurisdictional argument has prevented him from presenting evidence on the issue. Specifically, claimant argues he was foreclosed from producing evidence concerning communication problems attributable to his deafness, as well as his reliance upon representations made by his employer and EBI.

Generally we will not consider issues raised for the first time on Board review. Jeanne M. Grimes, 36 Van Natta 372 (1984); ORS 656.295. However, where the challenge to a hearing request is jurisdictional, the employer/insurer does not waive the defense by failing to initially raise the issue. Barbara A. Gilbert, 36 Van Natta 1485, 1487 (1984); Montmore Home Owners Assoc. v. Brydon, 55 Or App 242, 246 (1981). Accordingly, EBI's failure to raise the jurisdictional issue at hearing does not foreclose it from raising the issue before the Board. Furthermore, since the record establishes that claimant did not file his request for hearing within 180 days of receiving notification of EBI's denial there is no need to remand for the taking of further evidence concerning claimant's reasons for a late filing. ORS 656.319(1) does not provide a "good cause" exception for a request for hearing filed in excess of 180 days.

Since EBI's October 1982 denial is final by operation by law, any finding concerning its December 1983 denial would be academic at best. Therefore, we are left to address the compensability of claimant's aggravation claim with SAIF. Where the employer against whom the claim is filed is not the last employer where working conditions were potentially injurious, that employer may assert the last injurious exposure rule as a defense. SAIF v. Luhrs, 63 Or App 78 (1983); Dick L. Babcock, 35 Van Natta 325 (1983). Thus, SAIF is entitled to invoke the rule as a defense. However, whether it will be successful here depends on the medical evidence. Luhrs, supra. 63 Or App at 83-84.

Here the preponderance of the persuasive evidence establishes that claimant sustained an aggravation of his preexisting low back condition in February 1982 and not a new injury. Although several of the medical opinions do not specifically refer to claimant's 1977 injury, we are persuaded that the references to "preexisting condition" encompass the injury for which claimant had previously received a 5% permanent disability award. We are fortified in this conclusion by Dr. Langston's evaluation that claimant's disability attributable to the 1977 injury was mildly moderate and by the fact that claimant has experienced relatively constant symptoms since the 1977 injury, despite attempts to limit his activities. Moreover, the evidence is persuasive that the February 1982 incident did not independently contribute to claimant's disability. Accordingly, we conclude that SAIF is responsible for claimant's condition.

Although claimant filed a brief and argued a position on Board review that was adverse to one of the potentially responsible employers or insurers, his argument that EBI is the responsible party has not ultimately prevailed. Accordingly, claimant is not entitled to an attorney's fee for services on Board review. Leighton J. Bowman, 37 Van Natta 420 (1985); Robert Heilman, 34 Van Natta 1487 (1982). However, claimant is entitled to an attorney's fee for services rendered at the hearing for prevailing on a denied claim. ORS 656.386(1). Inasmuch as we have found SAIF to be the responsible party, it shall be responsible for payment, or reimbursement to EBI as the case may be, of claimant's attorney's fee for services at the hearing level as awarded by the Referee.

ORDER

The Referee's order dated August 24, 1984 is reversed. Claimant's request for hearing concerning EBI Companies' October 19, 1982 denial is dismissed for lack of jurisdiction. The SAIF Corporation's denial dated July 20, 1983 is set aside and the claim is remanded to SAIF for processing according to law. SAIF shall reimburse EBI for all claim costs paid pursuant to the Referee's order.

PATRICK H. McCARTY, Claimant
Elliott Lynn, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-04353
August 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of those portions of Referee Podnar's order that: (1) awarded claimant 144° for 45% unscheduled permanent partial disability for the low back in lieu of the 48° for 15% unscheduled disability granted by three previous Determination Orders; and (2) held that claimant was not medically stationary until approximately two months after the termination of his authorized vocational rehabilitation program. The issues on review are extent of unscheduled disability and claimant's medically stationary date.

Claimant is a former log faller who was compensably injured on September 23, 1980 when a rolling log pinned him against a stationary one, bruising and spraining his low back. Claimant's resulting low back discomfort was accompanied by right leg radiating pain. Ten months of conservative treatment proved

inadequate, and claimant ultimately underwent partial L4 and L5 laminectomies and a nerve root decompression at L5. After claimant's surgeries, vocational rehabilitation was recommended, along with claim closure. A December 16, 1981 Determination Order awarded 48° for 15% unscheduled disability.

In March of 1982 claimant began a welding training program, which he successfully completed on March 23, 1983. Approximately five months before completing the program, however, claimant suffered a severe exacerbation of his back problems, resulting in a one-week hospitalization. After the completion of the welding program, a Determination Order found claimant to have been stationary subsequent to the November exacerbation, but it properly ordered the payment of temporary disability compensation through the completion date of the training program.

Claimant visited his treating doctor, Dr. Horniman, in April of 1983. In addition, he was evaluated by psychiatrist, Dr. Maletzky. Claimant was examined on May 10, 1983 by Orthopaedic Consultants, who found him medically stationary as of that date.

The Referee used the May 10, 1983 medically stationary date for purposes of determining claimant's entitlement to temporary disability compensation. On review SAIF argues that claimant was stationary before the completion of his training program and that benefits were payable only through the date of the program's end. After reviewing the medical records for the period immediately following the termination of claimant's training program, we agree.

It is claimant's burden to prove that he was not medically stationary as of the date his claim was closed. Brad T. Gribble, 37 Van Natta 92 (1985). The determination of medically stationary status is usually a matter of medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981). In the present case, the only medical evidence between the time of claim closure and the date Orthopaedic Consultants found claimant stationary consists of a single report from Dr. Horniman and a psychiatric evaluation report. Neither of these reports suggests that further material improvement in claimant's condition would reasonably be expected from treatment or the passage of time. ORS 656.005(17). At most, they demonstrate a potential for continuing fluctuation in claimant's condition. A fluctuating condition, however, is not in and of itself synonomous with being not medically stationary. Maarefi v. SAIF, 69 Or App 527, 531 (1984). Neither is the fact that claimant may require continuing treatment dispositive. Claimant has received an award of permanent partial disability, raising the inference that he can be medically stationary within the meaning of the statute and still require treatment. Maarefi, supra, 69 Or App at 531. We find that claimant was medically stationary on or before March 23, 1985, the date his authorized training program ended.

The remaining issue is the extent of claimant's unscheduled disability. The first Determination Order granted 15% unscheduled disability. Subsequent orders of July 1, 1983 and March 15, 1984 made no further unscheduled award. At hearing, claimant asserted entitlement to additional compensation and the Referee agreed, granting an additional 30% unscheduled disability. The Referee found that claimant's ongoing medical problems and his preclusion from the work with which he was most familiar entitled him to an award totalling 45%. On review, SAIF argues that 45% is excessive. We agree.

A review of the medical record subsequent to the initial unscheduled award reveals little in the way of a worsening of claimant's condition. He has had periodic exacerbations, but little in the way of objective findings that would suggest that a substantial increase in claimant's award is warranted. After considering claimant's impairment and the relevant social and vocational factors, OAR 436-65-600, et seq., we find that claimant is entitled to an award of 64° for 20% unscheduled permanent partial disability. This award shall be in lieu of the Referee's award and all prior awards.

ORDER

The Referee's order dated December 12, 1984 is reversed in part, modified in part, and affirmed in part. That portion of the order that found claimant medically stationary as of May 10, 1983 is reversed. That portion of the order that awarded claimant 144° for 45% unscheduled permanent partial disability is modified. In lieu of the Referee's award and all prior awards, claimant is awarded 64° for 20% unscheduled permanent partial disability. Claimant's attorney's fee shall be modified consistent with the provisions of this order. The remainder of the order is affirmed.

JORGE NAVARRO, Claimant
Kenneth D. Peterson, Claimant's Attorney
Miller, et al., Defense Attorneys

WCB 84-01783
August 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Leahy's order which modified a Determination Order dated February 7, 1984 by assigning a medically stationary date of September 1, 1983 and reducing claimant's temporary total disability award accordingly. In addition, the Referee, in effect, affirmed the Determination Order insofar as it failed to award any compensation for unscheduled disability. Claimant requests remand for further evidence taking, claiming that the Referee erroneously refused to allow cross-examination of a physician. In addition, claimant contends that the Referee erred in refusing to continue the hearing ". . . when the employer cross-appealed the Determination Order for the first time at the hearing." In the alternative, claimant seeks an award for unscheduled disability and a ruling that extent of temporary disability was not properly before the Referee. Presumably, were we to find that there was no issue of temporary disability properly before the Referee, claimant would have us reinstate and affirm the Determination Order as issued, in this regard.

We have authority to remand the case if we find that it has been improperly, incompletely or otherwise insufficiently developed or heard, and that remand is otherwise an appropriate disposition. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 44 (1983).

We find that this case has not been improperly, incompletely or otherwise insufficiently developed or heard by the Referee; therefore, claimant's motion for remand is denied. We further find that the issue of temporary disability was properly before the Referee, and that his modification of the Determination Order was appropriate. Finally, we find that claimant has failed to satisfy his burden of proving entitlement to an award for unscheduled permanent disbility. Therefore, we affirm the Referee's order.

ORDER

The Referee's order dated October 17, 1984 is affirmed.

GEORGE A. PEHANICH, Claimant
Bloom, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-01617 & 83-11641
August 23, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of Referee Neal's order which set aside its aggravation claim denial and found claimant eligible for vocational assistance. Claimant cross-requested review; however, he seeks no affirmative relief and requests only that the Referee's order be affirmed. The issues are compensability of claimant's aggravation claim, i.e., whether claimant's condition has worsened since the last award or arrangement of compensation; Referee and Board jurisdiction to consider claimant's eligibility for vocational assistance; and, if there is jurisdiction to decide the issue, claimant's eligibility for vocational assistance. We reverse on the aggravation issue based on our conclusion that claimant has failed to establish a worsened condition. On the vocational assistance issues, we conclude that we have jurisdiction and that claimant is not eligible.

Claimant has worked for the employer as a "trouble shooter," or maintenance mechanic, since 1978. The employer is a steel products manufacturer. Claimant sustained the first of two low back injuries in June of 1980 while he was pulling a portable welder. He was treated conservatively by osteopathic physicians, primarily Dr. Szeto. Claimant was temporarily and totally disabled for approximately one month, after which he returned to his regular work. Claimant's job duties changed in that he performed mostly electrical repair work and was not required to perform heavy lifting. This job change was coincidental and was not based on restrictions resulting from claimant's injury or any related medical suggestions. This claim was closed in October of 1981 with an award for temporary disability and no permanent disability. The Determination Order became final by operation of law.

In August of 1981 claimant reinjured his back. Contemporaneous report forms and medical reports indicate that claimant was working on an overhead crane and he apparently twisted his back. At the hearing, however, claimant described a slip-and-fall type of injury in which he struck his back against a portion of a metal cage. The claim was accepted and claimant was off work for approximately two weeks. He then returned to work and continued his regular employment. Claimant testified that he experienced pain in performing his regular job duties; that he took pain medication intermittently; and that he sometimes missed work as a result of his back pain. The claim was closed in October of 1981 with an award for temporary total disability and no permanent disability. This Determination Order also became final by operation of law. Claimant sought no medical attention for a back problem in the 22 months that followed closure of this 1981 claim.

In July of 1983, claimant's employment was terminated because he did not have the proper licensing or certification to perform the electrical work that his job required. He challenged this termination by filing a grievance. Claimant did not prevail in this proceeding, however. He applied for and received unemployment compensation from July 25, 1983 through February 17, 1984.

On August 29, 1983 claimant sought medical care from Dr. Smith, a Portland neurosurgeon. Claimant related a history of a 1981 back injury that occurred while lifting a portable welder, and that X-rays taken at the time disclosed a "crack of [the] lower spine." Claimant apparently related that he was off work for approximately four months. Dr. Smith reported that claimant's pain increased with activity, and that resting afforded significant relief. Claimant apparently informed Dr. Smith that he was "laid off" in July. Dr. Smith recommended that a myelogram be performed in order to rule out a central protruded disc. He prescribed medication for claimant's back pain.

SAIF referred claimant for an examination by the Orthopaedic Consultants on October 19, 1983. A different panel of the Orthopaedic Consultants had previously examined claimant in September of 1981. This 1983 Consultants' report states in part:

> "[C]laimant has continued to have intermittent low back discomfort at work and several days of time loss intermittently through this period of time since his last visit. He has used his fiance's Valium intermittently for relief of discomfort. He indicates that he was recently laid off because of excessive time loss and was concerned about his insurance benefits and thought he had better check in with regard to medical care concerning his low back."

X-rays taken by the Consultants at the time of this examination, when compared with 1981 X-rays, disclosed no interval change. The Consultants diagnosed lumbar strain by history. They concluded that claimant's condition remained medically stationary, and that he did not exhibit any degree of objective worsening. They also felt that claimant should be able to continue in his same occupation without limitation.

On November 10, 1983 Dr. Smith reported to SAIF that claimant's claim should be reopened, "so that if his symptoms continue a myelogram could be performed." Dr. Smith also stated, "In my opinion, this patient relates a worsening of his condition." By letter of the same date, Dr. Smith reported to claimant's attorney that claimant's condition presently was worse than it was at the time of his October 1981 closure.

Claimant came under the care of Dr. Bell, a Vancouver neurologist. Dr. Bell took a history similar to that taken by Dr. Smith, although his initial report discusses a period of disability of approximately two or three months. Claimant apparently informed Dr. Bell that his employment was terminated in July of 1983 because he was unable to continue working very effectively or efficiently as a result of his back pain. Dr. Bell ordered a lumbar CT scan, which revealed no significant abnormalities. X-rays of the lumbar spine were also normal.

By letter dated December 5, 1983 SAIF denied an aggravation claim in connection with the June 1980 injury. There was no timely hearing request contesting this denial, and the Referee found that claimant had not established good cause. See ORS 656.319(1)(b).

On December 16, 1983 Dr. Bell reported to SAIF that because the CT scan showed no significant disc and X-rays were normal, he did not believe claimant needed a myelogram. He opined that claimant had "some permanent injury," and that claimant would be required to modify his work to something lighter in nature in order to be effective on the job market. He stated that there was not "anything easily correctable in this particular patient."

In January of 1984 Dr. Bell reported to SAIF that claimant's situation was "unchanged from the last time I saw him." He stated that subjectively claimant apparently was worse than he was prior to the "last closure." This statement was qualified, however, by the comment that because he had not examined claimant at that time, he could not "objectively" make any comments about claimant's possible worsening. Dr. Bell reiterated his primary point, however, as he did on succeeding occasions, that claimant probably would not be able to return to his previous occupation and needed "to be rehabilitated into" a lighter duty job.

In a letter dated February 6, 1984, addressed to claimant's attorney, SAIF noted some apparent confusion in claim numbers vis-a-vis claimant's request for claim reopening, and stated that the reasons for denying claim reopening expressed in the December 5, 1983 denial letter (entered in the 1980 claim) also applied with regard to the 1981 claim. Claimant filed another request for hearing, which was assigned a new WCB case number. It was this "informal denial" entered in the 1981 claim that the Referee set aside.

On March 9, 1984 Dr. Bell reported to claimant's attorney, after reviewing documents supplied to him, that he could not be certain whether claimant was "appreciably worse" since 1981 in view of the fact that he had only examined him since November of 1983.

On May 7, 1984 Dr. Bell reported to SAIF that claimant's complaints remained the same, and he had the same findings of muscle spasm. Claimant's condition was not improving, and Dr. Bell indicated that there was nothing that could be done to help him. He considered claimant's condition stable, and he saw "no significant improvement in the situation." Dr. Bell subsequently reported to claimant's attorney that, although claimant subjectively stated he was worse, he could find no "objective documentation of this." Dr. Bell concluded that, even if claimant wasn't worse, he should have some sort of vocational retraining so that he could function satisfactorily.

On or about May 14, 1984 claimant's attorney formally requested that SAIF provide claimant with vocational assistance or refer claimant to the Field Services Division of the Workers' Compensation Department for such purpose. By letter dated May 30, 1984 SAIF notified claimant of his ineligibility for vocational assistance. The reasons stated were that, in connection with claimant's 1980 claim, this was "a denied claim," and, therefore, claimant did not have "a disabling compensable injury on this

claim." With regard to the 1981 claim, inasmuch as there was a final Determination Order which closed the claim with no award for permanent partial disability, claimant was not entitled to vocational assistance under the applicable administrative rules.

At the hearing, claimant testified that he missed work on occasion due to his back pain. He would use sick time on these occasions. He also testified, however, that he missed time from work as a result of involvement in child custody litigation which necessitated his absence. On direct examination, claimant described increasing symptoms, particularly leg numbness, which he said began two or three months prior to termination of his employment. On cross-examination, however, claimant described limitations and a curtailment in physical activities which had been present since his second back injury. Claimant was questioned whether he would have continued working if his employment had not been terminated, and he responded, "I would have tried, yes."

In order to prevail, claimant must establish by a preponderance of the persuasive evidence that his injury-related condition has worsened since the last award or arrangement of compensation. The last award in this case is the October 1981 Determination Order which closed his August 1981 claim with no award for permanent disability. A month before that Determinaton Order, the Orthopaedic Consultants had stated that claimant could continue with the same occupation, since there appeared to be no modification of his work available. They stated, however, that, "If [claimant's] pain should persist then a job change may be necessary." A job change was not necessary, and claimant continued to work for almost two years until his employment was terminated for reasons unrelated to his injury. After being off work for slightly over one month, claimant reported to a physician, Dr. Smith, because he was having difficulty performing yard work at home, but also because he was concerned about his workers' compensation insurance benefits and thought he had better "check in" with regard to medical care concerning his back.

Claimant's testimony is more consistent with and characteristic of a chronic back problem, one which might form the basis for an award of permanent partial disability, rather than an acutely worsened condition requiring active medical management beginning in the summer or fall of 1983. The question of whether claimant may have been entitled to an award for permanent disability in connection with his 1981 injury claim, however, is no longer open for question. The Orthopaedic Consultants' report of minimal loss of back function in September of 1981 is consistent with Dr. Bell's 1983 statement that claimant has "some permanent injury."

Although Dr. Smith is of the opinion that claimant's condition is worse now than it was at the time of the 1981 claim closure, Orthopaedic Consultants are clearly of the opposite opinion, and Dr. Bell, claimant's present attending physician, remains noncommittal. Dr. Smith's opinion must be viewed with caution for at least two reasons. For one thing, he apparently believed it was necessary to reopen the claim in order to obtain a myelogram. Such is not the case. ORS 656.245. More significantly, however, it appears that claimant informed Dr. Smith that he was off work for about four months after his 1981

injury, which occurred "while lifting a portable welder," and that X-rays disclosed a "crack of his lower spine." Claimant missed approximately one month after his 1980 injury, returned to work for approximately a full year before experiencing a reinjury, at which time he missed only two weeks of work, and the only diagnosis either time was a soft tissue injury, or lumbosacral strain.

This leaves claimant's testimony which, in the proper case, might be sufficient to establish a worsened condition. Garbutt v. SAIF, 297 Or 148 (1984). As indicated above, however, reading claimant's entire testimony, we believe it is more consistent with a chronic problem that has been present since the second back injury as opposed to an acutely worsened condition requiring active medical management and/or entitling claimant to reopening pursuant to ORS 656.273. Claimant remains entitled to medical services; however, he has failed to persuade us that his claim should be reopened.

This case comes close to the facts in Bault v. Teledyne Wah Chang, 53 Or App 1 (1981), but is sufficiently different to require a different result. In Bault claimant sustained a low back strain which was treated with exercise and pain medication. X-rays were normal and no permanent impairment was found. The claim was eventually closed by a Determination Order which awarded temporary disability but no permanent disability. Claimant returned to his previous occupation, which required vigorous physical exertion. Claimant's union went on strike, and claimant was off work. After the strike settled, claimant did not return to work. Thereafter he contacted his former physician and informed him that he was unable to return to work. This physician did not examine claimant but had merely been informed of claimant's complaints by telephone. The physician later reported to claimant's attorney that claimant's injury-related condition had been materially aggravated or worsened following his return to work. Claimant's physician did eventually examine him, at which time he noted that claimant's complaints were mainly subjective. The physician also stated that the prognosis for complete recovery was poor, and it was questioned by another physician whether treatment of any kind could totally cure claimant. The court found sufficient evidence to establish a compensable aggravation stating, "The evidence establishes permanent disability where there was none after the original injury, which was concededly work-related." 53 Or App at 6.

In this case, by contrast, claimant never returned to the physicians who had treated him after either one of his compensable injuries. In fact, the Orthopaedic Consultants, who were the only physicians to have the opportunity to examine claimant both before and after his alleged aggravation, were expressly of the opinion that claimant remained stationary and was not worse. Although the 1983 panel consisted of different physicians than the 1981 panel, the more recent panel had the prior panel's report available, and they based their decision on a comparison of the 1981 findings with their own. Dr. Smith does not appear to have had this earlier information available; and when it was supplied to Dr. Bell, he reported that he was unable to make an objective statement concerning the possibility of a worsening.

Another difference between Bault and this case is the fact that, prior to the 1981 claim closure, claimant was considered to have some loss of function of the back as a result of his injury, i.e., some degree of impairment. The claimant in Bault was

medically determined not to have an impairment prior to his return to rigorous work activity.

With regard to the issues concerning claimant's entitlement to vocational assistance, we first will address the jurisdictional issue raised by SAIF. On the date that SAIF notified claimant of his alleged ineligibility for vocational assistance, ORS 656.728(6) required that if the claimant was dissatisfied with a vocational assistance decision by the department or employer/insurer, the claimant was required to apply for review of the decision by the Director of the Workers' Compensation Department prior to requesting a hearing pursuant to ORS 656.283. Subsections (5), (6) and (7) of ORS 656.728 became inoperative on July 1, 1984, however. Oregon Laws 1981, chapter 874, § 22. Therefore, on and after that date, claimant was not required to petition the Director for review of SAIF's decision concerning his eligibility for vocational assistance. Neither former nor current administrative rules governing administrative review of such decisions limited or limit the period within which a claimant may contest the department's or an employer/insurer's decision in such matters. Therefore, claimant was not prohibited from waiting until the law allowed him to directly request a hearing in order to challenge SAIF's decision. When claimant requested a hearing raising this issue in October of 1984, there was jurisdiction pursuant to ORS 656.283.

SAIF relies upon decisions in which we dismissed hearing requests raising vocational assistance issues based upon the claimants' failure to exhaust the administrative remedy provided by ORS 656.728. Forrest A. Laffin, 36 Van Natta 1239 (1984); Dan M. Miller, 36 Van Natta 245 (1984). Those decisions are inapposite, however, since, when those claimants filed their hearing requests, the statute in effect required administrative review by the Director as a prerequisite to requesting a hearing pursuant to ORS 656.283. Thus, we conclude that the Referee had jurisdiction to consider the issue, and, likewise, we have jurisdiction to review the Referee's decision.

Our conclusion that claimant is not entitled to claim reopening for a worsened condition is dispositive of the vocational assistance issue in this case. The fact that there is a final denial of an aggravation claim in the 1980 injury claim is irrelevant since the back claim remains in accepted status. What is relevant, however, is that in the 1980 claim, as well as the 1981 claim, Determination Orders were entered awarding no compensation for permanent disability. OAR 436-61-126(12) (WCD Adm. Order 5-1983, eff. January 1, 1984), provides that a worker's eligibility for vocational assistance terminates when the worker has been determined, under ORS 656.268, to have no permanent disability. If claimant's injury-related condition does compensably worsen sometime in the future, claimant then may become eligible for vocational assistance, assuming other conditions of eligibility are satisfied. OAR 436-61-100(5).

ORDER

The Referee's order dated December 10, 1984 is reversed. The SAIF Corporation's denial of claim reopening, issued in connection with claimant's August 14, 1981 injury claim, is affirmed. The Notice of Ineligibility for Vocational Assistance, dated May 30, 1984, is affirmed.

JACK REEF, Claimant
Doblie & McSwain, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-07364
August 23, 1985
Order on Reconsideration

The self-insured employer has requested that the Board reconsider its Order on Review issued July 30, 1985. In that order we affirmed the Referee's order that found claimant entitled to temporary total disability compensation for the period of February 25, 1981 to August 28, 1981, and assessed penalties and attorney fees against the employer for failure to make the payments at issue. In its request for reconsideration, the employer asks that we reconsider our decision regarding penalties and attorney fees, and asserts that under the circumstances of this case, its failure to make claimant's disability payments was reasonable.

Claimant was compensably injured in 1979. The employer paid temporary disability payments through early 1981, when an order suspending those payments issued from the Workers' Compensation Department, terminating claimant's benefits as of February 25, 1981. The order was issued pursuant to claimant's failure to submit to certain medical treatment. Claimant requested a hearing on the suspension, which was upheld at both the Hearings Division and Board levels. Claimant appealed the Board's order to the Court of Appeals.

In the meantime, the employer had requested that a determination of claimant's claim be made. A July 1981 Determination Order granted temporary total disability from the date of claimant's injury up through the effective date of the suspension. It further found claimant's file to include insufficient information upon which to determine his extent of permanent disability. Claimant requested a hearing on this order, but the request did not raise the issue of claimant's entitlement to temporary disability beyond the date of the Order of Suspension.

The parties ultimately entered into a stipulated agreement in which it was agreed that claimant would withdraw his request for hearing on the Determination Order and ask the Evaluation Division to reconsider it. In November of 1981 a second order issued, granting claimant 45% unscheduled permanent partial disability and temporary disability pursuant to the earlier stipulated agreement between the parties. Claimant again requested a hearing, and again raised only the issue of extent of permanent partial disability. The issue of temporary total disability was not raised. A subsequent Opinion and Order granted claimant additional unscheduled disability. Claimant appealed to the Board, which affirmed the Referee's order. Claimant then appealed to the Court of Appeals on the issue of permanent partial disability only.

While claimant's appeal was pending before the court, the court issued its decision regarding the earlier Order of Suspension. Reef v. Willamette Industries, 65 Or App 366 (1983). The court set aside the order, thereby effectively entitling claimant to temporary disability compensation for the period between the effective date of the suspension and the date the employer ultimately resumed paying time loss pursuant to the earlier stipulated agreement. The court's decision was dated November 9, 1983. Despite the court's ruling, the employer made no subsequent time loss payments to claimant.

On June 27, 1984, more than eight months after its decision on the Order of Suspension, the Court of Appeals affirmed without opinion the Board's order regarding claimant's claim of entitlement to a greater unscheduled award than that granted by the November 1981 Determination Order. Reef v. Willamette Industries, 68 Or App 925 (1984). This decision arguably conflicted with the court's earlier decision regarding the Order of Suspension because it effectively affirmed the 1981 Determination Order, which in turn had included an award of temporary total disability compensation only up through the effective date of the Order of Suspension.

In its request for reconsideration, the employer argues that these apparently conflicting court decisions raised a legitimate doubt as to its liability to make the payments effectively ordered by the court in its first decision. The employer further argues that because there was a legitimate doubt, its failure to make the payments at issue was not unreasonable so as to give rise to penalties and attorney fees. We disagree.

The court's November 1983 decision, which set aside the Order of Suspension, provided a clear directive to the employer to pay claimant the temporary disability payments to which he was held to be entitled as a result of the decision. For a period of more than eight months thereafter, there was no further word from the court regarding claimant's entitlement to disability compensation, either permanent or temporary. It was not until June 1984 that the court issued a simple affirmation of the Board's order without an opinion as to claimant's entitlement to temporary disability compensation. Until the court's last decision, the only adjudication that seemingly conflicted with the court's earlier decision was the Board's order affirming the Referee on the extent of claimant's permanent partial disability. To the extent that the Board's order conflicted with the court's November 1983 decision, the court's decision clearly controlled.

Until the court's June 1984 decision, there was no legitimate doubt as to the employer's liability to make claimant's temporary disability payments. The court had ordered the payments made, and it was unreasonable for the employer not to comply with the court's order. Penalties and attorney fees were warranted.

Now, therefore, having granted the self-insured employer's request for reconsideration, we adhere to and republish our previous order dated July 30, 1985.

IT IS SO ORDERED.

ROBERT L. TRUMP, Claimant
Wade P. Bettis, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-11081 & 84-11082
August 23, 1985
Order on Review

Reviewed by Board Members Ferris & McMurdo.

The SAIF Corporation requests review of Referee Wasley's order that set aside its denial of responsibility for claimant's medical services claim for benefits pursuant to ORS 656.245. On review, SAIF contends that Scott Wetzel Services, Inc. is responsible for claimant's low back surgery. We agree and reverse.

Claimant was 42 years of age at the time of hearing. He

sustained his initial compensable back injury in April 1969, while working as a delivery man for a furniture company. The injury occurred as he attempted to lift a roll of carpet. His condition was diagnosed as low back strain with radiating symptoms into the right leg. Following conservative treatment, the claim was closed in September 1970 without an award of permanent disability. Claimant eventually received an award of 15% unscheduled permanent disability as a result of this injury.

Between 1970 and 1975 claimant attended a business college, worked as a truckdriver, performed part-time bookkeeping duties, and engaged in a variety of manual labor duties for several construction companies. His symptoms continued, periodically necessitating a return for medical treatment.

In July 1975 while working for a building contractor, SAIF's insured, claimant again injured his low back. The injury apparently occurred sometime while claimant was unloading pipe from a truck. Dr. Stephens, claimant's treating orthopedist, diagnosed low back strain with underlying degenerative disc disease. Following conservative treatment and vocational rehabilitation, his claim was closed in March 1978. Claimant received a 10% permanent disability award.

For approximately the next six years claimant either worked as a deputy sheriff or on his small farm. He continued to seek medical treatment when his back pain became intolerable. These treatments occurred approximately once a year and consisted of pain medication and rest. Following these treatments his pain generally would subside within three days.

In May 1981 Dr. Stephens concluded that claimant's low back problems all resulted from his 1969 injury. The doctor based his opinion on a review of claimant's X-rays dating from 1969. In Dr. Stephens' opinion the films demonstrated a progression of degenerative changes since the 1969 injury.

In March 1984, while working on his farm, claimant experienced "very bad back pain." The pain was in the same area as on prior occasions, but the tingling sensation in his right leg had become a pain radiating down the back of his leg.

Claimant subsequently returned to Dr. Stephens, who recommended surgery. In August 1984 Dr. Stephens performed a laminectomy at L5, with decompression of the L5 and L4 nerve roots bilaterally and fusion at the L5-S1 level. Dr. Stephens continued to opine that claimant's back condition was directly related to his 1969 injury. In Dr. Stephens' opinion claimant's X-rays documented steadily advancing degenerative changes since the 1969 injury.

The Referee found that SAIF, as insurer on the risk at the time of the most recent injury, was responsible for claimant's current back condition. Citing Boise Cascade Corp. v. Starbuck, 296 Or 238 (1983) and Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), the Referee concluded that SAIF had failed to prove that there was no causal connection between the worsening of claimant's back condition and his 1975 injury. The Referee reasoned that the only reasonable conclusion from the medical testimony supported the existence of such a causal connection.

We agree with the Referee that this case is governed by the

above-mentioned authority. However, we find that SAIF has established that Scott Wetzel, the insurer on the risk at the time of claimant's 1969 injury, is responsible for claimant's current medical treatment. Dr. Stephens, claimant's attending physician since his 1975 injury as well as the treating surgeon, consistently supports the conclusion that claimant's low back condition is directly related to his 1969 injury. There is no evidence to the contrary. Dr. Stephens' opinion is both cogent and reasonable. Moreover, it is based upon a thorough review of claimant's medical record, which includes X-rays dating from the 1969 injury. Given the difficulties involved in analyzing this complex medical question, as well as the persuasiveness of the treating surgeon's opinion and the dearth of medical opinions in opposition to that opinion, we conclude that SAIF has established that Scott Wetzel is the responsible party.

Inasmuch as claimant's aggravation rights have expired, that portion of the Referee's order which pertains to claimant's requests for reopening is discussed in the Board's Own Motion Order issued this date. Robert L. Trump, 37 Van Natta ___ (August 23, 1985).

ORDER

The Referee's order dated February 15, 1985 is reversed. The SAIF Corporation's denial dated October 24, 1984 is reinstated and upheld. Scott Wetzel Services, Inc.'s denial dated October 1, 1984 is set aside insofar as it denies responsibility for claimant's medical treatment for his current low back condition. Scott Wetzel Services, Inc. shall reimburse SAIF for its claims costs incurred to date.

CLIFFORD HOWERTON, Claimant
Ormsbee & Corrigall, Claimant's Attorneys
Cummins, et al., Defense Attorneys

Own Motion 85-0196M
August 28, 1985
Own Motion Order on Reconsideration

Claimant, by and through his attorney, requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his 1977 injury-related condition. Claimant's aggravation rights have expired.

The claim was closed by Determination Order dated November 15, 1978, with an award for temporary disability only. In 1979 claimant received medical treatment for problems allegedly related to his original industrial injury. By denial dated February 23, 1984, the self-insured employer took the position that claimant's aggravation rights had expired and claimant, therefore, was not entitled to claim reopening pursuant to the aggravation statute, ORS 656.273; but that medical treatment causally related to claimant's original injury would be paid. Claimant timely requested a hearing challenging the employer's denial.

In addition, claimant filed a claim for occupational disease on or about July 27, 1984. This claim was formally denied on September 24, 1984. The denial was timely challenged.

In a disputed claim settlement agreement dated March 12, 1985, the parties agreed that claimant's ongoing back and left leg complaints were materially related to his 1977 industrial injury and not the result of an occupational disease. Claimant agreed

that his July 1984 occupational disease claim would remain in denied status. It was further agreed that claimant and the employer would jointly request that the Board exercise its own motion authority "concerning claimant's current complaints."

By application submitted to the Board in April of 1985, claimant requested that the Board exercise its own motion authority. Claimant's application to the Board was "concurred [in] and jointly requested by" the employer, as indicated by the signature of counsel for the employer on claimant's application.

After reviewing claimant's application and supporting medical information, the Board requested that the parties attempt to resolve the issues concerning claimant's request for own motion relief. See ORS 656.278(4). Claimant responded that the issues remaining for resolution -- the appropriate date of claim reopening and the allowance of a reasonable attorney's fee -- could not be resolved by stipulation. The employer responded that it was not amenable to voluntary reopening, and that it needed "something in writing from the Board as to the TTD commencement date and the amount of attorney fees claimant's attorney should [be allowed] out of compensation." By Own Motion Order dated June 10, 1985, we ordered claim reopening and payment of temporary disability as of February 5, 1984, said payments to continue, less time worked, until closure pursuant to ORS 656.278. In addition, we allowed claimant's attorney a reasonable attorney's fee payable out of claimant's compensation.

Thereafter, the employer requested reconsideration of the above-referenced Own Motion Order, arguing for the first time that claimant was not entitled to temporary disability benefits because his condition had remained in a medically stationary status from the time his claim was closed in 1978 up until the present time. Therefore, the employer objected to claim reopening for payment of temporary disability. Claimant responded, challenging the authorities cited by the employer in support of its position and request for reconsideration.

We have again reviewed the medical information provided by claimant in support of his request for own motion relief. We believe that the evidence tends to support the employer's assertion that claimant's condition does not warrant claim reopening for payment of temporary total disability. The evidence does tend to establish a chronic problem with limitations of a permanent nature, which may be alleviated in the future in the event that elective surgery is performed; however, at the present time, no curative treatment appears to be contemplated by claimant's physician.

Be that as it may, we decline to alter the terms of our original Own Motion Order reopening the claim for payment of temporary total disability, for the following reason. The above-referenced disputed claim settlement agreement anticipated the parties' joint request for own motion relief. This was followed by the parties' joint request for own motion relief. In that joint application, the parties requested that the Board exercise its discretionary authority and "allow the claim to be reopened" and compensation paid. Thus, we cannot avoid the conclusion that part of the quid pro quo for the disputed claim settlement agreement was that the employer would concur in claimant's request that his claim be reopened pursuant to ORS 656.278.

It was only after the Board acted on the parties' joint petition that the employer announced its position that claimant was not entitled to claim reopening for payment of temporary disability benefits. The employer could have asserted its position in response to our pre-order solicitation but failed to do so. Under the circumstances presented, we decline to alter the terms of our original order.

Claimant's attorney has rendered additional services in response to the employer's request for reconsideration. We find that an additional attorney's fee is warranted, payable out of claimant's compensation.

ORDER

On reconsideration of the Own Motion Order dated June 10, 1985, the Board adheres to and republishes its prior order, subject to the modification stated below concerning claimant's attorney's fee. For the sake of clarity, we reiterate that this claim is reopened for the payment of temporary disability as of February 5, 1984, said payments to continue, less time worked, until closure pursuant to ORS 656.278. In lieu of the attorney's fee allowed by our original order, claimant's attorney is allowed 25% of the compensation awarded herein, not to exceed $950, payable out of claimant's compensation and not in addition thereto.

MELVIN L. MARTIN, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 84-0521M
August 28, 1985
Interim Own Motion Order

The SAIF Corporation requested that the Board exercise its own motion authority pursuant to ORS 656.278. Claimant's aggravation rights have expired. At the time of SAIF's request, there was a hearing request pending in WCB Case No. 84-12042, the issue being the causal relationship between claimant's 1972 injury and low back surgery in 1984. Therefore, the Board entered an order postponing action on the petition for own motion relief.

By order dated June 24, 1985, a Referee set aside SAIF's denial on the basis of his conclusion that claimant's medical services, including surgery, were required as a direct result of his original industrial injury. Claimant thereafter requested that the Board exercise its own motion authority and reopen the claim for payment of temporary total disability. The Board corresponded with claimant and advised that, because SAIF had requested Board review of the Referee's order, it would continue to defer action on the petition for own motion relief until such time as there was "a final resolution" of the medical services issue. Claimant objected and requested that the Board consider the petition for own motion relief and order the payment of temporary disability benefits pending review of the Referee's order.

Claimant argues, in part:

> "The Board's refusal to exercise jurisdiction in this matter will not only encourage, but gives sufficient reason why insurance carriers should continue an appeal all the way to the Supreme Court of the State of Oregon to avoid payment of time loss benefits. Such a delay can be

well over a year and sometimes two years. We feel that the intent of the Workers' Compensation Law is to provide benefits to workers pending appeal. Own Motion Jurisdiction is no exception to that general philosophy."

Claimant was injured in 1972 and, therefore, has the lifetime right to receive reasonable and necessary medical treatment for conditions related to his industrial injury. ORS 656.245(1); see William A. Newell, 35 Van Natta 629 (1983). Because claimant's aggravation rights have expired, however, his "entitlement" to temporary and/or permanent disability benefits is a matter of discretionary relief. ORS 656.278.

Where the same causation issue is determinative, in whole or in part, of claimant's receipt of medical services pursuant to ORS 656.245 and temporary/permanent disability pursuant to ORS 656.278, we generally defer consideration of a petition for own motion relief pending resolution of the related medical services issue; and, if there is a request for review of the Referee's order deciding the medical services issue, we generally consider the petition for own motion relief in tandem with our review of the Referee's order pursuant to ORS 656.295. On a rare occasion, we have found the evidence sufficient to establish claimant's entitlement to medical services, but insufficient to persuade us to exercise our discretionary own motion authority. Charles Sparkman, 36 Van Natta 768 (1984); Michael R. Fischer, 35 Van Natta 2028, 35 Van Natta 2040 (1983).

Claimant's argument that he is entitled to claim reopening pending review of the Referee's order in this case fails to recognize the distinction between a claim for reopening as a matter of right, pursuant to the aggravation statute, ORS 656.273, and the discretionary remedy of own motion relief under ORS 656.278. The legislature has required the payment of time loss pending review or appeal of a claim reopened under the aggravation statute. ORS 656.313(1). The legislature has not, however, made the provisions of ORS 656.313(1) applicable to a claim reopening under the own motion statute. In the absence of bad faith or some similar extraordinary factor, we also decline to do so.

For the foregoing reasons, we decline to grant claimant's request for own motion relief at the present time. After WCB Case No. 84-12042 has been docketed and reviewed, we will issue our Own Motion Order addressing claimant's possible entitlement to claim reopening for payment of temporary and/or permanent disability benefits.

IT IS SO ORDERED.

HOWARD R. ROE, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03880
August 28, 1985
Order on Reconsideration

The SAIF Corporation has requested that the Board reconsider its Order on Review issued July 30, 1985. In that Order, we reversed that portion of Referee McCullough's order that awarded claimant interim compensation during a period in which claimant worked. The Referee's order was based on the Court of Appeals decision in Bono v. SAIF, 66 Or app 138 (1983). Our reversal was based on the Supreme Court's subsequent decision in Bono v. SAIF, 298 Or 405 (1984), which overturned the Court of Appeals' decision

and held that interim compensation is not payable to a worker who has not in fact left work. The Referee's order also assessed penalties and attorney fees against SAIF for its failure to pay the interim compensation at issue. We did not address that portion of the Referee's order in our Order on Review.

SAIF now asks that we modify our order to delete the penalty and fee, consistent with our reversal on the issue of interim compensation. In response to SAIF's request for reconsideration, claimant argues that the Court of Appeals decision in Bono was the law in effect at the time of the facts involved in the present case, and that it was, therefore, improper for SAIF to ignore existing law by not paying the interim compensation benefits at issue. After considering both parties' arguments, we agree with SAIF that we should modify our order to eliminate the penalty and attorney fee awarded by the Referee.

Implicit in the Supreme Court's Bono decision was the holding that if interim compensation is not due, penalties and attorney fees cannot be awarded, absent some other basis for awarding them. Claimant does not argue that the Supreme Court's Bono decision should not be given retroactive effect. Indeed, we know of no legal principle that prohibits retroactive application of judicial decisions. In fact, we note that the rule of Bauman v. SAIF, 295 Or 788 (1983), for example, has recently been applied retroactively by the Court of Appeals. Wagoner v. U.S. National Bank, 71 Or App 266 (1985).

Now, therefore, having granted the SAIF Corporation's request for reconsideration, and having considered claimant's argument in opposition, we modify our Order on Review dated July 30, 1985 and reverse that portion of the Referee's November 7, 1984 Opinion and Order that assessed a penalty and attorney fee for SAIF's failure to pay interim compensation. We adhere to and republish the remainder of our order.

IT IS SO ORDERED.

RICHARD E. BREWER, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 83-02699
August 29, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests, and claimant cross-requests, review of Referee Danner's order which awarded claimant permanent total disability on review of a Determination Order dated March 29, 1983, which awarded claimant no permanent disability in addition to prior awards. SAIF contends that claimant has failed to establish his entitlement to an award for permanent total disability, that claimant's prior award for 192° (60%) unscheduled disability adequately compensates him for the loss of earning capacity attributable to his industrial injury and that, therefore, the Determination Order should be affirmed. Claimant contends that the effective date of his award for permanent total disability should be February 23, 1983, rather than March 29, 1983, as ordered by the Referee.

On our de novo review, we find that claimant has failed to establish that he is entitled to an award for permanent total disability. Therefore, we reverse.

Claimant was 64 years of age at the time of hearing. He sustained this injury to his back in April of 1975 while working as a painter. He was painting a lookout in a state park when he fell backwards, falling approximately three or four feet onto concrete. He landed flat on his back and struck the back of his head. He suffered a lumbosacral strain and was treated conservatively.

Claimant had previously injured his back in November of 1967 while working in California and then in May of 1969 while working in Coos Bay, Oregon. He experienced low back symptoms for approximately one and one-half to two years after this 1969 injury. He returned to California and enrolled in a vocational rehabilitation program studying agricultural inspection. His program was terminated, however, due to lack of finances. In 1971 claimant resumed his occupation as a painter. He was symptom free until this 1975 injury.

After two months of conservative care, consisting of bedrest and pain medication, claimant was released to work in late June of 1975. Although claimant returned to work, it was necessary for him to limit his activities. He worked part time, three to four hours per day, with no lifting and no stooping. He continued to take his pain medication. In late July of 1975 claimant's attending physician considered claimant's condition stationary; however, claimant stopped working the following month.

In November of 1975 claimant was examined by Dr. Matteri at SAIF's request. Claimant complained of back and bilateral leg pain. In reviewing claimant's medical records, Dr. Matteri noted the previous diagnosis of osteoarthritis of the lower dorsal spine. Dr. Matteri diagnosed chronic lumbar and dorsolumbar insufficiency secondary to arthritic changes. He stated that claimant's job demands, which included carrying heavy ladders and scaffolding, were inconsistent with the degree of spinal degeneration indicated by X-ray. He stated that claimant was "significantly disabled with regard to his spine and the line of his employment as a painter." He also stated, however, that claimant was not, "by any means," unemployable in an occupation requiring less significant demands. He considered claimant's condition "stable," and indicated that, "this sort of problem usually progresses gradually with time."

In April of 1976 claimant was examined by Dr. Mason, medical examiner for the Disability Prevention Division of the Workmen's Compensation Board. Dr. Mason diagnosed a chronic, low back strain but stated that the degree was difficult to determine. His clinical examination disclosed no evidence of a herniated disc or nerve root compression. Dr. Mason believed there was "definite emotional overlay" on his examination, and he commented that, "this person is probably a claims-conscious individual." X-rays of the cervical spine showed evidence of disc degeneration and localized osteoarthritis at C5-6-7. X-rays of the mid and lower dorsal spine disclosed severe degenerative osteoarthritis. Dr. Mason stated that claimant probably did not need any treatment other than an exercise program. He stated that a job change might be advisable.

Dr. Vizzard performed a comprehensive psychological evaluation. Claimant's full scale IQ score placed him in the 57th percentile for persons within his age group. His verbal and nonverbal IQ scores fell "solidly in the average range," with his nonverbal score being at the upper end of average.

Claimant apparently indicated to Dr. Vizzard that, because of his physical condition, he felt he might have a hard time performing full-time employment; however, he was optimistic concerning his ability to perform part-time work. He was very general with respect to alternative job ideas, indicating preferences for working outdoors and being self-employed. Claimant expressed concern about his ability to return to work given his age, his education (formal eighth grade) and "the general employment situation." In addition, claimant admitted frustration about his inability to be as active as he once was. Dr. Vizzard stated: "This has resulted in a mild degree of over focus which is possibly moderately affecting his physical functioning."

In view of claimant's lack of any particular alternative job ideas, Dr. Vizzard felt that he should receive vocational guidance counseling in order to identify some goals. He felt that determining an area for claimant to turn to for retraining or reemployment would reduce some of his fears concerning his ability to return to productive work and, in turn, reduce some of the causes for the mild overfocusing on his physical symptoms.

Claimant was found to qualify for vocational rehabilitation services; however, these services were terminated when claimant failed to participate. It was felt that he had "questionable motivation" to return to light work.

Claimant was reexamined by Dr. Matteri in July of 1976. He again diagnosed chronic lumbar insufficiency and found claimant's condition stable. He reported, "He is significantly disabled both by virtue of the fact that he does not seem to be willing to work any lighter job and by the fact that he is in the chronic or attenuated state of his disease process." In terms of treatment, Dr. Matteri reported that there was little to offer other than conservative measures.

The claim was closed in December of 1976 with an award for 112° (35%) unscheduled disability for injury to claimant's low back. Claimant challenged the adequacy of the permanent disability award. He sought an award for permanent total disability. A May 31, 1977 Referee's order declined to award claimant compensation for permanent total disability. The Referee questioned claimant's motivation to be retrained or to return to the general labor market. He increased claimant's unscheduled award to 192° for 60% of the maximum allowable by law.

Claimant returned to California, where he used his permanent partial disability award to begin his own contracting business. He reactivated his contractor's license and advertised for work. He had two or three employes, including his son. Initially the business did well; however, claimant began to experience difficulty with his back and, as a result, had problems going to jobs and supervising his crew. Claimant was uncertain whether he was in business during 1978 and 1979, or during 1979 and 1980; however, he believed that he was in business for approximately one and one-half years. Claimant did not work thereafter. Claimant testified that he applied for "a couple of jobs," but that when the potential employers were informed of his back condition, he was not hired.

In November of 1981 claimant saw Dr. Van Pelt, an orthopedic

physician in Eureka, California, with complaints of "slightly more [back] pain." Claimant reported that his pain was made worse by any activity at all, and that he was unable to lift, bend, sit, twist, carry or drive for any period of time. He had no "clear-cut numbness, tingling, paresthesias, pins and needles, weakness or paralysis of either lower extremity but complained of stiffness." Dr. Van Pelt diagnosed degenerative arthritic changes of the entire spine, chronic lumbosacral pain, possible chronic pain syndrome, and no clear-cut evidence of neurologic involvement.

Claimant's medical records were made available to Dr. Van Pelt. He noted the "strong suggestion" throughout the records from other physicians who had examined claimant that there was a significant emotional component to claimant's complaints.

Claimant apparently informed Dr. Van Pelt that he had attempted to go back to work "for a brief period of time in 1977," but that he was unable to sustain any level of physical activity and, therefore, had not worked since 1977. In a November 5, 1981 report to SAIF, Dr. Van Pelt stated:

> ". . . [I]t is obvious from a pragmatic point of view that this patient has not worked for six years, and he states that anything he tries to do makes his back worse, and that 'nothing' relieves it. It is most improbable, given this situation, that he will ever return to the active employment arena."

In reporting the findings of his physical examination, Dr. Van Pelt stated that claimant seemed to be "somewhat anxious to demonstrate how disabled he is"; and that claimant either could not or would not perform a range of motion of his torso in any manner to convince the doctor that "a major effort" was being made. The motions that were performed, however, were less than 50% of normal. X-rays disclosed moderate calcification of the abdominal vasculature, but no "clear-cut aneurysm" could be detected.

Dr. Van Pelt stated that conservative treatment was appropriate, to include as little medication as needed, reevaluation for physical therapy and initiation of an exercise program, and weight control. He also felt that psychological testing with an MMPI was appropriate. His report concluded:

> "In the meantime, even though the patient has only stiffness as his primary physical finding, I don't think there is any job we are going to be able to get him to do. The extensive arthritis that he has is certainly a factor, and the calcification of the aorta and common iliacs may also be a problem. * * * * "

Dr. Van Pelt subsequently confirmed that claimant's current low back condition is related to his original 1975 injury, and that claimant's condition had gradually worsened. By stipulation dated November 8, 1982, the parties agreed that the claim would be roepened as of November 5, 1981.

Claimant was seen by Dr. Van Pelt in late February of 1983 for a closing examination. Dr. Van Pelt reported that claimant's overall condition had not changed, stating that his condition was "basically permanent and stationary" as of the time he saw claimant in 1981. He reported that claimant continued "to consider himself disabled," and that it was, "unreasonable to anticipate that there [would] be a spontaneous improvement to the point that would permit him to return to any type of gainful employment." Dr. Van Pelt concluded that subjectively, claimant was experiencing chronic low back pain exacerbated by virtually any activity. Objectively, however, the "factors of disability" were noted to be few, with "stiffness of the lumbar spine" being the primary finding.

The claim was reclosed by Determination Order dated March 29, 1983, which awarded temporary total disability and no additional award for permanent partial disability. Claimant's condition was found to be medically stationary on February 23, 1983. SAIF thereafter notified claimant of an overpayment for temporary total disability paid between the medically stationary date and the date of claim closure.

At the hearing, claimant described his limitations. Bending, twisting and climbing stairs produce pain. He is only able to walk 50 yards at a time before he begins to experience pain. He can only stand four or five minutes and sit 20 to 30 minutes. He is able to drive 25 to 30 miles before he has to get out of the car in order to relieve his back pain and leg numbness. He takes pain medication and Valium. He also takes medication for a cardiac arrhythmia.

For the 20 years preceding his injury, claimant's primary occupation was as a painter. Previous employment experience included farm work, heavy equipment operation, auto mechanics, and work as a laborer in the construction and plumbing industries. Claimant testified that he did not believe he was capable of performing any of his previous occupations as a result of his physical limitations.

The Referee noted the evidence, as well as the prior Referee's determination, suggesting that claimant's post-injury motivation to return to a lighter form of work was questionable. He found this mitigated by the evidence of claimant's attempt to establish a contracting business which failed as a result of his inability to maintain the necessary level of activity. He also found that claimant "appears to have a speech impediment," and that this would adversely affect claimant's ability to obtain gainful employment. It appears as though the Referee also took claimant's "heart condition" into consideration. He found that claimant had not sought employment since the 1977 extent of disability hearing, other than the aborted attempt to establish a contracting business; however, he considered this failure to seek employment excused based upon his conclusion that any such efforts would be futile.

SAIF objects to the Referee's "diagnosis" of a speech impediment without supporting medical evidence. The Referee's statements in this regard are more in the nature of his personal assessment of the manner in which claimant presents himself, as opposed to his own diagnosis of a medical problem. Such an evaluation of claimant's demeanor is within the province of the factfinder.

Claimant's heart ailment arose after his 1975 injury, not before. Therefore, to the extent that this condition might contribute to claimant's inability to return to heavy work, it is not properly a part of the permanent total disability calculus as a "pre-existing disability." Emmons v. SAIF, 34 Or App 603 (1978); Frank Mason, 34 Van Natta 568, aff'd mem. 60 Or App 786 (1982). Claimant does not contend that his heart condition is related to his industrial injury; nor is there any evidence to support such a conclusion.

Claimant's medical condition, standing alone, does not support an award for permanent total disability. Although he has advanced arthritic changes of the lumbar spine, he also has degenerative arthritis of his cervical and thoracic spine, all of which causes pain. Only the low back pain and resultant limitations are relevant. There is no persuasive medical evidence of neurologic involvement, and the only objective evidence of disability, other than claimant's X-ray findings, is "stiffness of the lumbar spine."

When we consider the relevant social/vocational factors in conjunction with the evidence of physical impairment, we conclude that although claimant suffers a significant disability, he is not so severely disabled as to be excused from the seek-work requirement of ORS 656.206(3). Claimant made one apparently serious attempt to become reemployed after his 1977 hearing, but this met with failure because the work was too physically demanding. In the ensuing years, claimant made "a couple" job contacts of an undefined nature. Since his injury, claimant has been capable of performing work which is less demanding than his previous occupation as a painter. Claimant has never exhibited the motivation to obtain employment suitable to his physical limitations. As Dr. Van Pelt recently commented, claimant continues to "consider himself disabled." Dr. Van Pelt's initial assessment was not that claimant was incapable of performing a gainful and suitable occupation, but that because of claimant's inactivity for six years, "from a pragmatic point of view," it was unrealistic to expect that claimant would return to gainful employment.

Although claimant only has a formal eighth grade education, he is of at least average intelligence, if not slightly above. He has had many years of experience in the painting industry, and he has a contractor's license. He obviously has a good deal of knowledge concerning auto mechanics and, therefore, automobile parts. There is no direct evidence, for example a vocational report, to establish that claimant would be incapable of obtaining and holding gainful employment utilizing the training and skills he has acquired by virtue of his past employment experience. Considering the evidence which strongly suggests a motivational deficit, we refuse to infer that reasonable efforts to obtain gainful and suitable employment would be fruitless.

With regard to the extent of claimant's permanent partial disability, we find that the Evaluation Division properly determined that claimant's previous award for 192° (60%) unscheduled disability adequately and appropriately compensates him for the loss of earning capacity attributable to his industrial injury. To begin with, there has been little change in claimant's condition since the 1977 hearing which resulted in the aforementioned award. Although Dr. Van Pelt's comments in 1981

and 1982 suggest a slow, gradual worsening of claimant's back condition, his final comments in March of 1983 indicate that claimant's condition was "permanent and stationary" when he first examined him, and that in the intervening year and a half there was little, if any, change.

Secondly, aside from the relative identity of claimant's 1977 back condition and 1984 back condition, our de novo review of this record satisfies us that claimant's injury-related permanent disability is no greater than that reflected by his 1977 award for 192° (60%) unscheduled disability.

ORDER

The Referee's order dated May 14, 1984, which awarded claimant compensation for permanent total disability, is reversed. The Determination Order dated March 29, 1983, which awarded claimant no compensation for permanent disability in addition to prior awards, is affirmed. Claimant's total permanent partial disability award to date is 192° (60%) unscheduled disability for injury to the low back.

MILDRED M. DeROUSSE, Claimant
Flaxel, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-01184
August 29, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Danner's order which dismissed claimant's hearing request for failure to prosecute her claim or to show good cause why she failed to prosecute her claim. The issue on review is whether the hearing request should have been dismissed.

Claimant was diagnosed as having carpal tunnel disease related to her work in July 1982. After surgical correction of the condition, she was released to return to her regular work in October 1983. A Determination Order dated December 28, 1983 closed the claim with no award of permanent disabilty. Claimant requested a hearing on the issues of premature closure and permanent partial disability. The first hearing was set for June 1984. Shortly before the hearing date, claimant's attorneys withdrew because they could not locate their client and had not communicated with her for several months. The Presiding Referee issued a 30-day Show Cause order on the date of the original hearing. On the sixtieth day after the Show Cause order issued, the Presiding Referee dismissed claimant's hearing request. Three weeks later, the Presiding Referee vacated his dismissal order based on a letter from claimant's new attorney and referred the case to Referee Danner. Three weeks after that, Referee Danner ordered dismissal of claimant's hearing request. Claimant, through yet another lawyer, requested review by the Board on November 7, 1984.

We note that none of the dismissals of claimant's original hearing request were "with prejudice." Claimant was given an opportunity to show good cause for failure to prosecute her first hearing request and offered only that she had moved from one area of the state to another and that it was inconvenient for her to keep in contact with her first attorney. The administrative rules

provide for discretionary dismissal when it appears that a claimant has abandoned his or her claim. In this case, claimant was offered an opportunity to show good cause why the case should not be dismissed and offered no good cause. We find that dismissal of the first hearing request was appropriate and affirm the Referee's order.

ORDER

The Referee's order dated October 5, 1984 is affirmed.

RICHARD J. GUERRERO, Claimant
Samuel A. Hall, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 84-03856 & 84-04470
August 29, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Seifert's order which upheld denials issued by the SAIF Corporation and EBI Companies in behalf of their respective insureds, denying the compensability of claimant's skin condition, diagnosed as allergic contact dermatitis. The issues are compensability and employer responsibility. We find and hold that claimant's condition is compensable as an occupational disease, ORS 656.802(1)(a), and that EBI Companies is responsible for payment of claimant's compensation.

Claimant is a 38-year-old cement mason who has worked in construction and carpentry most of his working life. His first exposure to wet cement occurred in the early 1960's when he was employed as a laborer. (Cement is a powdered product, which is used to manufacture concrete, a mixture of cement, sand, gravel, water and other substances. The "cement" and "concrete" terms are used interchangeably herein.)

Claimant first developed manifestations of a skin condition in 1972 after working with wet cement in Reno, Nevada. He developed a small rash on the calf of each leg, which he treated himself with calamine lotion. The rash subsided after two or three weeks. Thereafter, claimant avoided cement work and spent most of his time performing office chores. In 1977 or 1978 he again became involved with wet cement work in Nevada, and he developed a similar rash on his calves, ankles and knees. Claimant sought medical attention, and eventually the rash dissipated. Once again, claimant stopped working with cement for awhile, and he performed carpentry. In September of 1980 he moved to Oregon and worked as a carpenter until August of 1981, when he was laid off. Claimant remained unemployed until August of 1982, when he was hired by one of the employers herein, Eugene Sand & Gravel Company (hereinafter "Eugene Sand"), as a cement finisher. At the time claimant began this employment, he had no symptoms of any skin condition. Nor did he have any such symptoms during his work for this employer. Eugene Sand was insured by SAIF.

Claimant worked for Eugene Sand during two separate periods of time. The first time was for approximately one month during August and September of 1982. He worked as a curb and gutter finisher and rarely came in direct contact with cement. After working for Eugene Sand for approximately one month, claimant was laid off and remained unemployed for almost a year until he was

called back to work for this employer. During this interim, claimant did not experience any symptoms of a skin condition. He returned to work in late August of 1983, worked about one week, was off almost a week and then returned to work for two and a half days. The job that claimant performed during this period involved setting drains in an airport. Claimant's duties did not require him to come directly into contact with the wet cement. Neither during this period nor thereafter did claimant experience any rash or other sign of a skin condition.

In late September or early October of 1983, claimant went to work for the second employer herein, Pat Crain Concrete Construction (hereinafter "Pat Crain"). Pat Crain was insured by EBI. Claimant's skin was clear and he was experiencing no signs or symptoms of a skin condition when he commenced this employment. He worked a total of six or seven days for this employer over a period of one month. He worked on a job in Coos Bay one day the first week, one day the second week, two days the third week and two days the fourth week. Immediately after finishing this Coos Bay job, the work crew went to Roseburg, where they worked at an airplane hangar for one full day. Both of these jobs required claimant to stand in, shovel and hand finish wet cement. During his employment for Pat Crain, claimant was in direct contact with wet cement. Claimant wore rubber boots and gloves; however, the wet cement got inside the boots. In addition, claimant's clothing came in contact with the wet cement, and the clothing became saturated.

During claimant's employment with Pat Crain, he did not experience any signs or symptoms of a skin condition. It was not until three or four days after the last day claimant worked for this employer that the skin on his calves, ankles and feet broke out. These eruptions were worse than what claimant had experienced previously in Nevada. At first, claimant tried to treat the problem himself with hydrocortisone cream, which relieved the burning sensation but did not relieve the itching. Because the problem did not resolve, but instead worsened, claimant sought medical care. On or about December 3, 1983, claimant was examined by Dr. Craig, who arranged a consultation with Dr. Moyer. By the time claimant saw Dr. Moyer on December 8, 1983, he had "15 or more 2 to 3 cm. spots of nummular eczema involving skin around the ankles and running up as high as his waist, one of the largest [being] on one side of the buttocks." Claimant was given an injection of Kenalog and started on a steroid cream.

SAIF referred claimant for examination by Dr. Olson, a dermatologist. Dr. Olson first examined claimant on January 30, 1984. He diagnosed chromate allergic contact dermatitis manifested as nummular eczema, and he prescribed Topicort cream. By the time claimant was seen by Dr. Olson, his skin lesions were located mainly from his waist to his feet, and there were a few scattered over his arms. Dr. Olson became claimant's attending physician. He treated claimant through the spring and summer of 1984.

In August of 1984 Dr. Olson referred claimant for an evaluation at the Oregon Health Sciences University Contact Dermatitis Clinic. In a report dated August 31, 1984, Drs. Ebertz and Storrs reported to Dr. Olson their final diagnosis of significant chromate allergic contact dermatitis. In their

opinion, claimant's contact dermatitis was definitely work-related, the causative agent, in all probability, being cement. They noted that claimant's condition probably has a degree of permanence, since chromate allergy tends to persist in spite of avoidance of the offending material.

Claimant continued to treat with Dr. Olson. By the time of the hearing in December of 1984, he was still experiencing the symptoms and exhibiting the signs of his skin condition.

Shortly before the hearing, Dr. Storrs' deposition was taken. Dr. Storrs testified that claimant is allergic to potassium dichromate, one of the elements used in wet cement. He probably was allergic when he was working with cement in 1972 or 1973 and had skin eruptions at that time. Since that time, there probably has been a degree of permanence to the allergy. The nature of allergic contact dermatitis is such that it takes between 24 and 72 hours to develop signs of the allergy after being exposed to an offending substance. Claimant is very allergic to chromate, and his recent exposure did not make him "more allergic."

Chromate allergy is unlike most other types of allergic contact dermatitis. People who are allergic to chromates very often have dermatitis on their body even when they are not around any source of chromate. Thus, almost a year after claimant had last worked around cement, he still had active dermatitis on his skin.

Dr. Storrs carefully differentiated between the term "symptom" and the term "sign." A symptom is a subjective complaint. In this instance, claimant's symptoms were the itching and burning sensations associated with his condition. A sign, on the other hand, is an objective manifestation of a disease process. Thus, the dermatitis is a sign.

The kind of dermatitis that claimant manifests is called nummular, meaning coin-shaped, eczema. Dr. Storrs explained that once a person becomes allergic to chromate, whether it is initially developed on the person's hands or legs, other places on the body begin to develop "pieces of dermatitis," even in places that the chromate doesn't touch. The dermatitis that claimant was afflicted with when he was examined in August of 1984 is something that might have happened whether or not he had worked with Pat Crain. If Dr. Storrs could be assured that claimant had absolutely no skin eruptions between the time he left Eugene Sand and the time he started working for Pat Crain, it would be her opinion that claimant's employment with Pat Crain probably aggravated his underlying allergy. Dr. Storrs was asked, "When the condition in 1983 flared up or aggravated or became exacerbated, did the underlying condition also become worse at that time. . .?" Dr. Storrs responded:

> "Now, that is the same question I have been asked before so I am going to try on it again here. The underlying condition is one of allergy to chromate. He is allergic to chromate even when his skin is entirely clear. When it doesn't have any rash on it at all, he is still allergic to chromate. If he were to come and see me and didn't have any rash any place on his whole body

> and I did the kind of patch test that I did on his back, he would still break out like that. If you are allergic to poison oak, you are allergic to poison oak right now even though you don't have any rash on your body at all. If you go and work for PP&L putting up power lines and you walk through poison oak, somewhere between 24 hours and 72 hours later, you are going to break out in a dermatitis probably. By walking through the poison oak, you do not make yourself more allergic to poison oak. You simply put yourself in a situation where you had an opportunity to manifest a sign, or what you call a symptom, a sign of your allergy. So you became -- your allergy, if you will, became aggravated by your exposure in the work place which is the PP&L power lines."

Later in her deposition, Dr. Storrs testified that the flare-ups of dermatitis that claimant experiences are best understood as being examples of aggravation of his underlying allergy associated with new exposure to chromate in concrete.

Dr. Storrs explained that in reporting that claimant's chromate allergy is definitely work-related, she did not mean to specify a particular work exposure. She meant that claimant became allergic to chromate in a work environment, and that the work environment where he became chromate sensitive occurred probably between 1972 and 1973, based on claimant's history. It was predictable that, from that point forward, every time claimant worked with concrete, his underlying permanent allergy would be aggravated.

Dr. Storrs testified that chromates are found widely in our environment. Potassium dichromate is used to tan leather from which leather jackets and shoes are made. Nickel-plated chromates are used in construction. Chrome dyes are used in rugs, books and paint. Although a leather shoe, for example, has some measure of chrome in it, the degree is probably not sufficient to cause an allergic reaction, at least in claimant's case.

At the hearing, a Mr. Niedermeyer testified on behalf of Eugene Sand. Mr. Niedermeyer is the superintendent in the construction department. He explained that Eugene Sand is a producer of concrete products, and that cement is a product it purchases from other companies, which is used as a constituent of the concrete itself. In general, concrete is a combination of aggregates, or rock, water and cement. In addition, there are a "sheer unlimited variety of additives that are on the market" that may be used in combination with the basic ingredients. Eugene Sand, however, only uses two or three additives, and only when specifically requested by a customer. Eugene Sand purchases its cement from Ideal Basic Industries in Portland and has done so for 20 years.

A test certificate from Ideal Basic Industries' cement division was admitted into evidence. This document is a typical certification provided to guarantee that the product conforms to standards established by the American Society of Testing Materials

(ASTM), a testing institute that establishes standards and guidelines for the manufacture of various products used in the industry. The document contains the chemical composition of Type 1 cement. There are no chromates designated on the document. The document does not represent an analysis of the particular cement that claimant was exposed to during his employment with Eugene Sand; however, Mr. Niedermeyer explained that the chemical composition of all of the cement used by Eugene Sand is as represented on this document. The only variables are that the amount of each element listed may vary from shipment to shipment. Additives are not part of the analysis since they are added by the concrete manufacturer. Mr. Niedermeyer testified that, to his knowledge, Eugene Sand did not use potassium chromate or chromium chloride as an additive. With reference to the concrete used while claimant was working, neither potassium dichromate, chromium chloride nor chromium sulphate were used as additives.

Pat Crain testified in behalf of Pat Crain Concrete Construction. He testified that the concrete used on the Roseburg job was Type 1 cement. The only additive that was ordered or mixed with the concrete, of which he was aware, was air, "which is almost standard." Mr. Crain admitted, however, that he was not personally responsible for mixing additives to the cement, which was the responsibility of the general contractor who ordered the concrete. No one in his employment was responsible for adding anything to the cement. He thought that the cement was purchased from Beaver State, but it could have been either Ideal or Portland.

Both employers/insurers contest the compensability of claimant's skin condition. The Referee discounted all of the medical evidence, which assumes exposure to chromates, based upon his conclusion that the evidence establishes that none of the cement claimant was exposed to contained any chromates. He drew this conclusion on the basis of Mr. Niedermeyer's and Mr. Crain's testimony that the cement used was Type 1, as well as the aforementioned document detailing the chemical composition of the Type 1 cement used by Eugene Sand.

Although Mr. Niedermeyer testified that the cement used by Eugene Sand is typical of the cement used industry-wide, that is an insufficient basis on which to conclude that the cement or concrete to which claimant was exposed during his employment for Pat Crain did not contain any chromates. Mr. Crain obviously was not informed of the precise chemical composition of the cement used on the Roseburg job. The general contractor, not Pat Crain, was responsible for supplying the cement, as well as any additives requested. "Type 1" is not a reference to the chemical composition of the cement. Rather, it denotes the coarseness of the grind or texture of the cement. Thus, for example, Type 1 cement is coarser than Type 3.

The historical facts suggest that when claimant comes in direct contact with wet cement, he develops the signs and symptoms of allergic contact dermatitis. Dr. Storrs, an experienced professional in industrial skin disease, has confirmed claimant's chromate allergy, which is typically found in workers exposed to wet and dry cement. This is corroborated by Dr. Olson's report that claimant's current skin condition is directly related to his recent employment. We believe that this evidence is sufficient to satisfy claimant's burden of proving legal causation, i.e., that his condition is one which "arose out of and in the scope of employment." ORS 656.802(1)(a). A discussion of medical causation follows.

Claimant's skin condition preexisted his Oregon employment in 1982 and 1983. It was during his employment in Nevada that he originally contracted his allergic contact dermatitis. According to Dr. Storrs, it was during the 1970's that claimant became allergic. Thus, when claimant came to Oregon and became subject to Oregon's Workers' Compensation Law, his allergic contact dermatitis was a preexisting condition within the meaning of decisions such as Weller v. Union Carbide, 288 Or 27 (1979), and more recently, Wheeler v. Boise Cascade, 298 Or 425 (1985). In order to establish the compensability of claimant's skin condition as an occupational disease under Oregon law, therefore, it is necessary that the evidence establish that, as a result of his Oregon employment, claimant's preexisting allergic contact dermatitis pathologically worsened, as opposed to the mere recurrence or exacerbation of symptoms, Wheeler, supra; Weller, supra, and that claimant's Oregon work exposure was the major contributing cause of this worsened condition, Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); SAIF v. Gygi, 55 Or App 570 (1982).

Analyzing the evidence in the framework of these legal standards, we are persuaded that claimant's Oregon work activity caused a worsening of his preexisting, underlying allergic contact dermatitis, as opposed to causing merely the recurrence of symptoms. Dr. Storrs' deposition is persuasive in this regard. She testified that claimant became allergic in 1972 or 1973, and that his recent exposure did not make him "more allergic." However, she also testified that the new exposure to wet cement aggravated claimant's underlying allergy, thereby producing manifestations of the disease, i.e., dermatitis. This evidence satisfies the Weller/Wheeler criteria. Unlike Wheeler and SAIF v. Baer, 60 Or App 133 (1982), both of which were claims for skin disease, the record of this case establishes by a preponderance of the evidence that claimant suffered a worsening of his underlying condition, as opposed to merely increased symptoms, as a result of his Oregon work activity.

The evidence is likewise persuasive that claimant's work activity in Oregon was the major cause of this worsened condition. Although chromates are ubiquitous according to Dr. Storrs, there is no evidence suggesting that claimant came into contact with concentrations of chromate off the job which might be sufficient to cause or worsen his skin condition. Given the absence of signs or symptoms of the skin condition preceding claimant's employment with Pat Crain, Dr. Storrs was satisfied that, more likely than not, this employment exposure caused claimant's skin condition to worsen. So are we.

Having established that claimant's underlying condition was worsened, and that his Oregon work activity was the major contributing cause of this worsening, the remaining question is which of the two employers is responsible.

Claimant cites Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984), as authority for the conclusion that Pat Crain is liable for payment of compensation. In Starbuck the court discussed various applications of the last injurious exposure rule, in both the injury and occupational disease contexts. The opinion states in part:

"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. * * * " 296 Or at 243 (citations omitted).

Utilizing the last injurious exposure rule to assign liability in this case results in the conclusion that Pat Crain is the responsible employer because that is claimant's last employer where conditions existed which could have caused his skin condition. Fossum v. SAIF, 293 Or 252 (1982); FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified on reconsideration 73 Or App 223 (1985); Sylvia A. Weaver, 37 Van Natta 656 (1985); see also Bracke v. Baza'r, 293 Or 239 (1982).

ORDER

The Referee's order dated January 10, 1985 is reversed in part. That portion of the order which upheld EBI Companies' denial dated April 12, 1984 is reversed. That denial is set aside, and this claim is remanded to EBI Companies, as the insurer for Pat Crain Concrete Construction, for acceptance and processing in accordance with law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1500 for services at hearing and $550 for services on Board review, to be paid by EBI Companies, for prevailing on this denied claim.

KATIE C. HOLMES, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-08152
August 29, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Daron's order which denied claimant's request for penalties and attorney's fees for the SAIF Corporation's unreasonable delay in forwarding requested medical reports pertaining to a claim in the absence of delay or refusal to pay compensation to claimant. The issue on review is penalties and attorney's fees.

The case was submitted to the Referee on stipulated facts.

"Claimant's attorney filed demand for claims information with SAIF by letters of May 7 and June 4, 1984. SAIF did not send any of the requested documentary information to claimant's attorney until August 15, 1984. SAIF has no reasonable explanation for the delay. Claimant concedes SAIF has not refused, resisted or delayed payment of any compensation; therefore, no compensation was due claimant

at the time of the demand or the request for hearing submitting the matter at issue."

The Referee relied on and quoted from an Opinion and Order of another Referee in a similar case with exactly the same issue between the same insurance company and the same firm of attorneys.

SAIF relies on EBI Companies v. Thomas, 66 Or App 105 (1983), for the proposition that no penalty can be imposed for unreasonable claims processing under ORS 656.262(10) because there are no "amounts then due" upon which to base a penalty, which is expressed as a percentage of the compensation due claimant.

Claimant argues that the Supreme Court approved the penalty and attorney's fee provisions of then OAR 436-83-460, now OAR 438-07-015, and affirmed the assessment of penalties and attorney fees for unreasonable claims handling under then ORS 656.262(8), now ORS 656.262(10). Morgan v. Stimson Lumber Co., 288 Or 595, mod. 289 Or 93 (1980). As the court said:

> "The Board does not say, in the challenged sentence, that every failure or delay to furnish the requested documents to the claimant automatically entitles the claimant to the extra compensaton and attorney fees provided by the statute. On the other hand, when the Board believes this procedure to be necessary for the expeditious determination of claims, it need not let an employer disregard the requirement and wait to litigate whether or not it actually caused a delay. The Board's rule gives notice that noncompliance 'may be considered unreasonable delay' under the statute. The rule is consistent with the purpose of the statute, which is to secure promptness in claims disposition, not to invite the parties to speculate on such after-the-event litigation about the actual consequences of noncompliance in the particular case." 288 Or at 604.

Claimant also relies on Stella Phillips, 35 Van Natta 1276 (1983), aff'd mem. 69 Or App 327 (1984). In Phillips, the Board first affirmed the Referee's finding that claimant's condition was not compensable, then addressed the issue of penalties and attorney fees for delay in providing claims documents. The Board quoted from Morgan, supra, and then found that it had implied authority to create a remedy and awarded a $300 penalty and a $300 attorney fee for unreasonable delay in complying with the Board's procedural rule. Claimant appealed on the issue of the compensability of the claim; the insurer did not appeal the penalty and attorney fee. The Court of Appeals affirmed the Board's order without opinion.

Finally, claimant also relies on Arnold C. Blondell, 36 Van Natta 818 (1984), in which we stated that we would have awarded a penalty for late production of documents but that the maximum penalty had already been awarded, and we awarded a penalty-associated attorney fee. Blondell was not appealed.

Claimant argues that the Supreme Court's mandate in Bono v. SAIF, 298 Or 405 (1984), provides further indication that the court thinks that penalties can be assessed in the absence of a right to compensation.

We have recently considered the questions surrounding the issue of penalties and attorney's fees in two cases on remand from the Court of Appeals: Harold A. Lester, 37 Van Natta 745 (1985); and Anthony A. Bono, 37 Van Natta 956 (1985). We have concluded that penalties for unreasonable delay or resistance to compensation can only be imposed when there is either a refusal to pay or a delay of compensation to which claimant is entitled. If there has been no delay of compensation, then there is no amount "then due" upon which to base a penalty. In Mary J. Spontak, 37 Van Natta 230 (1985), we reversed that portion of a Referee's order which awarded penalties and attorney fees for delay in production of claims documents in the absence of delay or refusal to pay compensation in the context of a responsibility case.

We now overrule Stella Phillips and extend the finding in Spontak to include cases such as this where compensability may have been at issue and find that claimant is not entitled to penalties or attorney's fees simply on a showing that the insurer or employer has delayed production of relevant claims documents on demand. We recognize that this interpretation of the rule and statute mean there are no teeth in the discovery rules as they apply to insurers and employers so long as claimant is being paid all compensation due for disability and medical services. We think that is the legislature's purpose as embodied in the statute. We leave for another day questions regarding penalties and attorney fees in other contexts.

ORDER

The Referee's order dated February 15, 1985 is affirmed.

RONALD L. JAMES, Claimant
Ernest W. Kissling, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Nancy J. Meserow, Defense Attorney

WCB 83-10602 & 84-11667
August 29, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Wausau Insurance Company requests review of those portions of Referee Tuhy's order which set aside its denial of responsibility for claimant's low back condition due to a new injury and recommended to the Board that it deny reopening for claimant's own motion against the SAIF Corporation. Wausau additionally requests remand to reopen the record to consider newly created evidence that resulted from diagnostic testing subsequent to the hearing. The issues on review are responsibility and whether the record should be reopened to consider newly created evidence.

On the issue of the remand, Wausau offers the January 29 and February 1, 1985 progress notes of Dr. Kelley, one of claimant's treating physicians, which report findings on electromyographic examination of claimant's left leg. Dr. Kelley's reports may tend to show that claimant's problems are due to aggravation of claimant's injury suffered while working for SAIF's insured, rather than a new injury suffered while working for Wausau's

insured. By the time of hearing, Dr. Kelley had requested authorization from Wausau at least five times over a period of eight months to perform the EMG without receiving a reply from Wausau, according to the record. At the time of the hearing, the opinions of a treating doctor and of the independent examiners at Orthopaedic Consultants were that claimant had suffered a new injury, for which Wausau was responsible. Wausau argues that it was impossible to get the EMG report before hearing. We find that it was possible to get the necessary diagnostic test performed before the date of the hearing.

Wausau also argues that it would have had to determine that the underlying claim was compensable before it could pay for the diagnostic test, and that that "acceptance" would have precluded it from then denying compensability regardless of the result of the examination under the rationale of Bauman v. SAIF, 295 Or 788 (1983). Paying for diagnostic testing pending acceptance or denial of a claim does not constitute acceptance of a claim. Faught v. SAIF, 70 Or App 388 (1984); ORS 656.262(9). Nor does paying for independent medical examinations and diagnostic testing after issuing a formal denial constitute acceptance of a claim. It was clear at the time Dr. Kelley requested authorization to perform the EMG that there was no question of compensability of claimant's condition; however, no order could be entered under ORS 656.307 because the aggravation claim against SAIF was subject to own motion jurisdiction. As the Referee noted, it is unfortunate that claimant suffered as a result of ORS 656.307(2), but that appears to be the legislature's express intent in adopting the section. However, it was Wausau's gamble based on a misreading of the statute detailing responsibility for processing claims that led to the necessity for the hearing. It is true that Wausau was not obligated to pay for medical services, pursuant to ORS 656.262(6), but a reasonable consideration of the risk involved should have prompted the insurer to request an independent medical examination, such as the examination by Orthopaedic Consultants obtained by SAIF, which could have included the EMG and suggested CT scan that might have settled the question medically without the necessity of a hearing.

Wausau refers us to Muffett v. SAIF, 58 Or App 684 (1982), and Egge v. Nu-Steel, 57 Or App 327 (1982), for the proposition that it is improper for the Board to refuse remand when subsequent evidence reveals the cause of claimant's symptoms which cause had not been determined by the time of hearing. In this case, the reason why the cause had not been determined was the pre-hearing obstinacy of the insurer who lost the case at hearing. It appears from the record that Wausau decided to do nothing to develop the record on the issue of causation until after it lost the case. As SAIF's brief states: "The insurer can establish and maintain a denial, while requesting that certain diagnostic tests be performed in preparation for hearing." Even more persuasively, SAIF argues, "There would be little reason for holding hearings if parties are allowed to return again and again each time they happen to find or produce supportive evidence that could have been obtained with due diligence before the original hearing."

We agree with SAIF and claimant that Wausau has failed to show that the proffered evidence was not available in the exercise of due diligence before the original hearing. Therefore, we deny Wausau's request to remand the case to the Referee to reopen the record.

On de novo review of the record as it was developed before the Referee, the Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated November 23, 1984 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by Wausau Insurance Company.

RICHARD L. MANLEY, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-11309
August 29, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Gemmell's order which set aside its denial of aggravation of claimant's low back injury and awarded a $2,000 attorney fee. The issues on review are aggravation and attorney fees.

The Board affirms the order of the Referee with the following comment. Exhibits 13 and 26 prove that claimant's third surgery was performed at the same site for the same problems as a sequelae of the first two surgeries. The insurer's independent medical examiner who testified admitted that he had not read the medical reports beyond a cursory observation of the sites of surgery as reported. The insurer's other medical examiner also based his arguments against a causal relationship on the mistaken belief that the third surgery was performed at a different level of claimant's spine. Claimant's treating doctor did not state that the surgery was at the same level, but he did clearly state that the third surgery was related to claimant's original injury and previous surgeries based on his observations at surgery. We find that the surgeries performed at "L4-5" were actually performed at L5-S1, the level of the third surgery, as explained by the X-rays and explanation of the roentgenologist and that claimant's compensable condition worsened and that his claim should be reopened.

On review of claimant's attorney fee, we consider many factors, including the skill and standing of claimant's attorney, the value of the interest involved and the results obtained. Carol McKenna, 37 Van Natta 638 (1985). It is difficult to compare cases in the setting of reasonable attorney fees because each case is unique and the relevant factors mix together in different proportions. We find that the attorney's fee awarded at hearing was reasonable.

ORDER

The Referee's order dated January 24, 1985 is affirmed. Claimant's attorney is awarded $350 for services on Board review, to be paid by the insurer.

JAMES C. PERSHALL, Claimant
Evohl F. Malagon, Claimant's Attorney
Cowling, et al., Defense Attorneys

WCB 83-06904
August 29, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Nichols' order that found claimant entitled to an award of permanent total disability. Subsequent to the issuance of the order, the Referee issued an amended order in which she corrected an improper attorney fee award. The remainder of the order was republished and remained in effect. On review, the insurer argues that claimant has failed to prove that he is permanently and totally disabled. We agree with the insurer and modify the Referee's order.

Claimant was compensably injured on November 20, 1982 when he slipped on a ladder, caught himself and, in doing so, injured his right foot and cervical spine. Initially, only the right foot was symptomatic. A few weeks after the accident, however, claimant began to experience neck problems. He was ultimately diagnosed as suffering from a cervical subluxation that may have preexisted his industrial injury. Claimant's known preexisting problems are a 1979 right hip replacement and low back pain.

Claimant's neck problem has manifested itself primarily in the form of significantly reduced range of cervical motion. He also experiences ongoing left arm numbness and tingling. In February of 1983, claimant underwent a successful fusion of the subluxated cervical vertebrae, although he continued to complain of symptoms following the surgery. The medical record reveals at least some neck improvement since the surgery.

Claimant's initial treating physician was neurologist, Dr. Martinez. In a one-line report issued in September of 1983, Dr. Martinez stated that it was unlikely that claimant would recover sufficiently to return to work. He rated claimant's impairment as moderately severe. A November 1983 Determination Order awarded claimant 80° for 25% unscheduled disability for the neck and 76.8° for 40% scheduled disability for the left arm.

Subsequent to the Determination Order, claimant was offered vocational assistance. When he was first contacted, he declined assistance, informing the vocational consultant that he was retired, unable to work, and not interested in retraining. After conferring with his attorney, however, claimant changed his mind. He subsequently was offered approximately ten months of assistance. At the end of ten months, however, it was recommended that his file be closed because of what his counselor saw as claimant's inability to participate due to his medical situation.

During the vocational assistance period, Dr. Sacks became claimant's treating physician after Dr. Martinez relocated to California. Dr. Sacks has always maintained that claimant is capable of sedentary work. Claimant twice represented to his vocational counselor, however, that Dr. Sacks had advised him not to work. At his deposition, Dr. Sacks denied having given claimant that advice, and stated that in his opinion, claimant is not as disabled as he represents that he is. He also offered his observation that claimant is not interested in returning to work.

At hearing, claimant testified that day-to-day activities, including walking, bending and stooping, are often difficult for him. A surveillance film offered and shown at hearing tends to refute that assertion, however. The film shows claimant bending, getting to and from a kneeling position and briskly walking approximately 100 yards without significant difficulty. The film was authenticated and corroborated by the independent private investigator who took it. The Referee made no specific finding regarding claimant's credibility, but did note that claimant tended to structure his testimony in a way most favorable to his claim.

The Referee found claimant permanently and totally disabled. She found that although the medical record alone did not establish total disability, claimant's physical restrictions, preexisting problems and unfavorable social/vocational factors did, when combined. The Referee also found that although claimant's work search had been minimal, he was excused from the seek-work requirement of ORS 656.206(3), because such a search would be futile. After reviewing the record, we disagree.

We are mindful of Dr. Sacks' repeated statements that claimant is capable of work. We also note that although claimant's vocational file was closed in October of 1984, closure may have been precipitated at least partially by claimant's erroneous statements that Dr. Sacks had advised him not to work. We are not convinced that claimant is as physically debilitated as he states he is, and we conclude that a meaningful search for lighter work would have been appropriate and perhaps fruitful. We are not persuaded that it would have been futile. Claimant has failed to establish entitlement to permanent total disability.

Although claimant is not totally disabled, we find that he is entitled to an increased unscheduled disability award. Claimant was 59 years old at the time of the hearing. He has an eighth grade education and a GED obtained more than 30 years ago. Claimant has always worked in heavy occupations, but is now capable of only sedentary work. Considering claimant's impairment, along with the relevant social and vocational factors, we find claimant entitled to an award of 75% unscheduled permanent partial disability, which is an increase of 50% over the prior Determination Order. Claimant's scheduled award of 40% for the left arm will remain unchanged.

ORDER

The Referee's order dated January 24, 1985, as amended, is modified. In lieu of the Referee's award and the prior award of unscheduled disability, claimant is awarded 240° for 75% unscheduled permanent partial disability. Claimant's attorney is allowed a fee equal to 25% of claimant's increased unscheduled disability compensation, not to exceed $2,000, payable out of claimant's compensation and not in addition thereto.

DONALD M. VAN DINTER, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwenn, et al., Attorneys
Meyers & Terrall, Defense Attorneys
Roberts, et al., Attorneys
Lindsay, et al., Attorneys

WCB 81-05303, 82-06302, 82-07084, 82-09038, 83-02631, 83-06962, 83-06963 & 83-06964
August 29, 1985
Order on Reconsideration

Fireman's Fund Insurance Company has requested reconsideration of the Board's Order on Review dated May 31, 1985. On June 28, 1985 we abated our order to consider Fireman's request and to allow claimant an opportunity to respond to Fireman's contentions. We have now completed our consideration of Fireman's arguments, as well as claimant's response.

In its request for reconsideration Fireman's renews its contentions that claimant has received "double payments" of temporary disability compensation covering overlapping periods. We have addressed these issues in our Order on Review and are comfortable with the reasoning and conclusions expressed therein.

Fireman's further contends that claimant's awards of attorney fees were excessive. In Barbara A. Wheeler, 37 Van Natta 122 (1985), we discussed what factors must be considered in determining the reasonableness of attorney's fees. Those factors included: (1) the time devoted to the case; (2) the complexity of the issues; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; and (6) the results secured. Wheeler, supra., 37 Van Natta at 123. After considering these factors, as well as those points previously mentioned in our Order on Review, we conclude that the Referee's awards of attorney's fees were appropriate, except for those awards which we previously reversed in WCB Case No. 83-06962 or modified in WCB Case Nos. 82-07084 and 83-02631.

Finally, in the interests of clarification, we supplement that portion of our order which pertained to the modification of attorney's fees in WCB Case Nos. 82-07084 and 83-02631. Our modification applies only to attorney fees awarded in conjunction with the penalty issues in the above-mentioned cases. All awards of attorney fees for prevailing on denied claims remain unchanged. Thus, in WCB Case No. 83-02631, the $1500 attorney fee awarded by the Referee has been modified to $500. In addition, the $750 attorney fee ($400 in WCB Case No. 83-02631 and $350 in WCB Case No. 82-07084) awarded for failing to pay interim compensation between July 7, 1982 and September 8, 1982, as well as failing to comply with Referee Pferdner's order, has been modified to $400.

Accordingly, Fireman's request for reconsideration is granted. On reconsideration, the Board adheres to and republishes its former order, as supplemented herein.

IT IS SO ORDERED.

LEROY C. CHARLES, Claimant
Evohl F. Malagon, Claimant's Attorney
Cowling & Heysell, Defense Attorney

WCB 84-00386
August 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Quillinan's order that set aside its denial of claimant's low back aggravation claim. The issue on review is aggravation.

Claimant injured his low back on February 3, 1981. The resulting claim was accepted. Claimant was briefly hospitalized in April of 1981, and was released to return to work in July. An October 8, 1981 Determination Order awarded temporary total disability but no unscheduled permanent partial disability compensation. The order was not appealed.

Claimant's symptoms, which were located in both the low back and left leg, continued and in July of 1982 he visited Dr. Martinez. A month later Dr. Martinez performed a facet rhizotomy of the L4-5, S-1 nerve roots. The procedure greatly improved claimant's left leg symptoms for approximately six months. In September of 1982 he was declared medically stationary, and on October 22, 1982 a second Determination Order granted claimant 64° for 20% unscheduled permanent partial disability.

Following the issuance of the Determination Order, claimant went back to work. His back and leg symptoms returned, however, and he once again visited Dr. Martinez. In the meantime, a hearing was held on the second Determination Order regarding the extent of claimant's unscheduled disability. An Opinion and Order later issued, granting claimant no additional unscheduled disability. On June 28, 1983 the parties entered into a stipulated agreement whereby claimant was awarded an additional 5% unscheduled disability, bringing his total award to 25%. This stipulation was the last arrangement of compensation.

A year later claimant visited Dr. Smith, once again complaining of low back and leg symptoms. On examination, claimant exhibited mildly decreased ranges of low back motion in some areas and mild improvement in others. A myelogram and CT scan were performed but Dr. Smith was unable to delineate any objective cause for claimant's ongoing pain. He released claimant to return to work.

Dr. Smith was asked to report on whether claimant's condition had worsened since the June 28, 1983 stipulation. He responded:

> "With respect to the patient's condition worsening, by his definition and his subjective complaints, yes, it has worsened. He has little objective physical findings which can be used to verify either the condition or its worsening."

Dr. Smith's report is the only one that directly speaks to whether claimant's condition has worsened.

At hearing, claimant testified that he cannot do things now that he could do in 1983. His wife corroborated his testimony.

The Referee found claimant's credible testimony, when combined with Dr. Smith's report, to be sufficient to establish a compensable claim for aggravation.

On review, the insurer argues that because the record is essentially devoid of objective evidence of worsening, claimant's testimony must be closely scrutinized to determine whether a worsening has in fact occurred. At hearing, the insurer offered as evidence the transcript of the 1983 hearing on the extent of claimant's unscheduled disability. On review, it argues that claimant's 1983 testimony, in which he discusses his disability as of that date, is so similar to his testimony at the 1984 hearing that there has been a failure to prove a worsening.

After reviewing the transcripts of both the 1983 and 1984 proceedings, we agree with the insurer. Claimant's 1984 testimony regarding his symptoms, reduced capabilities, use of medications and other factors is nearly identical to his testimony in 1983. We do not doubt claimant's credibility. We do, however, doubt his ability to accurately recall the extent of his disability in 1983. A comparison of the two transcripts reveals that neither claimant's condition nor his symptoms have materially changed since the last arrangement of compensation. Further, because Dr. Smith's opinion is based almost exclusively on claimant's subjective complaints, we find that it adds little support to the claim. Claimant has failed to establish a compensable aggravation.

ORDER

The Referee's order dated February 13, 1985 is reversed and the insurer's denial is reinstated.

BRUCE D. CRAIG, Claimant
Olson Law Firm, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 83-10740
August 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Howell's order that: (1) awarded claimant 32° for 10% unscheduled permanent partial disability in addition to the 64° for 20% unscheduled disability granted by prior awards, bringing claimant's total award to 96° for 30% unscheduled disability; and (2) allowed the insurer to offset an overpayment of temporary total disability compensation in the amount of $2,576.33. Claimant also asserts that the Referee improperly reopened the hearing for the receipt of additional documentary evidence pertinent to the issue of overpayment. The insurer cross-requests review, asserting that the Referee improperly admitted an exhibit in violation of OAR 438-07-005(3). The issues on review are extent of unscheduled disability, the offset, and the propriety of the Referee's admission of evidence.

On the issue of extent of unscheduled disability, we affirm.

On the offset issue, claimant does not contest the propriety of the offset per se. Rather, claimant argues that the insurer is estopped from recovering the offset. He asserts that an agent of the insurer improperly advised him that he could not receive unemployment compensation and temporary total disability compensation payments contemporaneously, and that he should,

therefore, terminate his unemployment benefits. Claimant asserts that he justifiably relied on this advice and, as a result, was harmed by the loss of his unemployment compensation.

The record does not support claimant's assertions. While claimant did, in fact, speak to the insurer's agent regarding the propriety of receiving two forms of benefits contemporaneously, the agent did not advise claimant to terminate his unemployment compensation. From the record, it appears that in a telephone contact with the agent, claimant stated his own opinion that he was not entitled to receive two forms of benefits at the same time. At most, the agent agreed with that assessment. She did not initiate the discussion nor specifically advise claimant to take action. We do not believe that claimant was entitled to rely on the agent's passive concurrence with his statement. The elements of an enforceable estoppel, therefore, are not present. See Johnson v. Kenter, 71 Or App 61, 72 (1984); Bennett v. City of Salem, 192 Or 531, 541 (1951).

The remaining issues are evidentiary. Each party asserts that the Referee improperly admitted certain evidence in contravention of the administrative rules. Claimant argues that the Referee abused his discretion by reopening the record post-closure in order to receive certain documents relevant to the offset issue. Claimant reads OAR 438-07-025 to constrain the Referee from admitting evidence until he makes a specific finding that the evidence sought to be admitted was not obtainable with due diligence before the hearing. Claimant fails to recognize, however, that the requirement he seeks to have enforced appears to be applicable only in those instances in which one of the parties moves the Referee to reopen the record. OAR 438-07-025 also recognizes the Referee's discretionary power to reopen the record on his own motion. The rule appears to allow for an own motion reopening by the Referee without requiring him to make evidentiary findings as a condition precedent to reopening.

In the present case, the Referee reopened the record on his own motion after determining that it was not possible to calculate the alleged overpayment of claimant's time loss without additional documentary evidence. The insurer did not seek reopening. Under these circumstances, we find that the Referee properly exercised his discretion pursuant to OAR 438-07-025(1).

On cross-review, the insurer argues that the Referee improperly admitted an exhibit submitted by claimant in violation of OAR 438-07-005(3)(b). That rule provides that a claimant must file with the Hearings Division any evidence upon which he intends to rely not less than 10 days prior to the hearing. In the present case, claimant submitted an exhibit relevant to the issue of extent of unscheduled disability eight days before hearing. At hearing, the insurer objected to its admission on the basis that it was untimely filed. The Referee admitted the exhibit without explaining the basis for its admission. On review, the insurer renews its objection.

OAR 438-05-005(4) provides that a Referee has discretion to admit evidence not filed in compliance with the "10-day" rule. The rule further provides, however, that in exercising his discretion the Referee must determine if good cause has been shown for failure to comply with the prescribed time limits. The insurer argues on review that the Referee failed to determine

whether good cause had been shown. It argues in the alternative that good cause had not, in fact, been established.

Claimant responds that the provisions of the 10-day rule were met. He asserts that although the exhibit in question was received by the Hearings Division only eight days before the hearing, the tenth day before hearing was a Saturday, thereby precluding submission of the exhibit on that day. Claimant points to OAR 438-05-040(4)(c), which in effect excuses late submissions when the due date falls on a Saturday or a Sunday.

The record reveals that the exhibit in question was prepared by claimant's physician some six months prior to the hearing. Despite the exhibit's apparent long-term availability, claimant's attorney did not actually take possession of it until the eighth day prior to the hearing. The exhibit was submitted to the Hearings Division on that day. Claimant has failed to demonstrate good cause for failure to comply with the 10-day rule.

Assuming OAR 438-05-040(c) is applicable to the 10-day rule, it would not excuse claimant's late submission. The rule provides that time periods are to be computed in calendar days, and that the first full day after the "time begins to run" is to be counted as the first day. Generally, an application of the rule involves a counting forward, from the day the "time begins to run" toward a final day. Under this "forward" application of the rule, if the final day is a Saturday or Sunday, the party has until the next business day (usually a Monday) in which to file. In the present case, on the other hand, the date the "time begins to run" is the hearing date, and a proper computation requires counting backward, away from the date of the hearing to the final day. A consistent application of rule requires that when counting backward from the hearing date, and where the final day is a Saturday, the "next business day" must be the Friday before that Saturday. It would be inconsistent, when counting backward, to stop at the Monday after the Saturday/final day, for Monday would represent only the eighth day back from the hearing date. If the rule is to be applied, it must be applied consistently, whether the computation involves counting forward or backward.

We agree with the insurer that the Referee's admission of claimant's exhibit without first establishing good cause was improper. Therefore, on review we have not considered the exhibit, which pertains to the extent of claimant's unscheduled disability. Because the insurer does not request that the Referee's award of unscheduled disability be reduced, however, we affirm the award.

ORDER

The Referee's order dated February 14, 1985 is affirmed.

PATRICIA J. KUBISHTA, Claimant
Gatti, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-06795
August 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of that portion of Referee Quillinan's order which set aside its denial of medical treatment for claimant's low back and right hip condition. Claimant cross-requests review of those portions of the Referee's

order which: (1) upheld SAIF's aggravation denials; (2) declined to award additional interim compensation; and (3) declined to award penalties and attorney's fees for alleged unreasonable (a) aggravation denials, (b) medical services denial, (c) failure to accept or deny the aggravation claim within 60 days, (d) failure to pay additional interim compensation and (e) failure to make timely medical payments.

SAIF received claimant's aggravation claim on July 6, 1984. The claim consisted of a letter from claimant's attorney enclosing a report from the treating chiropractor which stated that claimant's underlying condition had worsened and authorized time loss from June 15, 1984. SAIF paid interim compensation from July 10, 1984 through the date of its denial. We affirm the Referee in upholding the denial.

When an aggravation claim is denied more than 14 days after notice or knowledge of the claim and the denial is upheld, interim compensation is due from the date of notice of inability to work through the date of the denial for periods during which claimant left work as a result of the condition. See Donald Wischnofske, 32 Van Natta 136 (1981), 34 Van Natta 664 (1982). Claimant is entitled to additional interim compensation for the period from July 6 through July 9, 1984.

In Robert Smeltzer, 36 Van Natta 1364 (1984), we stated:

> "Failure to accept or deny within fourteen days and failure to pay interim compensation pending acceptance or denial constitutes unreasonable resistance to the payment of compensation."

In Smeltzer, we awarded a 15% penalty and insurer-paid attorney fee for the insurer's failure to pay interim compensation for a 24-day period before it denied the claim. Although there is such an underpayment in this case, it is much less substantial. We do not feel that a penalty is warranted.

The Referee's order is affirmed in all other respects.

ORDER

The Referee's order dated January 30, 1985 is affirmed in part and reversed in part. Claimant is awarded additional temporary disability for the period from July 6 through July 9, 1984. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $750, as a reasonable attorney's fee. Claimant's attorney is also awarded $300 for services on Board review relative to the issue raised by the SAIF Corporation, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

ELLEN LANKFORD, Claimant
Evohl Malagon, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 83-11629
August 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Thye's order which affirmed the Determination Order dated September 7, 1983 which awarded claimant permanent total disability due to injury to the right shoulder. The issue on review is extent of permanent disability.

Claimant was injured in the course of her employment as a cabinet maker for a mobile home manufacturer in April 1979. Her condition was at first diagnosed as calcific tendinitis, but an arthrogram revealed a ruptured rotator cuff. Claimant has undergone six surgeries related to her industrial injury, including fusion of the shoulder and two unsuccessful attempts to graft and reunite her humerus. Claimant has underlying osteoporosis which prevents union of the two sections of her humerus, but the bone is stabilized by metal plates and a rod that have been inserted and attached. Claimant's shoulder joint is totally fused, but she has some motion of the arm remaining due to scapulothoracic mobility. Claimant has preexisting degenerative disc disease at L5-S1, partial gastrectomy and ulcers, left medial meniscectomy, varicose veins, and fusion of C5-7.

Subsequent to her injury, claimant shows electrocardiographic indications of having had a mild myocardial infarction and she shows some signs of mental confusion and inability to perform simple tasks that she had performed as part of her work.

Also subsequent to her industrial injury, claimant's driver's license was revoked for a period of time for a conviction related to the death of a friend while claimant was driving. Claimant suffered emotional distress after the auto accident and formed the resolve to take care of her invalid ex-husband. Claimant refused to drive at all for a period after the accident, but has had her license restored with restrictions based on her physical condition only.

Orthopaedic Consultants examined claimant four times with the final examination on September 28, 1981. Their final assessment of claimant was moderately severe impairment due to the shoulder condition at that time. The unsuccessful grafting surgeries were subsequent to their last examination. In 1981 they opined, "It will be most difficult indeed to adjust this 61 year old woman to any gainful occupation, though at sometime in the future an effort should be made."

In April 1983 claimant was evaluated at the Callahan Center. The occupational therapists and psychologist were unable to identify any possible area of gainful employment for claimant, and the medical examiner generally agreed. The Field Services Division of the Workers' Compensation Department terminated vocational rehabilitation services because, "There are no areas where client could be gainfully employed."

The insurer obtained the services of Columbia Rehabilitation Consultants, Inc., to evaluate claimant's potential employability. It identified the areas of home health care aide or retail sales clerk as possible employments within claimant's physical limitations, but subsequently revised those opinions and settled on the area of respite care provider. A respite care provider, as explained by Mr. Alverson, is a person who provides companionship and minimal supervision of elderly invalids while the primary care provider, usually a relative, is out of the home.

Claimant's attending physician has approved the job description of respite care provider, although the doctor is very concerned that claimant not be placed in a position where she might have to provide physical assistance or support because of the danger to her right arm and shoulder. Three respite care

provider referral services who have been told of claimant's medical limitations have asked to have claimant submit an application. They provided information that providers make between $1.50 and $5.00 per hour. A fourth provider service has no current openings, but would be interested in claimant if it did have openings. Persons on ambulatory respiratory therapy have held positions as respite care providers, according to the evidence.

Claimant presently performs the type of services described as respite care provider for her ex-husband on a live-in basis. She performs only the lightest of housekeeping duties and provides the mobility to seek and obtain help when it is needed. Claimant performs the work to relieve her daughter, who lives across the street, from some of the burden of daily care for her invalid father.

There is no question that claimant is severely and nearly totally disabled. Her medical limitations based on her injury and her preexisting conditions and social and vocational considerations establish that almost all of the potential labor market has been excluded from claimant's capacities. However, through resourceful job market analysis, a vocational rehabilitation counselor has located employment that claimant's doctor considers to be within claimant's limitations and which offers claimant an opportunity to earn wages for work she is presently performing without wages. According to one of the referral services, there is a shortage of providers of the type of services claimant is willing and capable of performing.

We find that claimant is not permanently and totally disabled based on medical factors alone, because her attending physician believes that claimant is capable of performing some work. We find that claimant is not excused from seeking work based on her training and experience because she was employed as a housekeeper for one year in a private residence and for about two years in a nursing home and now performs similar services for her ex-husband. We also find that it would not be futile for claimant to attempt to obtain employment as a respite care provider in light of the facts that she is presently performing activities that fit that description and her attending physician believes that she is capable of performing the work.

Because this case arose as an appeal from a Determination Order which awarded permanent total disability, it was the insurer's burden to prove that claimant could be employed rather than claimant's burden to prove that she could not be employed. Patricia A. Anderson, 35 Van Natta 1057 (1983). We find that the insurer has carried its burden of proof and that claimant failed to rebut that evidence.

In a similar context, in Keith Phillips, 35 Van Natta 388 (1983), we set forth the analysis we believed appropriate in cases involving a claimant's refusal to accept employment:

> "(1) If the evidence affirmatively establishes that the claimant is capable of performing the job, then ORS 656.206(3) forecloses an award for total disability; (2) if the evidence affirmatively establishes that the claimant is not capable of performing the job, then ORS 656.206(3) is irrelevant to an award for

> total disability; and (3) if . . . the evidence is inconclusive and the claimant may or may not be capable of performing the job, then we think ORS 656.206(3) requires that the claimant do what is reasonable and try to perform the offered employment. Cf. Dock A. Perkins, 31 Van Natta 180, 181 (1981), in which we referred to 'the acid test of applying for work'; that metaphore [sic] is even more applicable to attempting offered work which a claimant may be capable of doing."

The Court of Appeals reversed the Board's conclusion in Phillips v. Liberty Mutual, 67 Or App 692 (1984), based on its de novo review of the facts that it felt established that claimant was precluded from the offered employment by his physical limitations. The Court of Appeals did not disagree with the Board's analysis of the considerations applicable to cases involving a claimant's refusal of employment. In this context, claimant has refused to even apply for work that she is currently performing and work that she says she would do if someone hired her.

Claimant raised the question whether the position of respite care provider can be fairly considered "gainful and suitable employment." The only evidence in the record is that claimant can obtain employment as a respite care provider within her limitations at a rate of pay between $1.50 and $5.00 per hour and as many hours per week as she is willing and able to work. The rate of pay apparently can approach claimant's rate of pay at the time of injury, which was about $5.00 per hour. Claimant argues that the reasoning in Frame v. Crown Zellerbach, 63 Or App 827, modified 65 Or App 801 (1983), precludes a finding that the possibility of employment as a respite care provider is "gainful and suitable," and relies on the reasoning of a Referee in the case of Walter R. LaChappelle. On Board review, we modified the Referee's order in Walter R. LaChappelle, 36 Van Natta 1565 (1984), to explain our finding that the claimant was permanently and totally disabled, but that the reasoning in Frame was inapplicable to the issue whether the claimant had satisfied the requirement of ORS 656.206(3):

> "The focus of the Frame decision is restoring the worker to a condition of self-support. Given that goal, the court did not feel it would be reasonable to preclude a worker who was earning substantially more than the minimum wage prior to his injury from vocational rehabilitation. It seemed to believe that a part of the goal of rehabilitation was to restore a claimant to a job at a rate of pay which was reasonably comparable to his previous rate of pay. . . . While the purpose of vocational rehabilitation is to restore the claimant, the purpose of permanent total disability is to maintain the claimant when he is totally precluded by his injury from supporting himself.

> While it may be unfair to preclude an injured worker from vocational rehabilitation which would restore him to his pre-injury rate, it is not unfair to deny claimant the maintenance benefits of a permanent total disability award when he is capable of earning a living, even at a rate below his pre-injury earning rate." LaChappelle, 36 Van Natta at 1566; emphasis in original.

Claimant finally argues that she does not drive and would be required to depend on others living 18 to 22 miles away for transportation and assistance in emergencies. We find that claimant's testimony that she drives in and around her rural community and in Albany, but not in Eugene, proves that claimant could reasonably transport herself to places of respite care employment. In addition to our finding, claimant's inability or lack of desire to drive arose subsequently to the date of her injury, was unrelated to her injury, and cannot be considered in deciding the issue whether claimant is permanently and totally disabled due to her industrial injury. See John D. Kreutzer, 36 Van Natta 284, aff'd mem. 71 Or App 355 (1984).

Finally, claimant may not be able to obtain employment and perform the duties of a respite care provider as a full-time permanent job, but that would not entitle her to an award of permanent total disability if she is able to partially support herself by regularly providing respite care for wages. See Thomas J. Stokes, 37 Van Natta 134 (1985). There is no evidence in this record that would support a finding that providers of respite care services are in a sheltered or otherwise distorted labor market, or that claimant would require superhuman efforts to perform adequately on the job. Cf. Harris v. SAIF, 292 Or 683 (1982) (Claimant was able to generate income through infrequent investment activity; ability to work, not income generated, was determinative); and Hill v. SAIF, 25 Or App 697 (1976) (A finding that claimant can perform regular part-time employment may defeat a claim for permanent total disability benefits). We find that the insurer has sustained its burden of proof that claimant is not permanently and totally disabled as a result of her industrial injury and her preexisting disabilities because claimant unreasonably refused to attempt to apply for gainful and suitable employment that her attending physician believes she is capable of adequately performing.

Considering claimant's compensable physical impairments, her eighth grade education, the very narrow field of employment available to her, and other social and vocational considerations, and the guidelines contained in OAR 436-65-600, et seq., we find that claimant would be most appropriately compensated by an award of 320° for 100% unscheduled permanent partial disability.

Because the question does not arise until there is a modification of a prior award of permanent total disability, we consider whether there should be an offset granted for compensation already paid to claimant. We conclude that no offset for payment of compensation on the Determination Order and Referee's order will be allowed. SAIF v. Casteel, 74 Or App 566 (1985).

We have also considered the question whether claimant is entitled to an attorney fee for services on review. We find that claimant's compensation award has been reduced and, therefore, claimant is not entitled to an attorney fee on review. ORS 656.382(2).

ORDER

The Referee's order dated January 25, 1985 is reversed. Claimant is awarded 320° for 100% unscheduled permanent partial disability in lieu of prior awards. No offset for payment on prior awards is allowed. No attorney fee is awarded to claimant for services on review.

DAVID F. LARRISON, Claimant
Welch, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 84-08335
August 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of that portion of Referee Galton's order which awarded 76.8° for 40% scheduled permanent partial disability due to loss of function and use of claimant's right arm in addition to the Determination Order dated July 20, 1984 which awarded 38.4° for 20% scheduled disability. The issue on review is extent of scheduled permanent partial disability.

Claimant suffered an injury to his right elbow in the course of his employment as a truck refueler and washer on July 6, 1983. After a period of conservative therapy, he had surgery to correct epicondylitis. At surgery it was discovered that claimant also had degenerative arthritis of the radial side of the humeral condyle of the right elbow.

Claimant's attending physician has released claimant to return to work, but with limitations on the use of the right arm. Claimant is to limit his lifting with his right arm to ten pounds and is not to perform jobs requiring repetitive bending and twisting of the right elbow and arm nor repetitive pushing or pulling of more than ten pounds. Claimant's former employer has no work within claimant's prescribed limitations.

Claimant misrepresented his work history to the assigned vocational rehabilitation counselor and was warned of the risk of termination of assistance for non-cooperation. Claimant and his counselor identified the return to work goal of truck driving. Claimant passed a recertification examination by driving a ten-speed truck around the Portland metropolitan area for approximately an hour. A doctor examined and certified claimant to be fit without limitations to drive trucks in interstate commerce. Claimant has not been able to locate a job, but there is no evidence that his failure to obtain employment is related to his industrial injury rather than any other factor.

Claimant's range of motion of his right arm is limited to 130° of extension and 100° of flexion. He has some pain and swelling after exertion and takes an ibuprofen analgesic twice a week. Testing reveals that his hand grip strength decreased by approximately 20%. Claimant's doctor consistently opined that claimant's loss of use or function of the right arm was minimal.

Claimant's doctor was very familiar with the AMA Guides to the Evaluation of Permanent Impairment and the difference between impairment and disability.

We find the attending physician's opinion of impairment persuasive. It is clear that claimant has lost a substantial portion of the use and function of his dominant right arm, but we are not persuaded that that loss is greater than one-quarter of the use of the arm. We have considered claimant's testimony, which the Referee found credible and reliable, and the guidelines contained in OAR 436-65-500 to 532 and find that claimant would be appropriately compensated by an award of 48° for 25% scheduled permanent partial disability of his right arm due to his industrial injury.

ORDER

The Referee's order dated March 15, 1985 is modified to award claimant 48° for 25% scheduled permanent partial disability for loss of use and function of his right arm as a result of his industrial injury in lieu of all prior awards. Claimant's attorney fee shall be adjusted accordingly.

JACK D. LEDFORD, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Marcus Ward, Defense Attorney

WCB 84-08236 & 84-07078
August 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation, as insurer for C & C Cutting Contractors, Inc., requests review of Referee Podnar's order which set aside its denial of claimant's low back injury claim. Claimant cross-requests review to preserve the Board's jurisdiction over his injury claim against a previous employer, Umpqua Cutters, Inc., also insured by SAIF. On review, SAIF contends its denial should be reinstated. We agree and reverse.

Claimant was 33 years of age at the time of hearing. His work experience has primarily involved heavy manual labor activities. In approximately February 1982, while working for a Texas oil company, claimant sustained an injury to his low back. The injury occurred as claimant was attempting to lift a drill bit. X-rays revealed "a spondylolysis of the parsintararticularies [sic] of the L-5." Dr. Thomas, claimant's Texas treating physician, diagnosed symptomatic spondylolysis of L-5, with a very slight anterior slippage of L-5 over S-1. Dr. Thomas opined that if claimant's repeated episodes of discomfort persisted, a lateral mass fusion would be contemplated. Following a few days of rest and conservative treatment, claimant returned to work.

Claimant has been symptomatic since his 1982 Texas injury. In early 1983 he moved to Oregon and eventually began working as a timber bucker for Umpqua Cutters in approximately June or July 1983. He worked for Umpqua for some six to eight months. His back pain gradually worsened. Although he used heating pads and analgesics to relieve his pain, claimant did not seek medical treatment until January 1984. At that time claimant was examined by Dr. Schafer. Claimant complained of low back pain, which radiated down his right leg. Claimant attributed his pain to the

Texas injury. Dr. Schafer felt that claimant "had some significant problem" and subsequently recommended further X-rays and an orthopedic referral.

In March 1984 Dr. Freeman, orthopedist, examined claimant on referral from Dr. Schafer. The diagnosis was "spondylolisthesis, L5-S1, with probable nerve root involvement, right lower extremity." In response to claimant's wish to have the condition repaired, Dr. Freeman recommended a neurologic consultation and a CAT scan.

On March 26, 1984 claimant was examined by Dr. Mundall, neurologist. Dr. Mundall diagnosed low back pain with fractures, by history of unknown type, and right leg numbness. The neurologist suspected a radicular etiology. Before claimant underwent surgery, Dr. Mundall recommended that either a CAT scan or myelogram be scheduled.

On March 28, 1984 claimant began working as a timber cutter for C & C Cutters. He had been laid off from Umpqua for approximately one month. Claimant worked for C & C for four days. On one of those days, claimant was unsure which, he slipped while working on steep ground and landed on his buttocks. Claimant testified that his pain and numbness soon increased to the point that he could work no longer.

On April 11, 1984 claimant was examined by Dr. Rockey, orthopedist, on referral from Dr. Freeman. Claimant described ongoing lower back and right lower extremity pain since his 1982 Texas injury. Claimant's slip and fall episode while working for C & C was not mentioned. Dr. Rockey diagnosed chronic lumbosacral degenerative disc disease with probable herniation and instability due to Grade I spondylolisthesis. On April 29, 1984 Dr. Rockey performed a spinal fusion and laminectomy, noting that claimant had been particularly disabled from physical activities in the last few weeks.

Claimant apparently attempted to obtain compensation stemming from his 1982 Texas injury because on May 30, 1984 he was advised that his request for benefits was denied. Claimant's appeal from that denial was pending at the time of the hearing.

On June 8, 1984, through his attorney, claimant filed claims against both of his Oregon employers. Claimant's attorney advised the employers that claimant had either sustained an injury to his low back or had materially aggravated his preexisting condition while working under their employ. Both claims were denied.

By letter dated June 29, 1984 Dr. Rockey reported that claimant had given a history of a significant back injury while working in an oil field. Although claimant was subject to subsequent attacks of back pain since the injury, Dr. Rockey detected no major clinical significance from these later attacks. Dr. Rockey opined that claimant's spinal fusion appeared to be the result of the 1982 Texas injury.

In November 1984 Dr. Freeman reported that his notes did not mention claimant's slip and fall while working for C & C. However, the doctor was not sure that such an incident "substantially changes the overall picture." Dr. Freeman concluded that whatever occurred in early April 1984 pushed

claimant's pain intensity level to the point where he was unable to work. In Dr. Freeman's opinion claimant's subsequent exposure while employed by Umpqua and C & C likely made a bad condition even worse. If the doctor was apportioning liability, the greatest portion would be attributed to claimant's Texas employer, but in the event "an all-or-nothing determination" was required, he agreed with Dr. Rockey that the ultimate liability rested with claimant's Texas employer.

The Referee found C & C responsible for claimant's condition. Stating that claimant's credibility was not in question, the Referee reasoned that although claimant was unquestionably injured in Texas he was nonetheless able to engage in heavy manual labor in Oregon for more than one year before the April 1984 event left him disabled.

To establish compensability, claimant must prove that the April 1984 incident was a material contributing cause of his need for surgery. Summit v. Weyerhaeuser Co., 25 Or App 851, 856 (1976). A material cause is apparently something more than a minimal or de minimus cause. Patitucci Boise Cascade, 8 Or App 503 (1972). Work activity need not be the sole or primary cause, but only the precipitating factor. Summit, supra, at page 856. Claimant is required to prove compensability of his claim by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). In cases involving complex issues of medical causation, expert medical evidence is usually required. Uris v. Compensation Department, 247 Or 420 (1967).

We are not persuaded that claimant has established that the April 1984 incident was a material contributing cause of his need for low back surgery. The medical evidence not only indicates that surgery was contemplated before claimant's fall, but diagnostic tests and consultations were being conducted immediately prior to, and contemporaneously with, the date claimant alleged his fall occurred. Interestingly, other than an oblique reference in Dr. Rockey's April 29, 1984 chart notes to claimant's particularly disabling symptoms in the last few weeks, the April 1984 fall is not mentioned in any of the reports or chart notes which were generated during this time. The first general reference to an injury does not occur until claimant's attorney's June 1984 letter to the Oregon employers. Coincidentally, this letter and claimant's claims were not filed until his Texas claim had been denied. Furthermore, the first specific reference to the April 1984 fall does not appear until claimant's attorney's November 1984 letter to Dr. Freeman, who responds that the fall is not mentioned anywhere in claimant's medical record.

More important, Dr. Rockey attributed claimant's spinal fusion to the 1982 Texas injury. We accord greater weight to the opinion of Dr. Rockey, as the treating surgeon, than to the opinion of Dr. Freeman. Dr. Freeman opined that claimant's post-Texas employment likely made a bad condition even worse. However, Dr. Freeman examined claimant on just two occasions, in early March and early April 1984. In addition, the physician conceded that claimant has experienced ongoing symptoms since his 1982 Texas injury and that there was no contemporaneous record of the April 1984 fall. Moreover, Dr. Freeman concluded that the greatest portion of liability was attributable to claimant's Texas employer. Although it is not essential that a physician

specifically use the requisite magic words to establish compensability, the evidence when viewed as a whole must preponderate in favor of such a finding. Hutcheson, supra. We conclude that the preponderance of the persuasive evidence does not establish that claimant's work activities while working for C & C materially contributed to his current low back condition. Furthermore, if analyzed under an occupational disease theory, claimant's claim is not compensable inasmuch as the evidence fails to establish that claimant's work activities when employed by C & C were the major contributing cause of the worsening of his underlying low back condition. See Weller v. Union Carbide, 288 Or 27 (1979); Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570 (1982).

Finally, inasmuch as there is no persuasive evidence that claimant's work activities while employed by Umpqua was a material or major contributing cause of claimant's current low back condition or of the underlying condition's worsening, we agree with the Referee that SAIF's denial on behalf of Umpqua should be upheld.

ORDER

The Referee's order dated December 28, 1984 is reversed in part and affirmed in part. The SAIF Corporation's denial, on behalf of C & C Cutting Contractor's, Inc., dated June 22, 1984 is reinstated and upheld. Claimant's attorney's fee award is reversed. The remainder of the Referee's order is affirmed.

MARY G. MISCHKE, Claimant
Doblie & McSwain, Claimant's Attorneys
John E. Snarskis, Defense Attorney
Cummins, et al., Defense Attorneys

WCB 84-01332 & 84-02928
August 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Industrial Indemnity Company requests review of that portion of Referee Galton's order that set aside its denial of claimant's industrial injury claim based upon no coverage and ordered it to pay a penalty and attorney fee for unilateral termination of temporary disability compensation. American Fire and Casualty Company cross-requests review of that portion of the Referee's order that assessed against it an award of "interim" compensation and a penalty and associated attorney fee. The major issue is which of the two insurers' guaranty contracts was in effect at the time of claimant's industrial injury. The other issues involving penalties and attorney fees depend, in large part, upon resolution of the major issue.

On September 1, 1980 Industrial Indemnity issued its guaranty contract by which it assumed the employer's liability under the Oregon Workers' Compensation Act. On March 31, 1983 claimant sustained a compensable strain/sprain injury to her right arm. Claimant filed Form 801 with her employer on April 14, 1983 and Industrial Indemnity accepted the claim, first as nondisabling, on May 2, 1983 and finally as disabling on May 16, 1983. On June 17, 1983 American Fire and Casualty issued its guaranty contract by which it assumed the employer's liability under the Workers' Compensation Act effective March 28, 1983.

On June 28, 1983 the Workers' Compensation Department, Compliance Division, wrote to the employer, with a copy to Industrial Indemnity, requesting that a notice of cancellation of Industrial Indemnity's guaranty contract be filed, noting that coverage had been placed with another carrier effective March 28, 1983. On July 22, 1983 Industrial Indemnity issued a notice of cancellation effective 12:01 a.m. April 15, 1983. On August 2, 1983, the Workers' Compensation Department wrote directly to Industrial Indemnity and advised that its entire period of responsibility was September 1, 1980 through March 27, 1983. Industrial Indemnity continued to process claimant's claim and pay benefits, however, until January 12, 1984, when it denied claimant's claim on the basis that it did not provide coverage. On the same date, Industrial Indemnity transmitted claimant's file to American Fire and Casualty, along with a demand for reimbursement of claim expenses.

Claimant's attorney wrote to the Workers' Compensation Department on February 6, 1984 to request the issuance of an order designating a paying agent pursuant to ORS 656.307. Industrial Indemnity responded that its position was that it did not have coverage and that a paying agent was not warranted. On February 15, 1984 American Fire and Casualty issued another guaranty contract, apparently due to the employer having changed its corporate name. This guaranty contract was also effective March 28, 1983. On February 17, 1985 American sent a letter in the form of a denial in which it stated that its position was that Industrial Indemnity "cannot at this time deny ongoing responsibility for the compensable components of [claimant's] March 31, 1983 injury." On February 24, 1984 Industrial Indemnity changed its position with regard to the entry of a .307 order; however on February 28, 1984 American voiced its objection to such an order. A .307 order never was entered.

The Referee felt that his decision to hold Industrial Indemnity responsible for claimant's claim was compelled by the Supreme Court's decision in Bauman v. SAIF, 295 Or 788 (1983), and our decision in Cleve Retchless, 35 Van Natta 1788 (1983), although he characterized the result as "demonstratively unfair." Because of his reliance upon Bauman and Retchless, the Referee did not consider American's extensive estoppel argument. Since the Referee's decision in this case, the answer to the question whether the rule of Bauman v. SAIF, supra, applies to cases in which the issue is responsiblity between two or more insurers or employers has become somewhat less certain.

In Dena G. McGehee, 36 Van Natta 904 (1984), we took the same position we took in Cleve Retchless, supra, that the rule of Bauman v. SAIF, supra, does apply in responsibility cases. Both McGehee and Retchless were appealed to the Court of Appeals. In Jeld-Wen, Inc. v. McGehee, 72 Or App 12, rev den, 299 Or 203 (1985), the court affirmed our order, concluding:

> "We see nothing in the Supreme's Court's opinion in Bauman or in the nature of responsibility issues as opposed to compensability issues that persuades us to hold that the Bauman rule is not equally applicable in a responsibility dispute between employers." 72 Or App at 15.

However, in Retchless v. Laurelhurst Thriftway, 72 Or App 729, rev den, 299 Or 251 (1985), the court reversed our order, stating:

> "[T]he Board held that Industrial Indemnity's acceptance of the 1978 aggravation claim, and payment of benefits, barred it from later denying claimant's aggravation claim. The Board relied on Bauman v. SAIF, 295 Or 788 . . . (1983). We disagree with the Board's interpretation of Bauman.
>
> "We interpret Bauman to mean that Industrial Indemnity must pay compensation, at least until someone else is determined to be responsible. See Jeld-Wen, Inc., v. McGehee, 72 Or App 12 . . . (1985)." 72 Or App at 731.

The Supreme Court declined to review both cases, leaving an apparent disharmony between the two cases that, at first blush, appears to be irreconcilable. The court in Retchless cited McGehee as authority for the proposition that the rule of Bauman v. SAIF requires an employer/insurer which has accepted a claim to continue to pay compensation until some other entity is finally determined to be responsible for payment of compensation. We interpret this to mean that, although the employer/insurer may not deny the claim vis-a-vis the claimant, it may litigate the issue of responsibility vis-a-vis another employer/insurer, so long as the claimant continues to receive compensation. We conclude that Retchless and McGehee are not inconsistent when viewed in the context of the fact patterns unique to each of the cases.

In McGehee, the court merely stated that Bauman has application in responsibility cases. It did not have occasion to refine the applicability of Bauman by applying Bauman to a fact pattern in which a subsequent insurer is held to be liable in fact. It is important, although perhaps difficult, to remember that Bauman itself had nothing to do with responsibility between employers/insurers. Bauman involved purely the question whether a single employer/insurer could deny compensability several years after it had accepted a claim. The result of the rule in Bauman is to acheive some degree of finality in claims processing for the claimant. The Supreme Court held that once an insurer has begun paying the claimant on an accepted claim, it cannot stop doing so merely because it has changed its mind about liability. McGehee is consistent with this rationale by holding that the insurer in that case was not free to unilaterally terminate the claimant's benefits after it had accepted the claim.

This analysis changes drastically, however, when the additional facts, present in Retchless, are added to the calculus, i.e., a finding that a different, subsequent, insurer was liable in fact, thereby relieving the first insurer from liability. Considering this additional element, the law is that the first insurer to accept the claim is bound by Bauman to continue making payments, but not forever. In the responsibility context, once a different insurer is found liable under any applicable legal theory, the liability of the first insurer ends, because it no longer makes sense to hold that insurer liable. Like the "last

injury rule," the Bauman rule could not have been intended to transfer liability from the employer whose employment caused disability to another whose employment did not. Cf. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984). In McGehee, there was no other insurer, as there would be no other insurer in a pure compensability case. That is the difference between McGehee and Retchless, and that difference is what causes the cases to be in harmony. The Referee decided this case under our Retchless case, which used the McGehee analysis in a fact pattern in which there were two insurers. As we now know, that analysis was incomplete. This case presents the Retchless "multiple insurer" situation, which allows for litigation of the responsibility issue between employers/insurers, so long as the claimant continues to receive benefits.

There are two available procedures by which litigation as to responsiblity in the absence of a denial of compensability may be conducted. Where there are multiple claims, the procedure provided by ORS 656.307 should be invoked. Where there is one claim and one employer and multiple insurers, an insurer may upon motion or petition to the Referee join another. Inkley v. Forest Fiber Products Co., 288 Or 337, 347-48 (1980). This case presents the second, or Inkley, situation, and that procedure should have been followed. Although that procedure would require the employer/insurer, rather than the claimant, to request a hearing, it is the employer/insurer seeking relief. While Industrial Indemnity's denial in this case set the stage for the litigation that followed, it did so wrongfully at claimant's expense. We, therefore, agree with the Referee that Industrial Indemnity should be penalized for having unilaterally terminated claimant's compensation.

Having found that the rule of Bauman v. SAIF, supra, does not bind Industrial Indemnity to coverage forever as a matter of law, we turn now to the merits. We find the solution to this problem to be relatively simple. The Workers' Compensation Department rules, OAR 436-51-120(4) and (5), contemplate a "double coverage" situation, and provide:

> "(4) When there is a double coverage situation, the preceding insurer's responsibility will terminate with the effective date of a guaranty contract issued by the subsequent insurer.
>
> "(5) An insurer whose coverage responsibility is terminated by the filing of a guaranty contract by a subsequent insurer, must file a notice of termination as required by ORS 656.423 or 656.427 within 30 days after becoming aware of the need to terminate the guaranty contract."

Thus, by operation of the rule, Industrial Indemnity's coverage responsibility terminated upon the effective date of American's guaranty contract, March 28, 1983.

American argues that, notwithstanding the above-quoted rule, Industrial Indemnity is estopped from denying coverage or has waived its right to deny coverage. It is a fundamental precept of

insurance law that, "Waiver or estoppel cannot be the basis for creating an original grant of coverage where no such contract previously existed." Wyoming Sawmills v. Transportation Ins. Co., 282 Or 401, 410 (1978); McDonald v. Title Insurance Co. of Oregon, 49 Or App 1055, 1058 (1980). In this case, Industrial Indemnity's coverage ceased to exist, albeit retroactively, on March 28, 1983. The theories of waiver and estoppel cannot resurrect that coverage. Accordingly, we find American Fire and Casualty Company to be responsible for claimant's claim in its entirety.

This case was complicated by the fact that Industrial Indemnity's responsibility was terminated retroactively, which was the cause of the confusion. Industrial Indemnity could have mitigated a substantial amount of the difficulty of this case by promptly auditing its claims for this employer once it received notice from the Department that another insurer had assumed responsibility, and we heartily recommend that procedure in the future.

Finally, there is the question of penalties assessed against American Fire and Casualty. The Referee concluded that American should be penalized both for having unreasonably resisted the entry of a .307 order and for having failed to pay "interim" compensation once Industrial Indemnity notified it of the claim. Although we have held that, in a fact situation such as this case presents, the joinder mechanism set forth in Inkley v. Forest Fiber Products Co., supra, is the proper method of conducting litigation, a .307 order would have accomplished the same result for claimant in this case. We conclude that American's resistance to a .307 order was unreasonable and should be penalized. We also agree that, if claimant was not working during the interval between American's notification of the claim, January 10, 1984, and its denial, February 17, 1984, pursuant to the holding of Bono v. SAIF, 298 Or 405 (1985), American should have paid temporary total disability benefits as "interim" compensation, and that the penalty should be based on these "amounts then due." ORS 656.262(10); EBI Companies v. Thomas, 66 Or App 105, 111 (1983); Harold A. Lester, 37 Van Natta 745 (1985).

Claimant was a nominal party on Board review, and no additional attorney fees will be awarded. See Robert Heilman, 34 Van Natta 1487 (1982).

ORDER

The Referee's order dated August 10, 1984 is affirmed in part, reversed in part and modified in part. Those portions of the Referee's order that set aside Industrial Indemnity Company's denials and approved American Fire and Casualty Company's denial are reversed. Those portions of Industrial Indemnity Company's denials dated January 12, 1984 and July 6, 1984 that denied coverage of claimant's industrial injury are reinstated and affirmed. The remainder of Industrial Indemnity Company's January 12, 1984 and July 6, 1984 denials are set aside as moot. American Fire and Casualty Company's denial dated February 17, 1984 is set aside and claimant's claim is remanded to American Fire and Casualty Company for acceptance and processing according to law. The Referee's order is modified to award claimant's attorney a reasonable fee in the sum of $1,450 for services at hearing in overcoming American Fire and Casualty Company's denial, to be paid by that insurer in addition to and not out of claimant's compensation. The remainder of the Referee's order is

affirmed. American Fire and Casualty Company shall reimburse Industrial Indemnity Company for all claim costs, exclusive of penalties and attorney fees assessed against Industrial Indemnity Company by virtue of this order.

PHILLIP D.OHNEMUS, Claimant
Aitchison, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-07630
August 30, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Michael Johnson's order which awarded claimant an additional 32° (10%) unscheduled disability for injury to his neck on review of a Determination Order reclosing this claim pursuant to ORS 656.268(5), which awarded no compensation for permanent disability in addition to claimant's prior award of 64° (20%) unscheduled disability. The issue of the proper unscheduled award is two-fold: (1) legally, what is the appropriate analytical approach to the extent of disability issue where there has been a prior award or adjudication of disability, the claim is reopened for vocational rehabilitation and then reclosed; and (2) factually, did the Evaluation Division correctly determine that claimant's present loss of earning capacity is neither greater nor less than it was at the time of a 1982 Referee's order which awarded 20% unscheduled disability.

Claimant sustained this neck injury in August of 1980 while driving a skidder in the woods. The diagnosis was cervical strain, and claimant was treated conservatively. In March of 1981 he returned to work in the woods "bumping knots." This work was too strenuous; therefore, the following month, claimant went to work for the employer in the mill as a trim picker. Claimant experienced an exacerbation, and a myelogram and bone scan were performed. These diagnostic tests were negative. Claimant was examined by the Orthopaedic Consultants in August of 1981. With claimant's attending physician's concurrence, the claim was closed. A Determination Order was entered in August of 1981 with an award for 32° (10%) unscheduled disability for injury to the neck. Claimant continued to treat with his attending physician, Dr. Newby. In February of 1982 Dr. Newby reported that claimant was medically stationary, that he was released to return to work with limitations in his ability to bend repetitively, stoop, crawl or lift in excess of 50 pounds.

A hearing convened in April of 1982 with one of the issues being extent of permanent disability. Claimant testified that there had been a reduction in the work force at the mill, which apparently resulted in a layoff. He believed he was capable of continuing his work as a trim picker or working on fire watch; however, claimant felt he no longer was capable of working as a skidder operator. Claimant had sought work at various places, including other mills, but he remained unemployed as of the time of hearing. The Referee considered the facts that most of claimant's work experience had been in heavy labor, from which he was precluded; that claimant had a tenth grade education; that he was 46 years of age; and that he suffered mild permanent impairment as a result of his neck injury. The Referee awarded an additional 32° (10%) unscheduled disability for a total of 64° (20%). The Referee's order became final by operation of law.

The claim was reopened for vocational assistance in May of 1983. Claimant received on the job training in small engine repair. Upon completion of the training, claimant obtained full time employment with the company that had provided his training. The claim was reclosed by the Determination Order in issue, which was entered June 20, 1984.

Claimant challenged the Determination Order asserting entitlement to an additional unscheduled award. The employer contended that, in view of claimant's successful completion of an authorized training program and reentry to the labor market, claimant's earning capacity, in fact, had been increased. It is unclear, however, whether the employer's assertion of increased earning capacity was intended solely as a defense against claimant's request for additional permanent partial disability, or whether the employer sought a reduction in claimant's permanent disability award.

The Referee found that claimant's current physical limitations are approximately the same now as they were at the time of the 1982 hearing, and that, physically, claimant is feeling slightly better than he felt at the time of the 1982 hearing. We agree. He found no factor, "medical or otherwise," which had significantly decreased claimant's earning capacity since the last hearing. He found that the earlier determination of claimant's disability was based upon "inaccurate medical input from Dr. Newby," a finding with which we do not agree. Finally, the Referee felt at liberty to disregard the 1982 Referee's order "regardless of whether there has been a significant change in any circumstance since the earlier rating." In support of this conclusion, the Referee relied upon Hanna v. SAIF, 65 Or App 649 (1983).

In Billy Joe Jones, 36 Van Natta 1230, 1231 (1984), we stated, "On reclosure of a claim pursuant to ORS 656.268(5) we evaluate the claimant's unscheduled disability based upon presently existing facts and circumstances, but we take into consideration prior award or prior adjudications of unscheduled disability as part of the evaluation process." This is our understanding of the reevaluation process on reclosure upon completion of an authorized training program, or when a claimant otherwise ceases to be enrolled and actively engaged in an authorized training program. See Beverly J. Watkins, 36 Van Natta 1584, 1586 (1984).

The Referee compared claimant's present circumstances to the circumstances existing at the time of the prior hearing in analyzing the extent of disability issue. He considered the facts that in the interim claimant had obtained his GED, had acquired new skills, had obtained gainful employment, and had performed small engine repair work for over a year without missing any time from work. He mistakenly concluded that claimant is incapable of lifting more than 30 pounds. We understand the evidence to establish that claimant is capable of lifting and carrying up to 50 pounds frequently and up to 100 pounds occasionally, although claimant testified that he "get[s] by real well" if he works somewhere in the 30-pound area. This has essentially been the case since claimant was initially determined to be medically stationary in August of 1981.

Our decisions since Hanna v. SAIF, supra have been arguably inconsistent on the analytical approach to the post-vocational

rehabilitation evaluation of permanent disability. For example, compare Juan Alonzo, 37 Van Natta 57 (1985); Dwayne A. Kester, 36 Van Natta 1236 (1984); Martin A. Fulfer, 36 Van Natta 61 (1984); and James B. Arndt, 36 Van Natta 4 (1984), with Beverly J. Watkins, supra and Billy Joe Jones, supra. For the sake of clarity, we reiterate our statement in Jones that we consider presently existing facts and circumstances when we reevaluate the permanent disability question on reclosure pursuant to ORS 656.268(5), but we do not disregard prior awards or adjudications of permanent disability.

Whereas claimant's physical condition has remained essentially the same since the 1982 extent hearing, his vocational situation has markedly improved. The employer asserts that, for this reason, the Determination Order should be modified and claimant's permanent disability award reduced. Although we find that the Referee erred in increasing claimant's unscheduled disability award, we do not agree with the employer that claimant's unscheduled award should be reduced. Notwithstanding claimant's successful vocational rehabilitation, he is still precluded from a significant portion of the labor market as a result of the residual effects of his neck injury. When we consider claimant's employability in the broad field of general occupations, ORS 656.214(5), we find that the previous award of 64° (20%) unscheduled disability appropriately compensates claimant for the loss of earning capacity attributable to his industrial injury. Therefore, we affirm the Determination Order which reclosed the claim without modification of claimant's previous unscheduled award.

ORDER

The Referee's order dated January 15, 1985 is reversed and the Determination Order dated June 20, 1984 is affirmed.

GLORIA J. PARR, Claimant
W. Daniel Bates, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-06860 & 83-06861
August 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of that portion of Referee Thye's order upholding the SAIF Corporation's denial of compensability of ongoing medical services for her low back. SAIF seeks reversal of that portion of the Referee's order setting aside its aggravation denial relating to claimant's right ankle. SAIF contends in the alternative that claimant's condition is the responsibility of a subsequent employer.

The Board affirms and adopts those portions of the Referee's order upholding SAIF's denial of care and treatment of claimant's low back as unrelated to her compensable condition. However, we disagree with that portion of the order reopening claimant's right ankle claim.

Claimant injured her ankle at work in a cannery on November 21, 1978. Dr. Matteri, an orthopedic surgeon, performed a tarsal tunnel release on March 28, 1979, and a second ankle surgery on August 15, 1979. The claim was closed by a September 1980 Determination Order, but reopened in December 1980. The claim was again closed by a Determination Order in March 1981 and claimant requested review.

Dr. Degge examined claimant and reported on September 1, 1982 that claimant complained of aching in the ankle and foot, aggravated by prolonged walking or standing and also by cold or damp weather. Although claimant was then employed at her cannery job, she stated that her daily activities were severely limited and included no walks, no housework, no cooking and no grocery shopping. Dr. Degge recorded the range of motion in claimant's ankle and noted no abnormal weight-bearing calluses. His diagnosis included chronic strain syndrome or chronic reactive synovitis of the right ankle. He said:

> "This patient apparently reactivates a chronic synovitis which results in increased fluid within the ankle joint periodically on excessive use or activity which subsides with rest and treatment with anti-inflammatory medications. She seems to perform satisfactorily as long as excessive demands such as prolonged walking, standing, or climbing stairs can be avoided.
>
> "Restriction of her occupation to eliminate this type of activity is recommended."

A hearing was held on October 4, 1982 before Referee Peterson. The March 9, 1983 Opinion and Order summarized claimant's testimony as follows:

> "In her testimony, claimant confirmed that she limps (with a worse limp in damp weather); that she cannot take walks, run or jog; and that she has difficulty descending stairs. She cannot engage in activities that put significant pressure on the ankle. She wears only flat shoes. At the end of a working day, her ankle is very painful, and is swollen to the extent that if she removes her shoe she cannot get it back on. She describes a number of avocational and other off-the-job activities that she had given up."

The Referee increased claimant's total scheduled award to 50% of the right foot.

Claimant sought emergency treatment on March 25, 1983, complaining of pain in the bottom of her right foot and inability to bend her toes. On March 31, 1983 Dr. Matteri stated that claimant apparently had a recurrence of her tendinitis, but that she had been placed on anti-inflammatory medication and was improving. Dr. Matteri stated that claimant had been on her feet all day long working as a cook, but had not worked since March 25. He released her to return to work effective April 4, 1983, and stated that no additional disability would result.

Claimant came under the care of Dr. McCarthy, a chiropractor, on April 19, 1984. She was found to complain of extreme lumbosacral discomfort and marked discomfort in the right leg. The diagnosis included moderate to severe right S1 neuropathy

extending to the level of the ankle. On May 23, 1983 Dr. McCarthy authorized four to six weeks of time loss, stating that claimant's attempt to continue working as a cook had been met with increased subjective and objective findings to the point that were she to continue, the risk of irreversible degenerative tissue development was apparent.

Claimant was reexamined by Dr. Degge on June 14, 1983. She related sharp ankle pain on standing, fairly constant throughout the day. She noted that she twists the ankle easily. She experienced pain in the ball of her foot while driving when using the foot pedals. Dr. Degge found greater range of motion in the foot and ankle than he had reported in 1982. His diagnosis included functional overlay and dependent personality with drug abuse documented. He stated:

> "This patient's ankle complaints were reviewed. She does have some painful callosities on the plantar aspect of the second and third metatarsal heads which would be relieved by the use of a metatarsal pad. This symptom is probably aggravated by the limited dorsiflexion of her foot in the stepoff phase of her gait, producing excessive weight bearing on the forefoot."

Dr. Degge stated that claimant could return to the same occupation but should avoid prolonged walking, especially up or down stairs, or prolonged standing due to her postural low back problem. He estimated claimant's loss of function in the right ankle as essentially the same as it had been in September 1982 and stated that no increase in her permanent partial disability award was indicated.

Claimant's testimony at hearing contains serious inconsistencies and strongly suggests prior deceitful conduct. We assign it little weight.

Claimant has received a significant award of permanent partial disability for her foot. She has since experienced fluctuations, but not to such a degree as to exceed that foreseeable at that time of the prior award. Compare Francis Knoblauch, 35 Van Natta 218 (1983), with Thomas Black, 35 Van Natta 1193 (1983). Claimant's symptomatic worsening in March 1983 was in direct response to activities previously declared to be beyond her limitations. Dr. Matteri referred to claimant's March 1983 condition as merely a recurrence. Dr. Degge similarly found that claimant had not worsened. We find that claimant has failed to prove that her compensable condition worsened. ORS 656.273. Accordingly, we need not reach the issue of employer/insurer responsibility.

ORDER

The Referee's order dated January 31, 1985 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the SAIF Corporation's denial is reversed. SAIF's ankle aggravation denial of June 24, 1983 is reinstated and affirmed. The remainder of the Referee's order is affirmed.

IVAN L. PHIPPS, Claimant
Haugeberg, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-00176
August 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of Referee Quillinan's order which partially set aside its denial of chiropractic treatment. The Referee ordered payment of claimant's chiropractic treatment for his "back and hip complaints. . . through the date of last treatment in December 1983." The issue is the compensability of claimant's chiropractic treatment; i.e. whether it is causally related to claimant's 1974 right foot injury. We reverse.

Claimant sustained a compensable right foot injury in 1974 when he was working as a roofer and a ladder collapsed under him. Claimant fell eight or nine feet and landed on his right heel, fracturing the os calcis. The claim was closed in October of 1975 with an award of 27° scheduled disability for 20% loss of the right foot. By a September 1977 stipulation, claimant was granted an additional 20.25° for a total of 47.25° scheduled disability for 34% loss of the right foot. Claimant returned to work in a different occupation requiring no climbing.

In December of 1980, as a result of increasing foot or ankle pain, claimant stopped working. In June of 1981 his orthopedic surgeon, Dr. McKillop, performed a triple arthrodesis. By this time, the claim was in own motion status. ORS 656.278. By Own Motion Order dated February 10, 1981, the Board ordered claim reopening for payment of temporary total disability. The claim was reclosed by the Board in April of 1982, with an award for an additional 13.5° unscheduled disability, thereby granting claimant a total award of 60.75° or 45% loss of the right foot. Dr. McKillop released claimant for modified work, but claimant did not return to work.

In August of 1982 the parties entered into a disputed claim settlement agreement resolving issues relative to claimant's "aggravation claim."

Beginning in May or June of 1983, claimant began to experience pain spreading from his ankle, up his leg, into his right buttock and hip, into his low back on the right side, up the entire spine to the base of his head, causing headaches. He sought medical care and received treatment from Dr. Blake, an orthopedic physician. Dr. Blake injected cortisone into claimant's ankle, but the pain was not relieved.

Claimant then sought treatment from Dr. Pearson, a chiropractor, who became his attending physician. Dr. Pearson first treated claimant in July 1983 and diagnosed "marked right sacroiliac strain/sprain with attendant paravertebral spasms and Grade III neuralgia in the right lower extremity." Dr. Pearson reported that claimant was predisposed to this condition as a result of the fact that his right leg was one-half inch shorter than his left. This "foreshortened" right leg was a result of claimant's fall and 1981 operation. Dr. Pearson recommended manipulative treatment, rehabilitative exercise therapy and possibly, in the future, a corrective orthotic device to correct the leg length differential.

In August of 1983 Dr. Pearson reported to SAIF his impression that claimant was "incapable of returning to any gainful employment" due to his pain pattern, "marked antalgia and limping gait." He requested claim reopening.

In September of 1983 claimant was examined by a three-physician panel of the Orthopaedic Consultants. Their examination of claimant's lumbar spine and pelvis revealed no tenderness, except for slight right sacroiliac joint tenderness, and no visible or palpable muscle spasm. They found a slightly compensatory lumbar scoliosis relative to the leg length discrepancy. The lumbar scoliosis was noted to be "supple." The Consultants' diagnoses included muscle contraction headaches and spine pain, unrelated to the residuals of claimant's industrial injury. They noted, however, that it was "a reasonable consideration" to provide claimant with a shoe lift in order to equalize his leg lengths and thereby improve his gait. They found no medical basis for considering claimant unemployable, and it was felt that claimant was capable of performing full, light duty, for which he was released the preceding year.

SAIF then referred claimant for examination by Dr. Tilden, a chiropractor. On his examination, Dr. Tilden noted that claimant walked with a right limp and stood with his right hip lower than his left. There was an increase in the thoracic kyphosis and lumbar lordosis, but no evidence to visualization or palpation of any areas of muscular spasm along the entire spine. There was no scoliosis when claimant was sitting or recumbent. Thus, Dr. Tilden concluded that claimant's scoliosis was of a compensatory nature secondary to the right leg length deficiency. He found subjective tenderness over the spinous processes of all of the lumbar vertebrae "on an inconsistent basis." He found no sensory deficit to light touch or pinprick of the upper or lower extremities, with the exception of the area below the ankle and the surgical scar on claimant's right foot. Dr. Tilden diagnosed, among other things, tension headaches and general muscular tension state, by history, unrelated to claimant's injury.

Dr. Tilden explained that claimant's right lower extremity deficiency had caused a functional scoliosis, which could easily be corrected, and which he recommended be corrected. He stated that it is illogical, biomechanically, to attribute claimant's subjective symptoms to his leg length deficiency because weight bearing stresses have their effect on the side of the long extremity, rather than the short side, and claimant's symptoms were entirely on the stress free side. Dr. Tilden stated that it was understandable that Dr. Pearson's treatment relieved claimant's muscle tension symptoms, but that there was no objective evidence or rationale establishing a causal relationship between these symptoms and claimant's 1974 injury. Dr. Tilden concluded that, with the residuals of his injury, claimant was most likely suited for work in the light category.

Dr. Pearson apparently was provided a copy of Dr. Tilden's report, and in a letter to SAIF he expressed his disagreement with Dr. Tilden's conclusions. Dr. Pearson stated that his treatment was directed toward resolution or reduction of the functional scoliosis found in claimant's lumbar and thoracic spine, as well as attempting to correct the anatomical compensation caused by claimant's surgically induced shortened right leg.

SAIF referred claimant for examination by Dr. Struckman, another orthopedic physician, in March of 1984. Dr. Struckman found claimant's gait "rather interesting," and he commented:

> " * * * [I]t is interesting because an antalgic gait, a painful gait, is usually associated with a very short stance phase -- his stance phase actually is prolonged so that as he walks, he puts more weight on the right ankle for a longer period of time than he does with his left and actually then comes down on his left foot very hard -- this would indicate some conversion type of gait and would indicate that he is attempting to stress his limp to me."

Dr. Struckman concluded that claimant's hip pain was not of "significance," and that it was hard to know whether it was related to his injury. Dr. Struckman suspected that it was not. He had little to offer claimant other than to wear a shoe lift.

At the hearing, claimant described his symptoms and how Dr. Pearson's treatment afforded temporary relief. He had purchased an arch support with his own funds, which he wore, but which afforded no appreciable relief of his symptoms. He never submitted a bill for this device to SAIF. Nor did claimant request that SAIF purchase a leg lift.

The Referee concluded that the evidence establishes that claimant has developed a compensatory scoliosis as a result of the leg length differential. We agree. She reasoned, "It is reasonable to infer that this scoliosis could cause a certain degree of muscular tension and discomfort in the back and hip, though there is no direct medical evidence on this point." Because Dr. Pearson's treatment was directed at correcting the scoliosis and attendant muscle tension of the back, she found the chiropractic treatment compensable as a consequence of claimant's ankle injury. Because claimant had never been provided a leg lift, and it was reasonable to expect that such an orthotic device would alleviate claimant's back symptoms, "if, indeed, they are related to the scoliosis," the Referee ordered payment of Dr. Pearson's bills up to the date of his last treatment. She found claimant entitled to a shoe, or leg, lift and explained the reason for limiting her order to payment of Dr. Pearson's outstanding billings: "I am not convinced claimant is, at this time, entitled to any further chiropractic care absent a good trial of use of a properly fitted shoe support."

The issue that was brought before the Referee was the causal relationship between claimant's original ankle injury and his current chiropractic treatment. It is claimant's burden to prove that the requisite causal relationship exists. On our de novo review of the record, we are unable to conclude it is more likely than not that Dr. Pearson's chiropractic treatments are necessary as a result of the residuals of claimant's compensable right foot injury.

Claimant has a functional scoliosis as a result of his shortened right leg. Whether his right-sided symptomatology is related to or caused by this scoliosis is determinative. Dr.

Pearson claims he is treating the symptoms of the scoliosis. Dr. Tilden, on the other hand, asserts that it is biomechanically illogical to attribute claimant's subjective complaints to his leg length deficiency. Dr. Struckman suspects that claimant's symptoms are not related to his original injury, and the Orthopaedic Consultants found it "unlikely" that there was any correlation between claimant's symptoms and his injury-related residuals. Claimant's testimony is of little assistance in resolving this issue of medical causation.

For the foregoing reasons, we find and hold that claimant has failed to establish the compensability of his chiropractic treatment by a preponderance of the persuasive evidence. Therefore, SAIF's denial must be reinstated in its entirety.

ORDER

The Referee's order dated February 25, 1985 is reversed, and the SAIF Corporation's denial dated December 27, 1983 is reinstated and affirmed.

DARYL G. RICHMOND, Claimant
Philip H. Garrow, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-08780
August 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of that portion of Referee Nichols' order setting aside a disputed claim settlement. Claimant cross-requests review of those portions of the Referee's order which upheld SAIF's aggravation denial regarding claimant's back and ordered temporary disability benefits paid for claimant's psychological condition as of August 12, 1983. Claimant contends that he should receive temporary total disability from December 17, 1981, less temporary total disability previously paid. Claimant also requests modification of that portion of the Referee's order authorizing SAIF to offset the amount paid under the stipulation against compensation granted by the Referee's order.

The Board affirms the order of the Referee with the following comments. The disputed claim settlement provided that $15,000 was to be paid in settlement. It also provided that claimant's attorney was to receive a fee based on a percentage of the settlement amount. Claimant contends that since he only received $12,300, the remainder going to his attorney, the offset should be limited to the portion that he received.

The money paid to claimant's attorney in claimant's behalf out of funds otherwise due claimant may properly be considered to have been paid to claimant. See, e.g. Candy J. Hess, 37 Van Natta 12 (1985). SAIF is entitled to offset the entire amount paid out under the settlement.

ORDER

The Referee's order dated January 11, 1985 is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the SAIF Corporation.

GEORGE E. SALLENG, Claimant
Evohl F. Malagon, Claimant's Attorney
Beers, et al., Defense Attorneys

WCB 84-10523
August 30, 1985
Order Denying Motion to Dismiss

Claimant has moved the Board for an order dismissing the insurer's request for Board review of Referee Michael V. Johnson's order dated May 3, 1985 on the ground that the insurer did not mail a copy of its request for review to claimant. The request for Board review was mailed to the Board and a copy sent to claimant's attorney on May 14, 1985, less than 30 days after the Referee's order was mailed. The Board acknowledged the request for review on May 17, 1985, also less than 30 days after the Referee's order was mailed. Notice to a party in privity with a party is notice to the party. Specifically, notice to claimant's attorney is deemed to be notice to claimant. Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976). See also Ralph W. Gurwell, 35 Van Natta 1310 (1983). Even if claimant's attorney did not receive notice in the form of a copy of the request for review, the Board's acknowledgement of the request provided actual notice of the request within the statutory 30-day period. ORS 656.289(3). See Argonaut Insurance v. King, 63 Or App 847 (1983). Claimant's motion to dismiss is denied.

IT IS SO ORDERED.

DELORIS J. SPORES, Claimant
Carney, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03275
August 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of that portion of Referee St. Martin's order which awarded claimant interim compensation, as well as a penalty and an accompanying attorney's fee for failing to pay interim compensation and for a late denial. Claimant cross-requests review, contending SAIF's denial of her current medical treatment and her aggravation claim for a neck and upper back injury should be set aside. With her respondent's brief claimant has enclosed two affidavits and requests remand for the taking of further evidence on the issue of whether claimant "left work" because of her compensable injury.

Following our de novo review of the medical and lay evidence, including claimant's testimony, we are neither persuaded that: (1) claimant's current medical treatment is causally related to her compensable injury; nor that (2) claimant's compensable condition has worsened since the last award of compensation. Accordingly, we affirm those portions of the Referee's order which found that claimant's medical services and aggravation claims were not compensable.

We reverse those portions of the Referee's order which found that claimant was entitled to interim compensation, penalties, and attorney fees.

Claimant sustained a compensable back injury in December 1981 while lifting a bag of newspapers. Dr. Johnson, chiropractor, diagnosed her condition as myositis, neuritis, and biomechanical dysfunction subluxation of the cervical, thoracic, and lumbar spine. Claimant was off work for approximately three weeks. Her treatment, which consisted of spinal manipulation and electrotherapy, continued into April or May 1982. Dr. Johnson

expected full recovery with no impairment. A June 17, 1982 Determination Order closed her claim without an award of permanent disability.

Her back felt better at the time Dr. Johnson last treated her, but beginning in the fall of 1982, claimant's pain would periodically return. Claimant stopped working for SAIF's insured sometime in 1982. In July 1983, following a car trip between Portland and Tacoma, claimant's pain increased to the point that she sought medical treatment at the Western States Chiropractic College Clinic.

By letter dated September 7, 1983 Dr. Wegner, the clinic's director, reported that claimant had been initially examined in July 1983. The diagnosis was acute exacerbation of a chronic lumbosacral strain accompanied by radicular pain to both gluteal regions. Dr. Wegner reported that claimant had received seven treatments and would require further chiropractic treatments for the next two to three months. Dr. Wegner further stated as follows:

> "She is not employed at this time but would be capable of modified work, limitations being: no lifting and no prolonged sitting or standing.
>
> "Since [claimant] cannot relate her present condition to any recent injury we feel that this is related to the injury which occured on 12-16-81. Therefore, will SAIF Corporation authorize additional treatment in connection with this claim?"

Following further investigation and independent examinations, SAIF issued its denial in March 1984. Claimant received no interim compensation pending SAIF's denial.

The Referee concluded that claimant was entitled to interim compensation. The Referee reasoned that Dr. Wegner's September 1983 letter triggered a requirement to accept, deny or pay interim compensation until the date of denial. Inasmuch as SAIF had failed to take any of these actions in a timely manner, the Referee also assessed SAIF a penalty and attorney fees.

SAIF argues that claimant is not entitled to interim compensation because she failed to prove that she "left work" because of her compensable injury. SAIF relies on the Supreme Court's recent holding in Bono v. SAIF, 298 Or 405 (1984) as support for its argument. Unlike the present case, Bono did not involve an aggravation claim. Thus, this case is governed by ORS 656.273(6) which 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 medically verified inability to work resulting from the worsened condition." Since the "left work" analysis does not assist us in conducting our review, we deny claimant's request for remand for the taking of further evidence on the issue. Moreover, we do not consider this case "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Although we find the holding of Bono distinguishable, we agree that SAIF was not obligated to pay interim compensation. An aggravation claim triggers an obligation to accept or deny the claim within 60 days. ORS 656.262(6). However, the duty to pay interim compensation within 14 days is only simultaneously triggered with the aggravation claim if there is a "medically verified inability to work alleged to result from the worsened condition." ORS 656.273(6); Moore v. Commodore Corporation, 55 Or App 480 (1981); Silsby v. SAIF, 39 Or App 555 (1979).

Dr. Wegner's report is clearly a request for additional medical treatment. However, it does not provide medical verification of an inability to work. Dr. Wegner advised claimant to avoid certain physical activities. However, rather than forbidding claimant from engaging in work activities, Dr. Wegner opined that claimant was indeed capable of modified work. Inasmuch as Dr. Wegner's report does not verify claimant's inability to work, we find that SAIF was not obligated to pay interim compensation.

We further find that those portions of the Referee's order which assessed SAIF a penalty and accompanying attorney fees for failing to pay interim compensation and for a late denial should also be reversed. Because no interim compensation was due, imposition of a penalty and accompanying attorney fees for failing to pay interim compensation would be inappropriate. SAIF's denial, issued approximately 6 months after Dr. Wegner's September 1983 report, was unquestionably late. However, since claimant is not entitled to compensation stemming from any of her claims, there are no amounts "then due," either at the time the conduct being penalized occurred or at the time of the hearing, upon which to base a penalty and accompanying attorney fees. ORS 656.262(10); EBI Companies v. Thomas, 66 Or App 105, 111 (1983); Harold A. Lester, 37 Van Natta 745 (1985).

ORDER

The Referee's order dated December 31, 1984 is affirmed in part and reversed in part. That portion which ordered the SAIF Corporation to pay interim compensation, a 25% penalty, and accompanying attorney fees for failing to pay interim compensation and for a late denial is reversed. The remainder of the Referee's order is affirmed.

JOHN L. VERHOEF, Claimant
Carney, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-02853
August 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Leahy's order which upheld the SAIF Corporation's separate denials of his aggravation claim and request for authorization of surgery. Claimant contends that his injury-related condition has worsened since the last award or arrangement of compensation herein, a stipulation dated September 2, 1982, which awarded a total of 80° (25%) unscheduled permanent disability for injury to claimant's low back; and that the surgical procedure recommended by Dr. Nash, a decompressive lumbar laminectomy, is reasonable and necessary for treatment of claimant's injury-related condition. In addition, claimant contends that the Referee erroneously allowed SAIF to submit two reports from its in-house medical consultants, Drs. Reilly and Norton.

As a threshold matter, claimant has submitted two medical reports from Dr. Nash dated February 7, 1985 and March 14, 1985 respectively. Claimant moves the Board to include these additional documents as exhibits on review. In conducting our de novo review, we are limited to the evidentiary record developed before the Referee. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). Therefore, we regard claimant's submission of additional evidentiary material as a request for remand to the Referee for further evidence taking. We have authority to remand if we determine that a case has been improperly, incompletely or otherwise insufficiently developed or heard, and that remand is otherwise appropriate. ORS 656.295(5); Bailey v. SAIF, supra, 296 Or at 44. The reports submitted by claimant reflect the ongoing course of claimant's chronic back pain and his treatment by Dr. Nash. These reports do not indicate that this case has, in any way, been improperly, incompletely or otherwise insufficiently developed or heard. Therefore, claimant's request for remand is denied.

On the issues raised by claimant's request for review, we affirm the Referee's order with the following comments.

The administrative rules in effect at the time this claim for medical services was made and the hearing was held, former OAR 436-69-501 (WCD Admin. Order 5-1982), provided that when an attending surgeon believed elective surgery was necessary, the surgeon was required to notify the insurer, which then could require an independent consultation with a physician of its choice. The rule provided that if the surgeon and the consultant disagreed about the need for surgery, a third opinion would be sought "from a consultant mutually agreeable to the two physicians." OAR 436-69-501(3). Compare 436-69-501(4) (WCD Admin. Order 2-1985, eff. June 3, 1985).

When Dr. Nash recommended surgery in early 1983, SAIF referred claimant to Dr. Parsons for examination. Dr. Parsons had previously examined him in April of 1982. Dr. Parsons expressed the opinion that claimant would not benefit from lumbar surgery. A third opinion, as contemplated by the administrative rule, was sought. Claimant was examined by Dr. Mason who opined equivocally:

> "I think that a lumbar nerve root decompression at L3-4 and 4-5 bilaterally would probably result in some significant decrease in his lower extremity pain, though I do not think that it would have any significant effect with respect to his lumbar discomfort and lumbar anatomical changes which are evidence [sic] at this time."

SAIF thereafter requested an opinion of Dr. Reilly, its neurological consultant, as to whether Dr. Mason's report supported Dr. Parson's opinion concerning surgery or Dr. Nash's. After reviewing claimant's medical file, Dr. Reilly suggested that such an inquiry be directed to Dr. Mason. SAIF also requested an opinion from Dr. Norton, its medical administrator, as to whether the requested surgical decompression was for treatment of a condition related to claimant's 1979 injury. After reviewing the medical records, Dr. Norton concluded that claimant's 1979 injury had only a "minimal and transient" influence upon his underlying

spinal pathology, suggesting that the current request for surgery was related to the independent progression of claimant's degenerative disc disease with no material contribution from his industrial injury.

Claimant asserts that these medical opinions, obtained subsequent to Dr. Mason's, go beyond the procedure prescribed by the administrative rule, and that their admission to the record and consideration by the Referee "goes against all notions of fairness." OAR 436-69-501 does not limit the evidence which may be considered in a hearing conducted pursuant to ORS 656.283. The rule provides directives to the attending physician, allows the employer/insurer an opportunity to investigate the request for elective surgery and provides sanctions against the physician who fails to follow the dictates of the rule. Kemp v. Workers' Comp. Dept., 65 Or App 659, 669 (1983), mod. 67 Or App 270 (1984). When the issue of the reasonableness and necessity of proposed medical treatment, or its relationship to an industrial injury or occupational disease, is brought before this adjudicatory agency, the Rules of Practice and Procedure for Contested Cases, OAR 438-05-005 to 438-12-015, govern the submission and consideration of evidence.

There are two separate issues involved in the claim for medical services. One is the question whether the surgery proposed by Dr. Nash is reasonable and necessary. The other is whether the proposed treatment is causally related to a condition arising from claimant's 1979 injury. On questions of the need for treatment, we generally defer to the opinion of the attending physician, in the absence of some compelling reason not to do so. Lucine Schaffer, 33 Van Natta 511 (1981). We have held that where the preponderant medical opinion overwhelmingly weighs against the reasonableness and necessity of surgery proposed by an attending physician, the surgery will not be allowed. Stephanie A. Grimsley-Bruni, 36 Van Natta 437 (1985); James L. Saleen, 35 Van Natta 621 (1983). We believe that the medical evidence in this case clearly and convincingly weighs against the conclusion that the surgery proposed by Dr. Nash is reasonable or necessary.

In addition, there is substantial evidence that the decompression surgery is directed toward alleviation of symptomatology which is not caused, in material part, by claimant's industrial injury, originally diagnosed as a lumbar sprain. Thus, even if we were to defer to Dr. Nash's opinion concerning the reasonableness of surgery, the need for surgery does not arise, in material part, as a result of claimant's 1979 injury. This conclusion is supported by a preponderance of the medical evidence, which establishes that claimant's underlying degenerative disc disease has continued to progress since his injury, with little or no contribution from that 1979 strain.

Claimant's aggravation claim fails for two reasons. Considering the nature of claimant's injury and his underlying degenerative condition, we believe the question of whether claimant's injury-related condition has worsened since the last award or arrangement of compensation must be addressed by competent medical evidence. See Sharon C. Chase, 37 Van Natta 415 (1985); William C. Myers, 35 Van Natta 851, 855 (1984); cf. Garbutt v. SAIF, 297 Or 148 (1984). Although claimant testified to a worsening of his low back and lower extremity symptomatology since the September 1982 stipulation, the only medical practitioner expressing the opinion that claimant's condition had

worsened is Dr. Nash. Dr. Nash's opinion, however, is flawed in that, by his own admission, he is only able to state that claimant's condition "has evidently changed" since September of 1982, on the basis of his review of a March 11, 1981 report from claimant's former attending physician, Dr. Smith. With regard to this report of Dr. Smith's earlier examination, Dr. Nash states:

> "At that time the neurological deficits evident at the time of our examination were not present. They have developed in the interim and are present at this time."

Dr. Nash's impression that neurological deficits found on his 1983 examination were not present in March of 1981 is not illuminating with regard to the question of a worsened condition since September of 1982.

Furthermore, the evidence indicating that the surgery proposed by Dr. Nash is directed toward alleviating the symptoms of claimant's underlying degenerative condition, as opposed to the residuals of his 1979 back strain, likewise establishes that the increased symptoms described by claimant are more likely attributable to the natural and independent progression of the underlying degenerative process rather than claimant's industrial injury.

Claimant's contention that either one or both of SAIF's denials are precluded by Bauman v. SAIF, 295 Or 788 (1983), is without merit. See Clyde C. Wyant, 36 Van Natta 1067 (1984); John E. Russell, 36 Van Natta 678 (1984); see also Roller v. Weyerhaeuser Co., 67 Or App 583, 587, adhered to on recon. 68 Or App 743 (1984).

ORDER

The Referee's order dated January 11, 1985 is affirmed.

BEVERLI A. WATERS, Claimant
David J. Edstrom, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 83-01582
August 30, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Shebley's orders which partially set aside its denial of claimant's right knee condition insofar as it denied the compensability of claimant's chondromalacia. The issue is the compensability, as an occupational disease, of claimant's right knee chondromalacia. We reverse.

Claimant is a licensed practical nurse (LPN). In July of 1980 she injured her low back while working. This injury was accepted and benefits were paid. In association with this back injury, she experienced a burning sensation in the back of her right leg. She never sought treatment for a knee problem, however, until the fall of 1982 when she developed a cyst behind her right knee. Claimant's "back doctor" referred her to Dr. Achterman, an orthopedic surgeon, for evaluation and treatment of this apparent "Baker's cyst." Dr. Achterman became claimant's attending physician for treatment of her knee condition. Dr. Achterman also diagnosed a Baker's cyst, which he stated was

indicative of some type of internal derangement of the knee joint. He performed an arthrogram, which was found to be within normal limits. He performed a diagnostic arthroscopic examination to look for tears of either the medial or lateral meniscus or areas of chondromalacia. On arthroscopic examination, the medial meniscus and anterior cruciate ligament were found intact. Examination of the articular surfaces of the knee disclosed some evidence of early degenerative change along the medial margin of the femoral condyle, and the remainder of the medial compartment was within normal limits. The lateral meniscus was intact, and the articular surface of the tibia and lateral femoral condyle appeared to be normal. Examination of the patellofemoral joint was within normal limits. Dr. Achterman's final diagnosis was mild chondromalacia of the right knee.

In a January 1983 letter to the insurer, Dr. Achterman reported that he did not feel there was necessarily a causal relationship between claimant's low back injury and her "knee problem." He indicated, however, that claimant's "knee problem" was related to the type of activities in which she engaged while at work -- her walking, stooping and bending. Dr. Achterman subsequently reported that one could reasonably establish a causal relationship between claimant's work and the type of "knee problem" which she developed. The fact that the arthroscopy was negative did not detract from this opinion.

The insurer referred claimant for an independent examination by Dr. Puziss, an orthopedic surgeon. Dr. Puziss viewed X-ray films from Dr. Achterman's office, which were taken in October and November of 1982, a March 1982 lumbar myelogram, and the report of claimant's right knee arthrogram. Dr. Puziss diagnosed right popliteal cyst, the etiology and type of which were undetermined; bilateral patellofemoral lateral tracking syndrome with right chondromalacia of the patella; early degenerative arthritis of the medial femoral condyle by history; a history of low back pain without evidence of a herniated disc as cause for the posterior knee pain; and obesity.

In reviewing the records of claimant's arthroscopy, and Dr. Achterman's diagnosis of chondromalacia, Dr. Puziss stated, "I am not sure whether he is referring to the patella which she no doubt has, or to the medial femoral condyle." He stated that since there was no internal derangement of the knee, and since claimant had not reported any specific knee injury, "or any specific past with respect to her job that is unusual for a nurse to perform," he could not relate the onset of the popliteal mass to any activity at work. He considered any off the job activity at least as likely as her work activities to cause this "knee condition." He concluded that "this condition" was spontaneous in onset, and that there was no causal relationship between claimant's work and the "knee problem" which she developed. With regard to the patellofemoral tracking syndrome with lateral subluxation of the patellas, which was worse on the right side, Dr. Puziss indicated this was significant and probably was due to a combination of her "developmental defect anatomically" and obesity. He concluded that claimant had a preexisting anatomical lesion causing her to develop patellofemoral arthritic change. He believed that claimant's "knee condition" required further treatment, but not at the industrial insurer's expense. He recommended arthroscopic lateral retinacular release as a reasonable first step to alleviation of claimant's lateral tracking syndrome, and he opined that weight loss would be highly desirable. In conclusion, Dr. Puziss stated that claimant's preexisting condition had not been

"effected [sic]" by her work any more than other activities. Her present "knee problem" was, in his opinion, entirely unrelated to her work activities, although it clearly required further medical attention.

In response to an inquiry from claimant's attorney, Dr. Achterman subsequently confirmed that claimant's industrial exposure "contributed approximately one-third to the development of her knee symptomatology." He later refused, however, to state that claimant's employment conditions, when compared to non-employment exposure, were the major contributing factor of her chondromalacia. Instead of simply responding "yes" or "no" on the response form prepared by claimant's attorney, Dr. Achterman wrote a report stating:

> " * * * I do not feel that I can in good conscience, go ahead and sign the affidavit, which you present to me, as I feel that it makes me use phrases which I would not use in describing the condition.
>
> "I definitely feel that [claimant's] industrial exposure did contribute to the development of her knee symptomatology. I would not necessarily use the term 'major contributing factor.' As we all know, knee injuries can occur at any time, and in people who are approaching middle life, do not necessarily require definite trauma for their creation.
>
> "Once a knee injury has occurred, chondromalacia develops secondary to the muscle weakness acquired thereafter.
>
> "In summary, I feel that this patient's industrial exposure was a contributing factor to her right knee symptoms."

In a follow up letter, Dr. Achterman clarified that, although claimant's industrial exposure could not be regarded as "a major contributing factor" to her knee symptomatology, he believed that her work was "a substantial contributing factor" in that her work required prolonged periods of standing, as well as frequent episodes of stooping and bending.

In his initial order, the Referee set aside the insurer's denial in its entirety. He found this "knee claim" compensable on the basis of Dr. Achterman's reports and claimant's credible testimony concerning the strenuous nature of her work activity, compared to the relatively sedentary nature of her off the job activities. He assigned less weight to Dr. Puziss's opinion because Dr. Puziss examined claimant on only one occasion and because he understood Dr. Puziss's report to be inconsistent in certain regards.

The insurer requested reconsideration, pointing out that Dr. Puziss's report was not inconsistent. The insurer pointed out that Dr. Puziss had differentiated between the popliteal cyst on the one hand, and the diagnosis of chondromalacia or arthritic

changes of the patella, on the other hand. In an amended order, the Referee clarified his previous order to uphold the insurer's denial as it relates to compensability of the popliteal cyst and the condition diagnosed as bilateral patellofemoral lateral tracking syndrome, and to set the denial aside as it relates to the chondromalacia of the right knee.

Claimant contends that the Referee's orders should be affirmed. Thus, claimant does not argue that her popliteal cyst is compensable; nor does she contend that the condition diagnosed by Dr. Puziss as patellofemoral lateral tracking syndrome is caused by or related to her work activity. The only question is whether claimant's chondromalacia arose out of and in the scope of her employment within the meaning of the occupational disease statute. ORS 656.802(1)(a).

In order to establish the compensability of her right knee chondromalacia as an occupational disease, it is incumbent upon claimant to prove that her work activity is the major contributing cause of that condition. Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570 (1982). Magic words are not necessarily required in order to establish major causation of work activity; however, a physician's opinion must establish more than the fact that work activity is a cause of a condition. Roseburg Lumber Co. v. Killmer, 72 Or App 626, 630 (1985); see Tony Giuriolo, 34 Van Natta 1615 (1982), aff'd mem. 64 Or App 70 (1983).

In evaluating the medical evidence, it is helpful to understand the nature of the condition at issue. Chondromalacia is defined as a softening of the articular cartilage, most frequently in the patella. Patellar chondromalacia is defined as premature degeneration of the patellar cartilage, the patellar margins being tender so that pain is produced when the patella is pressed against the femur. Dorland's Illustrated Medical Dictionary (26th ed. 1981). The cause or causes of this degenerative condition is a question which necessarily must be determined by competent medical opinion evidence. Uris v. Compensation Department, 247 Or 420 (1967).

Dr. Achterman was willing to state that claimant's work activity contributed approximately one-third to the development of her "knee symptomatology," which is certainly "a substantial contributing factor." In our opinion, Dr. Achterman's reluctance to use the phrase "major cause" reflects his medical opinion that there are other significant factors which play a role in claimant's knee symptomatology. Furthermore, Dr. Achterman repeatedly speaks in terms of "symptoms" and "symptomatology" of the right knee, without ever specifying that claimant's work activities are responsible for causing the chondromalacia condition itself or its worsening. See Wheeler v. Boise Cascade, 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979).

We disagree with the Referee's analysis that claimant's testimony adds the necessary elements to Dr. Achterman's medical opinion. When we consider Dr. Puziss's clearly adverse opinion, the evidence simply fails to identify claimant's right knee chondromalacia as a compensable occupational disease. Therefore, it is necessary to reinstate the insurer's denial and affirm it in its entirety.

ORDER

The Referee's orders dated January 10, 1985 and February 8, 1985 are reversed and the insurer's denial dated January 19, 1983 is reinstated and affirmed.

SHARON L. ANDERSON, Claimant
Evohl F. Malagon, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 83-07816
September 4, 1985
Corrected Order on Reconsideration

We issued our Order on Review (Remanding) herein on August 12, 1985. The self-insured employer requested reconsideration.

In our order, we stated that the employer had not responded to claimant's motion to remand. In its request for reconsideration, the employer has pointed out that, in fact, it did respond and stated its opposition to claimant's motion. Apparently as the result of a clerical error by the Board, the employer's response was not routed to the file in this case and, therefore, was not considered prior to issuance of our order. We now have before us a copy of the employer's response to claimant's motion, as well as an additional medical report from Dr. Wilson.

Having considered the employer's response to claimant's motion, and reconsidered our decision to remand, we remain convinced that the appropriate disposition of this case is that stated in our original order.

ORDER

On reconsideration of the Order on Review (Remanding) dated August 12, 1985, the Board adheres to its original order, which hereby is republished effective this date.

RHETT J. DENNIS, Claimant
Robert J. Guarrasi, Claimant's Attorney
Lindsay, et al., Defense Attorneys
Edward C. Olson, Defense Attorney
Ron Rhodes, Defense Attorney

WCB 84-05495 & 84-07325
September 4, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

North Pacific Insurance Company requests review of that portion of Referee Nichols' order that set aside its denial of claimant's claim for a new industrial injury and approved Mid-Century Insurance Company's denial of claimant's low back aggravation claim. Claimant cross-requests review of that portion of the order that denied claimant's attorney's request for a fee for services at hearing. The issues on review are responsibility and attorney fees.

On the issue of responsibility, we affirm.

The remaining issue is claimant's attorney's entitlement to a fee for services at hearing. The Referee found that no fee was warranted because: (1) compensability was not an issue at hearing; and (2) claimant did not advance an argument at hearing regarding which insurer should be held responsible for claimant's

compensation. The Referee correctly noted that compensability was not an issue at hearing. She was incorrect, however, in finding that claimant had not advanced an argument at hearing regarding responsibility. Claimant did advance such an argument, albeit a brief one.

OAR 438-47-090 provides that in a responsibility case, wherein an order has been issued pursuant to ORS 656.307, claimant's attorney will receive no fee unless he or she actively and meaningfully participates at the hearing in behalf and in defense of claimant's rights. In the present case, claimant's attorney appeared on behalf of his client and advanced an argument that claimant's second injury effected an independent contribution to his disability, thereby rendering the second insurer responsible. This was "active and meaningful participation" under the administrative rule. See Dennis P. Cummings, 36 Van Natta 590 (1984); Robert Heilman, 34 Van Natta 1487 (1982). Claimant's attorney is entitled to a fee for his participation, both at the hearing and on Board review. Because his participation was abbreviated, however, his fee shall be nominal.

ORDER

The Referee's order dated November 30, 1985 is reversed in part and affirmed in part. That portion of the order that denied claimant's attorney's request for a fee for participation at the hearing is reversed. Claimant's attorney is awarded a fee in the amount of $250 for services at hearing. For services on Board review, claimant's attorney is awarded a fee in the amount of $150. Both fees shall be paid by North Pacific Insurance Company, in addition to compensation. The remainder of the Referee's order is affirmed.

ALLEN W. HAYS, JR., Claimant
Velure & Bruce, Claimant's Attorneys
Brian L. Pocock, Defense Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-03817
September 4, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Seifert's order that dismissed claimant's request for hearing as having been untimely filed. Although it has not specifically cross-requested review, the SAIF Corporation raises an issue on review regarding the propriety of the Referee's refusal to admit documentary evidence because it was generated through the insurer's ex parte contact with claimant's physician. The Association of Workers' Compensation Defense Attorneys has filed a brief Amicus Curiae in support of SAIF's position that the exclusion of the documentary evidence was improper. The issues on review are the timeliness of claimant's request for hearing and the propriety of the Referee's refusal to admit evidence. We review de novo.

Claimant was injured in a fall at work on July 19, 1983. He filed a claim with SAIF on July 25, 1983, alleging a compensable injury to the low back. He received conservative chiropractic care, and the claim was accepted as nondisabling on September 14, 1983.

Soon after his accident, claimant moved to California and continued receiving conservative care. Ultimately, SAIF asked

claimant's Oregon chiropractor for an opinion regarding whether claimant's ongoing treatments were related to his compensable injury. Upon receiving a negative response, SAIF issued a partial denial on September 15, 1983. The denial was deposited in the mail by way of a certified letter the same day.

Claimant did not receive the denial letter. It was sent to 7820 Redwood Drive, Stockton, California. Claimant does not live, nor has he ever lived at that address. Rather, claimant apparently lived on Brentwood Street in Stockton at the time the letter was mailed.

A SAIF claims consultant testified that he obtained the Redwood Drive address from claimant while claimant was still in Oregon. Claimant testified that he could not have given SAIF his California address while in this state because he did not know what it would be when he left Oregon. The consultant's file, however, does contain claimant's correct California telephone number, as well as the correct number of his Stockton apartment.

Because claimant did not receive SAIF's denial, he did not request a hearing within 60 days of its issue. In fact, he did not file a request until April 5, 1984, more than 200 days after the denial was mailed. There is evidence, however, that claimant was informed on or about September 29, 1983 by his California chiropractor that the insurer was not accepting responsibility for the chiropractic billings. In addition, claimant testified that while he was living in California he received a phone call from a SAIF representative who orally denied responsibility for the billings. Despite these contacts, claimant apparently took no action until some time in early 1984 when he sought counsel because the billings were not being paid.

The Referee found that although claimant did not actually receive the denial letter, his ultimate request for hearing was untimely. The Referee held that because SAIF complied with all statutory requirements regarding notice, and sent the denial letter to the last known address of claimant, it had fulfilled its obligations and the denial was effective.

ORS 656.319(1)(a) provides that a hearing request shall not be granted unless it is filed not later than the 60th day after the claimant was notified of the denial. Subsection (1)(b) of the statute outlines a "good cause" exception, allowing for an extension of the 60-day limit to 180 days upon a showing of good cause for failure to file within the ordinary time period. In the present case, neither the ordinary nor extended time limits were met, for claimant's request came more than 200 days after the denial issued.

"Notification" of denial is deemed given when the denial is deposited in the mails. Madewell v. Salvation Army, 49 Or App 713 (1980). The denial is effective whether it is sent by certified or regular mail. Stroh v. SAIF, 261 Or 117 (1972).

In Margaret J. Sugden, 35 Van Natta 1251 (1983), we held that a notice of denial that was sent to the right address, but which was not received by claimant because she was on vacation, was effective to provide notice. We have not had occasion, however, to decide a case involving the present circumstances, in which notice was not actually received because mailing was made to the wrong address.

Burkholder v. SAIF, 11 Or App 334 (1972), did involve a mailing to the wrong address. In that case, the court held that where an incorrect mailing is made, and the failure of receipt occurs through no fault of the claimant, a failure to timely request a hearing is excused. Burkholder differs from the present case, however, in that in Burkholder, there was simply no explanation given for the incorrect mailing. By contrast, there is a plausible explanation in the present case. SAIF presented evidence that the address to which it mailed the denial was one given to it by claimant. Claimant denies that he gave an address to SAIF, but after reviewing the record, we are satisfied that SAIF's explanation is the most plausible.

We believe that claimant gave SAIF a proposed California address and telephone number while he was still in Oregon. We note that if he had not given SAIF the information, the insurer could not have contacted him while he was in Stockton. Claimant testified that SAIF did in fact contact him there, and that the insurer informed him that it was denying responsibility for his ongoing chiropractic treatment.

Because there appears to be an explanation for the erroneous mailing in the present case, it is unlike Burkholder, and Burkholder does not control. After considering the unique circumstances presented here, we agree with the Referee that SAIF's reliance on the last address known to it was proper and that its compliance with the statutory notice requirements made notice of the denial effective. Claimant's failure to timely respond to this constructive notice was, therefore, unexcused and the Referee's dismissal was proper. See also Richard T. Reilley, 37 Van Natta 1192 WCB Case Nos. 84-01707 and 83-04203 (decided this date).

The remaining issue involves the Referee's ruling on evidence generated ex parte. As part of its defense, SAIF offered as an exhibit a copy of a letter issued by SAIF to claimant's treating physician. The letter asked the physician to respond to specific questions contained within the letter, and the physician complied. SAIF contacted the physician without prior notice to claimant or his counsel. At hearing, claimant objected to the admission of SAIF's exhibit on the grounds that it was generated ex parte. Claimant requested that the Referee refuse to admit the exhibit, consistent with prior rulings of the Board's Presiding Referee in the cases of Walter Fahlgren, (WCB Case Nos. 83-11499, 83-12152, 84-02034 and 84-02305, order issued July 19, 1984) and William K. Swanson, (WCB Case No. 84-01546, order issued June 5, 1984). The Referee sustained claimant's objection.

In Fahlgren and Swanson, the Presiding Referee ruled inter alia that although an employer or insurer is entitled to obtain information from a claimant's physician, the physician may not be contacted unless claimant or his representative has prior notice of the inquiry, as well as an opportunity to participate. In Fahlgren, the Presiding Referee stated: "I find ex parte contacts with claimant's doctor not in keeping with the spirit or purpose of the Workers' Compensation Law."

On review, SAIF argues that the Presiding Referee's pronouncement in Fahlgren amounted to a promulgation of a rule of procedure, an act that is not among the powers vested in the

Referee. SAIF's argument is echoed by the Association of Workers' Compensation Defense Attorneys, which has filed a brief Amicus Curiae. Both SAIF and the Association assert that the Presiding Referee's "rule" in Fahlgren and Swanson is inconsistent with the policies of full disclosure, expeditious claims administration and minimization of adversarial practices inherent in the Workers' Compensation Law.

The Oregon Legislature has declared that it is the policy of the Workers' Compensation Law "to provide a fair and just administrative system . . . that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable." ORS 656.012(2)(b). Pursuant to this policy, the Board has promulgated rules of practice and procedure designed to "expedite claim adjudication and amicably dispose of controversies." OAR 438-05-035. Among these rules are those pertaining to the generation of documentary evidence.

The Board's evidentiary rules are clearly designed to avoid delay and to reduce expense. See e.g., OAR 438-07-005(2). The use of interrogatories, depositions and other discovery devices is encouraged in order to expedite claims adjudication. OAR 438-07-005(6). Each party is entitled to full disclosure by the other. All pertinent records and reports, except those offered solely for impeachment, must be produced by each party. Failure to disclose may be considered unreasonable delay or refusal, thereby subjecting the noncomplying insurer to penalties under ORS 656.262(10), or the noncomplying claimant to postponement or dismissal of the request for hearing. OAR 438-07-015(2),(3).

We note that the issue of physician/client privilege, see ORS 40.235, was argued at hearing. Any such evidentiary privilege, however, was waived when this claimant filed his claim for compensation.

We find nothing in the statutes or rules requiring an insurer to give claimant prior notice of its intent to contact his or her physician. Further, we find that such a requirement is inconsistent with our stated policy of full, fair and expeditious disclosure of information between the parties. It is also inconsistent with the legislature's intent to create a compensation system that reduces litigation and minimizes the adversarial process.

We, therefore, hold that an insurer may request information from claimant's physician without prior notice to claimant or his representative. The excluded exhibit in the present case should have been entered into the record. Because of our holding that claimant's request for hearing was untimely, however, we need not remand the case for its inclusion.

ORDER

The Referee's Order of Dismissal dated October 31, 1984 is affirmed.

JOHN P. KLEGER, Claimant
Allen & Vick, Claimant's Attorneys
Richard Pearce, Defense Attorney

WCB 84-07458 & 83-10245
September 4, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of those portions of Referee Mulder's second amended order which set aside its denial of aggravation of claimant's cervical spine injury and increased claimant's attorney's fee award from $1,000 to $2,000 for services through the second hearing. The insurer also requests remand to the Referee to consider new evidence in the form of surveillance films and doctors' reports created after the first hearing but before the second hearing and doctors' reports created after the second hearing. Claimant has not appeared on review of the Referee's order nor on the motion to remand. The issues on review are whether the case should be remanded, whether claimant has proved a worsening of his condition since the last arrangement of compensation, and whether the attorney fee awarded after the second hearing was reasonable.

I

Claimant was compensably injured on November 22, 1978. In 1979 Dr. Mead performed a fusion at C6-7. The first Determination Order, dated April 1, 1980, awarded temporary disability compensation and 16° for 5% unscheduled permanent partial disability.

Claimant was involved in a non-compensable automobile accident in October 1980. In March 1981 X-rays revealed bone spurs at C4-5 and C5-6, and that the fusion was stable. In April 1982 claimant began complaining of right arm pain. Claimant submitted a claim for aggravation which the insurer denied. During May 1982 claimant suffered a slip and fall accident in a grocery store which resulted in a low back injury. After a hearing on the May 1982 denial, the Referee set aside the insurer's denial of compensability of the cervical condition at C5-6 by order dated October 29, 1982, and the insurer requested review by the Board. Pending review, claimant had an anterior diskectomy at C5-6 on November 30, 1982. A Determination Order dated June 8, 1983 closed the aggravation claim with awards for additional temporary disability compensation and an additional 32° for 10% unscheduled disability.

In July 1983 claimant obtained a cryptic note from an emergency room doctor that claimant should not return to work until his orthopedic surgeon released him to return to work because of cervical disc disease. In August 1983 the insurer denied reopening of the claim because there was nothing medically to substantiate a worsening of his condition and suggested that he contact the grocery store's insurer about his complaints.

On October 24, 1983 claimant was examined by Dr. Dine who diagnosed possible nerve root compression in the cervical area of the spine, recommended tomography, and referred claimant to Dr. Waller, who became the attending physician. On October 25, 1983 claimant was terminated from vocational rehabilitation assistance for the second time for failure to fully participate in the return-to-work plan.

On October 26, 1983 the Board issued its Order on Review reversing the Referee's October 1982 order and reinstating the insurer's denial of compensability of claimant's C5-6 condition and surgery. 35 Van Natta 1612 (1983). The Board relied on claimant's original attending physician's opinion, which included a more complete history and the opportunity to compare symptomatology, and on claimant's lack of credibility based on the record: "His tendency to exaggerate and to fabricate stories is apparent throughout the record." The Board's order became final by operation of law. The effect of the Board's order was to nullify the Determination Order of June 8, 1983 because the underlying aggravation claim was found non-compensable. Therefore, the last arrangement of compensation was the first Determination Order, dated April 1, 1980. See Roy M. Hoke, 37 Van Natta 477 (April 26, 1985); Joseph R. Klinsky, 35 Van Natta 332, aff'd mem. 66 Or App 193 (1983); cf. SAIF v. Maddox, 295 Or 448, 454 (1983) (determination of extent of disability shall not be stayed pending ultimate resolution of compensability issue).

In January 1984 the insurer denied payment for medical services and repeated its denial of reopening of the claim. Dr. Waller subsequently ordered tomography and myelography that suggested pathology at C6-7 that objectively correlated with claimant's reports of pain and dysfunction. Dr. Waller reported that the two prior surgeries had not relieved claimant's persistent left arm pain, but recommended another surgery to perform laminectomy and foraminotomies at C5-6 and C6-7. Claimant requested hearings on the August 1983 and January 1984 denials and a hearing was held on May 30, 1984. The Referee "modified" the denials. The insurer requested review. Claimant requested remand to the Referee to clarify the order, whether temporary disability compensation should be paid, and requested a hearing on the issue of non-payment of temporary disability compensation allegedly awarded by the Referee's order. The insurer did not appear on claimant's motion to remand. A hearing was set for September 10, 1984 on claimant's hearing request to enforce payment of temporary disability compensation. On September 6, the Board remanded the case to the Referee "for clarification of his order" and recommended consolidation with the hearing scheduled on payment of the temporary disability compensation. The temporary disability compensation hearing was reset for December 1984.

During October 1984 the insurer hired a private investigator to obtain surveillance movies of claimant. Approximately two hours of movie film were obtained which revealed claimant performing activities exceeding limits described in his testimony. On November 19, the insurer requested reopening of the record by motions directed to the Board and to the Referee. On December 3, the Board advised the parties by letter that the Referee had jurisdiction over the case. The movies were shown to Dr. Waller with claimant's attorney present. Dr. Waller then withdrew his recommendation to perform surgery.

The second hearing convened on December 17, 1984. The Referee considered that the remand order allowed only clarification of the July 1984 order and refused to reopen the record, but he permitted the insurer to put on its evidence as an offer of proof. The insurer offered the testimony of the investigator, the movies, and two letters from Dr. Waller. Claimant had witnesses waiting at the hearing room but put on no

evidence and did not cross-examine the insurer's witness. The Referee issued his amended order to clarify that he had awarded temporary disability compensation in addition to medical services based on the record at the first hearing.

The insurer requests review of the Referee's second amended order and requests remand to consider the evidence created between the first and second hearing and to consider evidence created since the second hearing in the form of additional doctors' reports. The latest doctors' reports are a subsequent letter from claimant's attending physician who, after a subsequent physical examination, reiterated his withdrawal of his recommendation of surgery, and the report of a physical examination by another surgeon who recommends discography for conditions related to levels of the cervical spine already found not related to claimant's industrial injury and who will consider further diagnostic or treatment procedures only after he reviews the surveillance movies.

II

The first question to resolve is whether the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the Referee under ORS 656.295(5). The issues at the first hearing were whether claimant's need for medical services was related to his industrial injury so as to entitle him to additional medical services under ORS 656.245 and whether his compensable condition had worsened so that in addition to medical services he was also entitled to reopening of his claim and payment of temporary disability compensation under ORS 656.273. The first hearing was held on May 30, 1984. Claimant was the only witness. The insurer cross-examined claimant and obtained impeaching testimony from claimant on the extent of his problems by observing that claimant's hands were calloused and dirty although claimant characterized them as soft and clean. The Referee relied on claimant's attending physician's opinion and not on claimant's testimony to find that the compensable condition was related to his industrial injury. When asked on cross-examination how much he could lift with his painful left arm, claimant opined that he thought he could lift a glass of water; the surveillance films show claimant performing work of a very heavy nature with his left arm five months later.

This is obviously newly created evidence in relation to claimant's medical condition and it potentially has some bearing on claimant's credibility. It is equally obvious that movies of claimant's activities in October 1984 could not be taken before May 1984 and, therefore, no amount of diligence could have produced them. The insurer requests remand because of the alleged falsity of claimant's testimony, and relies on Bailey v. SAIF, 296 Or 41 (1983); Egge v. Nu-Steel, 57 Or App 327 (1982); Ervin M. Strickland, concurring opinion, 36 Van Natta 173 (1984); and Jerry J. Meola, 36 Van Natta 565 (1984). In the concurring opinion in Strickland, after reviewing the appellate court decisions above, it was stated, "any situation in which there is a colorable showing of possible false testimony by any party presents a compelling reason for remand." The decision to remand is not automatic, although it is very tempting to include everything that might be relevant in the record. There is the practical consideration, however, that claimants and insurers will never be able to have a determination of their respective rights if the

hearing process is allowed to be reopened and relitigated on the basis of "newly discovered evidence" every time claimant goes to a doctor for additional treatment. We must consider each item of proffered evidence separately to determine if it is appropriate to exercise our discretion and remand the case to reopen the record.

First, we consider the investigator's testimony and his surveillance movies. The purpose of the investigator's testimony and movies was to impeach claimant's testimony offered at hearing. The movies show claimant performing activities which by misrepresentation he suggested he could not perform. The Referee did not rely on claimant's testimony, which he considered to have been impeached by the physical evidence of claimant's hands which tended to show that claimant had been performing rough and dirty work. The insurer knew of claimant's tendency to exaggerate and fabricate after its experience with him at the aggravation hearing which led to the Referee's order in October 1982. The Board's order which found claimant exaggerated his complaints and fabricated stories about his past and present conditions was published seven months before the May 1984 hearing on this claim. Therefore, although the investigator's testimony and his movies may be relevant and competent, we are persuaded that the insurer's belated attempt to buttress the finding of claimant's lack of credibility with cumulative evidence that was obtainable with due diligence before the scheduled hearing does not warrant remand and we deny the insurer's motion to remand to receive the investigator's testimony and movies into evidence.

This decision is distinguished by its procedural facts from other cases in which remand to rebut false testimony has been granted. In the other cases cited, the insurer or employer heard for the first time at hearing something that was a false representation, and upon post-hearing confirmation of the facts asserted at hearing, learned of the falsity of the representation. In this case, claimant testified falsely at the hearing that led to the October 1982 order, the Referee so noted, and the Board specifically found claimant to have exaggerated his complaints and fabricated stories to enhance his position in its October 1983 Order on Review of the October 1982 Referee's order. The insurer cannot now say that it was surprised at the May 1984 hearing by claimant's exaggeration of his symptoms and limitations and by his tendency to provide false testimony. That claimant's activities in October 1984 could not have been observed sooner is of no help because whatever claimant's activities were in 1983 and the first half of 1984 they could have been observed to impeach reasonably expected false testimony on the issue of claimant's limitations. See Delfina P. Lopez, 37 Van Natta 164 (1985).

Second, we consider the attending physician's opinion rendered by letter of December 7, 1984. The letter briefly summarizes claimant's history and the surveillance movies and then the doctor retracts his recommendation to perform surgery. He relied on the inconsistency between claimant's complaints and the activities shown in the movies. The doctor reported that the decision to perform surgery had been based on claimant's complaints of inadequate function and pain because the objective physical abnormalities would not alone indicate surgery. It is obvious from the letter that the doctor's opinion was influenced by the movies, and that discovery of claimant's actual physical capacities would have resulted in the doctor rendering the same

opinion regardless of the timing of the discovery. Therefore, if the insurer had conducted the investigation to determine claimant's true physical capacities in a timely fashion, i.e. between the publication of the Referee's order in October 1982 and the hearing in May 1984, and supplied the movies to the doctor during that time, the doctor would have retracted his recommendation to perform surgery at that time. If it was not excusable delay to fail to undertake surveillance of claimant in a timely fashion, it was likewise not excusable delay to wait until after the hearing to confront claimant's treating doctor with incontrovertible evidence of claimant's physical capacities after the hearing. Therefore, we similarly deny the insurer's motion to remand the case to the Referee to consider the opinion letter dated December 7, 1984.

Third, we consider the second letter of claimant's attending physician dated December 7, 1984. The doctor addressed a reply to a dentist about his plans for claimant's surgery and the issue of delaying surgery for some unspecified dental treatments. The letter may be relevant to show claimant may have misrepresented the course of his orthopedic surgery to his dentist, if it can be read to show that, but beyond that there is no apparent relevancy. No significance beyond claimant's credibility has been attached to the letter. We found above that claimant's testimony was effectively impeached by the physical evidence of his hands alone and that more probative evidence was unnecessarily cumulative on the issue, therefore, we also deny the insurer's motion to remand to consider the attending physician's letter to a dentist.

Fourth, we consider the letter of claimant's attending physician dated February 22, 1985. Dr. Waller reexamined claimant, confirmed his opinion of December 7, 1984 and reported his opinion that claimant was medically stationary at the time of his first examination and no worse than when the doctor first saw claimant in October 1983. This letter is only further cumulative evidence pendent from the post-hearing investigation and surveillance and the insurer's motion to remand to consider the February 22 letter is similarly denied. The insurer also requests that the Board reopen the record and admit the letter on its own motion. The request is denied. ORS 656.295(5).

Last, we consider the letter of Dr. Smith dated March 5, 1985. Dr. Smith examined claimant and recommended discography. He specifically stated: "It would be my OPINION [sic] that Mr. Kleger has a continuing neck-shoulder-arm pain problem which probably originates from the C5-6 level and is associated with non-fusion of the previous operated level of discectomy." He also reported that after performing discography "I would intend to review the patient's 'movies' showing him to be extremely physically active, for my own evaluation and interpretation." We find that Dr. Smith's opinion letter would be persuasive that claimant's current symptomatology does not emanate from his compensable cervical spine condition and that proposed diagnostic testing would not be related to claimant's compensable condition, but would not outweigh the attending physician's opinion that the compensable injury was causally related to the current symptomatology. But on the issue whether the record should be reopened so this opinion could be admitted and considered, we are not persuaded that the insurer could not with due diligence have obtained this cumulative examination report before the hearing. If the insurer wanted an independent medical examination, the

rules provide for such and there was ample opportunity to obtain such an examination between the time of claimant's aggravation claim in the summer of 1983 and the hearing in May 1984. The record reveals no attempt by the insurer to obtain any independent medical examination since the aggravation claim was presented. We are not persuaded that the insurer has shown due diligence in investigation and preparation of this case for hearing or that the record should be reopened to admit Dr. Smith's opinion letter. The insurer also requests that the Board reopen the record on its own motion to accept the opinion letter. The requests are denied. ORS 656.295(5).

The insurer also requests remand, citing as error by the Referee, that he did not reopen the record on its original motion. The case was remanded to the Referee to clarify his original order. We find that the Referee did not abuse his discretion in refusing to reopen the record when the mandate from the Board was to clarify the order issued as the result of the first hearing.

Finally, the insurer protests the original remand on the grounds of lack of jurisdiction. The insurer requested review of the July 1984 order which vested jurisdiction with the Board. Claimant did not cross-request review. Claimant requested remand to clarify the July 1984 order. Whether the July 1984 order awarded temporary disability was an issue best settled summarily by the Referee who issued the order rather than by another Referee in another evidentiary hearing or by the Board on review of the ambiguous order. The insurer did not protest the remand at the time it was ordered and then requested reopening of the record after remand.

III

We turn now to the merits of the claim, considering only those exhibits and testimony received into evidence by the Referee at the hearing on May 30, 1984. The initial question is whether claimant's medical condition at the time of the 1983 claims and the hearing was causally related to his industrial injury in 1978. His attending physician at the time of the hearing, Dr. Waller, reported by letter dated May 7, 1984 that current symptomatology was associated with the original injury and that myelography confirmed defects at C6-7, the compensable portion of claimant's cervical spine condition, and other areas. He also felt that the primary source of problems was the industrial injury and the compensable surgery in 1979. There is no opinion contrary to the attending physician's. We find that claimant has proven that his cervical spine condition, as it is related to the site of his injury and compensable surgery at C6-7, is compensable and that he is entitled to medical services to treat it pursuant to ORS 656.245.

The next question to consider is whether claimant's condition has worsened since the last arrangement of compensation so that he is entitled to reopening of his claim pursuant to ORS 656.273. The date of the last arrangement of compensation, by operation of law, was April 1, 1980. Comparing objective findings with reports of claimant's complaints in 1979 after surgery and 1980 to objective findings with reports of claimant's complaints in 1983 and 1984, we find that claimant did not prove that his compensable

condition has worsened temporarily or permanently and, therefore, we reverse that portion of the Referee's order which awarded temporary disability compensation and ordered reopening of the claim.

The final issue is the amount of claimant's attorney's fee for services through hearing. The Referee awarded $1,000 for services through the first hearing. The Referee's second amended order awarded $2,000 for services through the subsequent hearing, although the second amended order was decided on the basis of the record developed at the first hearing. The Referee found that claimant proved a worsening of his condition, although he found it had worsened since the 1983 Determination Order. The insurer argues that the Referee was without authority to alter the attorney's fee awarded and that claimant had withdrawn the penalties and attorney's fees issues at the December 1984 hearing. The insurer concedes that $1,000 would be a reasonable fee if claimant prevails on the medical services issue. Because we find that claimant prevailed on the medical services issue, and that $1,000 is a reasonable fee considering the efforts expended and results obtained, among other things, we award claimant attorney's fees for services through hearing in the amount of $1,000. See Barbara A. Wheeler, 37 Van Natta 122 (1985). The fee awarded includes claimant's attorney's services through the second hearing where no evidence was taken because the Referee ruled against the insurer's motion to reopen the record. No attorney fee will be awarded to claimant's attorney on review or on the motion to remand as no brief nor memorandum in opposition was filed.

ORDER

The Referee's second amended order dated January 14, 1985 is reversed in part and modified in part. That portion of the order which awarded temporary disability compensation is reversed. That portion of the order which awarded medical services is modified to award reasonable and necessary medical services related to claimant's 1978 industrial injury and 1979 surgery at C6-7. That portion of the order which awarded claimant an attorney's fee of $2,000 is modified to award $1,000 for services through the second hearing. No attorney fee will be awarded to claimant's attorney on review as no brief was filed.

DENNIS E. NAUGHT, Claimant
Kenneth Bourne, Claimant's Attorney
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 84-02671, 84-04467 & 84-09197
September 4, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

EBI Companies requests review of those portions of Referee Mulder's order which set aside its March 1, 1984 aggravation claim denial and that portion of its May 24, 1984 denial which denied responsibility for claimant's low back condition. EBI contends that: (1) Claimant's "Request for Hearing" contesting its May 24, 1984 denial should be dismissed because claimant failed to request a hearing within 60 days and failed to establish good cause, ORS 656.319(1); (2) alternatively, that its May 24, 1984 low back denial should be upheld on the grounds that claimant's recent work activity, during a period that EBI no longer provided the

employer's workers' compensation coverage, materially and independently contributed to claimant's low back condition; and that (3) its March 1, 1984 denial should be upheld on the grounds that claimant's current cervical, upper and mid back condition is the result of "a new injury" rather than an aggravation of claimant's June 16, 1980 injury.

Claimant has worked for the same employer during all times pertinent herein. On or about January 1, 1982, the employer terminated its coverage with EBI Companies and became self-insured. Therefore, the potentially responsible insuring entities are EBI Companies or the employer in its capacity as a self-insurer.

We agree with the Referee's analysis and conclusions on the issues of responsibility. Therefore, we affirm and adopt that portion of his order which set aside EBI Companies' March 1, 1984 aggravation claim denial. However, we disagree with the Referee's determination that claimant established good cause for his failure to timely request a hearing challenging EBI's May 24, 1984 denial of claimant's low back condition. In fact, claimant never requested a hearing challenging this denial, and the hearing convened 176 days after the date of denial. The Referee found there was good cause for claimant's failure to request a hearing reasoning, "The insurance change, the anatomic diversity of the problems, the sequences of events, numbers of doctors and complexity of treatments -- all contributed to whatever failure, if any, occurred."

Claimant was represented by an attorney when EBI issued its May 24, 1984 denial. The denial indicates that a courtesy copy was provided to claimant's attorney. There was no evidence offered to explain claimant's failure to request a hearing within 60 days of the denial. Claimant did not testify to any "understandable confusion" arising from the fact that these two insuring entities were disputing responsibility for claimant's various back complaints. There is no evidentiary foundation to conclude that claimant was caught in a "cross-fire" between insurers. Compare, Guy E. Stephenson, 36 Van Natta 1055 (1984); Curtis A. Lowden, 30 Van Natta 642 (1981). The mere fact that the employer, in its self-insured capacity, issued a number of written denials, each one of which was challenged in a timely fashion, does not excuse claimant's failure to timely request a hearing challenging EBI's single, clear and unambiguous denial of his low back condition.

Although we are not entirely certain, claimant appears to argue that, because EBI no longer provided the employer's workers' compensation coverage, and because it is the employer who is ultimately liable for claimant's back condition, EBI had no authority to issue its denial. If that is claimant's position, it is clearly erroneous.

On or about March 14, 1984, Drs. Buttler and McMahon, chiropractic physicians, reported their examination findings to Dr. Plewes, claimant's attending chiropractic physician. A copy of this report was forwarded to EBI Companies. This report diagnoses a primary, persistent thoracic sprain and strain with a spreading syndrome to the cervical and lumbosacral areas; it states that claimant continues to suffer from his June 1980 industrial injury, which was the responsibility of EBI; and that

claimant's condition apparently has worsened. These physicians opine that, as of the date of their examination, claimant was not ready to resume employment due to the severity of his symptoms.

This physicians' report clearly constitutes a claim for aggravation submitted to EBI in claimant's behalf. ORS 656.273(2) provides that a claim for aggravation is to be filed with the insurer or self-insured employer; i.e. with the insuring entity responsible for processing the original injury claim. See also Robert L. Fowler, 36 Van Natta 1222 (9184). EBI, therefore, had an obligation to process the claim by paying interim compensation within 14 days or denying. The fact that there was an issue of insurer responsibility did not excuse EBI from its claims processing obligations. Elliott v. Loveness Lumber Co., 61 Or App 269 (1983). Thus, EBI was not merely "authorized" to issue the denial in question; it was legally obligated to do so.

Another possibility is suggested by claimant's argument. It is the possibility that because the only real issue concerning payment of compensation for claimant's low back condition is one of insurer responsibility, claimant was not obligated to request a hearing challenging EBI's denial. In this regard, it is noteworthy that two weeks before EBI denied "responsibility [for] the low back condition" EBI and the employer in its capacity as a self-insurer entered into an Order Designating a Paying Agent Pursuant to ORS 656.307. This order specifically referred only to claimant's "upper back condition," and incorporated the parties' agreement that "the low back condition" was not encompassed within the order. Claimant received a copy of this order, as did his attorney.

In Hanna v. McGrew Bros. Sawmill, 44 Or App 189 (1980), the court excused the claimant's failure to request a hearing contesting one insurer's denial (the aggravation insurer) where another insurer had requested designation of a paying agent pursuant to ORS 656.307 and, apparently, also requested a hearing pursuant to ORS 656.283 regarding which of two insurers was responsible; and an order was entered pursuant to ORS 656.307 referring the responsibility issue to the Hearings Division, all within 60 days of the aggravation insurer's denial. See also Calder v. Hughes & Ladd, 23 Or App 66 (1975). In Saltmarsh v. SAIF, 35 Or App 763 (1978), discussed in Hanna, the court held that the claimant's failure to request a hearing in compliance with the time requirements of ORS 656.319 was not excused by ORS 656.307 where there was no admission that claimant's condition was "otherwise compensable." The court stated, "ORS 656.307 does not have the effect of excusing a claimant from complying with statutory procedures for objecting to an insurer's or employer's denial of his claim for compensation." 35 Or App at 768.

Although EBI Companies' May 24, 1984 denial denies responsiblility of claimant's low back condition on the grounds that it was not an aggravation or continuation of claimant's June 1980 injury but "a new injury," it is apparent, by virtue of the parties' earlier agreement to a tailored 307 order, that claimant's low back condition was not considered "otherwise compensable." Under these circumstances, claimant was obligated to request a hearing within 60 days of EBI Companies' denial, or establish good cause for his failure to do so. Because we find insufficient evidence to satisfy claimant's burden of establishing good cause, Cogswell v. SAIF, 74 Or App 234, 237 (1985); Henry A. Schmidt, 34 Van Natta 582 (1982), the claim for a low back condition filed with EBI Companies is barred.

In conclusion, under the terms of our order, EBI Companies is responsible for payment of compensation for claimant's cervical, upper and mid back condition. Claimant is entitled to no compensation for the condition of his low back.

Most of the effort expended by claimant's attorney on Board review is directed to defending the Referee's conclusion that claimant established good cause for his failure to challenge EBI's partial denial in a timely fashion. Claimant also argues, although it is little more than a nominal effort, that the Referee's determination of insurer responsibility should be affirmed. Thus, on the issue of insurer responsibility for claimant's cervical, upper and mid back condition, claimant's attorney has "actively and meaningfully" participated on review, entitling him to a fee for services rendered in this regard. Dennis P. Cummings, 36 Van Natta 590, 591 (1984); Robert Heilman, 34 Van Natta 1487 (1982).

ORDER

The Referee's order dated January 15, 1985, is vacated in part. That portion of the order which partially set aside EBI Companies' May 24, 1984 partial denial insofar as it denied responsibility for claimant's low back condition, is vacated. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $250 for services on Board review, to be paid by EBI Companies.

RICHARD T. REILLEY, Claimant
Francesconi & Cash, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-01707 & 83-04203
September 4, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer, Owens-Illinois, requests, and claimant cross-requests, review of Referee Fink's order which set aside Owens-Illinois' denial of claimant's worsened right shoulder condition and upheld the SAIF Corporation's denial, based upon his conclusion that claimant's current shoulder condition is the responsibility of Owens-Illinois as an occupational disease. The Referee also found that claimant did not establish good cause for failure to request a hearing within 60 days of SAIF's formal, September 7, 1983 denial, although he concluded that the matter was moot in view of his determination of the responsibility issue. Owens-Illinois (hereinafter "Owens") contends that SAIF, as the insurer for claimant's more recent employer, Pesznecker Brothers, is responsible for claimant's current shoulder condition. Claimant and Owens both contend that the record establishes good cause for claimant's failure to request a hearing within 60 days of SAIF's denial. Thus, the issues are employer responsibility for claimant's shoulder condition in April of 1983 and thereafter; and whether claimant has established good cause for his failure to timely request a hearing contesting SAIF's denial.

Like the Referee, we find that the record fails to establish good cause. Claimant's failure to request a hearing within 60 days of SAIF's denial, therefore, bars any claim against SAIF. ORS 656.319(1). Unlike the Referee, however, we conclude that

Owens is not responsible for the current condition of claimant's right shoulder. Therefore, we reverse that portion of the order which set aside Owens' denial.

Claimant worked as a layer attendant for Owens beginning in June of 1978. This employer manufactures glass containers. Claimant's job was to stack cases of soda pop bottles on pallets. In early March of 1979 claimant noted the onset of fairly sharp right shoulder pain while he was working. He was given lighter duty for a week, during which time his shoulder pain dissipated to some extent. He then went back to his regular work activity, which caused a recurrence of severe pain and consequent difficulty moving his right arm. On March 24, 1979 he was seen in the emergency room of Portland Adventist Medical Center. Dr. Manley examined claimant and diagnosed probable tendinitis of the right shoulder involving the deltoid muscle, with restriction of shoulder motion. Claimant filed a claim with Owens. The claim was accepted as one for a disabling industrial injury. Dr. Manley recommended that claimant stop working for approximately two weeks, and a program of physical therapy was initiated. Claimant's shoulder responded well to the physical therapy, and he returned to work in two weeks. He worked approximately three days, but repetitive lifting caused an increase in symptomatology. Dr. Manley authorized time loss again, and physical therapy was continued. Claimant remained off work for approximately six weeks. In June of 1979 claimant returned to work performing lighter duties. The claim was closed in September of 1979 with an award for temporary total disability only.

Claimant worked until November of 1979, at which time he began to experience increasing shoulder problems as his work duties gradually became heavier. Claimant returned to see Dr. Manley and remained off work for two or three weeks. He then returned to work, but only worked four days before being laid off in a year-end plant shutdown. Claimant returned to work when the plant resumed operations in early January of 1980; however, he worked approximately two weeks and then stopped after seeing Dr. Manley for continuing complaints of right shoulder pain, popping and catching.

In December of 1979 claimant had been examined by Dr. Griffin, a rheumatologist, on referral by Dr. Manley. Dr. Griffin ultimately concluded that claimant's condition was more characteristic of a traumatic or mechanical arthritis, as opposed to an inflammatory process.

In January of 1980 Dr. Manley suggested that claimant be examined by the Orthopaedic Consultants. The Consultants stated their "impression" as "recurrent discomfort, right shoulder of uncertain etiology, possible recurrent anterior subluxation." They stated that, because claimant appeared to be relatively stationary, his claim could be closed, in the absence of any intent to proceed with exploration of the shoulder joint, which they did not feel was indicated. They found impairment in the upper range of the minimal category. They considered it unlikely that claimant would return successfully to his previous occupation, and they recommended that he receive vocational assistance.

The claim was reclosed in March of 1980 with an award for temporary total disability only; however, this Determination Order

was modified the following month to award claimant 19.2° scheduled disability for 10% loss of the right arm (shoulder). (Claimant was entitled to an award for unscheduled disability, OSEA v. Workers' Compensation Dept., 51 Or App 55, 62 (1981); Audas v. Galaxie, 2 Or App 520 (1970); however, this Determination Order was not challenged.)

Claimant was referred for vocational assistance in the spring of 1980. He was enrolled in an authorized training program. This program was interrupted effective February of 1981 as a result of poor attendance, which apparently was attributable in part to domestic difficulties claimant was experiencing. The program was eventually terminated.

Thereafter claimant moved to California, where he was intermittently employed performing shipyard work and other, part-time work. Apparently none of these jobs required lifting or working with the arms outstretched or above shoulder level.

Claimant eventually returned to Oregon and went to work for Pesznecker Brothers, which is in the business of manufacturing sprockets. Claimant initially worked on a broach machine for approximately a year. Claimant was not required to use his right shoulder, which he was able to keep "tucked in," thereby avoiding any increased shoulder difficulties. Claimant's job changed, and he went to work on the plating line. Claimant operated an overhead crane, which entailed use of his arms above shoulder level on a frequent basis.

Claimant was never without shoulder pain. So long as he limited his activities, he was able to protect the shoulder and keep his pain or discomfort at a tolerable level. After performing his job on the plating line, he gradually began to experience increasing shoulder pain. On the morning of April 16, 1983 claimant sought treatment at the Portland Adventist Medical Center emergency room. Bicipital tendinitis was diagnosed; anti-inflammatory and analgesic medications were prescribed; claimant's arm was placed in a splint, and he was advised to return to Dr. Manley for follow-up.

The emergency room record and billing were forwarded to Owens' workers' compensation adjusting company, which formally denied claimant's right shoulder condition on the grounds that the medical evidence failed to support a causal relationship between claimant's work activity for Owens and his present symptomatology.

Claimant continued working. He was examined by Dr. Manley on April 29, 1983, who diagnosed "a very significant impingement-type syndrome." He indicated that this was a continuation of claimant's "previous problem" and recommended that his claim be reopened. In a subsequent report to Owens' adjusting company, Dr. Manley stated that claimant had been using his arms and shoulders in performing heavy and moderately heavy work, which "most certainly aggravated his pre-existing problem." Claimant continued working, although using his arms above shoulder level caused significant pain.

Claimant retained an attorney to challenge Owens' denial, and a Request for Hearing was filed on or about May 5, 1983. Apparently on the advice of his attorney, claimant completed an 801 claim form with Pesznecker Brothers on or about June 10,

1983. This claim form describes claimant's original 1979 shoulder injury, and the fact that claimant's shoulder continued to hurt since that time.

On July 27, 1983 Dr. Manley reported to SAIF requesting authorization to proceed with arthroscopy of the right shoulder and possible debridement. The following month he again requested authorization. Claimant continued working.

Claimant testified that he went to one of SAIF's offices and spoke with a SAIF employe concerning the claim he filed with Pesznecker Brothers. He was informed at that time, which was prior to any formal denial by SAIF, that his claim would be denied. Claimant's attorney apparently was informed of this fact as well. In late June of 1983, claimant changed attorneys. In October of 1983 a formal substitution of attorneys was filed with the Board.

By letter dated September 7, 1983, SAIF formally denied the claim filed with Pesznecker Brothers. The denial states:

> "We are unable to relate the onset or cause of this condition to your employment as a machine operator for Pesznecker Brothers, Inc. We feel this condition is a continuation of your March 1979 injury while employed with Owens-Illinois Glass."

This denial is addressed to claimant at the address provided on the above-referenced claim form. The address in Portland is claimant's brother's residence. Claimant was not residing at this address when the denial was delivered by certified mail. Claimant's sister-in-law accepted delivery and signed the return receipt. She never notified claimant of the written denial. There is no indication on the face of the denial that a copy was provided to claimant's attorney.

In October claimant's attorney filed an application for a hearing date. In early November claimant submitted an affidavit requesting an expedited setting on the basis of medical necessity; i.e. in order to obtain authorization for the medical procedure recommended by Dr. Manley. The case was set for hearing on January 4, 1984 before Referee St. Martin. A Notice of Hearing dated November 22, 1983 advised the parties of this setting. By letter dated November 28, 1983, counsel for Owens advised Referee St. Martin that Owens had been attempting to join Pesznecker Brothers as a party to the proceeding. Counsel stated that he had communicated with claimant's attorney with that goal in mind. The Referee was informed of Owens' position that, if claimant's current condition was compensable at all, under the last injurious exposure rule, Pesznecker Brothers was the responsible employer.

The hearing convened as scheduled. SAIF, as the insurer for Pesznecker Brothers, had not been joined. Claimant testified (during the hearing before Referee Fink) that he was advised at that time of SAIF's formal, written denial. The hearing was continued, apparently for the purpose of allowing claimant to join Pesznecker Brothers as a party by requesting a hearing challenging SAIF's denial. The Referee provided counsel for claimant and Owens with a copy of SAIF's September 7, 1983 denial and the return receipt signed by claimant's sister-in-law.

Claimant again changed attorneys, and his present attorney of record requested a hearing on or about February 15, 1984 challenging SAIF's denial. The matters were consolidated for hearing, and on January 8, 1985, all parties appeared before Referee Fink.

In the meantime, Owens' adjusting company had referred claimant to Dr. Thompson, orthopedic surgeon, for examination in February of 1984. Dr. Thompson diagnosed chronic bicipital tendinitis of the right shoulder. He did not believe that claimant's condition represented "strictly an impingement syndrome." He opined that claimant's work activity for Pesznecker Brothers contributed independently to a worsening of claimant's condition, stating, "I think his work activity at Owens-Illinois caused the original problem with the shoulder, i.e., biceps tendinitis and that this had gone into a low grade chronic stage and then the work activity at Pesznecker Brothers in 1982 and 1983 has caused it to become an acute problem." Dr. Thompson further stated that, if conservative measures had been exhausted, it would be reasonable to consider a tenodesis of the biceps tendon and possibly an anterior acromioplasty.

In May of 1984 SAIF referred claimant for examination by Dr. Higgins, another orthopedic surgeon. He diagnosed impingement syndrome of the right shoulder and stated the opinion that claimant's current problems represent the residuals of his original March 1979 injury, ". . . the symptoms of which have been aggravated by the nature of his work at his current place of employment . . . ." Dr. Higgins was unable to state, based on objective findings, that claimant's condition had materially worsened; however, he was able to state "with certainty" that, as a result of his current employment, claimant's symptoms indeed had been aggravated. Dr. Higgins subsequently clarified his impression that, although claimant's symptoms had been aggravated by his recent work activities, his condition had not, in fact, materially worsened as a result thereof.

Dr. Thompson clarified his opinion, at the request of Owens' adjusting company, that claimant's work activity with Pesznecker Brothers was "the major contributing factor to the worsening of his condition and to his present problem." Dr. Thompson stated that claimant's recent work activity was "the major contributing factor to the present state of his arm."

In a report to claimant's attorney, Dr. Manley stated his impression that claimant's present problem began following his 1979 injury, but that it was "significantly aggravated by his return to work at Pesznecker Brothers operating the overhead crane." He attributed "the major contribution" of claimant's current problem to his original 1979 injury. He admitted that assigning percentages was somewhat arbitrary; however, he felt that claimant's original injury would be "from 60 to 65%" of claimant's current problem, and the remainder would be the result of his work on the crane. Dr. Manley later confirmed his opinion that the overhead crane work at Pesznecker Brothers "significantly aggravated [claimant's] underlying condition" and, therefore, SAIF was responsible for claimant's present condition.

In resolving the employer responsibility issue, a threshold

determination that might be of some consequence is whether claimant's current shoulder condition represents an industrial injury or an occupational disease. The 1979 claim was accepted and processed as one for an industrial injury, which we believe was supported by the circumstances surrounding that episode. See also Donald Drake Co. v. Lundmark, 63 Or App 261 (1983); Valtinson v. SAIF, 56 Or App 184 (1982); Clarice Banks, 34 Van Natta 689, 692-96 (1982), aff'd United Pac. Reliance Ins. Co. v. Banks, 64 Or App 644 (1983). The Referee determined that claimant's current shoulder condition is more properly considered as an occupational disease. The parties argue about whether the claim is more properly viewed as one for an injury or occupational disease. In this particular case, we find the distinction of little significance.

Neither employer seriously contends that claimant's current shoulder condition is not compensable, and any such contention would find little or no support in the evidence of record. Although it is a fact that claimant continued to experience shoulder pain and limitations after his 1979 injury/exposure with Owens, the medical and circumstantial evidence clearly preponderates in favor of the conclusion that claimant's more recent work activity with Peszneker Brothers actually, independently and materially contributed to a worsening of claimant's underlying condition, as opposed to merely causing a recurrence or exacerbation of symptoms. All possible responsibility analyses lead to the conclusion that SAIF is the responsible insurer, based upon our factual finding of independent contribution to claimant's underlying condition. Although there is a difference of medical opinion concerning the proper diagnosis of claimant's current shoulder condition, this fact does not detract from our conclusion.

Claimant's failure to request a hearing within 60 days of SAIF's denial bars the claim with Pesznecker Brothers, however, unless claimant establishes good cause for his failure to request a hearing within 60 days. It is claimant's burden to establish good cause. Cogswell v. SAIF, 74 Or App 234 (1985); Henry A. Schmidt, 34 Van Natta 582 (1982). Claimant and Owens argue that claimant is excused from his failure to request a hearing within 60 days of SAIF's denial because claimant never received notice of SAIF's written denial until the January 1984 hearing.

ORS 656.319(1)(a) requires that a Request for Hearing be filed "not later than the 60th day after the claimant was notified of the denial . . . ." ORS 656.262(8) provides, "The worker may request a hearing on the denial at any time within 60 days after the mailing of the notice of denial." These two arguably conflicting statutory provisions were construed in Norton v. Compensation Department, 252 Or 75 (1968), and the court held date of mailing controlling. The court stated:

> "It is, of course, conceivable that the mailing of the notice of denial will not bring notice of the denial to the workman within 60 days after the denial or will not bring notice within a reasonably substantial time after the mailing, all through no fault of the workman. What relief can be granted to the workman in such event will have to depend upon the particular circumstances of each case." 252 Or at 78. -1197-

See also Stroh v. SAIF, 261 Or 117, 119 (1972); Madewell v. Salvation Army, 49 Or App 713 (1980); Margaret J. Sugden, 35 Van Natta 1251, 1252-53 (1983).

SAIF mailed the denial letter to the address provided by claimant on the Form 801. The denial letter was received by claimant's sister-in-law at that address. Claimant, and apparently his former attorney, knew of the impending denial. If claimant could no longer be contacted at the address provided on the claim form, he had an obligation to inform SAIF of that fact. Under these circumstances, we hold that the 60-day period for requesting a hearing commenced on the date of SAIF's denial. Margaret J. Sugden, supra. Compare Burkholder v. SAIF, 11 Or App 334 (1972) (denial letter mailed to address of unexplained derivation rather than to an address at which claimant had lived or received mail). Claimant failed to request a hearing within the 60-day period, and he has failed to establish good cause for his failure to do so. Accordingly, SAIF's motion to dismiss, which was made at the commencement of the hearing, must be granted. See also Allen W. Hays, Jr., WCB Case No. 84-03817, 37 Van Natta 1179 (decided this date).

ORDER

The Referee's order dated January 11, 1985 is reversed in part and modified in part. That portion of the order which set aside the denial issued in behalf of the self-insured employer Owens-Illinois is reversed, and that denial dated April 26, 1983 is reinstated and affirmed. That portion of the order which upheld SAIF's September 7, 1983 denial is modified to provide that claimant's Request for Hearing contesting SAIF's denial is dismissed as untimely.

BETTY A. SMITH, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-03544
September 4, 1985
Order Denying Motion in Abeyance

Claimant has requested Board review of Referee Tuhy's order that set aside the SAIF Corporation's denial of medical services, on the ground that the Referee should also have awarded compensation for temporary disability. Claimant has moved the Board to hold the briefing schedule in abeyance pending receipt of additional medical reports. Implicit in claimant's request is the notion that we should consider such additional medical reports as claimant seeks to generate. We would not be able to do so. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 (1983); Muffett v. SAIF, 58 Or App 684, 687 (1982). Claimant's motion in abeyance is denied.

Claimant's appellant's brief shall be filed within 20 days after the mailing date of this order. Briefing shall thereafter be accomplished in accordance with OAR 438-11-010(3).

IT IS SO ORDERED.

TERRY L. LANG, Claimant
Christopher Moore, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-09181
September 6, 1985
Order on Review (Remanding)

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Seifert's order which dismissed his claim for medical services based on his November 15, 1978 industrial injury.

Claimant compensably injured his low back in November 1978 while employed by the City of Sutherlin, the SAIF Corporation's insured. On March 1, 1982 he and SAIF stipulated that SAIF's denial of a subsequent claim against a later employer would remain in full force and effect and that SAIF would pay claimant's medical bills for low back problems commencing in March 1981 under the 1978 claim number. On February 14, 1983 SAIF denied reopening of the 1978 claim, based on a lack of indication that the low back condition resulting from the 1978 injury had worsened. A hearing was held. The Referee's March 19, 1983 order upheld the denial, finding that claimant had suffered a second work injury in 1981, not an aggravation of the 1978 injury. On August 12, 1983 the Referee dismissed a subsequent request for hearing on the claim against the later employer as barred by the March 1, 1982 stipulation.

Claimant currently requests that SAIF pay under the 1978 claim for certain alleged medical services rendered in 1984. SAIF argues and the Referee found that the Opinion and Order dated March 19, 1983 constitutes a final order that claimant's 1978 claim is no longer compensable in that claimant suffered an intervening and superseding injury. SAIF also contests the compensability of the claimed expenses on the merits.

In SAIF v. Mathews, 66 Or App 175 (1983), the court held that a prior employer was not released from all future responsibility for a claimant's condition by the fact that a later employer accepted a claim for reinjury to the affected portion of the body. It held that instead, the evidence had to be weighed to determine which employer was responsible. The court also considered the effect of a disputed claim settlement entered into between the claimant and the later employer. It held that although the settlement barred recovery against the later employer, the settlement was irrelevant with respect to the claim against the prior employer. See also Seeber v. Marlette Homes, Inc., 30 Or App 233 (1977) (where a claimant enters a disputed claim settlement regarding the compensability of the initial claim, there can be no later aggravation claim). Claimant's claim for 1984 medical services based on the 1978 industrial injury is not procedurally barred.

The prior hearing having been confined to SAIF's Motion to Dismiss, we remand this case to the Hearings Division for further evidence taking and consideration on the merits. The Referee who conducts the hearing is requested to submit a copy of his/her order to the Board for consideration in connection with Own Motion No. 84-0434M.

ORDER

The Referee's order dated January 21, 1985 is reversed and claimant's request for hearing is reinstated. This case is remanded to the Hearings Division for further evidence taking and consideration on the merits.

DAN W. HEDRICK, Claimant
Hayner, et al. Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 84-10652
September 10, 1985
Order on Reconsideration of Order Denying Request to Dismiss

The employer has requested that we reconsider our Order Denying Request to Dismiss mailed August 16, 1985, to the extent that the order does not clearly state that the employer-appellant is permitted by the terms of the order to file either an appellant's opening brief or a reply brief. The order does specify that claimant was granted 20 days from the date of the order to file his respondent's brief. After the issuance of our earlier order, we received the employer's request for an extension of time within which to file the appellant's opening brief. This extension request was apparently prompted by claimant's motion to dismiss. The appellant's opening brief was due July 17, 1985.

There is no statutory requirement that a party on Board review file a brief. Although we view briefs as a significant aid in the review process, we will not dismiss a request for review on the ground of failure to file a brief. However, we have established time periods within which briefs are to be filed, if the parties choose to do so. OAR 438-11-010(3). The time for filing briefs is calculated based upon the mailing of the transcript to the parties. We have adopted language included on the cover letter attached to the transcript which sets the briefing schedule by reference to specific dates on or before which each brief is due. The letter concludes with the following language: "All extensions require prior approval. Extensions of time for filing briefs will be granted only on written motion and only for good cause."

The employer-appellant in this case did not request an extension of time within which to file its opening brief until 30 days after the brief was due. Under these circumstances, we decline to grant an extension. The employer shall, however, be allowed to file a brief in reply to the claimant-respondent's brief, which is due September 7, 1985. The reply brief shall be filed within ten days of claimant-respondent's brief, and shall be confined to matters of reply.

IT IS SO ORDERED.

LELAND O. BALES, Claimant
Johnson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-04721
September 12, 1985
Order of Dismissal

The SAIF Corporation has requested review of Referee Michael V. Johnson's order dated June 14, 1985. Claimant has moved the Board for an order dismissing SAIF's request for review on the ground that it was untimely. SAIF's request for review was filed August 27, 1985.

SAIF contends that its request for review is timely because

its attorney allegedly did not receive a copy of the Referee's order until shortly after August 12, 1985. On August 12, 1985 the Referee mailed a copy of the order to SAIF counsel, after having received a request from counsel that he do so. The Referee's order recites that a copy of the order was mailed to SAIF on June 14, 1985. Appeal rights cannot be extended by requesting a duplicate copy of an order after it has become final.

Because SAIF did not file its request for Board review within 30 days after the date the Referee's order was mailed, the order is final, ORS 656.289(3), and we are without jurisdiction to review it. Claimant's motion to dismiss SAIF's request for review is allowed. The SAIF Corporation's request for Board review is dismissed.

IT IS SO ORDERED.

JOHN R. BRENNER, Claimant
Merrill & O'Sullivan, Claimant's Attorneys
Roberts, et al., Defense Attorneys

Own Motion 85-0090M
September 12, 1985
Own Motion Order Vacating Previous Own Motion Order and Referring for Hearing

The employer, Diamond International, and its contract claims administrator, Fred S. James & Co., have requested the Board abate its Own Motion Order entered May 30, 1985 in which we ordered claimant's claim be reopened for payment of temporary total disability benefits on account of an aggravation of his November 17, 1978 industrial injury. Claimant's aggravation rights have expired. The employer further requests that we refer this matter to the Hearings Division, OAR 438-12-010, for consolidation with WCB Case No. 85-07631, which is a request for hearing on Industrial Indemnity Company's denial of a claim for a new injury allegedly occurring February 22, 1985. This hearing request was filed June 25, 1985.

It is Board policy that requests for own motion relief under ORS 656.278 will not be acted upon while a claimant has other administrative or judicial relief available. OAR 438-12-005(1)(a). Claimant's request for hearing on the Industrial Indemnity denial raises the issue of which employer is responsible for payment of temporary disability benefits to claimant. Consistent with our policy of deferring action on own motion requests while other remedies are available, we hereby vacate our Own Motion Order dated May 30, 1985, effective this date.

We are aware that by vacating our previous Own Motion Order, we are, in effect, terminating claimant's temporary total disability compensation. We have been advised that Industrial Indemnity Company sought an order designating a paying agent pursuant to ORS 656.307, but that such an order could not be issued because claimant's remedy as to Diamond International is governed by ORS 656.278. Diamond International has suggested that we fashion an order in the image of a .307 order under our own motion jurisdiction. We conclude that we are unable to do so, because we do not have jurisdiction over Industrial Indemnity under ORS 656.278. Diamond International, of course, is not prevented from paying benefits pending resolution of the responsibility question. ORS 656.278(4).

So that the question of responsibility as between the two employers may be decided on the basis of a complete record, we hereby refer the own motion matter, Own Motion No. 85-0090M, to the Hearings Division and order that the own motion matter be consolidated for hearing with WCB Case No. 85-07631. At the conclusion of the hearing, the Referee shall forward all documentary evidence received together with a transcript of the hearing and his/her recommendations on the resolution of the own motion request to the Board.

IT IS SO ORDERED.

DELBERT W. CARTER, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Beers, et al., Defense Attorneys

WCB 83-11330 & 83-05558
September 12, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

EBI Companies request review of Referee Baker's order that set aside its denial of claimant's low back aggravation claim. EBI contends that the SAIF Corporation is responsible for claimant's back condition as an occupational disease. The issue is responsibility.

Claimant began working for the employer in 1959. From 1953 to 1977 the employer was insured by SAIF. Between 1977 and 1982 EBI Companies provided workers' compensation coverage. SAIF was again on the risk between 1982 and 1983. The employer has been self-insured since July 1983. Claimant's principal job duties have been involved with installing and servicing underground pipelines.

Claimant's first back injury occurred in 1964. In 1974 he underwent a laminectomy and discectomy at L5-S1. He received an award of 15% unscheduled permanent partial disability in April 1975. In November 1975 and again in November 1976 claimant had back injuries that involved temporary disability only. Each time claimant's back condition flared up, he was able to return to his strenuous work. On June 6, 1980 claimant sustained another back injury involving a slightly different distribution of pain than that of his previous injuries. This injury was accepted by EBI as a new injury. Claimant was off work until March 1981. Claimant's back pain flared again in October 1981, resulting in his being off work until May 1982. This flare-up was accepted by EBI as an aggravation of the June 1980 injury. Neither of the accepted EBI claims resulted in increased permanent disability awards. On April 23, 1983 claimant leaned over a pool table while off the job and experienced immediate, severe low back pain. He has not worked since.

There is medical evidence that lends some support to three possible theories under which to determine responsibility. Dr. Buza, neurosurgeon, and a panel of the Orthopaedic Consultants opine that claimant's present condition is a result of aggravation of the original 1974 back injury that resulted in surgery. Dr. Warner, claimant's treating chiropractor, asserts that claimant's present condition is an aggravation of the June 1980 injury. Dr. Murphy, orthopedist, states:

> "It is my opinion that this individual's current state is a result of the past 20 years of back pain and not related to any specific incident on any given date during this time frame. His back pain occurred in 1964 and he has had multiple episodes of back pain of a work related nature which are well documented. He had surgical intervention with a diskectomy at the L5-S1 level in 1974 as a result of these injuries. His current condition is a consequence of repeated injuries to his back over a 20 year period.
>
> "It is my opinion that [claimant's] current condition is largely a result of work related injuries and trauma, due to the nature of his work over the past 19-20 years. Since he has not worked for at least a year, it is my opinion that his work activities have not directly contributed to his current condition in an acute fashion, but rather his current condition represents an end result of many years of repeated trauma to his back."

The Referee concluded:

> "The worst pain [claimant] ever experienced was when he straightened up from the pool table in April 1983. However, no doctor believes that incident was the sole cause. On the entire record, I find it more likely than not that claimant's back condition is the result of repeated trauma over his many years of labor for this employer, including the documented specific injuries. The last documented work injury is the June 6, 1980, claim. As noted, claimant's back condition through May 5, 1982, was accepted by EBI as an aggravation under the 1980 claim. There has been no intervening work injury. I conclude that claimant's back condition on and after April 18, 1983, is the responsibility of EBI as an aggravation under the 1980 claim."

We agree with the Referee's finding that on the record as a whole it is most likely that claimant's present condition is the result of repeated trauma over his 20 years of employment with this employer, no one specific incident being more or less a cause of the end result than any other. However, we disagree that this finding should result in EBI being held responsible for claimant's condition. We note that claimant has had only one employer since 1959, and that there is no contention that the employer qua employer is not ultimately responsible, whether as a self-insured or through one of its insurers, for claimant's condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified, 73 Or App 223 (1985).

The "last injurious exposure rule" applies to cases in which

there is one employer and successive insurers just as it does to cases in which there are successive employers, Inkley v. Forest Fiber Products Co., 288 Or 337, 343 (1980), at least insofar as it establishes a rule of proof, see Bracke v. Baza'r, 293 Or 239 (1982); FMC Corp. v. Liberty Mutual Ins. Co., supra, 73 Or App at 227-28 (1985). Approximately three years passed from the last specific injury, in June 1980, to the time claimant's condition became such that he could no longer work, in April 1983. While it is agreed by the medical experts that claimant's off the job pool table incident had some effect on his condition, all the experts assign claimant's present condition in major part to one or another industrial cause. Cf. Grable v. Weyerhaeuser Company, 291 Or 387, 402 (1981) (work injury material contributing factor in condition also caused by off-job injury). Because claimant had only this one employer, we are persuaded by a preponderance of the evidence that claimant's condition is work related, and neither EBI nor SAIF disputes that point. See Inkley v. Forest Fiber Products Co., supra, 288 Or at 334 (1980).

We also find Dr. Murphy's assessment to be the most persuasive, and we conclude that the preponderance of the evidence establishes that claimant has experienced a worsening of his underlying back condition, not just a worsening of symptoms. His present condition is, we therefore find, compensable as an occupational disease. ORS 656.802(1)(a); Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979). Cf. Richard A. Scharback, 37 Van Natta 598 (1985).

Although Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984), speaks only in terms of successive employment situations, we believe its analysis is applicable to this single employer, successive insurer situation. The court said:

> "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. . . ." 296 Or at 243.

Applying this statement to the facts of this case, we arrive at the following: If a worker's disability results from exposure to potentially causal conditions in a single employment, the insurer, or the employer, if self-insured, responsible for workers' compensation benefits at the last time the worker was exposed to the potentially causal conditions is deemed responsible for providing benefits even though the claimant has not proved that the most recent conditions actually caused the disease and even though previous conditions also possibly caused the disease. This is the result reached by the Court of Appeals in FMC Corp. v. Liberty Mutual Ins. Co., supra, and is consistent with Starbuck and Inkley. We conclude that under this analysis, SAIF is responsible for claimant's condition.

Claimant's appearance on Board review was limited to asserting that one of the insurers was liable. A nominal attorney fee shall be awarded. See Robert Heilman, 34 Van Natta 1487 (1982).

ORDER

The Referee's order dated June 28, 1984 is reversed in part and modified. EBI Companies denial dated May 20, 1983 is reinstated and affirmed. The SAIF Corporation's denial dated November 18, 1983 is set aside and SAIF Corporation shall accept claimant's claim and process it pursuant to law. The SAIF Corporation shall reimburse EBI Companies for all claim expenditures made pursuant to the Referee's order. The Referee's award of an attorney fee to claimant's attorney for services at hearing is modified insofar as the fee shall be paid by the SAIF Corporation. Claimant's attorney is awarded $150 for services on Board review, to be paid by the SAIF Corporation.

THEODORE C. COLLIER, Claimant
L. Thomas Clark, Claimant's Attorney
Van Vactor, et al., Attorneys
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Ass't. Attorney General
David O. Horne, Defense Attorney

WCB 84-02785 & 84-02786
September 12, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Seymour's order that set aside its denial of claimant's accidental injury claim. The sole issue on review is whether claimant's injuries arose out of and in the course of his employment.

In October of 1983 the Benge Paving Company secured a contract with the U.S. Forest Service to pave a portion of a highway in central Oregon. Pursuant to this contract, Benge subcontracted with Mr. Ray, the owner of a dump truck, to haul paving materials. Ray then hired claimant to do the driving.

Claimant and Ray apparently agreed that claimant could use the dump truck to commute to work from his home in Prineville. Claimant erroneously understood that Benge would provide the fuel for the commute. Upon beginning work, however, claimant was informed by Benge that the company would not provide fuel. Thereafter, claimant drove his own car to and from work, and at the end of the day he parked Ray's dump truck in a spot designated by Benge.

At the end of his shift on October 26, 1983, claimant parked the truck in the designated spot, helped a fellow employe remove a rock from a hubcap on one of the other trucks, and began his trip home. Earlier that day, Benge had paved the northbound lane of the public highway leading toward claimant's home. In order to prohibit autos from rolling over the newly-paved lane, Benge parked one of its trucks in the lane and directed one of its drivers to act as a flagman for oncoming cars.

Claimant pulled onto the northbound lane of the highway and headed for home. Because it was dark, he did not see Benge's unlit truck parked in that lane until he was nearly upon it. He swerved into the southbound lane to avoid the truck, only to find Benge's flagman standing in that lane. Claimant swerved back into the northbound lane, striking the parked truck as well as the flagman. Claimant also received injuries from the accident.

Claimant filed a notice of claim against Ray. Ray, however, had no workers' compensation insurance and a proceeding was instituted to declare him a non-complying employer. A hearing was held before Referee Seymour in which Ray's non-complying status and the compensability of claimant's claim were at issue. The Referee found that on the evening of the accident claimant was a subject employe of Ray and that Ray was non-complying. Because Ray was the subcontractor under a contract with Benge, Benge became the employer responsible for any compensable injuries to claimant arising from the October 26, 1983 accident. ORS 656.029. Wausau, Benge's insurer, has accepted responsibility for any benefits to which claimant is held to be entitled.

The Referee found claimant's claim to be compensable. He found that the employer had in effect ordered claimant to park his dump truck in an area from which claimant had no choice but to leave the worksite through a dangerous area. The Referee also found that at the time of claimant's accident, the employer was exercising control over the public thoroughfare upon which claimant had to travel in order to return home. These elements, the Referee reasoned, combined to make the claim compensable.

On review, the insurer argues that because claimant's accident occurred on a public highway after claimant had left work for the day, his resulting injuries occurred during a period of non-employment and are, therefore, not compensable. Claimant responds that the employer's exercise of control over the public area in which claimant was injured made any injuries occurring in that area compensable.

As a general rule, injuries sustained by a worker while going to or coming from work are not compensable. Brown v. SAIF, 43 Or App 447 (1979); Gumbrecht v. SAIF, 21 Or App 389 (1975); Theodore P. Brown, 36 Van Natta 51 (1984). An exception to the general rule exists, however, when the employe is injured while going to or coming from work through an area controlled by the employer that is the only practicable means of getting to or from the worksite. Montgomery Ward v. Malinen, 71 Or App 457, 460 (1984). See also, Montgomery v. SIAC, 224 Or 380 (1960); Montgomery Ward v. Cutter, 64 Or App 759 (1983); Willis v. SAIF, 3 Or App 565 (1970). In the present case, Benge clearly exercised control over the public thoroughfare upon which claimant was injured by placing its truck in the highway's northbound lane. It also placed its flagman there to control traffic. The highway was the only practicable route claimant could travel in order to head home. Under these circumstances, claimant's injuries are compensable.

ORDER

The Referee's order dated December 10, 1984 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

VANESSA DORTCH, Claimant
Patrick K. Mackin, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-05649
September 12, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of those portions of Referee Neal's order that set aside its denial of aggravation of claimant's low back injury, awarded temporary disability compensation and awarded 32° for 10% unscheduled permanent partial disability in addition to the Determination Order's award of temporary disability compensation only on the original injury claim. Claimant cross-requests review of those portions of the order which found the aggravation denial was neither late nor unreasonable, awarded no attorney fee for reopening the claim, and awarded unscheduled permanent partial disability on the ground that the award was inadequate. Claimant also cites as error the Referee's admission of eight exhibits. Claimant additionally has moved to strike SAIF's brief because it was filed late. The issues on review are whether to accept SAIF's appellant brief on review, admissibility of eight exhibits, compensability of an aggravation claim, unreasonableness or lateness of the aggravation denial, attorney fees for obtaining reopening, and extent of unscheduled permanent partial disability.

On the issues of the compensability of the aggravation claim, extent of unscheduled permanent partial disability, penalty, attorney fees and the Referee's evidentiary rulings, the Board affirms and adopts the order of the Referee. We address separately the question whether to strike SAIF's appellant's brief.

SAIF's opening brief was originally due May 16, 1985. SAIF requested an extension of time prior to the due date and claimant did not object to the request. The extension was granted and a new brief filing date of May 30, 1985 was established. No further extensions were requested and SAIF's brief was received by the Board June 4, 1985.

There is no statutory requirement that a party on Board review file a brief. Although we view briefs as a significant aid in the review process, we will not dismiss a request for review on the ground of failure to file a brief. However, we have established time periods within which briefs are to be filed, if the parties choose to do so. OAR 438-11-010(3). The time for filing briefs is calculated based upon the mailing of the transcript to the parties. We have included language which sets the briefing schedule by reference to specific dates on or before which each brief is due on the cover letter attached to the transcript. The letter concludes with the following language: "All extensions require prior approval. Extensions of time for filing briefs will be granted only on written motion and only for good cause." When, as in this case, an extension within which to file a brief is granted, the extension is in writing and sets forth a specific date by which the brief is due.

In Nancy J. Rensing, 37 Van Natta 3 (1985), we discussed the recurrent problem of late filing of briefs on Board review. We noted that it was then our general practice to allow consideration of briefs filed a day or two late. We then stated:

"We note, however, that our practice of

tolerating such late submissions is actively under reconsideration by the Board. We intend to closely monitor the filing of briefs to determine how big a problem late filing is. After study and reflection the Board may change its present policy to a policy of strict enforcement of our present rule. . . ."

We have reconsidered our previous acquiescence to the late submission of briefs on Board review and have concluded that strict enforcement of our present rule is both necessary and desirable. The submission of briefs is an action that is entirely within the control of the parties. We conclude that henceforth OAR 438-11-010(3) will be strictly enforced, and that briefs not filed in conformity with that rule will not be considered by the Board. We note that the Board's policy of granting reasonable extensions of time within which to file briefs is unchanged. Such extensions will be allowed upon motion and showing of good cause, if made prior to the date the brief is due. See also Dan W. Hedrick, 37 Van Natta 1200 (WCB Case No. 84-10652, September 10, 1985) (extension requested for appellant's brief 30 days after brief due not allowed -- appellant authorized to file reply brief limited to matters of reply).

We feel constrained to apply the policy enunciated here prospectively, even though the late submission in this case strains the limits of flexibility of Nancy J. Rensing, supra. SAIF's brief was considered on Board review.

ORDER

The Referee's order dated January 10, 1985 is affirmed. Claimant's attorney is awarded $450 for services on Board review for having prevailed on the issues of the aggravation claim and the unscheduled permanent partial disability award, to be paid by the SAIF Corporation.

JOVITA P. GARCIA, Claimant
KELLY ENTERPRISES, INC., Employer
LON D. KELLY & MICHAEL R. KELLY
Joseph C. Post, Claimant's Attorney
Paul J. Rask, Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Ass't. Attorney General

WCB 83-10430
September 12, 1985
Order of Dismissal

The alleged noncomplying employer has requested Board review of Referee Neal's order that approved the Director of the Workers' Compensation Department's order that held the employer to be a noncomplying employer of a subject worker. Claimant has moved the Board for an order dismissing the request for review on the ground that this Board lacks jurisdiction. In its initial request for hearing, the employer protested the SAIF Corporation's acceptance of claimant's claim, thus placing in issue claimant's right to compensation. At hearing, the employer withdrew its objection to SAIF's acceptance and the proceeding was held on the sole issue of whether the alleged noncomplying employer was a subject employer and claimant a subject worker.

The Referee's order contained the following notice of appeal rights:

"This Order is final unless, within 60 days after this Order is served on the parties, one of the parties appeals to the Court of Appeals for judicial review as provided per ORS 183.482."

Pursuant to ORS 656.740(3), contested cases involving an employer's complying status under ORS 656.017 must be litigated and reviewed under the provisions of the Adminstrative Procedures Act relating to contested cases, ORS 183.310 to 183.550, unless the complying status is litigated in the same hearing as "matters concerning a claim." See Gary O. Soderstrom, 35 Van Natta 1710 (1983). ORS 656.704(3) defines "matters concerning a claim" for purposes of determining hearing and review procedures as "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." This case did not involve "matters concerning a claim," because there was no issue as to compensability, thus claimant's right to compensation, at the hearing. The proper avenue of review was to the Court of Appeals and not to this Board. We conclude we lack jurisdiction. The noncomplying employer's request for review is, therefore, dismissed.

We note that claimant requests an attorney fee for presenting the motion to dismiss. We also note that claimant recognizes the paradox in her request. We conclude that, because we lack jurisdiction, we can do nothing more than dismiss the request for review. See also Rodney C. Strauss, 37 Van Natta 1212 (WCB Case Nos. 84-10699 and 84-13439, decided this date) (no attorney fee in employer appeal where case dismissed without decision on merits).

IT IS SO ORDERED.

THOMAS E. HARLOW, Claimant
Hayner, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 84-09970, 85-02851, 85-02852 & 85-02853
September 12, 1985
Order Denying Motion to Strike Brief

Claimant has moved the Board for an order striking the self-insured employer's appellant's brief on Board review on the ground that it was not filed within the time prescribed by OAR 438-11-010(3).

There is no statutory requirement that a party on Board review file a brief. Although we view briefs as a significant aid in the review process, we will not dismiss a request for review on the ground of failure to file a brief. However, we have established time periods within which briefs are to be filed, if the parties choose to do so. OAR 438-11-010(3). The time for filing briefs is calculated based upon the mailing of the transcript to the parties. We have adopted language included on the cover letter attached to the transcript which sets the briefing schedule by reference to specific dates on or before which each brief is due. The letter concludes with the following language: "All extensions require prior approval. Extensions of time for filing briefs will be granted only on written motion and only for good cause." In this case, no extension was requested.

In Nancy J. Rensing, 37 Van Natta 3 (1985), we discussed the recurrent problem of late filing of briefs on Board review. We

noted that it was then our general practice to allow consideration of briefs filed a day or two late. In Vanessa Dortch, 37 Van Natta 1207, (WCB Case No. 84-05649, decided this date), we announced that we have reconsidered our acquiesence to late brief submissions and that henceforth OAR 438-11-010(3) will be strictly enforced. The brief under consideration in Dortch was filed five days late, after one extension had been requested and granted. The brief under consideration in this case was filed eight days late, no extension having been requested or granted. See also Dan W. Hedrick, 37 Van Natta 1200 (WCB Case No. 84-10652, September 10, 1985) (extension requested 30 days after brief due not allowed -- appellant permitted to file reply brief limited to matters of reply).

Because we feel constrained to apply our policy prospectively, even though the late submission in this case strains the limits of flexibility of Nancy J. Rensing, supra, to the breaking point, the self-insured employer's appellant's brief will be considered in this case. Claimant's motion to strike the self-insured employer's brief is denied. Claimant is allowed 20 days from the mailing date of this order to file a respondent's brief. The employer is allowed 10 days from the date of respondent's brief is filed to file a reply brief.

IT IS SO ORDERED.

EARL P. HOUSTON, Claimant
Richard O. Nesting, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 83-00851
September 12, 1985
Order Denying Motion to Dismiss

The employer has moved the Board for an order dismissing claimant's request for review on the ground that claimant's appellant's brief was not timely filed. The Board granted claimant's request for an extension of time within which to file an opening brief, extending the due date to July 10, 1985. On July 19, 1985 claimant submitted, in lieu of a brief, a copy of the request for reconsideration earlier provided to the Referee. This request for reconsideration is already a part of the record.

There is no statutory requirement that a party on Board review file a brief. Although we view briefs as a significant aid in the review process, we will not dismiss a request for review on the ground of failure to file a brief. However, we have established time periods within which briefs are to be filed, if the parties choose to do so. OAR 438-11-010(3). The time for filing briefs is calculated based upon the mailing of the transcript to the parties. We have adopted language included on the cover letter attached to the transcript which sets the briefing schedule by reference to specific dates on or before which each brief is due. The letter concludes with the following language: "All extensions require prior approval. Extensions of time for filing briefs will be granted only on written motion and only for good cause." When, as in this case, an extension within which to file a brief is granted, the extension is in writing and sets forth a specific date by which the brief is due.

We have this date issued our order on review in Vanessa Dortch, 37 Van Natta 1207 (WCB Case No. 84-05649, decided this date), in which we have announced our policy that the rule establishing the time periods within which briefs must be filed, OAR 438-11-010(3), will be strictly enforced, and that late briefs

will not be considered. We note, however, that in this case, the document sent in lieu of claimant's opening brief is already a part of the record.

The insurer's motion to dismiss claimant's request for review is denied. The insurer is granted 20 days from the mailing date of this order to file a respondent's brief. Claimant is allowed 10 days from the date respondent's brief is filed to submit a reply brief limited to matters of reply.

IT IS SO ORDERED.

DONNA JOHNSON, Claimant
Heiling & Morrison, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-06055
September 12, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Brown's order which upheld the SAIF Corporation's denial of the claim for thrombophlebitis of the right leg. The issue on review is compensability.

The Board affirms the Referee's order with the following comment. We find that claimant failed to carry her burden of proof that her thrombophlebitis was the result of an injury as opposed to any other possible cause unrelated to her employment. See John B. Bruce, 37 Van Natta 135 (1985).

ORDER

The Referee's order dated March 7, 1985 is affirmed.

GEORGE L. LACY, Claimant
Evohl F. Malagon, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 84-09680
September 12, 1985
Order Denying Motion to Strike Brief Reply

The insurer has moved the Board for an order striking claimant's reply brief on Board review on the ground that it was not filed within the time prescribed by OAR 438-11-010(3). The brief in question was filed four days late.

We announced in Nancy J. Rensing, 37 Van Natta 3 (1985), that our previous acquiescence to submissions one or two days late was being reconsidered. We have this date issued our order in Vanessa Dortch, 37 Van Natta 1207 (WCB Case No. 84-05649, decided this date), in which we have announced that OAR 438-11-010(3) will henceforth be strictly enforced. We feel constrained to apply the policy enunciated in Dortch prospectively, even though the late submission in this case strains the limits of flexibility of Nancy J. Rensing, supra. Claimant's reply brief will be considered on Board review of this case. See also Thomas E. Harlow, 37 Van Natta 1209 (WCB Case No. 84-09970, decided this date) (appellant's brief eight days late); Earl P. Houston, 37 Van Natta 1210 (WCB Case No. 83-00851, decided this date) (submission in lieu of appellant's brief nine days late); Dan W. Hedrick, 37 Van Natta 1200 (WCB Case No. 84-10652, September 10, 1985) (request for extension 30 days after brief due not allowed -- appellant permitted to file reply brief limited to matters in reply).

IT IS SO ORDERED.

RODNEY C. STRAUSS, Claimant
Spears, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Nancy J. Meserow, Defense Attorney

WCB 84-10699 & 84-13439
September 12, 1985
Order of Dismissal

Wausau Insurance Company requested review of Referee Seifert's order that set aside its denial of claimant's low back injury claim. Wausau has now withdrawn its request for Board review and moves that its request be dismissed. Claimant has requested that the Board award a penalty and attorney fee for what he characterizes as Wassau's unreasonable resistance to the payment of compensation. Claimant relies upon ORS 656.262(10) and 656.382 as authority in support of his request for a penalty and attorney fee.

Addressing the penalty question first, claimant argues that Wausau's request for Board review was "frivolous and made only for purposes of delay." In support of this argument, claimant points out that Wausau requested a 30-day extension of time within which to file its opening brief, was granted a 14-day extension, and, nevertheless, did not submit a brief within the time allowed by the extension. Wausau mailed its withdrawal of the request for review 14 days after the extended due date for the brief.

We decline to speculate as to why Wausau elected to withdraw its request for Board review. Although we have not evaluated the record on the merits, our review of the Referee's order and the evidence in this case establishes that fairly complex issues of compensability and employer responsibility were involved at hearing. Any party is entitled to request review of a Referee's order as a matter of right. ORS 656.289(3); 656.295(1). Although there is statutory authority for a Referee to order an employer to pay a penalty upon finding that the employer requested a hearing for purposes of delay or some other vexatious reason, ORS 656.382(3), there is no such authority granted to the Board or the courts, see ORS 656.295(6); 656.298(6). While we give no opinion whatsoever on the merits of the Referee's decision in this case, we conclude that Wausau's request for review of that decision was not unreasonable, and we would not award a penalty for doing so even if we had statutory authority to do so.

The question whether claimant's attorney is entitled to a fee on Board review is a closer one. ORS 656.382(2) provides in relevant part:

> "If a request for . . . review . . . is initiated by an employer or insurer, and the . . . board . . . finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney's fee in an amount set by the . . . board . . . for legal representation by an attorney for the claimant at and prior to the . . . review . . . ."

ORS 656.382(2) also authorizes the courts to award employer/insurer paid attorney fees upon employer/insurer appeals in which compensation is not disallowed or reduced. In SAIF v. Curry, 297 Or 504 (1984), the Supreme Court denied claimant's petition for attorney fees in a case in which the claimant's

attorney performed legal services in response to an insurer's petition for Supreme Court review which was ultimately denied. The court reasoned that its denial of claimant's petition for attorney fees was supported by a literal reading of the statute, which requires the court to find that compensation should not be disallowed or reduced, and that court's oft-stated holding that denial of a petition for review is not a "finding," but merely a decision not to entertain an appeal. The court further relied upon the legislative history of the 1983 amendment to ORS 656.382(2), finding that the legislative intent was to allow attorney fees in the Supreme Court only when that court allowed an employer/insurer's petition for review and made a final decision that a claimant's compensation should not be disallowed or reduced.

In Agripac, Inc. v. Kitchel, 73 Or App 132 (1985), the Court of Appeals denied claimant's petition for attorney fees in a case in which the employer's petition for judicial review was dismissed on the claimant's motion. Relying on SAIF v. Curry, supra, the court specifically overruled its decision in SAIF v. Bond, 64 Or App 505 (1983), in which it had held that ORS 656.382(2) mandated an employer/insurer paid attorney fee when the claimant prevails on an employer/insurer appeal, whether on the merits or by reason of dismissal of the appeal. In Agripac, Inc. v. Kitchel, supra, the court said:

> "The precise question is whether in dismissing employer's petition for judicial review on claimant's motion the court has found that the compensation awarded to claimant should not be disallowed or reduced." 73 Or App at 134.

The court relied upon the Supreme Court's discussion of the legislative history of the 1983 amendment to ORS 656.382(2), in particular the statement that:

> "'[T]he [Senate Labor Committee] considered, but rejected, a proposal that would have allowed an award of attorney fees to a claimant's attorney who works on an appeal initiated by an employer or insurer, but which is dismissed on the employer/insurer's motion prior to a decision.' 29[7] Or at 510." (Emphasis added.)

The court concluded that:

> "[W]hen an employer or insurer's petition for judicial review is dismissed without a finding 'that the compensation awarded to a claimant should not be disallowed or reduced,' the claimant is not entitled to an award of attorney fees." 73 Or App at 135.

The Supreme Court in SAIF v. Curry, supra, took care to reiterate that its decision was limited to consideration only of the 1983 amendment to ORS 656.382(2), which provided for attorney fees in the Supreme Court, where the previous edition of the statute did not. The Court of Appeals in Agripac, Inc. v. Kitchel, supra, however, wrote with a much broader brush. As the Court of Appeals could find no meaningful distinction between

Kitchel and Curry, we find no meaningful distinction between this case and Kitchel, especially in view of the Supreme Court's discussion of the legislative history, quoted above. ORS 656.382(2) does not treat any reviewing entity in this system, from Referees to the Supreme Court, differently from each other. We are mindful, as was the Supreme Court, that this ruling will occasionally produce harsh results for claimants' attorneys; however, we are bound by the decisions in Curry and Kitchel to hold that ORS 656.382(2) does not permit us to award an employer/insurer paid attorney fee to a claimant's attorney in an employer/insurer appeal which is dismissed prior to a decision on the merits.

Wausau Insurance Company's motion to dismiss its request for review is allowed and said request is hereby dismissed. The Referee's order dated April 15, 1985 is final by operation of law. Claimant's request for a penalty and attorney fee is denied.

IT IS SO ORDERED.

DARREL A. CHASTAIN, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 81-03963 & 81-03962
September 16, 1985
Order on Remand

This case is before the Board on remand from the Court of Appeals. Chastain v. SAIF, 72 Or App 422 (Per Curiam), rev den, 299 Or 251 (1985). We have been directed by the court to order reinstatement of the SAIF Corporation's acceptance of claimant's claim.

Now, therefore, the Referee's order dated November 22, 1982 is modified. The April 6, 1981 and January 27, 1982 denials of Fremont Indemnity/UG Insurance, Inc., are reinstated and affirmed. The SAIF Corporation's denials dated April 14, 1981 and January 25, 1982 are set aside and this matter is remanded to the SAIF Corporation for acceptance and processing according to law.

IT IS SO ORDERED.

CALVIN L. GRANTOM, Claimant
Dwyer, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 84-01061
September 16, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of that portion of Referee Danner's order which set aside its partial denial of claimant's headache condition as unrelated to his industrial injury to his left eye. The issue on review is compensability.

The Board affirms and adopts the order of the Referee. See Bradshaw v. SAIF, 69 Or App 587 (1984) (treating doctor ruled out ordinary causes by diagnostic testing, leaving the alleged cause as the most probable among uncommon causes).

ORDER

The Referee's order dated February 21, 1985 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

RICHARD T. FOSTER, Claimant
Schwabe, et al., Defense Attorneys

WCB 84-06963
September 17, 1985
Order of Dismissal

Claimant requested review of Referee Holtan's order dated July 22, 1985. The self-insured employer has moved to dismiss claimant's request for review on the ground that timely notice of the request was not afforded the employer.

As stated, the Referee's order was mailed to the parties on July 22, 1985. Claimant's request for review was received by the Board on August 19, 1985 and, therefore, was timely. ORS 656.289(3). However, claimant did not mail copies of his request for review to any of the other parties. ORS 656.295(2). The employer received actual notice of the request for review upon receipt of the Board's acknowledgement of the request, on August 23, 1985, more than 30 days from the date of the Referee's order.

In Argonaut Insurance v. King, 63 Or App 847, 852 (1983), the court held, "[T]hat compliance with ORS 656.295 requires the statutory notice of the request for review be mailed or actual notice be received within the statutory period." In this case, neither event occurred within the 30 days mandated by statute. The requirement is jurisdictional. The employer's motion to dismiss claimant's request for review is allowed. Claimant's request for review is hereby dismissed. The Referee's order is final by operation of law.

IT IS SO ORDERED.

GLENN HALE, Claimant
Richard O. Nesting, Claimant's Attorney
Scott M. Kelley & Assoc., Defense Attorneys

WCB 84-00665
September 17, 1985
Order on Review

Reviewed by the Board en banc.

The insurer requests review of Referee Knapp's order that granted claimant an award of permanent total disability. On review, the insurer argues that claimant has failed to establish entitlement to an award of permanent total disability. Claimant submitted no brief on review.

Claimant suffered a compensable injury in May of 1977 when he strained his low back while lifting I-beams. He was treated conservatively and was able to return to work until recurring symptoms forced him to quit in August of 1977. He was evaluated at the Callahan Center, where he was found to exhibit mild degenerative disc disease at the L4-5 level. He was found to be capable of medium work and was given a 50-pound lifting restriction. He was told not to engage in work involving repetitive bending or stooping.

Vocational assistance was arranged, but claimant's anxiety during training led to his being referred to a psychologist, Dr. Glaudin. Dr. Glaudin found that claimant was experiencing an anxiety reaction due to his loss of job. Medication was prescribed and job training was recommended. Claimant subsequently went to St. Vincent de Paul for job evaluation, and was placed in an auto painting training program. The program was

soon terminated, however, because of claimant's problems with asthma and his sinuses.

Claimant was examined by Dr. Pasquesi in January of 1979. Dr. Pasquesi felt that claimant was medically stationary and rated his impairment at 15% due to moderate-to-severe pain. Dr. Pasquesi agreed with the 50-pound restriction earlier imposed and advised claimant to avoid repetitive twisting, stooping and bending. The first Determination Order awarded claimant 20% unscheduled disability for the low back in March of 1979. This was increased to 35% by a November 26, 1979 Opinion and Order. Two days later, claimant was hospitalized for low back pain. All objective tests, however, were normal. Upon his discharge from the hospital, claimant was referred to a pain center for evaluation. The pain center personnel found claimant to be suffering from a "typical pain syndrome." He made good progress at the center and was once again referred for vocational assistance.

Claimant attempted a training program in heavy equipment operation. He was physically able to perform the work, but was unable to handle the arithmetic computations required for grading loads. His back pain returned and the training program was terminated in June of 1980. Adult education classes were tried, but once again a return of claimant's back symptoms frustrated the completion of the program. Dr. Marble, claimant's treating physician at the time, saw him soon thereafter and noted that claimant was anxious and depressed. Dr. Marble felt that claimant was reacting to the stress of his training program. Dr. Marble suggested claim closure. The counseling agency closed claimant's file and questioned his motivation to return to work. A November 7, 1980 Determination Order gave temporary total disability benefits but no additional permanent partial disability.

Claimant then began a relationship with Cascade Rehabilitation in October of 1980. After an evaluation, claimant was given a position as a service station attendant. He quit after a few hours, however, complaining of back symptoms. Additional basic education was recommended, and claimant successfully completed a six-month program. A request for an additional two months was granted, but the program ended when claimant complained of stress-related pain thought to be attributable to the classroom environment.

Cascade Rehabilitation next secured a locksmith training slot for claimant. He did well initially, but soon developed problems with his supervisor and the training program ended.

Dr. Reynolds became claimant's treating physician in mid-1981. He referred claimant to orthopedist Dr. Berselli, who found a normal range of back motion and no evidence of neurological deficit. In January of 1982 Dr. Berselli found claimant medically stationary and recommended another attempt at vocational rehabilitation. A second locksmith training site was then developed and claimant began an abbreviated training schedule in March of 1982. The program began well, and claimant's supervisor was pleased with his early work product. After a few months, however, absences began to occur. The training program was further interrupted by a trip to the east taken by the claimant in June of 1982, and by his hospitalization for a pancreas condition in September of that year. Largely through the

efforts of his vocational counselor, claimant was kept in training, but claimant alleged a reinjury at the training site in November and his program was terminated. Prior to the termination, claimant's supervisor had repeatedly threatened to fire him because of his being absent without contacting the supervisor as to his whereabouts.

Dr. Reynolds released claimant to return to light work in February of 1983. The Field Services Division refused to authorize further training, however, because of the several unsuccessful attempts that had already occurred. A wage subsidy program was offered to claimant's former supervisor, but the offer was declined because of claimant's prior absences and lack of enthusiasm. Claimant's vocational file was then closed. His counselor felt that maximum services had been provided, but that claimant had not been totally cooperative.

Dr. Reynolds found claimant stationary once again on August 16, 1983 and recommended vocational assistance to find claimant a light duty job. A Determination Order of January 3, 1984 awarded time loss through November 28, 1983, an additional award of 20% unscheduled for the low back, and a 5% scheduled award for the left leg. At the time of the hearing, therefore, claimant's unscheduled awards totalled 55%, while his scheduled disability stood at 5%.

The Referee found that although claimant was not totally disabled from a physical standpoint alone, the combination of his physical and psychological disabilities rendered him unemployable when they were added to his substantial social/vocational deficits. The Referee concluded that it would be futile for claimant to search for work and, therefore, excused him from the ORS 656.206(3) seek work requirement on the basis of Butcher v. SAIF, 45 Or App 313 (1980).

Claimant has the burden of proving entitlement to an award of permanent total disability. ORS 656.206(3); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). He can prove it one of two ways: he can prove that he is incapacitated from a physical and/or psychological standpoint alone, or he can prove that the combination of his less-than-total physical disability and unfavorable social/vocational factors renders him unemployable. Allison v. SAIF, 65 Or App 134 (1983). If the physical disability is less than total, claimant must demonstrate that he is willing to reenter the work force and that he has, in fact, made a reasonable effort to do so, Allison, 65 Or App at 136-37, unless such an effort would be futile. Butcher, supra 45 Or App at 317.

Claimant is clearly not physically incapacitated. His physicians have consistently stated that he is capable of light work, and have rated his impairment at 15%. At deposition, Dr. Reynolds did suggest that claimant might not be employable, but that statement directly conflicts with all of his previous conclusions regarding claimant's capacity for light work. Neither does claimant's psychological reaction render him unemployable. While it appears that he has suffered an anxiety reaction to being unemployed, no psychologist has stated that claimant cannot reenter the workforce as a result.

Because claimant's physical and mental disabilities are less than total, we are left to decide whether it would be futile for

him to search for work. Except for the several failed vocational attempts, claimant has not looked for work since the time of his injury more than eight years ago. After a review of the record, we conclude that it would not be futile for claimant to search for work. We also find that he has made insufficient efforts to do so and that an award of permanent total disability is not warranted.

We base our conclusion largely on the vocational evidence. The record is replete with references to claimant's failure to cooperate. It also appears that he has directly or indirectly frustrated the several attempts made on his behalf to get him back into the workforce. We are convinced that claimant would have and could have succeeded in becoming gainfully employed as a locksmith's assistant had it not been for his many unexcused absences from the work site and his general lack of enthusiasm for the job. While we recognize that claimant was suddenly placed in a very difficult position by the effects of his industrial injury, we are not satisfied that those effects were so severe as to render him unemployable.

Although we do not feel that claimant is permanently totally disabled, we conclude that he is entitled to additional unscheduled disability. Claimant was 47 years of age at the time of the hearing. He has only a third grade education and has limited mental capabilities. He has been effectively precluded from engaging in the only work he has ever done. After reviewing the entire record, we conclude that claimant is entitled to an additional 15% unscheduled disability, bringing his total unscheduled award to 70%. The 5% scheduled award will remain unchanged.

ORDER

The Referee's order dated November 28, 1985 is reversed. In lieu of prior unscheduled awards, claimant is awarded 70% (224°) unscheduled permanent partial disability for the low back. The 5% (7.05°) scheduled disability awarded by Determination Order is reinstated. Claimant's attorney's fee shall be adjusted accordingly and shall not exceed $2,000.

BOARD MEMBER LEWIS DISSENTING:

Because I agree with the Referee that claimant is permanently and totally disabled, I respectfully dissent from the majority opinion. A claimant proves entitlement to permanent total disability compensation when he demonstrates that his compensable injury and its effects have precluded him from "regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a). As used in the statute, a "suitable occupation" is one that the worker has the ability and the training or experience to perform, or an occupation that the worker is able to perform after rehabilitation.

After reviewing the record, I am convinced that the effects of claimant's injuries have rendered him incapable of regularly performing work at a suitable occupation. I recognize that claimant's physical incapacity is not total. However, I believe that the combination of his physical disabilitites, his marked social and vocational deficits and the adverse emotional reaction he experienced upon being removed from the workforce, has resulted in his being "permanently incapacitated" as that phrase is used in the statute.

Claimant's pre-injury work record was solid. He sometimes worked two heavy jobs simultaneously, and he worked for this employer for fifteen years prior to this injury. Whereas the majority opinion suggests that claimant is now directly or indirectly frustrating attempts at rehabilitating him, I find that claimant himself is understandably frustrated by the untenable situation in which he now finds himself. The psychological evidence reveals that before his compensable injury, claimant measured his self-worth in terms of his ability to use his body in heavy work. Now that that ability is gone, claimant's self-concept has deteriorated to the point that it is difficult for him to confidently engage in any employment activity. The majority apparently feels that this is malingering; I feel that it represents a reasonable reaction under the circumstances.

I note that the most significant attempt at returning claimant to work was the provision of a wage subsidy locksmith's assistant job. Claimant's testimony, which I accept, was that so long as he regularly received the subsidy employer's guidance, he performed satisfactorily. He also testified, however, that once the subsidy period ended, the employer refused to hire him because he did not feel that claimant was capable of performing any but the most elementary work without constant supervision. I take this to mean that claimant could not perform the employer's "regular" work; claimant's skills are such that he must have constant supervision in order to succeed. I do not find this surprising considering claimant's profound lack of education and his markedly unsophisticated background.

Claimant was a healthy and hardworking individual prior to his industrial injury. In my opinion, the injury set in motion a series of events that have rendered him incapable of regularly performing suitable work. I agree with the Referee that claimant is permanently totally disabled.

BRIAN L. HAYES, Claimant
Dwyer, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-11272
September 17, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Seifert's order which affirmed the Determination Order dated October 29, 1984 which awarded 32° for 10% unscheduled permanent partial disability due to injury to claimant's low back. The insurer, in its brief on review, requests reduction of the Determination Order award. The issue on review is extent of unscheduled permanent partial disability.

Claimant injured his back while delivering a fireproof filing cabinet on August 8, 1983. A strain or sprain was diagnosed. In January 1984 Dr. Filarski reported that X-rays showed an L1 compression fracture of less than 20%. A CT scan in March 1984 showed no fractures from T12 through L2, but showed wedging of T12-L1 secondary to old trauma. In June 1984 claimant was examined by a panel at Orthopaedic Consultants who reported their opinion that the wedging was a residual of old Scheuerman's disease, that claimant should discontinue narcotic medication, that claimant was able to return to work as far as his back was

concerned, and that claimant had no permanent impairment of his back. Claimant's attending physician disagreed with some of the comments unrelated to claimant's disability made by the Orthopaedic Consultants panel, but did not otherwise disagree with their assessment of claimant's disability.

The attending physician imposed a lifting limit of 50 pounds, and limited bending and twisting. The limits were based solely on claimant's subjective complaints which were not substantiated by objective pathology. Claimant's treatment was terminated when he missed five consecutive physical therapy treatments without prior notification. The attending physician's final opinion was that claimant's complaints of unrelenting and unremitting pain without "demonstrably causal pathology" raised doubts in his mind, but he considered the 10% disability award reasonably related to claimant's functional status.

We find that claimant has not proven that the limitations prescribed by his doctor are the result of his August 1983 industrial injury and, therefore, reverse the Referee's order and set aside the Determination Order award. The evidence does not persuade us that claimant's low back wedging causes him any impairment or that it is related to his industrial injury. The evidence also does not persuade us that the limitations that claimant described are related to his low back strain or sprain injury as opposed to any other source of limitations unrelated to this particular employment and injury.

ORDER

The Referee's order dated March 8, 1985 is reversed and the Determination Order award of 32° for 10% unscheduled permanent partial disability is set aside.

TERENCE R. JONES, Claimant
Kenneth D. Peterson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-05972
September 17, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which: (1) found that his claim for a back injury was not prematurely closed; (2) affirmed a March 29, 1983 Determination Order which had awarded no permanent disability; (3) upheld the SAIF Corporation's denial of claimant's aggravation claim; and (4) upheld SAIF's denial of responsibility for claimant's out-of-state chiropractic treatment.

The Board affirms the order of the Referee with the following comment concerning SAIF's denial of claimant's choice of an out-of-state physician. Although ORS 656.245(3) limits workers' choices of doctors outside of Oregon, it does not limit their right to receive medical service under ORS 656.245(1), wherever they are. Rivers v. SAIF, 45 Or App 1105 (1980). If an insurer gives a claimant a reasonable basis to believe that the insurer has approved the claimant's choice of an out-of-state doctor, the claimant need not obtain the insurer's consent to medical services the doctor provides for conditions resulting from the compensable injury. Mogliotti v. Reynolds Metals, 67 Or App 142 (1984).

Following our de novo review of the medical and lay evidence, which includes claimant's unreliable testimony and his history of heavy physical labor immediately preceding his current treatment, we are not persuaded that SAIF gave claimant a reasonable basis to believe that it had approved claimant's choice of an out-of-state physician nor are we persuaded that claimant's current condition resulted from the compensable injury. Accordingly, SAIF's denial of out-of-state chiropractic treatment is upheld.

ORDER

The Referee's order dated July 20, 1984 is affirmed.

LYDA K. MOE (BRYANT), Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-11761
September 17, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Seymour's order upholding the SAIF Corporation's denial of compensability of claimant's left foot condition as an occupational disease. Specifically, claimant seeks benefits in connection with her tendinitis of the Achilles tendon and plantar fasciitis, but not for her calcaneus bone spur.

In November 1981 claimant became employed at Fairview Hospital and Training Center as an aide. Claimant's preexisting bone spur in her left heel became symptomatic in August 1982 due primarily to extensive time spent on her feet on hard floors at work. After the heel became symptomatic, claimant avoided putting pressure on it by walking on the ball of her left foot. As a result, she developed plantar fasciitis and tendinitis of the left Achilles tendon.

Claimant sought medical treatment for the tendinitis in October 1982. Dr. Craven prescribed a shoe insert. Claimant quit work in February 1983, in part due to her foot condition. After leaving work, claimant's symptoms gradually resolved. By April 1983 the pain was gone.

Dr. Craven explained in September 1984 that a calcaneus bone spur can often be present without symptoms, and that these are often a sign of inflammation around the heel and not the actual cause of the problem. Because he had not seen claimant since October 1982, he suggested reexamination. After reexamining claimant in November 1984, he stated:

> "From the history she gave me, and from what [claimant's attorney] gave me in [his] recent letter, I do believe that her work activities are more likely responsible for her heel pain. The pain in her heel started in approximately August 1982, while she was at work in Fairview, and lasted until she had to quit work. I would think her on-the-job activities were the major factor in her problems with her feet, as opposed to her duties off the job."

In Weller v. Union Carbide, 288 Or 27, 35 (1979), the court held that to prevail in an occupational disease claim involving a preexisting pathological condition, claimant must prove by a preponderance of the evidence that the work activity and conditions caused a worsening of the underlying condition resulting in an increase in pain to the extent that it produces disability or requires medical services. Accord Wheeler v. Boise Cascade, 298 Or 452 (1985). The Referee reasoned that since the bone spur was preexisting and the evidence does not preponderate that the work activities and conditions caused it to worsen other than symptomatically, and since the tendinitis and fasciitis were due solely to an altered gait due to pain caused by the noncompensable bone spur, the tendinitis and fasciitis were also noncompensable.

Claimant's Achilles tendon and plantar fascia were not pathological before she began her employment at Fairview Hospital and Training Center. Weller is inapplicable where there is no preexisting pathology. The record demonstrates that claimant's work activities caused the Achilles tendon and plantar fascia to become inflamed, resulting in pain and requiring medical services. That claimant's work activities may have affected the tendon and fascia in a way that they might not otherwise have, absent the altered gait, does not change the fact that the work activities caused the new inflammation. Claimant's work activities were the major contributing cause of the tendinitis and fasciitis. Accordingly, compensation for those conditions is warranted. See Saif v. Gygi, 55 Or App 570, 574, review denied, 292 Or 825 (1982).

ORDER

The Referee's order dated February 14, 1985 is reversed. The SAIF Corporation's denial of compensability of claimant's foot condition is set aside as to claimant's tendinitis of the left Achilles tendon and left plantar faciitis, and the claim is remanded to SAIF for acceptance and processing according to law. Claimant's attorney is awarded $800 for services at hearing, plus $400 for services on Board review, to be paid by the SAIF Corporation.

KATHERINE OLLISON, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-08584
September 17, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Neal's order that: (1) affirmed the Determination Order granting claimant temporary total disability for two days only, August 19 and 20, 1983; (2) denied claimant's request for penalties and attorney fees for SAIF's alleged unreasonable refusal to pay temporary disability; and (3) denied claimant's request for penalties and attorney fees for SAIF's alleged unilateral termination of claimant's temporary disability. The issues on review are claimant's entitlement to temporary disability beyond the date provided in the Determination Order, and penalties and attorney fees.

Claimant is a nursing assistant who developed scabies in

August of 1983 while employed at a nursing home. She was pregnant at the time of her exposure. She visited Dr. Rajdev on August 16, and the physician gave claimant a "disability slip" authorizing a release from work from August 16 through August 20, 1983. On August 20, Dr. Rajdev issued a second slip that released claimant to return to work effective that date. Claimant did return to work on that date, but was told that the scabies was spreading. Claimant left work and did not return.

Claimant apparently told her doctor that scabies was spreading throughout the worksite, for on August 26, 1983 Dr. Rajdev issued a third slip stating: "[Claimant] is advised to stay off work until possible sources of the infection are. . ." Unfortunately, the remainder of the note is illegible and no evidence was produced at hearing to clear up the meaning of the note. A review of the remaining record, however, suggests that Dr. Rajdev wished to keep claimant away from the worksite due to her pregnancy. The treatment of scabies involves the topical application of a toxic substance that might have implications for a pregnancy. Claimant testified that Dr. Rajdev instructed her not to return to work while the disease was communicable, either by her or by other patients at the nursing home.

Claimant continued to be contagious despite the treatments she received from Drs. Rajdev, Cohen and Kitterman. She did not cease being contagious until sometime after December 28, 1983 when Dr. Kitterman first began treating her. By January 19, 1984 claimant's condition had apparently resolved.

On review, claimant argues that even though Dr. Rajdev released her to return to work on August 20, 1983, the doctor's subsequent note of August 26th operated to rescind the release. Claimant argues that she was entitled to continuing temporary total disability compensation until she became medically stationary, returned to work or was released to return to work. See Jackson v. SAIF, 7 Or App 109 (1971). Claimant further argues that because she was contagious through the end of 1983, and allegedly into mid-January of 1984, she was precluded from returning to work as a result of her industrial exposure, thereby giving rise to entitlement to temporary disability compensation until she was no longer contagious and unable to work.

SAIF argues that the effect of Dr. Rajdev's August 26th note advising claimant to stay off work was merely to keep claimant from incurring further exposure to the disease. SAIF argues that there is a difference between not wanting to be further exposed and the ability to do work. It suggests that claimant would clearly have been able to resume her duties if she had returned to work, and the fact that she did not do so because of a fear of further exposure should not be the responsibility of the insurer.

After reviewing the arguments, we agree with claimant that her exposure to scabies initially forced her to leave work, and that her remaining contagious condition effectively precluded her from returning until she was no longer infectious. Perhaps claimant could have performed her job duties if she had been able to do so in isolation. The nature of claimant's nursing job, however, involves frequent contact with others. It simply makes no sense to conclude that claimant could perform nursing duties without making contact with the patients whom she is employed to serve. We find, therefore, that claimant was temporarily totally disabled from

August 16, 1983 through the date she was last contagious. We find that date to be December 28, 1983, the date Dr. Kitterman last confirmed that claimant was still suffering from scabies. There is evidence that claimant may have remained contagious after that date, but it is not persuasive.

The remaining issues involve penalties and fees. Claimant alleges that it was unreasonable for SAIF to ignore Dr. Rajdev's August 26th note rather than conducting an investigation to determine its meaning. We agree. SAIF had a duty to process the claim using all of the information in its possession. That information included Dr. Rajdev's August 26th note. Although the note is somewhat cryptic, we find that it was sufficiently clear to have triggered SAIF's duty to investigate whether it was responsible for additional temporary disability.

Likewise, we think it was unreasonable for SAIF to unilaterally terminate claimant's temporary disability when it did. By way of stipulation, SAIF agreed to pay temporary disability until the time claimant's claim could be properly closed pursuant to ORS 656.268. SAIF apparently relied on Dr. Rajdev's August 20, 1983 note to conclude that claimant was released to return to work. Again, however, SAIF ignored Dr. Rajdev's note issued six days later that arguably rescinded the earlier release. Once it received the August 26th note, SAIF had a duty to investigate further. Its failure to do so was unreasonable.

ORDER

The Referee's order dated March 21, 1985 is reversed in part and affirmed in part. Those portions of the order that affirmed the Determination Order granting temporary disability for August 19 and 20, 1983, and which denied claimant's request for penalties and attorney fees for SAIF's alleged improper claims handling are reversed. Claimant is awarded temporary total disability compensation for the period from August 16, 1983 through December 28, 1983. SAIF is assessed a penalty in the amount of 25% of the compensation due claimant. Claimant's attorney is allowed 25% of claimant's increased temporary total disability compensation, not to exceed $750. In addition, for prevailing on the penalty issue, claimant's attorney is awarded a fee of $250, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

CHRISTOPHER M. RIDDLE, Claimant
ELLIS L. PETTYJOHN, Employer
Joseph T. McNaught, Claimant's Attorney
Winter & Daugherty, Attorneys
SAIF Corp Legal, Defense Attorneys
Carl M. Davis, Ass't. Attorney General

WCB 84-02879 & 84-03207
September 17, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order that: (1) found claimant not to have been a subject worker at the time of his accidental injury; and (2) found that claimant's alleged employer was not in fact a noncomplying subject employer. The issues on review are the compensability of claimant's claim and the status of the alleged employer.

Claimant was injured on January 8, 1981 when a wheat truck he was driving left the road, jostling him around in the cab and

causing injuries to his neck. There is no question that the accident occurred or that claimant was injured thereby. The question is whether claimant was a subject worker of an alleged subject employer at the time of the accident.

The alleged employer is Ellis Pettyjohn. Pettyjohn, along with his brother and son, lease two acreages near Heppner where they grow wheat. Ellis Pettyjohn also occasionally acts as foreman on a ranch owned by Bill Bafus. In the past, claimant has worked for both Pettyjohn and Bafus as a ranch hand. It appears that when claimant worked for Bafus, he would sometimes ask Pettyjohn, in his capacity as Bafus's foreman, for an advance on what Bafus owed him. Pettyjohn would then advance claimant his pay from his own pocket and later take reimbursement from Bafus. This arrangement apparently went on for several summers prior to 1981.

Claimant also worked directly for the Pettyjohns a few times between 1977 and 1981. He testified that while he worked for Pettyjohn he was paid either at a rate of $3.50 to $4.00 per hour or $50 per day.

Sometime before the accident at issue, claimant was injured by a bull. The resulting injuries kept him from doing his regular ranch work, but he continued to attempt lighter work. In January of 1981 he heard that the Pettyjohns would be transporting 14,000 bushels of wheat from the Heppner area to a storage site near the community of Ione. Claimant approached Ellis Pettyjohn about the possibility of helping out with the transport. Pettyjohn testified that he told claimant he did not need help because there were three Pettyjohns to operate the three transport trucks available. A fourth man was not needed. Claimant persisted, however, and Pettyjohn eventually allowed claimant to drive.

It is uncontroverted that Pettyjohn and claimant never discussed whether nor how much claimant would be paid for transporting the wheat. Claimant testified, however, that he expected to be paid for the work as he had been in the past. It is also uncontroverted that once claimant did in fact drive, Pettyjohn generally directed his activities, telling where to pick up and deliver the wheat.

On claimant's second day, the wheat truck developed brake trouble. Pettyjohn asked claimant to take the truck to Heppner and leave it at a service station for repairs. Claimant took the truck to Heppner, but instead of leaving it at the service station and returning to the ranch, claimant waited for the truck to be repaired. It was on the way back to the ranch after the repairs were made that claimant's accident occurred.

Claimant was hospitalized with neck pain. While in the hospital he was visited by Pettyjohn, who later gave claimant's father $40 to give to claimant. Pettyjohn considered this a gift rather than wages for employment. He had made similar gifts to claimant in the past, and had allowed him to eat and stay with the Pettyjohn family from time to time when claimant was not working and out of money.

The Referee found the claim to be not compensable, and Pettyjohn not to be a subject employer as that term is used in ORS 656.023. The Referee also held claimant's employment to be

"casual," ORS 656.027(3), and that claimant was on a "deviation" from his work at the time of his injuries by virtue of his not following his employer's specific instructions.

The Referee did not address what we deem to be the fundamental question in this case, i.e., whether there was a contract for hire between claimant and Pettyjohn at the time of claimant's accident. In order for an accidental injury to be compensable, it must arise out of and in the course of employment. ORS 656.005(8)(a). "Employment" is a relationship between an employer and an employe evidenced by a contract for hire, be it express or implied. Hix v. SAIF, 34 Or App 819 (1978).

We find Hix, as well as John R. Dayton, 37 Van Natta 210 (1985), instructive in resolving the fundamental contractual issue in this case. In Hix, the claimant was a 16-year-old who suffered an arm injury while working on a lime plant conveyor belt. The claimant's father had been assisting the owner of the plant, and the claimant accompanied him to the plant as a way of spending extra time. While the lime was being processed, the claimant performed work that clearly benefitted the employer. The amount of time the claimant actually spent working, however, was small.

At one point, the employer gave the claimant's father a check for the work and instructed the father to give $40 from the check to the claimant for the work he had performed. The employer later gave claimant an additional $100 "to buy school clothes."

The employer testified that he did, in fact, ask the claimant to do certain chores around the plant, but that he did not feel that he had the right to control the claimant's activities. The evidence was that the claimant generally showed up at the plant unannounced and performed work at his leisure.

The court found the claimant's performance of services to be "gratuitous." Hix, 34 Or App at 824. It found that although the employer did ask the claimant to perform chores, he could not rely in advance on the claimant's presence, nor could he expect to exercise control over the claimant's activities. The court further found that the amounts of money paid to the claimant were more in the form of the employer's moral recognition to remunerate the claimant for the work that he had done than wages arising from a contractual relationship. Id.

In John R. Dayton, supra, the claimant was a nephew of the alleged employer when he was hurt on the employer's farm. The claimant regularly assisted his cousin, a son of the employer, in doing his chores around the farm. When the cousin would receive his allowance he would give half of it to the claimant for the work he had done. The employer knew that the boys were sharing the allowance. The claimant also assisted his cousin in a hay-hauling job, for which the cousin was given a check for $70. Everyone, including the employer, knew that the claimant was to receive half of this payment. The claimant received one additional payment of $20, which the employer characterized as a Christmas gift and the claimant characterized as wages.

The Board held that there was no contract for hire. It found that the employer's knowledge that the claimant was receiving a portion of his cousin's allowance did not amount to an implied contract between the employer and the claimant. The Board also found the element of control to be lacking, for although the

employer did tell the claimant what to do from time to time, the direction was not offered pursuant to an expectation that the claimant would have to perform or be fired. Dayton, 37 Van Natta at 213.

Although the present case is not on all fours with either Hix or Dayton, we find that the conclusions reached in those cases are applicable herein. We read Hix and Dayton to require that there be, at a minimum, a meeting of the minds between the employer and the employe with regard to what work is to be done, for how long and for what wage. In Hix and Dayton, the relationships between the employer and employe were so ill-defined that it could not be said that there was a meeting of the minds with regard to the elements requisite to a contract for hire. We find the same to be true in the present case.

The relationship between claimant and the alleged employer bordered on the familial. Claimant spent a great deal of time with the employer and his family in his times of need. He had been the recipient of gifts from the employer and appears to have been treated almost like a son. It is uncontroverted that the employer did not need the services of claimant on the day he was injured; rather, the employer acquiesced to claimant's repeated requests to help out. There was no discussion of wages and the employer's control over claimant's activities was limited.

We find that there could have been no reasonable expectation on the part of either claimant or the alleged employer that a contract for hire, express or implied, existed at the time of claimant's injuries. Rather, we find claimant's "employment" was gratuitous, and the payment made indirectly to him by the employer was made out of a sense of moral obligation rather than pursuant to an employment contract. Because there was no contract for hire, claimant was not a subject worker. Oremus v. Ore. Publishing Co./Leibrand, 11 Or App 444 (1972).

Even if we were to find sufficient evidence of an employer/employe relationship, we would be unable to conclude that claimant has established his status as a subject worker. ORS 656.027 provides that all workers are subject workers, except those specifically exempted by the statute. ORS 656.027(3) exempts "casual" workers from the subject worker category. A "casual" worker is one whose employment is either not in the course of the employer's trade, business or profession, or is in the course of that trade, business or profession, but the employer is nonsubject. For purposes of the statute, "casual" refers to employments in which the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200.

The issue of "casual" employment was thoroughly discussed in Konell v. Konell, 48 Or App 551 (1980), rev den, 290 Or 449 (1981). In that case, the claimant was the nephew of the alleged employer. He had worked for his uncle during the summer months for two years prior to his injury in late 1977. When the claimant worked, it was merely for a few days at a time.

In December 1977 the claimant approached his uncle for a job and the uncle indicated that the claimant could help out "for a few days." Although the testimony was in conflict regarding what claimant was to be paid, the court found that claimant's wage rate

was to be $3.00 per hour. Neither was there agreement on the length of the employment, although the most reliable evidence was that the work would be for a "few days" per week over a two-week period.

The court found that a determination of the period of employment was central to its decision, for the length of the job had bearing on the question of how much the claimant would have worked and, thus, earned but for his injury. Id. 48 Or App at 556. The court placed on the claimant the burden of proving that the alleged employer's labor costs would exceed the statutory amount of $200 in any thirty day period. Id., at 557. The court further found that the claimant had failed to sustain that burden in that even if the claimant had continued to work uninjured, his wages during the work period would not have exceeded $200. The claimant's employment was deemed "casual." Id.

The court noted that even though the claimant's employment was casual, he could still prevail unless it was established that the alleged employer was nonsubject. Buckner v. Kennedy's Riding Academy, 18 Or App 516, rev den (1974). Because the court had found that the claimant was not a subject worker, it assigned him the burden of establishing that the employer employed another "subject worker," as the phrase is defined by statute. ORS 656.005(28); Konell, supra, 48 Or App at 557-58. Because it could not be shown that the employer employed other subject workers, the claimant was held to have no claim against the alleged employer.

Konell is very similar to the present case. The most reliable evidence here reveals that claimant would have been paid $3.00 per hour (if at all) for a period of up to six days while Pettyjohn's wheat was being transported. The evidence also reveals that claimant would likely have worked approximately six hours on each of those six days. Thus, claimant's total number of hours for the six day work period would have been 36. At $3.00 per hour, his total wage would have been $108.00, a figure far below the statutory minimum of $200.00. Claimant's employment was casual.

As in Konell, however, claimant can still prevail if he can establish that Pettyjohn was a subject employer by virtue of his employing other subject workers. On review, claimant asserts that Pettyjohn's brother and son were "employees" because Ellis Pettyjohn made most of the decisions regarding the harvesting and sale of the family wheat. After reviewing the record, however, we find that the relationship between the three Pettyjohns was more a partnership than a relationship between an employer and his workers. Although Ellis Pettyjohn did take the lead in many family transactions, he had no expectation that he could control the activities of his brother and son, and the money generated from the sale of wheat was split equally among the three family members.

There is insufficient evidence to support a finding that Pettyjohn employed any subject worker at the time claimant was injured. This being so, he was not a subject employer as defined in the Workers' Compensation Law. ORS 656.023. Claimant's employment was casual. He has failed to establish a valid claim.

ORDER

The Referee's order dated January 17, 1985 is affirmed.

RONNIE L. SIEBEN, Claimant
Velure & Bruce, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-08395
September 17, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Thye's order that affirmed the SAIF Corporation's denial of claimant's low back aggravation claim. The issue on review is compensability.

We affirm the Referee's order with the following comment. The Referee characterized this case as one arising under ORS 656.245 because claimant's original claim, which was accepted as nondisabling, was never closed. Subsequent to the Referee's order we decided Deborah L. Greene, 37 Van Natta 575 (1985); and Garland Combs, 37 Van Natta 756 (1985). In Greene and Combs, we held that where a claimant fails to either request a hearing or claim that a nondisabling injury has become disabling within one year from the date of the injury, a subsequent claim for temporary total disability compensation and medical services for an alleged worsened condition must be treated as a claim for aggravation. ORS 656.262(12), 656.273(4)(b). In the present case, claimant neither requested a hearing nor claimed that his claim had become disabling within a year of his injury. His later claim should have been treated as one for aggravation.

After reviewing the record, we find that claimant has failed to prove a compensable worsening of his condition since the last arrangement of compensation. ORS 656.273(1).

The Board affirms the order of the Referee.

ORDER

The Referee's order dated November 21, 1984 is affirmed.

RANDALL S. WILLIAMS, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys

WCB 83-04958 & 83-07351
September 17, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Farmers Insurance Group requests review of Referee Podnar's order that set aside its denial of claimant's claim for his low back condition. The issue is responsibility for claimant's low back claim as between Farmers and EBI Companies. The compensability of claimant's low back condition is not contested by either insurer.

Claimant first injured his back in 1978. The injury resolved and claimant was awarded no permanent disability. On March 5, 1981 claimant injured his low back while lifting a five-gallon water cooler weighing approximately 50 pounds. At the time, he was employed by Farmers' insured as a carpenter. He ultimately required surgical decompression of the L5 nerve roots and a fusion of L5-S1. He was off work for about 15 months. After being released to work, claimant worked for a time as a scoop loader operator without incident, although claimant testified that he experienced low back pain more or less continuously.

On September 1, 1982 claimant began working for EBI's insured as a carpenter. On September 2, 1982 claimant slipped and fell through joists about two-and-a-half feet to the ground, jarring his back. Claimant testified that his back pain immediately increased, but that he was able to complete his shift that day. The next day, September 3, 1982, claimant again experienced increased back pain while lifting a 50-pound box of nails. He did not complete his shift and had not worked since that date, as of the hearing.

The medical evidence is far from clear as to whether claimant's present disability is an aggravation of the 1981 injury and subsequent surgery or is the result of new injury in September 1982. Claimant's treating orthopedic surgeon, Dr. Boyd, has expressed what appear to be both views at one time or another. The Orthopaedic Consultants opined that claimant's back fusion was not solid prior to the September 1982 incidents, but that claimant probably sprained the joint above the fusion in September 1982, thereby increasing his back pain. What is clear to us is that the lifting incident in 1981 and the lifting incident in 1982 involved identical, or so nearly so as to make no significant difference, insults to claimant's low back.

In Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-45 (1984), the Supreme Court explained the "last injury rule" thusly:

> "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."

Prior to the Supreme Court's decision in Starbuck, we stated in Duane Kearns, 35 Van Natta 772, 777 (1983), aff'd, Industrial Indemnity v. Kearns, 70 Or App 583 (1984):

> "When there are multiple accepted injuries involving the same body part, we will assume that the last injury contributed independently to the condition now requiring further medical services or resulting in additional disability, and the employer/insurer on the risk at the time of

> the most recent injury has the burden of proving that some other accepted injury last contributed independently to the condition which presently gives rise to the claim for compensation . . . ."

In affirming our order, the Court of Appeals, with the benefit of the Supreme Court's Starbuck decision, said:

> "Under the Board's rule, a rebuttable presumption exists that a claimant's last industrial injury contributed independently to the worsened condition and that the insurer at that time is responsible. We conclude that that approach is not inconsistent with the Supreme Court's language [quoted in part supra] in Boise Cascade Corp. v. Starbuck . . . ." 70 Or App at 587.

We believe this is exactly the kind of case contemplated by the court in Starbuck. As noted there, and earlier in Bracke v. Baza'r, 293 Or 242, 245-46 (1982), public policy supports application of the "last injury rule" in successive injury cases by assuring that the worker is compensated and by dispensing with the need for costly, and frequently barely possible, allocation of partial responsibility amongst multiple insurers. We find the evidence in this case, both medical and lay, to be inconclusive as to which of claimant's two relevant employments is the cause of his present claim for compensation. That is, we are "unconvinced that any one employment is the more likely cause of [claimant's] disability . . . ." Boise Cascade v. Starbuck, supra, 296 Or at 238. EBI Companies has not carried its burden of showing that another employment last contributed independently to claimant's condition. Accordingly, we find EBI Companies to be responsible for claimant's condition.

ORDER

The Referee's order dated December 30, 1983 is modified. EBI Companies is hereby declared to be the responsible insurer in this matter, pursuant to ORS 656.307. The Farmers Insurance Group's denials dated October 25, 1982 and July 20, 1983 are reinstated and affirmed. EBI Companies shall reimburse the Farmers Insurance Group any monies paid on account of the Referee's order. The reasonable attorney fee awarded to claimant's attorney at the hearing level shall be paid by EBI Companies, in addition to and not out of any compensation due claimant.

LAWTON W. WROE, Claimant
Emmons, et al., Claimant's Attorneys
Daniel J. DeNorch, Defense Attorney

WCB 84-13449
September 17, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Liberty Northwest Insurance Corporation requests review of Referee Michael Johnson's order which: (1) found the claim continued in open status; (2) affirmed the Determination Order dated December 3, 1984 which set aside it's Notice of Closure as

statutorily incorrect; (3) awarded a 20% penalty for unreasonable refusal to pay compensation ordered by the Determination Order; and (4) awarded $1500 for prevailing on a denied claim and $300 penalty associated attorney fees. Liberty Northwest requests relief in the form of findings that: (1) compensation paid for the period June 12 through September 27, 1984 was gratuitous and an overpayment; (2) the Notice of Closure was correct; (3) the Determination Order was incorrect; (4) claimant's demand for compensation after the Notice of Closure was an aggravation claim; (5) claimant's condition did not worsen after the Notice of Closure; (6) any compensation paid to claimant pursuant to either Referee's order constitutes an overpayment; (7) unilateral termination of benefits without closure by Notice of Closure or Determination Order was correct; (8) the denial issued after the Determination Order was reasonable; and (9) "claimant failed to sustain his burden of proving by a preponderance of the evidence the circumstances justifying prior termination of time loss benefits no longer existed due in material part to the effects of his compensable condition and affirm the insurer's denial of December 27, 1984." Liberty Northwest argues that the Referee's failure to accept its characterization of the issues at hearing led to error in finding the claim continued in open status and awarding penalties and attorney fees.

In addition to the review requested in this case, Liberty Northwest requested review of Referee Seymour's order which found the claim compensable and requested reconsideration of the Board's order dated May 31, 1985 which affirmed Referee Seymour's order. In addition to the requests for review and reconsideration, Liberty Northwest requests consolidation of the two claims and expedited review. Liberty Northwest also submitted the affidavit of a senior claims examiner in support of its motions for reconsideration, consolidation and expedited review.

The issues of reconsideration and consolidation are discussed and decided in the Board's order issued this same date in the companion case, WCB Case No. 84-00779. Reconsideration of the Board's original order affirming the Referee was granted and the Board adhered to its original order; therefore, the claim was compensable. This record contains the documentary evidence which was submitted at the first hearing in addition to the documents generated since the first hearing relating to processing of the claim after the initial order setting aside Liberty Northwest's denial. Consolidation of the two cases was denied.

The affidavit submitted by Liberty Northwest was considered only in the context of the motion for expedited review. There is no provision for expedited review in either statute or administrative rules but, in any event, the request for expedited review was moot because both cases had been docketed and were before the Board for review at the time of the request. Although we usually consider the submission of documents to be in the nature of motions to remand, in this case the submitted affidavit is more in the nature of a short statement of Liberty Northwest's theory of the case and a plea for relief. To the extent the affidavit could be considered a motion to remand, the motion is denied. To the extent the affidavit could be considered a motion to expand the record, the motion is denied.

The issues on review as framed by Liberty Northwest are:

"1. In either an open or closed claim, is a carrier entitled to issue a denial of time loss benefits when it disputes the authorizaton for those benefits?

"2. Must a carrier pay time loss benefits pursuant to a time loss authorization where all medical evidence and lay testimony establish the compensable condition was never disabling, is medically stationary and has completely resolved without residuals at the time the authorization is issued?

"3. Has claimant established entitlement to time loss benefits for any period before or after September 28, 1984?"

Claimant responds that the issues Liberty Northwest raises were reserved by the Referee and that the issues are unilateral termination of temporary total disability compensation and the insurer's failure to comply with the Department's December 3, 1984 order setting aside the Notice of Closure.

The issues on review are the limitation of the issues considered by the Referee, claimant's entitlement to temporary disability compensation, reasonableness of Liberty Northwest's actions in disregarding the Determination Order, and reasonableness of Liberty Northwest's December 1984 denial of compensability.

I

In May 1983 claimant injured his low back while working for an employer insured by the SAIF Corporation. Claimant obtained treatment and lost time from work. In September 1983 claimant obtained employment at a seed warehouse insured by Liberty Northwest. In October 1983 claimant injured his cervical spine in the course of his employment. Lawton W. Wroe, 37 Van Natta 1239 (WCB Case No. 84-00779, Sept. 17, 1985). Claimant obtained chiropractic treatment from Dr. Burdell, who reported on the First Medical Report that claimant had a cervical sprain and lumbosacral sprain and that claimant was released to return to regular work but would need chiropractic treatment over the next six to ten weeks. Then Dr. Burdell opined on November 9, 1983 that claimant was medically stationary, had returned to his pre-injury condition, and would have no permanent impairment from his industrial injury. On November 18, 1983 Dr. Clibborn examined claimant and assumed chiropractic treatment of claimant's upper and lower back complaints and reported that claimant was not released to return to work due to his cervical spine condition. Dr. Clibborn wrote a letter on November 28, 1983 to claimant's counsel which does not support the earlier report that claimant was unable to return to work due to the cervical spine injury as opposed to the low back injury for which SAIF was responsible. On November 30, 1983 Dr. Burdell reported that he considered claimant recovered from his cervical spine injury and that claimant had transferred his care to Dr. Clibborn. On December 7, 1983 Dr. Burdell reported that claimant had suffered no time loss due to his cervical spine injury. On December 30, 1983 Liberty Northwest issued its general denial.

On January 23, 1984 claimant was examined for the first time by Orthopaedic Consultants. Drs. Logan, Noall and Kloos attended the examination. They found claimant had no injury to his cervical spine, "just symptoms secondary to overhead lifting." They also noted that claimant was not a candidate for a laboring type occupation because of his obesity and lack of muscle tone.

On March 14, 1984 Dr. Clibborn wrote a letter to claimant's counsel in which he reported that claimant's cervical spine problem did not keep him from working but that the condition was continuing to improve with chiropractic treatment; therefore, claimant's condition was not medically stationary. Dr. Clibborn reported that claimant's low back condition, which was SAIF's responsibility, was disabling and prevented claimant from working.

In April 1984 claimant was referred to the Callahan Center. Dr. Skelley opined that claimant was limited to performing work in the medium range due to his obesity and physical conditioning but that claimant had no limitations related to his cervical spine injury. In May 1984 after claimant returned home from the Callahan Center, Dr. Clibborn reported that claimant was still not medically stationary nor released to return to work.

On June 12, 1984 claimant was again examined by Orthopaedic Consultants. Drs. Logan, Boyden and Rich attended the examination. They reported that claimant's physical examination findings were completely normal and they thought claimant should discontinue chiropractic care because it was detrimental. They noted that claimant had made no attempt to exercise or lose weight.

In June 1984 SAIF denied responsibility for claimant's cervical spine condition. In July 1984 a Determination Order issued on SAIF's low back claim which awarded claimant temporary disability compensation only. In August 1984 Liberty Northwest requested SAIF's medical file relative to claimant. Claimant requested hearings on the extent of his disability due to his low back injury, covered by SAIF, and on the denial of his cervical spine condition, covered by Liberty Northwest. On September 21, 1984 Referee Seymour's order was published. Referee Seymour found that claimant's cervical spine condition was compensable. In his companion order, the Referee found that SAIF was not responsible for claimant's cervical spine condition and affirmed the Determination Order.

On September 25, 1984 someone at Liberty Northwest wrote a memorandum to the file to pay claimant temporary disability compensation by October 5, 1984 if it was authorized. On October 2, 1984 someone wrote a memo to claims representative Lewis requesting that she verify dates of temporary total disability. On October 4 Lewis called Dr. Clibborn's office and learned that claimant had been authorized time loss since October 26, 1983 that time loss was still authorized, and that claimant was still undergoing curative treatment. Lewis determined that temporary total disability compensation should be paid for 45 weeks from November 18, 1983 through September 27, 1984. On October 5, 1984 Liberty Northwest sent a Form 1502 to the Workers' Compensation Department notifying the Department that the claim was now in accepted status and that it was classified as disabling. Also on October 5, 1984 Liberty Northwest sent claimant a draft for $4,834.71 with a letter signed by senior

claims examiner Sapp. On October 10, 1984 Liberty Northwest sent a letter to Dr. Clibborn requesting medical and time loss information. On October 12, 1984 someone wrote a memo to Lewis advising that the payment of temporary disability compensation to claimant was in error, that it was overpaid even if any compensation was due, that return of the money should be pursued, that the Form 1502 should be amended to show the claim as non-disabling, that a Notice of Closure should be issued forthwith, and that coordination should be worked out with the SAIF Corporation regarding apportionment of the temporary disability compensation between them. On October 19, 1984 senior claims examiner Sapp signed and sent a Notice of Closure which stated: "We find that medical treatment for this injury or disease has been completed and no permanent disability resulted; therefore, you are entitled to compensation for temporary disability during the period(s): 11/18/83 thru 9/27/84." Also on October 19 senior claims examiner Sapp signed a Form 1502 which clearly stated that it was issued to rescind the October 5 Form 1502, but which clearly showed that Liberty Northwest considered the claim was disabling and notified the Department that it was correcting the wage or temporary total disability rate. On October 25 Lewis wrote a letter to claimant's attorney requesting the dates SAIF had paid temporary disability compensation and the return of the $4,834.71. Lewis also notified claimant's attorney that Liberty Northwest was going to issue a corrected Form 1502 showing the claim was for a non-disabling condition.

On November 2, 1984 someone wrote another memo to Lewis advising her to contact SAIF and send another Form 1502 because the October 19 report still showed the claim as disabling. Also on November 2, 1984 Dr. Clibborn reported that claimant had been authorized time loss since September 28, 1984 which was the day after Liberty Northwest's termination of benefits, and that claimant continued to be non-stationary and was not released to return to work. On November 19 claims examiner Howden signed a Form 1502 which changed the status of the claim to non-disabling along with a Form 1503 which notified the Department that the temporary disability compensation paid was considered an overpayment and that Liberty Northwest was requesting a Determination Order based on a statutory qualification for closure as of March 14, 1984. On November 21, 1984 the Evaluation Division of the Workers' Compensation Department requested copies of all medical and other records on which Liberty Northwest based the Notice of Closure. On November 28 claims examiner Howden signed another Form 1502 which changed the status of the claim back to disabling but continued to report an overpayment of temporary disability compensation. On December 3, 1984 Lewis initialed a statement indicating that the request from the Department had been complied with. On December 3, 1984 the Department issued its Determination Order which rescinded the Notice of Closure because the "claim did not qualify statutorily for closure when the Notice of Closure was issued." On December 6, 1984 claimant's attorney requested payment of temporary disability compensation pursuant to Dr. Clibborn's authorization and payment of Dr. Clibborn's bills. On December 20, 1984 Dr. Clibborn answered Liberty Northwest's October 10 letter. Also on December 20 the Board received claimant's December 19, 1984 hearing request which specified the issues of temporary total disability, penalties and attorney fees, and failure to reimburse for transportation expenses. On December 27, 1984 Lewis sent a denial letter which stated:

"Reviewing your file we find that we received this information on December 14, 1984 and feel we are prejudiced by this and we must respectfully deny your application for compensation benefits as well as compensability. We suggest you look through [sic] your group insurance carrier for assistance."

On December 27, 1984 senior claims examiner Sapp signed a Form 1502 which reported that it was the first report of a claim for aggravation, that Liberty Northwest was denying, that the claim was disabling, that there was no compensation due, and that the first Notice of Closure was dated October 19, 1984. On December 31, 1984 the Board received Liberty Northwest's response to claimant's hearing request denying that claimant was entitled to additional temporary disability compensaton or penalties and attorney fees. On January 3, 1985 the Board received claimant's December 28, 1984 application to schedule a hearing which listed as an issue the denial of December 27, 1984 along with a supplemental hearing request. Also on January 3, 1985 the Board received Liberty Northwest's response which denied that claimant sustained a work-related accidental injury or occupational disease and repeated the denial of additional temporary disability compensation and which cross-requested a hearing to affirm the denial.

On January 22, 1985 claimant attended his third examination by Orthopaedic Consultants. The examiners were Drs. Logan, Case and Rich. They commented on claimant's obesity. They found that claimant's back was normal and that he had no cervical disease. They recommended that chiropractic treatment stop. In conjunction with the Orthopaedic Consultants' examination, claimant was examined by Dr. Colbach, psychiatrist. Dr. Colbach diagnosed malingering or overfocus on pain to meet psychological needs, chronic pain and obesity, and a mixed personality disorder of the dependency-inadequacy type. He commented that claimant and his wife had become closer since they began sharing pain complaints related to industrial injuries. Dr. Colbach reported that the chiropractic care was not curative but was addictive.

On January 28, 1985 SAIF notified Liberty Northwest of the dates it had paid temporary disability compensation to claimant: May 25 through June 22, 1983 and November 28, 1983 through July 11, 1984.

On February 5, 1985 counsel for Liberty Northwest wrote an explanation letter to claimant's attorney and referred to a letter from claimant's attorney to Presiding Referee Daughtry which was not included in the record. Liberty Northwest amended its December 27, 1984 denial by the letter of February 5. Liberty Northwest asserted that it was prejudiced by its late receipt of Dr. Clibborn's retroactive time loss authorization, that it did not believe that claimant had a compensable worsening of his cervical spine condition since November 9, 1983 and that claimant had never had a disabling condition of his cervical spine. On February 5, 1985 Dr. Burdell, claimant's original attending physician, conducted an independent medical examination. Dr. Burdell opined that claimant was no worse than the last time he was examined in November 1983, that claimant had a slight nerve

root compression, that claimant had no disability at that time, and that claimant was not precluded from working by his cervical spine condition.

The hearing convened on February 14, 1985. The Referee issued his opinion on March 19, 1985. On March 26 Liberty Northwest requested reconsideration and abatement of the Referee's order. A conference call was held among the Referee and the parties on March 29 at which time the Referee advised the parties that he would not reconsider nor abate his order and he issued a formal order the same date. On April 1, 1985 Liberty Northwest requested review of WCB Case No. 84-13449. The Board issued its Order on Review in WCB Case No. 84-00779 on May 31, 1985 and on June 20, 1985 the Board received Liberty Northwest's June 18 request to reconsider the Order on Review in WCB Case No. 84-00779, consolidate WCB Case No. 84-00779 with WCB Case No. 84-13449, and expedite review of the consolidated case.

II

At hearing, claimant stated the issues were unreasonable unilateral cessation of time loss benefits, penalties and attorney fees, and failure to reimburse transportation expenses. Liberty Northwest attempted to convince the Referee that its issues of restoring the Notice of Closure and setting aside the Evaluation Division's order were the same as claimant's time loss issue. The insurer based its argument to the Referee on its contention that the claim was for a non-disabling injury that had been closed without need of formal closing. It argued that the formal closing that was issued was to satisfy a technical requirement of the Workers' Compensation Department that had nothing to do with this claim. Then, based on these contentions, Liberty Northwest requested authorization to recoup temporary disability compensation already paid from any future benefits that might be awarded to claimant.

Liberty Northwest admitted that the draft for $4,834.71 was sent to claimant through its own fault by not coordinating the files between its legal and claims departments. Liberty Northwest admitted that it failed to send the requested medical information generated since March 1984 to the Evaluation Division although it characterized the failure as the Department's. It also admitted that the Department would probably have rescinded it's Notice of Closure even if it had been provided the full medical file. Liberty Northwest then characterized the denial as for an aggravation claim submitted after proper closing. At the time of the denial the closing had been set aside by the Department's order. The denial itself notified claimant that Liberty Northwest considered that the injury had never been disabling and the clarification did not retract that aspect of the denial. Claimant insisted that he was not prepared to litigate an aggravation claim because he had not presented an aggravation claim to Liberty Northwest because the claim was still open according to the Evaluation Division's order.

The Referee decided that the issues to litigate were to be those issues identified by claimant. Claimant relied on Dr. Clibborn's continuing authorization of time loss and his continuing opinion that claimant was not medically stationary. Liberty Northwest contended that claimant was never authorized time loss. The Referee upheld the Department's order that set aside Liberty Northwest's Notice of Closure and reopened the claim.

We find that the Referee should have considered Liberty Northwest's argument that the claim should have been closed sooner than the Notice of Closure because the issue of improper termination of temporary disability compensation was inextricably attached to the claim for temporary disability compensation. Claimant was entitled to that temporary disability compensation for which he had a legitimate claim until termination by the appropriate method, subject to Liberty Northwest's right to offset overpaid temporary disability compensation against any award for permanent partial disability. Jackson v. SAIF, 7 Or App 109 (1971). The insurer was limited in its recovery of overpaid temporary disability compensation by its duty to process the claim in a timely fashion and thereby prevent an unduly large overpayment which might not be recoverable. See Georgia Pacific v. Awmiller, 64 Or App 56 (1983).

On review Liberty Northwest relies on its contention that claimant was never authorized time loss as a result of his compensable cervical spine injury. We find that Dr. Clibborn authorized temporary disability compensation due to claimant's cervical spine condition in November 1983. Orthopaedic Consultants agreed that claimant could not be released to return to the same job he had been performing at the time of injury, although they opined that claimant was medically stationary at the time of their examination in January 1984. The evidence persuades us that claimant's condition was disabling for some period of time after November 18, 1983 until some time before the examination by Orthopaedic Consultants and, therefore, we find that formal closure of the claim was necessary. That fact does not terminate the entitlement to compensation for temporary disability at that time. Termination of temporary disability compensation requires a release to return to regular work, a return to work, or the determination that claimant is medically stationary with authorization to terminate temporary disability compensation granted by a Determination Order. Jackson v. SAIF, supra; Richard L. Hoffee, 37 Van Natta 248 (1985). We consider the issues and evidence presented before the Referee as contesting the entitlement to temporary disability compensation in this light. We find that claimant was entitled to temporary disability compensation through December 19, 1984 by reason of Liberty Northwest's failure to obtain timely closure of the claim. The date of December 19, 1984 was chosen because it was the date on which claimant requested a hearing on the issue of temporary disability compensation. Cf. Georgia Pacific v. Awmiller, supra (temporary disability compensation approved through date of Determination Order). Prior to December 19, 1984 Liberty Northwest still had the option of obtaining a reconsideration of the Department's order by submitting additional medical evidence, but after claimant requested a hearing jurisdiction lay only with the Hearings Division. OAR 436-65-005(6).

Liberty Northwest could have closed the claim formally or obtained a Determination Order as soon as the claim qualified for closure pending resolution of the compensability issue. SAIF v. Maddox, 295 Or 448 (1983). It chose not to pursue those opportunities at the earliest statutorily appropriate times. Liberty Northwest must now satisfy the administrative requirements of the Workers' Compensation Act to properly process the claim.

We find that the claim should be submitted at this time for

closure and a determination by the Evaluation Division of the Workers' Compensation Department. See OAR 438-06-040. The claim will be remanded to Liberty Northwest with instructions that it be submitted to the Department pursuant to ORS 656.268(2).

Liberty Northwest cross-requested a hearing on the issue of upholding its backup denial dated December 27, 1984. The Referee ruled that claimant had prevailed on that issue and that the denial was unreasonable and awarded a total of $1,800 in attorney fees. The Referee also found that the denial was just one example of Liberty Northwest's unreasonable conduct in response to the Department's order and that he did not consider it a separate issue. We find that the denial was a separate issue, was so identified by both parties, and that claimant did prevail on a denied claim and was entitled to attorney fees for prevailing on a denied claim. The insurer's unreasonableness in issuing the denial was penalized in the general penalty the Referee awarded. A penalty associated attorney's fee was also awarded. We agree with the Referee's assessment and affirm the Referee's awards of penalties and attorney fees.

All other requests for relief are denied.

ORDER

The Referee's order dated March 19, 1985 is modified. The claim is remanded to Liberty Northwest Insurance Corporation for submission forthwith to the Evaluation Division of the Workers' Compensation Department consistent with this order. Claimant's attorney is awarded $600 for services on Board review on the issue of the denial, to be paid by Liberty Northwest.

LAWTON W. WROE, Claimant
Emmons, et al., Claimant's Attorneys
Daniel J. DeNorch, Defense Attorney

WCB 84-00779
September 17, 1985
Order on Reconsideration

Liberty Northwest Insurance Corporation requests reconsideration of the Board's Order on Review dated May 31, 1985. It also requests consolidation with a subsequent Board case in which the issues were related to subsequent processing and enforcement of the original Opinion and Order at issue in this case. It requests reconsideration and consolidation:

> "[I]n order that the Board may re-examination [sic] arguments made on appeal in the context of the case as a whole. The Board will recall [the Referee] found 'Claimant's work activities at [employer] on October 26, 1983 caused problems in the claimant's cervical region requiring medical treatment.' [italics in original] (Opinion and Order, Pg. 2, WCB Case No. 84-00779). Assisted by his chiropractor, claimant has parlayed a non-disabling, medical only 'injury' into twelve full months of time loss and twenty-one months of chiropractic treatment notwithstanding an additional forty-eight hundred dollar ($4800) overpayment of time loss as a result of a claims processing

> error. [The second Referee's] Opinion and Order merely added insult to injury. It is unlikely any action by the Board can undo the injury, but it can certainly stop future injury and end the insult."

The initial issue to be decided is whether there should be any reconsideration of the Board's Order on Review dated May 31, 1985. Then, if it is appropriate to reconsider the order, the issue is whether the record developed subsequent to the first hearing in WCB Case No. 84-13449 should be consolidated with the record at the first hearing to decide all issues in the context of the entire case.

In the original Order on Review in case 84-00779, we affirmed and adopted the Referee's Order. We abated the Order on Review to allow the parties to present their positions on reconsideration and consolidation. We grant reconsideration of the Order on Review because we want to make our reasoning clear.

The Referee relied on claimant's complaints of cervical spine pain and reports from claimant's first and second treating chiropractors, as well as the report of Orthopaedic Consultants, that claimant had suffered some injury which was related to his employment and which required some medical treatment. Liberty Northwest argued that claimant's testimony was not perfectly consistent and was not corroborated and that claimant's failure to warn the employer of his prior low back injury before accepting the job showed that claimant was untrustworthy. There was no medical evidence contradicting claimant's treating chiropractors. We agree with the Referee and find that claimant suffered an injury in the course of his employment which reasonably required medical treatment.

Nothing more was submitted for the Referee to decide at the first hearing. Nothing more was submitted for the Board to consider as a request to remand to develop the case further because of newly discovered evidence relevant to the question of whether claimant was compensably injured. Liberty Northwest's denial of compensability of the claim is set aside because claimant proved at the first hearing that he was entitled to compensation for medical services.

Liberty Northwest requests consolidation with WCB Case No. 84-13449 in order that the Board may review the entire complex situation which has resulted since the hearing on August 23, 1984. There is nothing about the subsequent processing of the claim or later medical information which is relevant to the issue whether claimant suffered a compensable injury in the course of his employment in October 1983. We deny the request to consolidate WCB Case No. 84-00779 with WCB Case No. 84-13449.

Accordingly, Liberty Northwest's request for reconsideraton is granted. On reconsideration, the Board adheres to and republishes its former order, as supplemented herein. Claimant's attorney is awarded $750 for services on Board review, to be paid by Liberty Northwest. This award is in lieu of the attorney fee awarded in our Order on Review.

IT IS SO ORDERED.

LAWRENCE M. SULLIVAN, Claimant
Evohl F. Malagon, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 82-10103
September 20, 1985
Interim Order of Remand

Claimant requests review of that portion of Referee Menashe's order which upheld the insurer's denial of medical services related to an unsuccessful suicide attempt. The insurer cross-requests review of that portion of the order which set aside its denial of claimant's right shoulder condition and surgery.

In our review of the record in this case, we found that an exhibit that was offered during the deposition of Dr. Johnson was not in the record. The missing exhibit was the original chartnotes with typewritten transcription. There was an objection to admission of the exhibit, but there was no ruling on the objection. We find that the record in this case is incomplete, therefore, we remand to the Referee for the purpose of completing the record with respect to the deposition of Dr. Johnson. ORS 656.295(5).

IT IS SO ORDERED.

BILL F. CLOER, Claimant
Coons, et al., Claimant's Attorneys
David Horne, Defense Attorney

WCB 84-11939
September 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Danner's order that held that the insurer's termination of claimant's temporary total disability payments was proper because of claimant's refusal to accept light duty employment. The issue on review is whether the insurer's termination of benefits was proper. Claimant offers an alternative argument that even if the termination was initially proper, payments should have been reinstated once claimant's physician reported that he could not perform the light duty work.

After reviewing the record, we agree with the Referee that the insurer's termination was proper. ORS 656.325(5); OAR 436-54-222(5).

We also agree with claimant, however, that temporary disability payments should have resumed once claimant's physician reported that claimant was unable to perform the light duty work offered by the employer. Temporary disability payments are due during periods in which, as a result of a compensable injury, claimant is not medically stationary or released for regular work. Jackson v. SAIF, 7 Or App 109 (1971); Richard L. Hoffee, 37 Van Natta 248 (1985).

Claimant argues that his physician withdrew his light duty work release on November 28, 1984. After reviewing the record, however, we find that the rescission of the release did not definitively occur until December 12, 1984. Claimant is entitled to the resumption of temporary disability benefits as of that date and continuing through the date of the next proper closure under ORS 656.268.

ORDER

The Referee's order dated January 29, 1985 is modified. The order is affirmed as to its approval of the insurer's termination

of temporary total disability compensation. The order is modified by awarding claimant temporary total disability compensation beginning December 12, 1984 and continuing through the date of the next proper closure according to law. Claimant's attorney is allowed 25% of the temporary total disability compensation awarded by this order, not to exceed $750.

WANDA L. DRYDEN, Claimant
Quintin B. Estell, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-04625
September 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of that portion of Referee Nichols' order which set aside its partial denial of claimant's psychological condition. On review, SAIF contends that claimant's psychological problems are not related to her compensable arm, neck, and back conditions. Claimant cross-requests review of those portions of the Referee's order which: (1) found that claimant's physical condition had not worsened; and (2) declined to rate claimant's permanent disability.

The Board affirms the order of the Referee with the following comment. Since the Referee found that claimant's current psychological condition was compensable and that the condition was not medically stationary, the Referee concluded that it would not be appropriate to rate claimant's permanent disability. Claimant contends that the extent of her permanent disability should be rated even though her claim has been reopened. We have already addressed this issue in other cases and have reached a conclusion contrary to the position that claimant espouses. See Thomas D. Craft, 36 Van Natta 1649, 1652 (1984); Andrew Simer, 37 Van Natta 154 (1985).

ORDER

The Referee's order dated January 3, 1985 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

IDA M. KELLEY, Claimant
Joel B. Reeder, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-07532
September 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Mongrain's order which set aside its denial that there was an employment relationship upon which to base a workers' compensation claim. The issue on review is whether claimant was a subject worker of a subject employer.

Claimant was injured when a horse kicked her in the face on May 9, 1984. She received medical services. An investigation was made to determine the complying status of the alleged employer. The investigator concluded that there was no employment relationship upon which to base a claim for worker's compensation with respect to this alleged employe. SAIF issued its denial and claimant requested a hearing.

The alleged employer, Mr. Peyton, was a disabled truck driver

whose primary source of income was a combination of disability pensions. In order to supplement his pensions, he operated a consignment tack shop under the business name "Will's Place Tack Shop" and boarded horses in a borrowed stable. Claimant was unaware that the three horses that Peyton boarded were not his personal property. Two of the horses were unbroken, but the third horse was broken to riding.

Claimant had experience as a teenager breaking two-year-old colts and had ridden cutting horses. The last time claimant owned a horse was in 1974.

In April 1984 claimant and Peyton reached an agreement of some kind, although there is no agreement on the terms. Claimant believed that she had been hired to break and train the two unbroken horses in exchange for an unspecified horse to be purchased with profits to be obtained upon the sale of the two horses to be broken. Peyton testified that he allowed claimant to take care of the horses in exchange for riding lessons because claimant knew absolutely nothing about riding or breaking horses. Claimant testified that she reported for work every day for two weeks for six to eight hours per day; Peyton testified that claimant was at the stable three or four times over a two or three week period. Both parties testified that there was no written agreement and that they thought things were on a friendly basis that would work out to their mutual satisfaction.

In order to find there was an employer-employe relationship there must be either an express or implied contract of hire and a right of control by the employer. Oremus v. Ore. Pub. Co./Leibrand, 11 Or App 72 (1972), rev. denied, (1973). An implied contract of hire was found by the conduct of the parties in Buckner v. Kennedy's Riding Academy, 18 Or App 516 (1974), in which the employer originally admitted the claimant was an employe but denied that the injury was sustained in the course of her employment. Claimant was one of a group of teen-age girls who performed chores around the stable in exchange for free rides on the horses, lunch, and occasional payments of small amounts of money. The Court in Buckner found an employment contract based on the parties' conduct. Another element of the court's decision was that the employer had not appealed from the determination that he was a non-complying employer. In Hix v. SAIF, 34 Or App 819 (1978), the Court found there was no contract of hire in spite of two payments for services performed.

In the Board case Christopher M. Riddle, 37 Van Natta 1224 (WCB Case No. 84-03207, September 17, 1985), we stated that three elements of a contract of hire must be clearly agreed to between the employer and employe: wages, term of employment, and nature of the work.

We find that the alleged employer never paid claimant anything for services she may have performed for his business. We find that the possibility that claimant might have received an unspecified horse of unspecified value at some unspecified time in the future an illusory consideration and insufficient evidence upon which to find that an employment contract had been formed. Therefore, we find that claimant was not an employe and reverse the Referee's order.

ORDER

The Referee's order dated January 16, 1985 is reversed and the SAIF Corporation's denial is reinstated.

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

WCB 79-04418 & 79-08745
September 23, 1985
Order on Remand

This matter is before the Board for further proceedings on remand from the Court of Appeals. Retchless v. Laurelhurst Thriftway, 72 Or App 729, rev den, 299 Or 251 (1985). In our earlier Order on Review, 35 Van Natta 1788 (1983), we held that, although we found as a matter of fact that claimant sustained a new injury in 1978 while employed by Laurelhurst Thriftway, Industrial Indemnity Company as insurer for claimant's 1974 back injury while employed at Butler's continued to be liable for claimant's compensation under the rule of Bauman v. SAIF, 295 Or 788 (1983). The court agreed with our finding that claimant had sustained a new injury at Laurelhurst, which was insured by United Grocers Insurance, but reversed our holding that Industrial Indemnity was liable under Bauman v. SAIF, supra.

Under the court's analysis, our previous finding of fact that claimant sustained a new injury should have shifted liability to Laurelhurst Thriftway/United Grocers Insurance, notwithstanding Bauman. That is the result we now reach on remand.

The court did not reach the question whether claimant was entitled to an attorney fee to be paid by Laurelhurst/United Grocers. In our original Order on Review, we awarded claimant's attorney a fee to be paid by Laurelhurst/United Grocers, however, because we reached a different result on reconsideration, we ultimately awarded no attorney fee. Having returned to the original result, we reinstate the attorney fee award.

ORDER

The Referee's order dated November 24, 1982 is affirmed. Claimant's attorney is awarded a reasonable attorney fee of $500 for services on Board review, to be paid by United Grocers Insurance.

FREDA L. SCOTT, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-09069
September 23, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Baker's order which upheld a Determination Order bringing claimant's total award to 25% (80°) unscheduled permanent partial disability for her neck and declined to award a penalty and attorney fee for alleged unreasonable failure to refer claimant for vocational rehabilitation. In the alternative, claimant requests remand for the admission of additional evidence.

ORS 656.295 permits the Board to remand in appropriate cases upon a finding that the case has been improperly, incompletely or

otherwise insufficiently developed or heard by the Referee. The Board has a restrictive policy regarding remands, both because there are numerous mechanisms for keeping the record open and because once the record closes, it is in the interest of administrative economy that the record be as final as possible. See Casimer Witkowski, 35 Van Natta 1661 (1983). Claimant seeks remand for the admission of Dr. Karasek's January 17, 1985 chart note. Shortly after the Opinion and Order issued, claimant also sought to supplement the record at the hearing level with Dr. Bert's August 29, 1984 memorandum. There being no sufficient explanation why Dr. Bert's memorandum was not included in the record before it closed and there being little in Dr. Karasek's chart note not otherwise established in the record, we find that remand would be inappropriate in this case.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated January 29, 1985 is affirmed.

VINCENT M. BIRD, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Horne & Meserow, Defense Attorneys

WCB 82-06512, 82-06513, 82-06514 & 82-06515
September 24, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Knapp's order which upheld the denials of claimant's occupational disease claims for hearing loss issued by Wausau Insurance Companies and the SAIF Corporation. On review, the issues are compensability and responsibility.

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

In upholding the insurers' denials the Referee cited Williams v. SAIF, 22 Or App 350 (1975), for the proposition that claimant's testimony concerning noise levels at the workplace was insufficient to establish a causal relationship between hearing loss and employment. The Referee's order could be interpreted to suggest that sound level studies are indispensable to establishing a compensable hearing loss claim. Such an interpretation would be incorrect.

In Herb Ferris, 34 Van Natta 470, 471 (1982), the Board found that "claimant has not proven that noise exposure in his working environment was the major contributing cause of his hearing loss because we further find no proof of the sound level, excessive or otherwise, to which he was exposed while working. Accordingly, the Board upheld the denial of compensability, finding claimant's subjective evidence concerning work-related noise insufficient to sustain his burden of proof. The Court of Appeals reversed, per curiam, the Board's order and reinstated the Referee's order which had set aside the denial of compensability. Ferris v. Willamette Industries, 61 Or App 227 (1982). The Ferris court cited Bowman v. Oregon Transfer, 33 Or App 241 (1978). In Bowman the court stated its intention to refrain from issuing written opinions in workers' compensation cases which presented only factual issues.

33 Or App at 245. Thus, the Board's conclusion in Ferris concerning the necessity for sound level studies and the insufficiency of a worker's subjective testimony was rejected.

Following our de novo review of the medical and lay evidence, which includes claimant's testimony concerning the noise levels he experienced at work, we are not persuaded that claimant's work-related noise exposure was the major contributing cause of any hearing loss he might have.

ORDER

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

DELMAR R. GOODRICH, Claimant
Joseph C. Post, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 85-0047M
September 24, 1985
Own Motion Determination

The Board issued its Own Motion Order in the above-entitled matter on July 8, 1985 reopening claimant's claim for a worsened condition related to his industrial injury of January 3, 1975.

The claim was submitted for closure by SAIF on July 26, 1985 based on a report of Dr. Ott dated July 16 which indicated that claimant's condition was medically stationary. Claimant requested that the Board not close the claim, indicating that there was a conflict between Dr. Ott's July 16 report and a subsequent report issued on August 1, 1985. Claimant waived receipt of temporary total disability benefits after July 16, 1985 to allow time to obtain a more complete report from Dr. Ott. Claimant has now submitted a four-page report written by his attorney and signed by Dr. Ott for our consideration.

Dr. Ott has signed a statement which indicates that claimant's condition is not medically stationary as he expects to see gradual improvement in claimant's condition in the future. However, the preponderance of the evidence in the record indicates to the contrary. Dr. Ott recommends that claimant continue with osteopathic manipulation, undergo periodic trigger point injections, decrease his caloric intake and increase his exercise. He indicates that claimant's condition is chronic and the treatment is an attempt to keep claimant encouraged and to "try to preserve what little strength and flexibility remains in his back." He states that even surgery would not provide an increase in claimant's function, but could only hope to allow claimant some relief from his pain. We conclude that the treatment described by Dr. Ott is not intended to be curative, but is for the purpose of maintenance.

Notwithstanding Dr. Ott's attributed statement to the contrary, the evidence persuades us that claimant's condition is permanent and chronic. Claimant has received disability awards totaling 144° for 45% unscheduled permanent partial disability for injury to his low back. Although claimant established that he was experiencing a worsening of symptomatolgy when we reopened his claim, see Richard A. Scharback, 37 Van Natta 598 (1985), the weight of the persuasive medical evidence is that claimant has returned to his pre-aggravation status. Such symptoms as he continues to experience have persisted on and off for a number of years, and are consistent with waxing and waning that is to be anticipated given the level of disability for which claimant has already been compensated.

While You Were Out

To _____

Date _____ Time _____

_____ called

of _____

Phone _____

- ☐ Telephoned
- ☐ Please call
- ☐ Will call again
- ☐ In person
- ☐ Wants to see you
- ☐ Returned your call

Message _____

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Taken by _____

FORM CS 97883

Recyled Paper

Claimant is entitled to continuing medical treatment under the provisions of ORS 656.245 for so long as the treatment is reasonably related to his industrial injury; however, we are not persuaded to keep the claim open for the payment of temporary total disability benefits. We conclude that claimant's claim should be closed and that claimant is entitled to compensation for temporary total disability from January 10, 1985 through July 16, 1985 only. Deduction of overpaid temporary disability, if any, from unpaid temporary and permanent disability is approved.

IT IS SO ORDERED.

VERNA B. HERB, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-07323
September 24, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee T. Lavere Johnson's order that approved the SAIF Corporation's denial of claimant's massage therapy billings. The issue on review is claimant's entitlement to payment of those billings.

Claimant compensably injured her right arm and shoulder in September of 1983. The claim was accepted as nondisabling. Claimant visited a physical therapist at the suggestion of her attending physician, Dr. Altizer. The therapy was apparently too painful, however, and claimant terminated it. She returned to Dr. Altizer and asked to be referred to a massage technician. Dr. Altizer made the referral to a licensed massage technician, Mr. Ashe.

Claimant visited Ashe seven or eight times, obtained complete relief of her arm and shoulder symptoms, and terminated treatment. She later had a flare-up of symptoms and was again referred to Ashe, this time by Dr. Altizer's associate, Dr. Orwick. Dr. Altizer remained the attending physician, however.

SAIF paid for the physical therapy treatments, but refused to accept the billings of the massage technician. Its denial was predicated on OAR 436-69-301(2), which provides:

> "Attending physicians may prescribe treatment to be carried out by persons licensed to provide a medical service, or persons not licensed to provide a medical service who work under the direct control and supervision of the attending physician."

SAIF asserted that claimant's massage technician was neither qualified to provide medical services, nor under the control and supervision of the attending physician at the time therapy was provided. It, therefore, refused to pay for the technician's treatments. The Referee agreed with SAIF and upheld the denial.

On review, claimant offers alternative arguments: first, that a licensed massage technician is among those persons qualified to provide "medical services," as that phrase is used in the administrative rules; and second, that the technician was under Dr. Altizer's control and supervision at the time therapy was provided to claimant.

With regard to claimant's first argument, we have previously expressed our doubt that a licensed massage technician is qualified to provide medical services. Randy Townsend, 37 Van Natta 58 (1985). We now hold that a massage technician is not so qualified.

With regard to claimant's second argument, we have not previously had occasion to interpret the phrase "direct control and supervision of the attending physician," as the phrase is used in the administrative rule. The rule does not further define the phrase. On review, claimant argues that the rule merely requires a referral by an attending physician, coupled with what the claimant terms "guidelines and monitoring" communicated from the attending physician to the technician. In the present case, claimant's attending physician made a referral to the massage technician and suggested that therapy be provided for a period of three weeks at a frequency of three times per week. No further contact between the physician and the technician occurred. Claimant argues that the referral, coupled with the physician's suggestions regarding the frequency of treatment, satisfies the requirements of the rule. We disagree.

We interpret the administrative rule to require more than a referral. While we recognize that it is not directly applicable to massage therapy, we are guided by OAR 436-69-201(4)(a), which governs the provision of physical therapy, biofeedback or acupuncture. The rule requires that these services are not reimbursible unless carried out under a specific treatment plan prescribed prior to the commencement of treatment and approved by the attending physician within a week of its commencement. The rule further requires that the precribed plan include specific treatment objectives and modalities. We note that the requirements of this rule are formal and specific. A simple referral by an attending physician for one or more of the enumerated services would not satisfy the rule. Neither would a referral, coupled with the physician's suggestions regarding the frequency of treatment. More is required.

Likewise, we interpret OAR 436-69-301(2) to require more than has been suggested by the present claimant. We interpret it to require, at a minimum, a referral by the attending physician, his or her recomendations regarding the frequency of treatment, and at least some subsequent contact between the attending physician and the technician, designed to monitor both the activities of the technician and the progress of the patient. In the present case, Dr. Altizer had no contact with the massage technician subsequent to the referral. There was no cooperative effort between the professionals, nor did the technician ever receive instructions or suggestions from the physician regarding how massage therapy might best be integrated into claimant's overall treatment. Under these circumstances, it can hardly be said that the technician was under the "direct control and supervision of the attending physician."

ORDER

The Referee's order dated January 29, 1985 is affirmed.

AURELIA M. URBANO, Claimant
Gatti, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 84-08748
September 24, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Michael Johnson's order that awarded claimant 107° for approximately 30% unscheduled permanent partial disability in lieu of the Determination Order that awarded no permanent partial disability. The sole issue on review is extent of unscheduled disability.

Claimant compensably injured her neck and upper back while lifting boxes at a cannery. She missed only one day of work but has received ongoing chiropractic treatment. Claimant was 38 years of age at the time of the hearing and has a second grade education, which she acquired in Mexico. Claimant does not read, write nor speak English. Her work history consists of heavy labor as a migrant field worker and light duty at a cannery. At the time of the hearing claimant had returned to her regular cannery job.

The medical evidence consists of the opinions of claimant's treating chiropractor and a panel of two Independent Chiropractic Consultants. Claimant's chiropractor has stated that claimant suffers from impairment in the form of a "moderate spinal injury with secondary effects." The Consultants found no impairment, although a review of their examination report reveals objective evidence of disability in the form of right forearm weakness and a flattening of the cervical curvature.

The Referee found claimant to be a credible witness and accepted her testimony regarding what the Referee found to be disabling pain. Harwell v. Argonaut Ins. Co., 296 Or 505 (1984). After considering the evidence, the Referee found that claimant would be fairly compensated by an award of approximately 30% unscheduled permanent partial disability.

On review, the insurer argues that claimant has failed to prove that she suffers from any impairment whatsoever. In the alternative, it argues that the Referee's award is excessive. Our review of the record leads us to conclude that claimant has incurred at least minimal permanent partial disability. We agree with the insurer, however, that the Referee's award of 30% was excessive. While we recognize that claimant suffers from significant educational and social deficits, we also note that she has returned to her regular work at the cannery. Considering claimant's physical impairment along with the pertinent social and vocational factors, we conclude that claimant will be adequately compensated by an award of 48° for 15% unscheduled permanent partial disability.

ORDER

The Referee's order dated February 22, 1985 is modified. In lieu of the Referee's award and all prior awards, claimant is awarded 48° for 15% unscheduled permanent partial disability. Claimant's attorney's fee will be adjusted accordingly.

BETTY S. DIAMOND, Claimant
Michael Henderson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-07605
September 25, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Mongrain's order which upheld the SAIF Corporation's denial of claimant's left shoulder condition as either an injury or an occupational disease. Claimant cites as error the Referee's exclusion of two exhibits for late submission without showing good cause or diligence in trial preparation. The issues on review are admissibility of documents submitted at hearing and compensability.

The exhibits which the Referee excluded were Exhibit 29 and Exhibit 33. Exhibit 29 was seven pages of progress notes and letters from the physical therapist who treated claimant according to Dr. Kho's instructions between July 31 and October 9, 1984. Exhibit 33 was a letter from Dr. Kho, claimant's neurologist, in which he stated his opinion of causation based on his examinations and claimant's history. Dr. Kho's letter was dated January 2, 1985. Claimant offered no good cause why the documents could not have been obtained and submitted according to the rules for submission of exhibits, OAR 438-07-005 effective May 1, 1984 and, therefore, the Referee was within his discretion to exclude them from the record. Exhibits 29 and 33 were not considered on review except for the limited purpose of determining their admissibility.

Claimant was working as a waitress on April 18, 1984 when she felt a tearing or ripping sensation in her left shoulder while carrying a load of dishes. She had immediate discomfort and complained of pain, but continued working. X-rays revealed foraminal encroachment at C6-7 and Dr. Sutherland diagnosed probable nerve root impairment. A myelogram and CT scan proved normal and Dr. Sutherland then diagnosed probable thoracic outlet syndrome. Dr. Isert, claimant's attending physician, reported that claimant's previous bursitis complaints were dissimilar to her present complaints and that claimant's current symptomatology was due to foraminal encroachment which was aggravated by her industrial injury. Dr. Isert then referred claimant to Dr. Kho, neurologist.

Dr. Kho first examined claimant on July 30, 1984 and opined that she had cervical sprain and myofascial pain of the left infraspinatus muscles which often mimic shoulder pain. He prescribed physical therapy. In mid-August Dr. Kho reported that claimant had a partial frozen sholder syndrome with adhesive capsulitis. At the next examination, claimant's condition seemed to have improved. On November 1, 1984 Dr. Kho examined claimant and discontinued her physical therapy, imposed temporary limitations, and opined that claimant's condition should resolve over the course of the next six months. He also opined that claimant should not return to work as a waitress because of the stresses placed on her left shoulder.

On November 27, 1984 Dr. Sutherland reviewed claimant's history and opined that claimant's shoulder condition was related to her work as a waitress and that it was superimposed on a preexisting cervical condition. On November 28, 1984 Dr. Isert's chart notes reveal that claimant had been restored to full range of motion of her left shoulder and neck.

Based on the sudden occurrence of pain in her shoulder and her corroborated testimony of a sudden change in her ability to carry out her customary tasks at home and her attending physician's opinion that her left shoulder condition was unlike her previous complaints of pain in her left arm, we find that claimant carried her burden of proof that she suffered an injury in the scope and course of her employment. The eventual diagnosis of adhesive capsulitis and treatment directed at correction of that condition is further proof that claimant suffered a compensable shoulder injury unrelated to her pre-injury bursitis complaints which had resolved with an injection. There is no medical opinion contrary to claimant's doctors' opinions that her job caused her symptomatology, although there was some confusion as diagnoses were tested by treatment and modified.

SAIF relies on inconsistencies in claimant's history and the suggestion that Dr. Kho only examined claimant one time to defend against the claim. We find that Dr. Kho's examinations and recommendations were made over a period of approximately three months. The inconsistencies in claimant's histories do not so discredit claimant as to make the overall substance of her complaints and testimony sufficiently unreliable that we could find her not credible based on the record in the absence of a credibility finding by the Referee. Cf. Davies v. Hanel Lbr. Co., 67 Or App 35 (1984).

ORDER

The Referee's order dated February 11, 1985 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to the SAIF Corporation for processing. Claimant's attorney is awarded $1,000 for services at hearing and $700 for services on Board review, to be paid by the SAIF Corporation.

LLOYD L. HAMILTON, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-01420
September 25, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Danner's order which set aside the Determination Order dated July 27, 1984 that found claimant was entitled to temporary disability compensation through June 25, 1984 and awarded 32° for 10% unscheduled permanent partial disability due to injury to claimant's low back. The issue on review is whether the claim was properly closed by the Determination Order.

Claimant injured his back on November 18, 1975. As a result of his injury, his spine was fused from L2 through S1. In the first half of 1984, claimant was in a rehabilitation program learning quality control with a battery manufacturer through an on-the-job training program. During the course of the training program, claimant suffered occasional exacerbations of his pain, but seemed to his attending physician to be stable. As part of his training program, SAIF was providing an apartment near the training site. As the training program came to a close, claimant's doctor opined that claimant should live near his employment to minimize driving time because driving tended to make claimant's back painful. Claimant was unable to find affordable housing near his employment, so he commuted approximately thirty miles each way.

In April 1984 Dr. Kenyon, claimant's doctor, reported that claimant's back condition was more painful, and he increased claimant's medication. He diagnosed an active lumbar strain. In June 1984 claimant was examined by Orthopaedic Consultants who reported that their x-rays showed the solid fusion from L2-S1 and opined that claimant was medically stationary with moderate impairment. They also opined that the current treatment by injections of claimant's back was palliative rather than curative. Dr. Colbach, psychiatrist, examined claimant and reported that claimant's psychological condition related to the industrial injury was stationary. Claimant's treating psychologist agreed with the assessments by Dr. Colbach and Orthopaedic Consultants but disagreed with the terminology used to describe claimant's psychological condition. According to the record, Dr. Kenyon's opinion regarding claimant's condition was not solicited.

On August 8, 1984 Dr. Kenyon reported that claimant's active lumbar strain was about the same as it had been at the time of the April examination. Straight leg raising tests were bilaterally negative. The next time claimant consulted his physician was in October for chest pains. On October 25, 1984 claimant had sudden sharp back pain and shooting pain which he had never had before in his left leg. Dr. Kenyon examined claimant on October 29 and reported a positive straight leg raising test at 50 degrees on the left. He diagnosed active lumbar strain, lumbar disc disease and left sciatica. On October 31 Dr. Kenyon dropped active lumbar strain from his diagnosis and wrote a letter to SAIF requesting reopening of the claim and reporting that claimant worsened on October 25, 1984.

Subsequent X-ray examinations revealed that claimant's fusion was failing progressively. By mid-December 1984 claimant was not fused above L5. In January 1985 Dr Kenyon opined that claimant's condition had worsened in October 1984 with the appearance of the leg pains.

Claimant is entitled to temporary disability compensation until his medical condition becomes medically stationary, he returns to work, or he is released to return to regular work. Jackson v. SAIF, 7 Or App 109 (1971). No date when claimant was determined to be medically stationary was noted on the Determination Order, therefore, we find the order to have been issued on the basis of claimant's employment at the job for which he had been trained. He worked without losing time due to his back injury for four full months, although his back condition continued to cause him pain. We find that symptomatology was consistent with claimant's awards for 50% disability. There is no evidence in the record to persuade us that claimant's back condition was other than medically stationary as defined in ORS 656.005(17) at the time of the Determination Order. See Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985). Claimant's attending physician was persuasive when he pointed to the date in October when claimant's leg pains began as the time when claimant's condition worsened. We find that the Determination Order should be reinstated and affirmed and, therefore, reverse that portion of the Referee's order which set aside the Determination Order.

Reinstatement of the Determination Order requires modification of the attorney fee awarded for services at hearing. The Referee awarded one attorney fee for services related to

claims for premature closure, unpaid temporary disability compensation, and late payment of medical bills. There was no apportionment among the claims for the value of the services. We find that the apportionment among the claims to be $1000 for services related to the issue of premature closure, $350 for services related to the issue of unpaid temporary disability compensation, and $150 for services related to late payment of medical bills. As a result of our finding that the Referee's order on the issue of premature closure must be reversed, we also reduce the attorney fee awarded for services at hearing by the amount we find to be apportionable to the issue of premature closure. See Deborah M. Cook, 37 Van Natta 542 (1985). There was no request to review the issues of temporary disability compensation and late payment of medical bills and there was no brief filed on those issues, therefore, no attorney fee is awarded on Board review.

ORDER

The Referee's order dated February 6, 1985 is reversed in part, modified in part, and affirmed in part. That portion of the order which set aside the Determination Order dated July 27, 1984 is reversed and the Determination Order is reinstated. The attorney fee award is modified to award $500 for services at hearing, to be paid by the SAIF Corporation. The remainder of the order is affirmed.

JEFFREY P. HOUGH, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 83-05794
September 25, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Mulder's order which: (1) authorized the SAIF Corporation to offset temporary disability benefits allegedly overpaid prior to a previous Determination Order against permanent disability benefits awarded by the Referee; and (2) failed to assess a penalty and attorney's fee for SAIF's unilateral termination of temporary total disability benefits. SAIF cross-requests review of those portions of the Referee's order which awarded claimant additional permanent disability benefits following a vocational rehabilitation program. Claimant also moves to exclude a document submitted within ten days of the hearing.

On the evidentiary issue, we find that the Referee did not abuse his discretion in considering the disputed document.

On the merits, we find: Claimant compensably injured his low back on February 23, 1977. He was granted an award for 10% (32°) unscheduled disability by a Determination Order of July 11, 1978. The claim was later opened for a vocational rehabilitation program. The vocational rehabilitation program was suspended on September 10, 1979 because claimant did not report his spring or winter term grades and did not attend school during the summer of 1979. The suspension letter informed claimant that SAIF was entitled to recover any temporary total disability benefits paid after June 9, 1979. The program was terminated effective October 1, 1979. On October 12, 1979 Orthopaedic Consultants reported that claimant was not medically stationary. On February 3, 1981

Orthopaedic Consultants again evaluated claimant and reported that he was then medically stationary. A Determination Order issued on March 18, 1981 which granted claimant no additional award for permanent disability and which awarded claimant temporary total disability benefits from June 19, 1978 until June 8, 1979 and from October 12, 1979 through February 3, 1981. The Determination Order contained boilerplate language which stated:

> "Any temporary total disability payment you might have received for a period after the termination date specified will be treated as an advance on your award, if any."

On March 25, 1981 SAIF sent claimant a letter indicating that SAIF had overpaid claimant temporary total disability benefits of $4,290.56. This alleged overpayment was created because SAIF paid temporary total disability benefits between June 8, 1979 and October 12, 1979 and also paid temporary total disability benefits between February 3, 1981 and the date of the Determination Order.

On April 29, 1981 claimant entered another vocational rehabilitation program. The vocational rehabilitation program ended on January 14, 1983. SAIF terminated temporary total disability benefits as of that date. A third Determination Order then issued on January 31, 1983 which granted claimant no additional award for permanent disability.

Claimant requested a hearing raising as issues his entitlement to additional permanent and temporary disability benefits plus a penalty and attorney's fee. SAIF responded and raised as an issue the alleged overpayment.

At hearing SAIF moved to dismiss claimant's request for hearing insofar as it put in issue the prior Determination Orders. Claimant moved to dismiss the request for authorization to offset the alleged overpayment on the ground that SAIF had not sought authorization for the offset within one year of the Determination Order which created the alleged overpayment. Both motions were denied.

The Referee held that claimant was entitled to have the extent of his permanent disability rerated following the vocational rehabilitation program even absent any evidence of changed circumstances. The Referee correctly anticipated the Court of Appeals holding in Hanna v. SAIF, 65 Or App 649 (1983), in which the Court said:

> "ORS 656.268(5) provides that a new determination be made when a worker ceases to be enrolled in a program of vocational rehabilitation. The new determination would necessarily be based on the medical and other evidence available at that time, including that concerning the success or failure of the vocational rehabilitation program. A claimant's disability may be determined to be more or less than previously supposed after vocational rehabilitation, even absent a change in his medical condition. A change in claimant's condition is not required to obtain a redetermination of extent of disability on termination of a program of vocational rehabilitation." Hanna v. SAIF, supra at 652.

We find that the Referee was correct in awarding claimant an additional 15% (48°) unscheduled disability.

The Referee declined to assess a penalty against SAIF for its unilateral termination of temporary total disability benefits following the vocational rehabilitation program. He reasoned that because Boise Cascade v. Jones, 63 Or App 192 (1983), which requires the insurer to continue payment of temporary total disability benefits following vocational rehabilitation until a Determination Order issues, had not been decided at the time SAIF unilaterally terminated temporary total disability, no penalty was warranted. He opined that the fact that the Board's similar decision in the Jones case, Billy Joe Jones, 34 Van Natta 658, was in effect had no bearing on the penalty issue. We disagree. Our holding in Jones required the insurer to continue to pay temporary total disability benefits pending a Determination Order. SAIF, for whatever reason, ignored our holding. A penalty of 25% of the temporary total disability due between January 14, 1983 and January 31, 1983 is assessed against SAIF. Claimant's attorney is awarded an associated attorney's fee of $250.

On the overpayment issue, we believe that under Hanna, supra, not only may the extent of permanent disability be redetermined following a vocational rehabilitation program, but extent of temporary disability, including any alleged overpayments may be redetermined as well. Thus, SAIF is free to argue that it overpaid temporary total disability to claimant prior to the March 1981 Determination Order, and claimant is free to argue that he was entitled to temporary total disability during the period when SAIF allegedly overpaid temporary total disability benefits.

Thus, both the issue of SAIF's entitlement to offset an alleged overpayment and claimant's defense that he was not medically stationary at the time the temporary total disability was allegedly overpaid were issues properly before the Referee. Accordingly, on de novo review we consider those issues.

Claimant argues that during the period of June 8, 1979 through October 12, 1979 he was not medically stationary and, therefore, there was no overpayment of temporary total disability benefits during that period of time. On July 10, 1979 Dr. Siler reported that claimant was medically stationary but that a myelogram should be performed for the sake of completeness. Dr. Grewe, claimant's treating physician, suggested a myelogram in August 1979. On October 12, 1979 Orthopaedic Consultants agreed that a myelogram should be performed and opined that claimant was not then medically stationary. There is no indication prior to the Orthopaedic Consultant's report that claimant was not medically stationary. Claimant has failed to prove by a preponderance of the evidence that he was not medically stationary between June 8, 1979 and October 12, 1979. Accordingly, we find that SAIF overpaid claimant temporary total disability benefits as stated in the March 1981 Determination Order.

ORDER

The Referee's order dated September 27, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which declined to assess a penalty against SAIF for unilateral termination of temporary disability benefits are reversed.

Claimant is awarded 25% of the temporary disability benefits due between January 14, 1983 and January 31, 1983 plus an associated attorney's fee of $250. Those portions of the Referee's order granting claimant 15% (48°) unscheduled disability in addition to that previously awarded by Determination Order are affirmed. Those portions of the Referee's order which authorized the insurer to recover an overpayment are affirmed. Claimant's attorney is awarded $500 for services on Board review for prevailing on the issue of extent of permanent disability, to be paid by the SAIF Corporation.

DAVID L. HULBERT, Claimant
Evohl F. Malagon, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-06602
September 25, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of that portion of Referee Daron's order that set aside its denial of claimant's claim for the worsening of a preexisting psychological condition allegedly resulting from a compensable accidental injury. The sole issue on review is the compensability of claimant's psychological condition.

Claimant was compensably injured on May 18, 1983 when he was struck by an automobile in a parking lot. He incurred left shoulder, left leg and back injuries for which he underwent several surgeries. During the process of recovery, claimant was necessarily away from the small business he owned. The business ultimately closed, and claimant attributed its closure to his injury-related absence. He also testified that the closing of his business greatly increased his level of stress.

Approximately four months after the injury, claimant sought treatment from Dr. Carter, a psychiatrist. Claimant gave a history of having experienced an increase in aggression, tension and other abnormal behaviors he attributed to the sequelae of his industrial injury. Dr. Carter ultimately opined that claimant had suffered an increase in psychological symptoms, and that the worsened condition was the result of the compensable injury.

Claimant clearly suffers from a significant, preexisting psychological condition. His early history is characterized by problems at school, abuse by his parents, and a felony conviction. In 1980 he attempted suicide and ultimately sought treatment from Dr. Holland, a psychiatrist. By 1981, however, his psychological component had apparently resolved. This is best evidenced by claimant's acquisition and operation of his own business for a period of two years before the compensable injury.

After Dr. Carter's examination and report, the insurer engaged psychiatrist Dr. Parvaresh to examine claimant. It was Dr. Parvaresh's opinion that claimant indeed suffered from significant preexisting psychological problems. He was also of the opinion that the psychological component was of the type that takes a great deal of time to develop, and that it would not have been materially worsened by the injury sequelae.

Dr. Holland testified at the hearing. Although he had not examined claimant since treating him in 1981, Dr. Holland reviewed claimant's medical and psychiatric records before testifying. Like Dr. Parveresh, Dr. Holland was of the opinion that claimant's

underlying psychological condition was not "qualitatively" worsened by his injury. Because the record was devoid of psychometric test results, Dr. Holland was unable to determine whether the quantity of claimant's abnormal behaviors had increased.

The Referee found the claim compensable, relying on the opinion of Dr. Carter over that of Dr. Parvaresh. The Referee afforded Dr. Holland's opinion little weight because the psychiatrist had not examined claimant since 1981. In finding the claim compensable, the Referee was persuaded by the fact that claimant's psychological condition had been essentially dormant prior to the industrial injury, and that Dr. Carter attributed the post-injury flare-up to the sequelae of that injury.

In order to prove the compensability of his psychological condition, claimant must prove that his industrial injury resulted in a worsening of his preexisting psychological component. Hutcheson v. Weyerhauser, 288 Or 51 (1979); Partridge v. SAIF, 57 Or App 163, 167 (1982). The worsening must be material. Jeld-Wen v. Page, 73 Or App 136 (1985).

We find this case to be very close. On one hand, there is a close temporal relationship between claimant's industrial injury and a flare-up of his psychological component. On the other, there is split medical opinion regarding whether the sequelae of the injury in fact worsened the underlying condition. We are mindful that a temporal connection alone is generally insufficient to establish compensability. See e.g., Edwards v. SAIF, 30 Or App 21 (1977); Cf. Bradshaw v. SAIF, 69 Or App 587 (1984). We find in this case that the temporal connection alone is insufficient to persuade us and that our determination of the present compensability question must be based on the medical evidence, considered in light of the temporal connection.

After reviewing the evidence, we find the opinion of Dr. Parveresh most persuasive. In reaching this conclusion, we note that Dr. Parvaresh discussed not only the purported effect of claimant's industrial injury, but the effects of his preexisting disorder as well. Dr. Carter's reports, on the other hand, center primarily on the close temporal relationship between claimant's injury and his increased psychological disturbance, and the fact that claimant was essentially asymptomatic before the injury.

This case is somewhat similar to Gloria L. Mathieson, 36 Van Natta 1346, aff'd mem, 74 Or App 366 (1984). In Mathieson, the claimant asserted that her industrial injury resulted in the onset of psychological problems. The evidence revealed that the claimant's psychological problems preexisted her injury. She relied on the opinion of Dr. Carter, who stated that the claimant's psychogenic pain disorder was substantially related to her compensable injury. The insurer relied on the opinions of two psychiatrists, one of whom was Dr. Parvaresh, who indicated that the claimant's personality make-up, rather than the industrial injury, was the cause of her psychological condition. In finding the claim not compensable, the Board accepted the opinions of the insurer's experts over that of Dr. Carter, largely because Dr. Carter failed to consider the potential impact of the claimant's preexisting problems. Id. 36 Van Natta at 1349.

As in Mathieson, the present case involves the conflicting opinions of Drs. Carter and Parvaresh. And, as we did in

Mathieson, we find the opinion of Dr. Parvaresh more persuasive in the present case. We wish to make clear that we reach this result after independently weighing the evidence in this case and are not influenced by the medical findings of Mathieson. See Kuhn v. SAIF, 73 Or App 768 (1985); Giesbrecht v. SAIF, 58 Or App 218 (1982).

Dr. Carter has offered what is essentially a conclusory opinion regarding the purported relationship between the present claimant's injury and a recurrence of his psychological problems. Dr. Carter did not thoroughly address the significance of claimant's preexisting problems, however. At the very least, we feel that these problems should have been addressed in order to arrive at a complete, well-reasoned opinion. In the absence of that analysis, we are not persuaded that claimant's compensable injury was a material cause of his worsened psychological condition.

ORDER

The Referee's order dated January 18, 1985 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's psychological condition is reversed and the insurer's denial is reinstated. The remainder of the order is affirmed.

JAMES D. MANZO, Claimant
Richard W. Condon, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-07845
September 25, 1985
Order on Review (Remanding)

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of that portion of Referee Podnar's order which found that it was not entitled to an offset. On review, the insurer asks that this matter be remanded for the taking of further evidence concerning the amount of income and expenses claimant derived from his landscaping business while his claim was in open status. We grant the insurer's request for remand.

Claimant, 37 years of age at the time of hearing, sustained a compensable low back injury in December 1980. Following two low back surgeries and extensive physical and vocational rehabilitation efforts, his claim was closed in July 1984. Claimant was awarded approximately three and one-half years of temporary disability and 15% (48°) unscheduled permanent disability.

Sometime in 1981 claimant began a landscaping and yard maintenance business. His disability prevented him from performing most of the strenuous physical activities. Claimant believed that his physical limitations prevented him from conducting a profitable enterprise in that he was forced to employ additional workers. He testified that the business has consistently been unprofitable and has required the constant influx of capital, primarily through investing his temporary disability benefits. Claimant is presently attempting to rid himself of his business obligations.

The insurer withheld payment of claimant's permanent disability award, contending that it had overpaid approximately $10,000 in temporary disability benefits. The insurer based its overpayment assessment on claimant's 1982 tax return and upon references attributed to claimant concerning the profitability of

his business which were contained in several vocational reports. The 1982 tax return indicated claimant's "total income" was approximately $6,600, but after business deductions, his income became a net loss. The insurer had also received approximately 15 or 20 receipts which claimant represented to be his business records for 1981.

The insurer has apparently made several attempts to secure copies of claimant's business records. Between February 1984 and July 1984 there have been at least four written communiques between the parties concerning claimant's business records and/or tax returns. At the time of the hearing, the insurer had only received copies of the aforementioned 1981 receipts and 1982 tax returns. Although claimant's attorney's records indicated the insurer had also been sent a copy of claimant's 1983 tax returns, the insurer contended that it did not receive a copy until the date of the hearing. The 1983 returns indicated that claimant had an ordinary income of $1,575 and a net loss after applying business deductions.

Persuaded by the tax returns and claimant's testimony, the Referee concluded that no overpayment existed. Inasmuch as the insurer had not offered several vocational reports as evidence until the date of the hearing and because claimant's 1982 and 1983 tax returns were the "best evidence" of the profitability of his landscaping business, the Referee refused to admit the reports into evidence. Several of these vocational reports contained references concerning representations purportedly made by claimant regarding the business' monthly profits.

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing. Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

Following our de novo review of the record, we find that remand is appropriate. The evidence presented at the hearing concerning this issue is woefully inadequate and incomplete. Since this "self-owned business / temporary partial disability" issue appears to be one of first impression, and potentially will have far reaching implications and will undoubtedly have profound significance for the particular parties involved, we believe a full airing of the issue is needed. More important, a thorough development of this issue was contingent upon claimant's complete cooperation, which this record suggests was sadly lacking. Claimant should not, in effect, be rewarded for his dilatory conduct in responding to the insurer's inquiries and in providing financial information. Inasmuch as we are satisfied that the insurer's attempts to garner information concerning claimant's finances were both reasonable and persistent, we conclude that this evidence was not obtainable at the time of the hearing with due diligence.

Accordingly, this matter is remanded to the Referee for a full hearing on the merits of the offset issue. At that time the parties shall have the opportunity to present additional evidence and resubmit reports which were not admitted at the previous hearing. This evidence shall pertain to the issue of the amount of income and expenses claimant realized from his landscaping

business during the time he was also receiving temporary disability compensation. In all likelihood this additional evidence will provide illumination on the representations attributed to claimant in the vocational reports which the Referee refused to admit into evidence. We note in passing that the reports should have been admitted into evidence, if only for the purposes of impeachment. Marion R. Webb, 37 Van Natta 660, 750 (1985).

ORDER

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

CHERYL K. OLIVER, Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-00732
September 25, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Quillinan's order which remanded claimant's second mental stress claim for closure pursuant to ORS 656.268.

On April 22, 1984 claimant filed a claim for mental stress for the period from 1977 to April 1981. At about that time, claimant was transferred to another job with the same employer. The claim was denied and a hearing was requested. In early January 1982 claimant left her employment and filed a claim for continued job stress from April 1981 through the end of her employment. In mid January 1982 a hearing was held on the first stress claim. The parties agreed that the second claim would not be litigated, but rather that if the first stress claim were ultimately held to be compensable, SAIF would rescind its denial and accept the second claim. The first stress claim was ultimately found compensable by the Court of Appeals in February 1984. SAIF has consented to the setting aside of its denial of the second claim.

While the compensability of the first claim was being litigated the claim was submitted to the Evaluation Division for closure. A September 15, 1982 Determination Order awarded claimant temporary partial disability from November 12, 1980 through March 4, 1981 and no permanent disability. Neither party requested a hearing on the Determination Order.

SAIF contends that by stipulation, the first claim subsumed the second; and as a result, the September 15, 1982 Determination Order is res judicata as to claimant's disability. It also contends that claimant's entire compensable condition was considered by the Evaluation Division at the time of rating. Claimant contends that since the second stress claim involved different stressors, a different period of disability and different symptoms, the claim should now be separately closed.

ORS 656.268(2) in pertinent part provides:

> "When the injured worker's condition resulting from a disabling injury has become medically stationary * * * the

> insurer or self-insured employer shall so notify the Evaluation Division, the worker, and employer, if any, and request the claim to be examined and further compensation, if any, be determined. A copy of all medical reports and reports of vocational rehabilitation agencies or counselors shall be furnished to the Evaluation Division and to the worker and to the employer, if requested by such worker or employer."

The Department considers all medical reports accumulated during the life of a claim to be necessary for claim determination and requires that they be submitted to it. OAR 436-65-010(3) (renumbered OAR 436-30-030(3), May 1, 1985).

We find that claimant's two stress claims relate to a single mental condition. Claimant's employment related stress ceased several months before the Determination Order issued. The issuance of the Determination Order implied a finding that claimant's mental stress condition had become medically stationary. The Determination Order rated claimant's disability relative to that condition. Claimant does not contend that her condition has subsequently worsened. A second determination at this time would serve no purpose. Accordingly, that portion of the Referee's order directing that the second stress claim be separately closed is reversed.

ORDER

The Referee's order dated March 14, 1985 is affirmed in part and reversed in part. That portion of the Referee's order remanding the claim to Closing and Evaluation for further processing and payment of any benefits due until closure pursuant to ORS 656.268 is reversed. The Referee's order is affirmed in all other respects.

WILLI A. ARNDT, Claimant
Joseph C. Post, Claimant's Attorney
Marshall C. Cheney, Defense Attorney

WCB 81-08483
September 27, 1985
Order on Remand

This matter is before the Board on remand from the Court of Appeals. In Arndt v. National Appliance Co., 74 Or App 20 (1985), the court reversed our previous Order on Review and reinstated the Referee's award for permanent total disability. Claimant subsequently filed his petition for attorney fees in the court, and the court has remanded that petition to the Board for determination.

On consideration of claimant's attorney fee petition pursuant to OAR 438-47-045(1), claimant's agreement with his attorney for payment of attorney fees is approved. Claimant's attorney is allowed a reasonable fee of 25% of the increased compensation awarded claimant by the Court of Appeals, not to exceed $3,350, to be paid out of and not in addition to claimant's compensation.

IT IS SO ORDERED.

JUDY A. BRITTON, Claimant
Peter O. Hansen, Claimant's Attorney
Nancy J. Meserow, Defense Attorney

WCB 84-06935 & 84-04723
September 27, 1985
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 her occupational disease claim for a neck and upper back condition. On review, claimant contends that her condition is compensable.

With its respondent's brief the insurer has enclosed a copy of a chart note from claimant's treating surgeon and an affidavit from its attorney. The insurer requests that the Board consider this "new evidence" which it contends was unobtainable at the time of hearing. We treat this submission as a motion to remand for the taking of further evidence. We deny the motion. Following our de novo review, we are not persuaded that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Furthermore, we are unconvinced that this evidence was not obtainable with due diligence before the record was eventually closed. See Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

The Board affirms the order of the Referee.

ORDER

The Referee's order dated March 11, 1985 is affirmed.

RICHARD GILL, Claimant
Bennett, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 84-01913
September 27, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of Referee Peterson's order that ordered it to pay claimant temporary total disability compensation for the period from January 9, 1984 through April 3, 1984, and assessed a 25% penalty and an associated attorney fee for the employer's unreasonable termination of that compensation. The issues on review are claimant's entitlement to temporary total disability compensation and penalties and attorney fees.

Claimant was a 49-year-old steelworker when he sustained compensable arm and wrist injuries in May of 1983. While he was off work due to the injuries, claimant's union went on strike. The employer continued to operate the steel mill, however, using both newly-hired employes and existing workers who were willing to cross the picket line.

On December 2, 1983, while the strike was still in progress, the employer received a note from claimant's treating physician indicating that claimant was capable of returning to light duty work. The doctor also asked that he be shown a job description for any light job offered to claimant. The employer responded with a brief note to the doctor, stating that claimant would be offered a position training new employes and that the job "would not put any stress on his arm/wrist. . ." After receiving the note, claimant's physician responded: "I do think this would be a good job for [claimant], and he could start this immediately."

After receiving the doctor's response, the employer wrote to claimant advising him of the availability of light duty work. It also requested that he report for duty six days later. The letter advised claimant of the beginning time, place and date of the employment and that the treating doctor had approved the job as it had been described to him. The letter did not specify the wage rate to be paid, duration of the job or the specific job duties to be performed, other than to indicate that the work would involve training new employes.

After receiving the employer's letter, claimant met with his union representatives and decided not to accept the light duty job because it would require crossing the picket line. When claimant did not report to work on the designated day, the employer terminated his temporary disability compensation and vocational assistance. The employer sent a letter to claimant advising him of the reasons for terminating vocational services, but no communication was sent regarding the reasons for the termination of his temporary disability payments. There is no evidence that the Workers' Compensation Department, Compliance Division received copies of the correspondence sent to claimant. The Department's Rehabilitation Review Division did receive a copy of the vocational assistance termination letter, however.

Claimant requested a hearing, asserting that the employer's termination of benefits was unreasonable. He suggested that a refusal to cross a strike picket line is good cause for failure to accept light duty employment. The Referee agreed and held that requiring an injured worker to cross a picket line in order to maintain eligibility for workers' compensation benefits would put a "chilling effect" on the worker's federally-protected right to bargain collectively.

The Referee noted that at the time of his order, the Workers' Compensation Law did not address the labor issue presented by this case. He cited a section of ORS Chapter 657, however, that does. Chapter 657 is Oregon's Employment Law, and ORS 657.195(1) provides:

> "Notwithstanding any other provision of this chapter, no work is deemed suitable and benefits shall not be denied under this chapter to any otherwise eligible individual for refusing to accept new work under any of the following conditions:
>
> "(a) If the position offered is vacant due directly to a strike, lockout or other labor dispute. . . ."

The Referee felt that this section of the Employment Law indicated a legislative intent applicable to the Workers' Compensation Law as well. The Referee held, therefore, that claimant had not been offered a "suitable" job, as that term is used in the statute, and that temporary disability payments should not have been terminated. The Referee made an alternative finding that even if the termination was proper, the employer should have reinstated claimant's payments six weeks after the light duty job was offered, for the alternative employment was offered only for a six-week period. See OAR 436-54-222(6)(b) (renumbered OAR 436-60-030, May 1, 1985). The Referee found that although the employer's termination of vocational services was also improper,

the issue was mooted because of claimant's being released for regular employment before the first Determination Order issued. Finally, the Referee found the employer's conduct in terminating claimant's benefits to be unreasonable.

On review, the employer argues that the Referee erred by applying Chapter 657 provisions in a workers' compensation context. The employer asserts that if the legislature had intended to include the "strike" provisions of the Employment Law in the Workers' Compensation Law, it would have done so. Its failure to do so, the employer argues, must be viewed as deliberate.

Claimant responds that the Referee was correct in recognizing the legislature's overall policy of protecting a worker's labor rights. Claimant's primary argument, however, is that the employer failed to follow the administrative rules allowing for termination of disability benefits and that the termination was, therefore, unreasonable. The Referee mentioned only in passing that the employer may have failed to adhere to the rules governing benefit termination.

After reviewing the record, we find that we need not address the labor issue presented here, for it is clear that the employer failed to follow the requirements set forth in the administrative rules governing termination of temporary disability compensation. The termination of claimant's benefits was, therefore, unreasonable.

OAR 436-54-222 (renumbered OAR 436-60-030, May 1, 1985), sets forth the rules for terminating benefits. The pertinent portions of the rule provide:

> "(5) The insurer or self-insured employer shall cease paying temporary total disability compensation and start making payment of such temporary partial compensation as would be due in section (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 the worker's capabilities; and
>
> "(c) the employer has provided the injured worker with a written offer of employment which states the beginning time, date and place; the duration of the job, if known; 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. . . .
> "(7) An insurer or self-insured employer shall provide a written explanation to the

injured worker of the reasons for changes in the compensation rate and the method of computation whenever temporary total disability compensation is terminated and temporary partial disability compensation commences, and vice versa. A copy of the letter to the worker shall be sent to the Compliance Division in cases where the worker has refused wage earning employment."

We find that the employer in this case failed to meet the requirements of the foregoing rules in a number of respects. First, we are not satisfied that the employer sufficiently apprised claimant's physician of the "specific duties to be performed by the injured worker and the physical requirements thereof." The employer's note to the doctor merely indicated that the job would not injure claimant's arm. It did not discuss what claimant's specific duties would be and it clearly did not set forth the physical requirements of the work. The doctor's approval of the work without more information amounted to little approval at all.

Second, although the employer sent a letter to claimant advising him of the existence of light duty work, the letter did not comply with OAR 436-54-222(5)(c) (renumbered OAR 436-60-030, May 1, 1985). It did not indicate claimant's wage rate, job duration or an accurate job description. The employer argues that claimant obtained this information orally. The rule does not provide for oral notice, however; notice must be written.

Third, the employer failed to provide claimant with a written explanation of the reasons for the termination of his temporary total disablility compensation. Neither was the Compliance Division apprised of the employer's action. This failure was in direct contravention of OAR 436-54-222(7) (renumbered OAR 436-60-030, May 1, 1985).

Under these circumstances, we find that the employer's termination of benefits was unreasonable and that a penalty and attorney fee were warranted.

For the record, we note that the 1985 Oregon Legislative Assembly recently enacted Senate Bill 449, which permits an injured worker who has been released by the attending physician to return to work to refuse to return, without loss of vocational assistance, if a labor dispute is in progress at the place of employment. 1985 Or Laws, ch. 425 (effective September 20, 1985). Because the rights and liabilities of injured workers and their employers are generally determined by the statutes in effect at the time of the injury, however, Holmes v. SAIF, 38 Or App 145 (1979), the new law (to the extent that it is applicable herein) will not be retroactively applied. See Derenco v Benj. Franklin Sav. and Loan Ass'n, 281 Or 533, cert den 439 U.S. 1051 (1978).

ORDER

The Referee's order dated March 22, 1985 is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the self-insured employer.

ROY W. HAMMETT, Claimant
Kilpatricks & Pope, Claimant's Attorneys
Mitchell, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Reviewed by Board Members McMurdo and Ferris.

WCB 84-06239 & 83-09271
September 27, 1985
Order on Review

Claimant requests review of Referee Fink's order which upheld the SAIF Corporation's denial of aggravation of claimant's August 3, 1980 low back injury and upheld CDS of Oregon's denial of aggravation of claimant's March 13, 1979 low back injury. SAIF denied compensability of claimant's worsened condition as unrelated to the injury for which it was responsible. CDS of Oregon denied responsibility. The issues on review are compensability and responsibility.

SAIF argues that it is not responsible for claimant's worsened condition because there was a superceding intervening accident while working for SAIF's insured for which there was no claim made or that the medical evidence preponderates that the prior injury, insured by CDS of Oregon, is the cause of claimant's worsened condition. CDS of Oregon argues that SAIF is responsible for the last injury and that it failed to prove that the earlier injury was the cause of the worsened condition. Claimant argues that compensability of his worsened condition results from at least one if not all of his industrial injuries and that SAIF should be found responsible. There is no dispute that claimant's condition has worsened.

In 1966 claimant had a laminectomy, diskectomy and foraminotomy at L5-S1 to free his L5 nerve root. In 1972 he suffered a moderate to severe lumbosacral sprain. On March 13, 1979 claimant sustained a compensable injury to his low back in a lifting incident while employed at CDS of Oregon's insured. In June 1979 claimant submitted to the same type of surgery as he had in 1966 to remove bone and scar tissue that were results of the 1966 surgery entrapping the L5 nerve root and for a disc at L4-5. The claim was closed by Determination Order dated April 1, 1980, which awarded 32° for 10% unscheduled permanent partial disability.

He began work at Eastern Oregon State Hospital, SAIF's insured, in August 1979. After he returned to work, his doctor reported that claimant had absolutely no back or leg pain, but by November 1979 the right leg pain was returning. On August 3, 1980 claimant was tackled from behind by a patient. He was off work for four days, responded to conservative care, and returned to work without additional impairment. This claim was closed by Determination Order dated October 1, 1980 which awarded only temporary total disability.

In December of 1981 or 1982, claimant cannot be sure which year, claimant dropped three to four feet from the side of a scaffold while hanging seasonal lighting at SAIF's insured. He told his supervisor of the accident, but lost no time from work and sought no medical care related to this incident.

On June 6, 1983 a doctor noted that gradually increasing pain had reached the trouble point where it was interfering with claimant's ability to do his job. The doctor thought the increase in pain had occurred over the previous two weeks. On June 16,

1983 Dr. Weeks examined claimant and reported that claimant complained of pain in his back and right leg without recent injury, "just rather gradual onset of pain in the low back and radiating discomfort into the right lower extremity." Claimant was hospitalized for conservative treatment and diagnostic procedures from June 20 through June 27, 1983. The tentative diagnosis was possible herniated nucleus pulposus or perineural fibrosis. On June 24, 1983 Dr. Bingham reported CT scan findings of bulging disc or fibrosis or composite root exit at L5-S1. Dr. Weeks felt the CT scan was equivocal.

On July 14, 1983 claimant was examined by Dr. Gehling. Dr. Gehling felt that claimant needed EMG/NCV testing to further define claimant's condition. Dr. Isaacs reported that nerve conduction testing revealed sensory S-1 nerve root radiculopathy. On July 19, 1983 Dr. Gehling opined that, "There is a likelihood that the majority of his CT findings are related to scar tissue."

On July 20, 1983 claimant visited an emergency room complaining of pain in his low back. The emergency room reported that claimant's back pain problem had been bothering him over a two year period.

On July 25, 1983 Dr. Gehling wrote a letter to SAIF. He summarized claimant's history, including his impression that claimant's latest accident involved a collapsing scaffold and that claimant's symptoms had increased as a result of the collapsing scaffold incident. He summarized his assessment of the contribution of the various injuries to claimant's condition as follows:

> "You will also note that the patient has had two prior back surgeries, one in 1966 and one in 1979. Obviously these were points that were not admitted to the record on admission by Dr. Weeks and are certainly contributory toward the patient's present problems.
>
> "In my opinion, the major contributing cause of [claimant's] current condition must be two-fold. First, the patient describes an injury approximately one year ago at work of falling off scaffolding and since then having back problems. Secondly, the fact that the patient has had two back surgeries already would indicate that he has had significant pathology occur in his back such that obviously the surgeries and the prior injuries do have a pre-disposition towards further problems. Combined with this is the fact the patient does have a Torrance CT scan that demonstrated speckling and bulging with obliteration of the S-1 nerve root on the right at the 5-1 level. This is likely related to scarring and/or recurrent disc. Combined with this is the fact that the patient has physical findings to support this, that being an absent ankle reflex on the right and some S-1, S-2 type

hypoalgesia dysesthesia on the right foot, and electro-physiologic data to support this along with the suspected neuropathic process in the peroneal nerve on the right.

"In regards to the patient's 1980 work injury, I do not think this relates significantly to his current complaints since the patient describes an injury a year later that precipitated the new onset of discomfort."

The next and final statement on medical causation was Dr. Gehling's June 19, 1984 letter to CDS of Oregon's counsel. He stated:

"Certainly the patient has a predisposition towards back problems related to his prior surgeries in the affected area. However, the patient stated the onset of his new symptoms developed after his fall from the scaffolding and certainly this type of trauma could precipitate the new pathology that has contributed towards his present symptomatology, be this bony versus bulging disc, etcetera.

"Presently the patient has chronic back discomfort with some S-1 irritation and evidence for a neuropathy. His pain pattern has certainly been accelerated and likely resurfaced secondary to his fall from the scaffolding.

"As to his back injury in 1980, I have no opinion as regards how this contributes to his present complaints since he stated this resolved, and I do not have any indications as to its severity, etcetera."

The Referee found that he did not question claimant's testimony based on demeanor at hearing, but he discounted the testimony on the basis of conflicts with the medical documentation. Claimant testified that he had had right leg pain since the 1980 injury, but there was no complaint recorded until June 1983. The Referee did not rely on claimant's testimony and found that claimant's condition was not proven to be due to either compensable injury.

Claimant testified that the scaffolding incident did not cause him to lose time from work nor to seek medical attention. Claimant testified that the mobile scaffolding had tipped and claimant had let go and dropped straight down a short distance and landed on his feet. Whatever discomfort claimant incurred as a result of the scaffolding incident resolved quickly.

We find Dr. Gehling's opinion is persuasive that claimant's current condition is probably caused by scarring related to his prior injuries and surgeries. We find that the doctor's opinion is persuasive that the 1980 industrial injury was not contributory

to claimant's condition in 1983 because claimant had clearly recovered completely from what was a minor strain. But we do not find the doctor's opinion is persuasive that the scaffold incident that occurred six or eighteen months before the May 1983 request for medical treatment was causative of the probable scarring revealed by spinal tomography. There is further persuasive evidence that supports the finding of scar tissue formation as the cause of claimant's symptomatology in the form of the surgical findings at the 1979 surgery that claimant suffers from formation of scar tissue at the sites of his spinal surgeries. There is also the report of claimant's doctor in 1979 that claimant initially had relief from his leg pain after surgery, but within five months he was beginning to show minimal indications of the return of the radiculopathy. There is no evidence in this record to explain any cause of scarring at the site of claimant's prior surgeries other than the surgeries nor that claimant's subsequent injuries contributed to the progress of claimant's symptomatology related to the scarring.

Considering the medical and lay evidence as a whole, we find that the evidence preponderates that the insurer who was responsible for the last surgery is responsible for the scar tissue which was a natural consequence of that surgery, and which is the probable cause of claimant's worsened condition, and is, therefore, responsible for compensation for claimant's worsened condition. Ceco Corp. v. Bailey, 71 Or App 782 (1985); cf. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (rebuttable presumption that last injury was cause). Therefore, CDS of Oregon is the responsible insurer.

Claimant's attorney was instrumental in obtaining reversal of the denial of benefits, but failed to carry his case against SAIF. We find that claimant's attorney participated meaningfully at hearing and on Board review to the extent that there was a denial of compensability and that claimant was receiving no benefits before this order. The fee awarded is not as large as it might have been if claimant had proven his case against the insurer who was ultimately found liable. See Barbara A. Wheeler, 37 Van Natta 122 (1985).

ORDER

The Referee's order dated November 20, 1984 is reversed in part and affirmed in part. That portion of the Referee's order which set aside CDS of Oregon's denial is reversed and the claim is remanded to the insurer for acceptance and payment of compensation. The remainder of the order is affirmed. Claimant's attorney is awarded $500 for services at hearing and $250 for services on Board review, to be paid by CDS of Oregon in addition to and not out of compensation.

GERALDINE A. HARET, Claimant
Charles Robinowitz, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05250
September 27, 1985
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Haret v. SAIF, 72 Or App 668, rev den, 299 Or 313 (1985). We have been instructed by the court to order acceptance of claimant's cervical spine aggravation claim as of December 4, 1981 and to determine a penalty and associated attorney fee for the SAIF Corporation's late and unreasonable denial of the aggravation claim. The salient facts of the case are set forth in

the court's opinion and need not be repeated. The SAIF Corporation shall accept claimant's aggravation claim effective December 4, 1981.

As to additional compensation as a penalty, ORS 656.262(10), our interpretation of current law is that a penalty may actually be assessed if there are amounts due and unpaid either at the time of the occurrence of the conduct being penalized or as of the date of hearing. Harold A. Lester, 37 Van Natta 745 (1985). See also EBI Companies v. Thomas, 66 Or App 105, 111 (1983). In this case, claimant was entitled to temporary disability compensation as "interim" compensation commencing 14 days after SAIF received notice of the aggravation claim, which the evidence establishes was December 10, 1981, ORS 656.262(4), if she left work as a result of her compensable injury. ORS 656.210(3); Bono v. SAIF, 298 Or 405, 410 (1984).

We conclude that claimant is entitled to temporary disability compensation during the period December 4, 1981 through June 10, 1982. The record suggests that claimant performed some part-time work during this period and that benefits may be due for temporary partial disability for at least a portion of the relevant period. However, to the extent that SAIF is unable to calculate the amount of temporary disability benefits due during this period, it shall pay benefits for temporary total disability. Bono v. SAIF, supra, 298 Or at 410. Claimant is awarded an additional amount of 25% of the temporary disability benefits due between December 4, 1981 and June 10, 1982 as a penalty. Claimant's attorney is awarded $400 as a reasonable attorney fee for prevailing on the penalty issue, to be paid by the SAIF Corporation in addition to and not out of claimant's compensation.

IT IS SO ORDERED.

CLIFFORD HOWERTON, Claimant
Ormsbee & Corrigall, Claimant's Attorneys
Cummins, et al., Defense Attorneys

Own Motion 85-0196M
September 27, 1985
Own Motion Order on Reconsideration

The self-insured employer has again requested reconsideration of our previous order reopening claimant's 1977 industrial injury claim under our own motion authority. ORS 656.278. Claimant's aggravation rights have expired. In our first order, we ordered claimant's claim reopened with payment of temporary disability compensation from February 5, 1984. The employer requested that we reconsider our allowance of temporary disability compensation. We issued our Own Motion Order on Reconsideration, in which we adhered to our previous order. The employer has renewed its objection to our determination that claimant is entitled to temporary disability compensation.

The essence of employer's objection is its assertion that claimant is not entitled to temporary disability compensation unless and until he is hospitalized for surgery. Ancillary to this assertion are the arguments that claimant has been medically stationary since his last claim closure, in 1977, and that if claimant is entitled to further compensation that compensation should be for permanent, not temporary, disability.

In our most recent order, we discussed at some length the

fact that employer joined in claimant's original petition for own motion relief, both by means of a disputed claim settlement and by having executed, by counsel, the petition under the statement: "This application is concurred with and jointly requested by employer . . . ." We concluded that by joining with claimant in petitioning the Board to reopen claimant's claim under our discretionary own motion authority, employer agreed that claimant was entitled to temporary disability compensation, although we found that the parties were unable to agree on when such benefits should be paid. We took the joint petition at face value, concluding that the parties had intended the Board to resolve the question. We did so, obviously not to employer's satisfaction.

On this most recent request for reconsideration, employer finds most fault with our statement that our review of the medical evidence tended to support employer's contention that perhaps claimant's claim should not, as a matter of fact, be reopened, but that it was reopened because of the agreement of the parties. Claimant also takes issue with this statement, on the ground that he disagrees with our view of the medical evidence, and requests reconsideration of our order for that reason. We have reconsidered the record totally, and we now conclude that claimant is entitled to claim reopening and the payment of temporary disability benefits purely on the merits of his claim, and in accordance with long-established Board policy, although in the alternative, we would also adhere to our previous order on the ground that, when we initially decided this matter, employer's position on the record before us could be interpreted only as one of acquiescence.

In any aggravation claim, the central inquiry is always whether there has been a showing of a worsening of the underlying condition resulting from the original injury since the last award or arrangement of compensation. See ORS 656.273(1). The medical evidence before us unanimously establishes that claimant's underlying condition has significantly worsened since the first, and only, arrangement of compensation in 1977. We find the first manifestations of worsening in 1979; however, it was not until February 5, 1984 that the requisite causal connection was made, which has since been confirmed by all physicians that have treated or examined claimant. We also find medical verification of claimant's inability to perform his regular employment as of February 5, 1984. See ORS 656.273(6). Employer has not disputed the content of any of the medical evidence. We reject employer's interpretation of that evidence as having established that claimant has been medically stationary since 1977 as untennable. We therefore conclude that claimant is entitled to own motion relief.

We said in Vernon Michael, 34 Van Natta 1212, 1213 (1982):

> "When we grant own motion relief, we order compensation for temporary total disability for a claimant who was working or seeking work at the time his physical condition worsened; and we order compensation for temporary total disability for a claimant who was not working or seeking work due in whole or in significant part to physical problems causally linked to the prior compensable injury; but we do not order

compensation for temporary total disability for a claimant who was not working or seeking work for any other reason, such as voluntary withdrawal or retirement from the labor market."

See also Edward O. Miller, 37 Van Natta 549, 561 (1985).

We find that since February of 1984, claimant has either been working or has been unable to work due in significant part to his compensable disability. Therefore, under long-standing Board policy, claimant is entitled to compensation for temporary disability until such time as his claim is closed pursuant to ORS 656.278.

ORDER

Employer's and claimant's requests for reconsideration are granted. Our previous orders dated June 10, 1985 and August 28, 1985 are hereby withdrawn and vacated. The employer is ordered to reopen claimant's claim effective February 5, 1984 and to pay temporary total disability compensation from said date, less time worked, until closure pursuant to ORS 656.278. Claimant's attorney fee agreement is approved and claimant's attorney is allowed a reasonable attorney fee of 25% of the compensation ordered by this order, not to exceed $1,250.

DANNY J. McALPIN, Claimant
David C. Force, Claimant's Attorney
Coons,et al., Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-08279
September 27, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of those portions of Referee Thye's order which set aside its denial of claimant's industrial injury claim for urethral false passage and awarded $2,000 attorney fees for overturning its denial. In addition, SAIF cites as error the admission of Exhibits 2A and 2B and the exclusion of Exhibits 42 and 43. The issues on review are admissibility of exhibits, compensability, and attorney fees.

Claimant was injured on May 7, 1977 when he slipped on a stairway and landed on his right foot which was curled under his groin. He stayed home from work for three days and went to see a doctor on May 10. At that time he had tenderness in the area of his previously repaired hernia. An examination by Dr. Wilson on June 7, 1977 revealed swelling in claimant's groin by a vasectomy scar. In August 1977 Dr. McIlvaine reported claimant had pain in his right inguinal area and ejaculatory impotence secondary to pain. In June 1980 Dr. Narus reported a history of groin injury and that claimant's sexual function was unimpaired. In August 1982 Dr. Hebert reported the diagnosis of prostatitis and proposed cystoscopic examination to explore the site of the infection. Upon internal observation, Dr. Hebert discovered the source of claimant's discomfort was a urethral "false passage" which he repaired. Claimant submitted the operation report which showed the original diagnosis of prostatitis and the post-surgical diagnosis of urethral false passage. SAIF denied prostatitis was related to claimant's injury and claimant requested a hearing.

Dr. Norton, orthopedic surgeon, reviewed SAIF's exhibits, and opined that claimant had not suffered any genitourinary injury as

a result of his industrial accident. Dr. Olson, urologist, also reviewed SAIF's exhibits, and opined that claimant's false passage condition was unrelated to claimant's low back strain injury because there had been no complaints nor treatment of a genitourinary injury.

Dr. Hebert opined that claimant's history of swelling and pain at the time of the injury combined with short-term impotence shortly thereafter established to his satisfaction that claimant had suffered a sufficient blow to the urethra to cause the development of the false passage. He was further convinced by continuing complaints of unexplained pain for five and one-half years without intervening injury and that the pain was relieved by the cystoscopic surgery.

At the hearing, the parties stipulated that claimant's prostatitis was not compensable and that SAIF's denial of prostatitis could be upheld. The Referee allowed SAIF leave to amend its denial to include the false passage condition and both parties agreed to proceed with the hearing on the assumption that SAIF had denied the urethral false passage condition. SAIF subsequently submitted a letter advising that it considered its denial letter to have included the urethral false passage condition.

SAIF submitted an index with exhibits more than twenty days before the hearing. Claimant responded with no exhibits until the day of the hearing. Claimant submitted ten exhibits, numbered 2A through 2K, to Referee Mongrain. Referee Mongrain refused to admit the exhibits as offered too late, but then Referee Mongrain recused himself and Referee Thye became the hearing officer. Claimant submitted only Exhibits 2A and 2B to Referee Thye. Referee Thye observed that the exhibits were submitted late, but in his discretion he requested SAIF's response. SAIF responded that it was prejudiced by the surprise of having claimant present documentary evidence out of SAIF's file on the day of hearing and objected to its admission.

The admitted exhibits at issue are the chartnote of Dr. Wilson for June 7, 1977 and the chartnote of Dr. McIlvaine for August 16, 1977 referred to earlier. SAIF received Dr. Wilson's chartnote on June 13, 1977. There is no receipt stamp on Dr. McIlvaine's chartnote, but SAIF admitted that the chartnote had been used at a 1980 aggravation hearing. SAIF argued that the ten day rule should be strictly applied and that claimant's exhibits should be excluded. Claimant responded that when he received the exhibit list he thought SAIF was submitting the entire medical file as it had for the prior hearing on aggravation, but shortly before hearing had discovered that SAIF had removed from the medical file offered in this case all references to claimant's genitourinary symptoms and complaints. On review, SAIF renews its argument that the Referee should not have admitted the exhibits because claimant had not shown good cause for his failure to offer the exhibits ten days before hearing and that this was an example of the type of carelessness or gamesmanship which prejudices a Referee's evaluation of the evidence.

Subject to specific statutory limitations and our rules of procedure, the Referee's mandate is to "conduct the hearing in any manner that will achieve substantial justice." ORS 656.283(6). Our rules, OAR 438-07-005(4), provide that the Referee exercise discretion in admitting evidence first offered at hearing. We find that the Referee's decision on Exhibits 2A and 2B was within

his discretion. Cf. Dale R. David, 36 Van Natta 1531 (1984) (insurer offered exhibit at hearing that it had held in its file for more than one year). The fact that the exhibits had been offered and admitted in a previous aggravation hearing between the parties greatly reduces the factors of surprise and prejudice. The Referee offered SAIF the opportunity to cross-examine the physicians whose reports were admitted, and it declined. The exhibits do no more than corroborate claimant's testimony that he reported a groin injury to his doctors and that the doctors seemed interested only in claimant's back.

At the end of the hearing, the Referee allowed SAIF a continuance to clarify its denial, whether it was meant to include the urethral false passage which was the actual claim by the operation report. SAIF responded with its clarification letter that the denial included the urethral false passage condition and submitted Exhibits 42 and 43. Exhibit 42 is a second opinion letter from Dr. Norton. He reviewed SAIF's exhibits and opined that claimant had no genitourinary injury resulting from his fall because he did not complain of groin injury at the time of the fall nor did he complain of hematuria. Exhibit 43 is a second opinion letter from Dr. Olson. Dr. Olson opined that he might have expected to see some more dramatic symptoms than claimant reported but that he would respect the opinion of the attending physician that the urethral false passage was related to the fall. He remained firmly of the opinion that the prostate condition was unrelated. Both doctors reviewed summaries of the hearing and commented on Dr. Hebert's testimony. The Referee refused to admit the two exhibits on claimant's objection because the purpose of allowing the continuance was for SAIF to clarify its denial letter and to cross-examine Drs. Wilson and McIlvaine. We fail to discern the relevance or competence of Dr. Norton's and Dr. Olson's opinions on the issue whether claimant complained to his treating physicians in 1977 about genitourinary symptoms and we find that the Referee was within his discretion to exclude the proffered exhibits.

On the issues of compensability and the attorney fees awarded, the Board affirms and adopts the Referee's order with the following comment. We have stated the elements we will consider when reviewing attorney fee awards and repeat that we only determine whether a particular fee awarded in a particular case seems reasonable based on those factors. Comparison of fees awarded in other cases is unlikely to be useful unless there is nearly total identity of all of the relevant factors. See Carol McKenna, 37 Van Natta 638 (1985).

ORDER

The Referee's order dated January 21, 1985 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

BILL M. STURTEVANT, Claimant
Cummins, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-07560
September 27, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Howell's order that denied claimant's request for additional temporary total disability compensation. The SAIF Corporation cross-requests review of that portion of the Referee's order that assessed a penalty and insurer-paid attorney fee for alleged unreasonable refusal to pay temporary total disability compensation. The issues on review are entitlement to temporary total disability and penalty and attorney fees.

Claimant sustained a compensable industrial injury to his left ankle in February 1981. Although the claim was accepted as one for a disabling injury, little loss of time from work was involved. The claim was closed in April 1981 with no permanent disability award.

On June 2, 1983 claimant sought treatment from Dr. Stephen Stolzberg, neurologist, complaining of symptoms indicative of atrophy of one or more muscles of the left leg and back pain. Initially Dr. Stolzberg suspected a lesion at either the L5 or S1 nerve root, however, ultimately he diagnosed an injury to the left tibial nerve and reported that claimant was experiencing back pain secondary to a limp due to weakness of the left foot and ankle. SAIF denied responsibility for claimant's condition on July 22, 1983. On August 19, 1983 Dr. Stolzberg wrote to SAIF and made the following points: (1) claimant was not able to work and had not been able to work from June 2, 1983; (2) claimant's injured left leg was medically stationary; (3) claimant's back pain was related to his left leg weakness; and (4) it was medically probable that claimant's left leg and back problems were both related to the 1981 industrial injury.

On September 26, 1983 a hearing was held on SAIF's denial. The record remained open until April 1984 for additional medical depositions. On April 25, 1984 Referee McCullough issued his Opinion and Order in which he set aside SAIF's denial, ordered the claim reopened as of June 2, 1983, and ordered SAIF to pay "interim compensation" as an alternative to temporary total disability benefits from July 28, 1983 to the date of the hearing. We affirmed the relevant portions of Referee McCullough's order. Bill M. Sturtevant, 37 Van Natta 294 (1985).

Pursuant to Referee McCullough's order, SAIF paid temporary total disability benefits for the period July 29 through September 25, 1983. On July 30, 1984 a Determination Order reclosed claimant's claim, awarding additional temporary total disability from June 2 through August 19, 1983. SAIF paid temporary total disability for the period June 2 through July 28, 1983 pursuant to the Determination Order. The July 1984 Determination Order also awarded scheduled and unscheduled permanent partial disability, which is not at issue in this proceeding.

The issue we now face is raised by claimant's assertion that he is entitled to temporary total disability compensation under his open aggravation claim from September 26, 1983 through June 21, 1984, the latter date being the date of an Orthopaedic

Consultants' report that reported claimant was medically stationary or, alternatively, until July 30, 1984, the date of the Determination Order. Dr. Stolzberg concurred in the finding that claimant was medically stationary. However, the Evaluation Division, in issuing its July 1984 Determination Order, concluded that claimant was medically stationary as of August 19, 1983, the date of Dr. Stolzberg's first report that claimant was medically stationary. The Referee in this proceeding agreed, based upon all of the evidence, including claimant's testimony, that claimant was medically stationary as of August 19, 1983. After our review of the record, we agree with the Referee and adopt his finding of fact that claimant was medically stationary as of August 19, 1983.

The Referee concluded, based upon his finding of the medically stationary date, and in consideration of Referee McCullough's previous order, that claimant was not entitled to temporary total disability compensation after September 25, 1983. However, he went on to conclude:

> "By Opinion and Order dated April 25, 1984 claimant's back claim was ordered reopened. The Opinion and Order did not determine a medically stationary date. SAIF was, therefore, obligated to pay temporary disability compensation until claimant returned to work, was released for regular work or until a determination was made pursuant to ORS 656.268 that he had become medically stationary. SAIF's obligation to pay interim compensation for a specified period was independent of the requirements attendant with reopening for aggravation and nothing in the April 25, 1984 Opinion and Order suggests anything to the contrary. SAIF's interpretation that the Opinion and Order did not require it to pay temporary disability compensation on the open claim was unreasonable.
>
> "Effective September 26, 1983 SAIF unilaterally terminated temporary disability compensation. Payments should have continued until July 30, 1984 when a Determination Order was issued, pursuant to ORS 656.268, finding claimant medically stationary. Even though claimant is now found not to be entitled to compensation after August 19, 1983, when SAIF unreasonably terminated temporary disability compensation and during its continued refusal to pay such compensation, that compensation was "then due." See ORS 656.262(10). Claimant is entitled to a penalty and attorney fee for unreasonable refusal to pay temporary total disability from September 26, 1983 to July 30, 1983." (Emphasis in original.)

We find the Referee's conclusion that temporary disability compensation was "then due" inconsistent with his conclusion that SAIF is not required to pay that compensation. We find no

meaningful distinction between this case and Kenneth E. Awmiller, 34 Van Natta 1123 (1982), aff'd, Georgia Pacific v. Awmiller, 64 Or App 56 (1983). In Awmiller, the employer unilaterally terminated temporary disability compensation because of what the Referee, the Board and the court found was an unreasonable belief that the claimant had been released to return to work. The Referee ordered the employer to pay the withheld compensation and imposed a penalty in addition. We affirmed the Referee and the court in turn affirmed our order. See also Lester v. Weyerhaeuser Co., 70 Or App 307, rev den, 298 Or 427 (1984) (Penalty appropriate for delay in obtaining claim closure where temporary disability compensation paid during delay interval); Harold A. Lester, 37 Van Natta 745 (1985) (Order on Remand).

The only difference apparent in this case is that the Evaluation Division and the Referee found, and we agree, that claimant was in fact medically stationary in August 1983. The earliest that finding was made, however, was July 30, 1984. The evidence establishes that claimant did not return to work, nor was he released to return to regular work, during the interval between August 1983 and July 30, 1984. It is axiomatic that an employer or insurer must continue to pay temporary disability compensation to an injured worker whose claim is in open status until the worker returns to his regular work, is released by his attending physician to return to his regular work or "until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under [ORS 656.268]." ORS 656.268(2); Jackson v. SAIF, 7 Or App 109 (1971); Joel I. Harris, 36 Van Natta 829 (1984), aff'd mem, 72 Or App 591 (1985). The fact that claimant may have been, and in this case was, medically stationary for almost a year before the Evaluation Division issued its Determination Order does not abrogate the clear statutory mandate that temporary disability compensation be paid until the Evaluation Division speaks. See Lester v. Weyerhaeuser Co., supra; Georgia Pacific v. Awmiller, supra. We conclude that claimant is entitled to payment of temporary disability compensation during the period September 26, 1983 through July 30, 1984.

The Referee awarded additional compensation of 10% of the amount of temporary disability compensation due between September 26, 1983 and July 30, 1984 as a penalty. We conclude, consistent with the penalties assessed in Awmiller and Lester, that the penalty should be additional compensation of 25% of the temporary disability compensation due and unpaid between September 26, 1983 and July 30, 1984. This penalty covers the entire period of temporary disability compensation because even after Referee McCullough's order reopened the claim, SAIF made no effort to pay temporary disability compensation beyond the date the Referee ordered for payment of "interim" compensation, which was the date of the earlier hearing. We agree with the Referee in this case that SAIF's failure to recognize Referee McCullough's reopening of the claim as initiating a requirement to pay temporary disability compensation until a proper termination was authorized by ORS 656.268(2) was unreasonable. The penalty-associated attorney fee will be affirmed.

ORDER

The Referee's order dated September 18, 1984 is reversed in part, modified in part and affirmed in part. That portion of the

Referee's order that denied claimant's request for additional temporary disability compensation is reversed and claimant is awarded additional temporary total disability compensation from September 26, 1983 to July 30, 1984, inclusive. That portion of the Referee's order that assessed a penalty of 10% of the compensation due and unpaid is modified and the SAIF Corporation is ordered to pay additional compensation in the amount of 25% of temporary disability compensation awarded by this order as and for a penalty. The remainder of the Referee's order is affirmed. Claimant's attorney is allowed 25% of the increased compensation awarded by this order, not to exceed $2,000, as a reasonable attorney fee for obtaining increased compensation. Claimant's attorney is awarded $300 for services on Board review in connection with the penalty issue, to be paid by the SAIF Corporation in addition to compensation.

FERN F. TOLLEFSON, Claimant
Steven C. Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-09689
September 27, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Brown's order which declined to assess penalties and accompanying attorney fees against the SAIF Corporation for an allegedly unreasonable recovery of overpaid temporary total disability from a permanent disability award. On review, claimant contends that SAIF's conduct was unreasonable and that penalties/attorney fees are warranted.

The Board affirms the order of the Referee with the following comment. Assuming for the sake of argument that SAIF's action constituted a unilateral recovery of benefits without prior authorization and that claimant has not previously waived the right to raise the issue by subsequently executing a stipulation, we would not assess a penalty and attorney fee against SAIF. SAIF's action was taken prior to the Court of Appeals' decision in Forney v. Western States Plywood, 66 Or App 155 (1983). Actions accomplished in accordance with the provisions of an existing rule do not warrant the imposition of a penalty and attorney fee. See Zwahlen v. Crown Zellerbach Co., 67 Or App 3 (1984); William G. Hamrick, 37 Van Natta 70, 72 (1985).

ORDER

The Referee's order dated March 14, 1985 is affirmed.

JACQUELINE B. COAN, Claimant
Goldberg & Mechanic, Claimant's Attorneys
Mitchell, et al., Defense Attorneys

WCB 84-00719
September 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of Referee Mulder's order that set aside its denial of claimant's occupational disease claim for a right knee condition. On review, the employer contends that claimant has failed to prove that her underlying condition has worsened.

The Board affirms the order of the Referee with the following comment. To establish an occupational disease claim relating to a preexisting condition, a claimant must prove that work conditions

caused a worsening of the underlying condition producing disability or the need for medical services. Weller v. Union Carbide, 288 Or 27 (1979). In addition, claimant must prove that the work conditions were the major contributing cause of the worsening of the preexisting condition. Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570, rev den 292 Or 825 (1982). Following our de novo review of the medical and lay evidence, including claimant's credible testimony, we find that claimant has established that her work activities since August 1981 were the major contributing cause of the worsening of her underlying right knee condition. Accordingly, we agree with the Referee's ultimate conclusion that claimant's occupational disease claim is compensable.

ORDER

The Referee's order dated February 14, 1985 is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the self-insured employer.

ADA K. COOPER, Claimant
Gatti, et al., Claimant's Attorneys
Miller, et al., Defense Attorneys

WCB 84-06472
September 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Nichols' order that upheld the Determination Order rating claimant's disability at 96° for 30%, but awarding 16° for 5% unscheduled permanent partial disability for the low back because of claimant's failure to lose weight. The self-insured employer cross-requests review of that portion of the order that approved the temporary total disability provision of the same Determination Order, granting claimant temporary total disability for the period of January 3, 1984 through March 20, 1984. The issues on review are whether the Determination Order properly reduced claimant's award of disability, and claimant's entitlement to temporary total disability from January 3 through March 20, 1984.

Claimant compensably injured her low back on September 7, 1982 when she slipped on some steps at a cannery and twisted her low back. At the time of the injury claimant was 5' 5" tall and weighed approximately 210 pounds. She received conservative chiropractic care and it was recommended that she lose at least 50 pounds.

After chiropractic treatment proved ineffective claimant visited Dr. Smith, a neurosurgeon. Dr. Smith performed a myelogram which revealed a central disc protrusion at L4-5 and a slight bulging at L5-S1. Dr. Smith recommended that these lesions be surgically repaired, but he felt claimant to be a poor surgical risk because of her excessive weight. He recommended that claimant lose 50 to 60 pounds before undergoing surgery.

Claimant was referred to a diet center where she was placed on a weight loss regimen designed to reduce her weight by approximately 40 pounds in 16 weeks. The program was largely unsuccessful, however, and claimant had lost only six and one-half pounds at the program's end. Diet center personnel expressed disappointment at claimant's failure to reduce and indicated that even persons who "cheated" on the diet program generally lost a minimum of 15 pounds.

In early 1984 claimant was examined by Drs. Rosenbaum, Utter and Mason. Drs. Rosenbaum and Mason felt claimant was a poor surgical risk because of her obesity, and that excess weight was causing damaging structural changes in her low back. Dr. Utter felt that no amount of weight loss would reduce claimant's low back symptoms.

A June 8, 1984 Determination Order rated claimant's low back disability at 30%, but granted only 16° for 5% unscheduled disability because of claimant's failure to lose weight. Subsequent to the issuance of the order, claimant was examined by her family physician to determine possible medical causes for her inability to reduce. None were found.

The Referee affirmed the reduced award, holding that the self-insured employer had satisfied its burden of proving that claimant had unreasonably failed to follow her physicians' weight loss advice. Nelson v. EBI, 296 Or 246 (1984). In Nelson, the Court held that an overweight worker's disability award may be reduced if the insurer or self-insured employer proves that the worker has unreasonably failed to heed his or her doctor's recommendations regarding weight loss. A reduced award is proper unless the record establishes that claimant has made reasonable, albeit unsuccessful, attempts at following her physician's advice. See Christensen v. Argonaut Ins. Co., 72 Or App 110 (1985).

After reviewing the record, we agree with the Referee that claimant has not made a reasonable attempt at losing weight. While she initially cooperated by entering the diet center program, she did not benefit because she failed to follow the diet plan prescribed for her. There is no medical reason for claimant's failure to reduce. Her difficulty is solely a function of her appetite. Although claimant complained that the food prescribed for her was expensive and that she had to fix separate meals for her family and herself, we do not find these reasons for failing to follow the diet plan persuasive. The reduction of claimant's unscheduled award was warranted.

The remaining issue is claimant's entitlement to temporary total disability compensation for the period of January 3, through March 20, 1984. The Referee affirmed the Determination Order granting that compensation, while noting that claimant's treating physician had declared her medically stationary as of January 3, 1984. On review, the employer argues that because claimant was stationary as of January 3, no temporary disability compensation was due subsequent to that date. We disagree.

It is axiomatic that an employer or insurer must continue to pay temporary disability compensation to an injured worker whose claim is in an open status until the worker returns to regular work, is released by the attending physician to return to regular work or "until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under [ORS 656.268]." ORS 656.268(2); Jackson v. SAIF, 7 Or App 109 (1971); Bill M. Sturtevant, 37 Van Natta 1275 (WCB Case No. 84-07560, September 27, 1985). In the present case, claimant was declared medically stationary approximately ten weeks prior to the issuance of the Determination Order granting temporary total disability compensation through

March 20, 1985. She did not, however, return to regular work nor was she released to do so prior to the date of the order. The fact that claimant was stationary prior to the issuance of the order does not abrogate the clear statutory mandate that temporary disability compensation be paid until a determination under ORS 656.268 is made. See Lester v. Weyerhaeuser Co., 70 Or App 307, rev den, 298 Or 427 (1984). The award granted by the Determination Order was proper.

Although claimant has prevailed on the issue of entitlement to temporary total disability, which was raised by way of the self-insured employer's cross-request for review, her attorney offered no argument in defense of her entitlement to that compensation. Therefore, no attorney fee is awarded for services before the Board.

ORDER

The Referee's order dated March 5, 1985 is affirmed.

LORETTA J. DIMMICK, Claimant
Jim Vick & Assoc., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-07870 & 83-07871
September 30, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Galton's order that granted claimant an award of 128° for 40% unscheduled permanent partial disability in addition to the 64° for 20% award granted by the Determination Order, for a total award of 192° for 60% disability of the low back. The issue is extent of unscheduled permanent partial disability.

The employer asserts that the Referee erred in three respects: (1) by not considering that claimant's disability was affected by noncompensable factors of osteoarthritis, spondylolisthesis and obesity; (2) by not taking into account what the employer calls a lack of motivation to return to work; and (3) by concluding that claimant has few, if any transferable vocational skills.

We agree with the Referee's findings of fact, which we adopt. Based upon his findings, the Referee concluded that claimant was entitled to an increased award of permanent partial disability. Claimant was age 53 at the time of the hearing and had a high school diploma and one year of junior college. Her impairment has been rated as mild to mildly moderate, and the physicians agreed that she could perform light work. Determination Orders had previously awarded claimant 64° (20%) unscheduled permanent partial disability for injury to the low back.

While we agree that claimant is entitled to an increased award of disability, we believe the Referee's award was excessive. Considering claimant's physical impairment and all of the relevant social and vocational factors, we conclude that claimant would be most appropriately compensated by an award of 128° for 40% unscheduled permanent partial disability. In arriving at this award, we have considered each of the employer's contentions, and find that only one merits further discussion.

The employer asserts that claimant's award should be reduced because she has failed to follow medical advice to lose weight and, thereby, mitigate her disability. The employer relies upon Nelson v. EBI Companies, 296 Or 246 (1984). Claimant is five feet, six inches tall and her weight has fluctuated between 165 and 177 pounds. Although Dr. Robinson opined that claimant's ideal weight is around 135 pounds, he specifically stated that weight loss to that ideal weight would not have any significant effect on her back problems. Other physicians have stated that it would be "nice" if claimant lost some weight, but none has persuasively stated that any significant relief of back disability would result from such weight loss. Under Nelson v. EBI Companies, supra, an employer has the burden of proving that a claimant has unreasonably failed to follow medical advice to lose weight or otherwise mitigate disability. We find that there is no clear medical opinion that claimant's back condition would be improved by weight loss; therefore, we need not address the question whether claimant unreasonably refused medical advice to lose weight. See Christensen v. Argonaut Ins. Co., 72 Or App 110 (1985).

ORDER

The Referee's order dated August 10, 1984 is modified in part and affirmed in part. Claimant is awarded 128° for 40% of the maximum award for unscheduled permanent partial disability for injury to her low back. This award is in lieu of all previous awards. Claimant's attorney's fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed.

THOMAS E. DONAHUE, Claimant
Jim Vick & Assoc., Claimant's Attorneys
Bottini & Bottini, Defense Attorneys

WCB 84-03394, 84-04334 & 84-04335
September 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Danner's order that: (1) held that the self-insured employer's denial was permissible under the "fraud, misrepresentation or other illegal activity" exception of Bauman v. SAIF, 295 Or 7888 (1983); (2) authorized the self-insured employer to offset against any future compensation awarded to claimant an amount of temporary total disability compensation erroneously paid in 1984; and (3) denied claimant's request for an employer-paid attorney fee for successfully defending claimant's receipt of temporary total disability compensation arising from claimant's compensable shoulder claim. The issues on review are whether the self-insured employer's retroactive denial was permissible, the offset, and whether claimant's attorney is entitled to a fee for the defense of claimant's temporary total disability arising from his shoulder claim.

We affirm the Referee's order with the following comments regarding the attorney fee issue. One issue before the Referee was claimant's entitlement to temporary total disability compensation for two periods in 1982 and 1983 for an injury to the right shoulder. The self-insured employer alleged that claimant was released to return to work by his treating physician in late 1982, and that its payment of temporary disability compensation subsequent to that date was erroneous. The self-insured employer sought recovery of the amounts alleged to have been erroneously paid.

The Referee held that there was insufficient evidence to support the self-insured employer's assertions, and he denied the offset request. The Referee did not award an employer-paid fee, however, for claimant's successful defense on the issue. He reasoned that although the employer orally framed the issues at hearing as including an offset of temporary disability compensation for both claimant's low back and shoulder claims, the employer's written cross-request indicated that it would be litigating only the issue of an offset on claimant's low back claim. Because the employer had prevailed on that issue at hearing, the Referee concluded that no fee was awardable to claimant's attorney.

ORS 656.382(2) provides that if an insurer or self-insured employer initiates a request for hearing and the Referee finds that the compensation awarded to the claimant should not be disallowed or reduced, the insurer or employer shall pay to the claimant or his attorney a reasonable attorney fee. In Gleason W. Rippey, 36 Van Natta 778 (1984), the claimant requested a hearing in which he sought an increase in permanent partial disability over that awarded by Determination Order. The employer did not submit a written cross-request on that issue, but did orally argue for a reduction of the Determination Order's award at hearing. The claimant ultimately defended the amount granted by the order and the Referee awarded the claimant's attorney a fee for a successful defense on what the Referee held to be an employer-initiated request for hearing.

We reversed, interpreting ORS 656.382(2) to require that in order for the claimant's attorney to be awarded a fee, the insurer or employer must have affirmatively initiated a request for hearing on an issue separate from or in addition to the issues raised in the litigation initiated by the claimant. See Teel v. Weyerhaeuser, 294 Or 588 (1983); Ralph Benchcoach, 36 Van Natta 681 (1984). Because the claimant had initiated the litigation on the Determination Order, and the employer's oral cross-request was no more than a response to an issue raised by the claimant, we held that no attorney fee was due.

The present case is similar to Rippey. Although the present employer submitted a written cross-request for hearing, the request was limited to the issue of an offset of temporary disability on claimant's low back claim. The employer initiated nothing regarding claimant's shoulder claim. It was only after claimant submitted a request for hearing on the shoulder claim that the employer orally argued for an offset of temporary disability on that claim. We interpret the employer's oral cross-request to be little more than a response to a claimant-initiated request for hearing. The employer raised no issue "separate from or in addition to" the issue raised by claimant. No attorney fee is due.

ORDER

The Referee's order dated September 24, 1984 is affirmed.

DOROTHY J. JOCHIM, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-05419
September 30, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Mulder's order which set aside its denial of medical services, finding that they were compensably related to a condition caused by claimant's 1975 industrial low back strain.

Claimant suffered a compensable low back strain in October 1973 at the age of 48. She told Dr. Rusch, the treating orthopedic surgeon, that even before the 1973 injury she had experienced intermittent episodes of low back pain aggravated by activity, relieved by rest and worse during menstrual periods in her younger years; but never previously incapacitating. Dr. Rush diagnosed lumbosacral pain secondary to abnormal lumbosacral facet orientation, with probable early lumbosacral disc degeneration. After about a month claimant returned to light work. She was declared medically stationary the following May. Claimant continued to experience occasional back pain after excess activity.

In September 1975 claimant reinjured her back when she fell at work. The diagnosis again was acute lumbosacral strain, post-traumatic, superimposed on preexisting lumbosacral disc degeneration and facet osteoarthritis. Claimant was hospitalized briefly and treated conservatively. She was released for regular work in November 1975. Dr. Rusch declared her medically stationary in January 1976. He stated that there had been no significant permanent aggravation of her underlying condition and that no significant disability had resulted from her injury. He reported that claimant continued to experience periodic recurrent back spasms and pain.

Claimant continued to experience back pains; but they were not severe, did not prevent her from working and did not cause her to seek further medical attention. The employer laid claimant off in June 1980. She suffered a compression fracture of L1 in 1981, which resolved without significantly worsening her ongoing symptomatic condition.

Dr. Schuler, an orthopedic surgeon, reported on August 5, 1982 that claimant had continued to have sporadic pain in her low back and had had another episode of pain during the previous week. Based on the limited information that he had at that time, his impression was that the problems were referable to the industrial injuries. Dr. Schuler changed his mind, however, after he was provided copies of claimant's earlier medical records. He now attributes her condition to arthritis not materially related to the back strains in 1973 and 1975.

Claimant has the burden of proving that the condition for which she received medical services was caused by her compensable injury and that the treatment was reasonable and necessary. Poole v. SAIF, 69 Or App 503 (1984); see ORS 656.245.

The Referee found claimant credible, and we have no reason to question her testimony regarding the chronic nature of her back condition. We are unpersuaded that her condition remains materially related to the 1975 industrial injury, however. We

find Dr. Schuler's most recent analysis of claimant's condition to be persuasive on the crucial question of medical causation. Accordingly, we reinstate the insurer's medical services denial.

ORDER

The Referee's order dated February 27, 1985 is reversed. The insurer's denial of medical services is reinstated and affirmed.

JOEL J. JOHNSON, Claimant
Michael Bostwick, Defense Attorney

WCB 85-01309
September 30, 1985
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 the claim for injury to claimant's cervical and thoracic spine arising out of an incident subsequent to claimant's having been terminated from employment. Claimant appears on review without counsel. The insurer waived filing of a brief. The issue on review is compensability.

Claimant was employed by a retail business supply firm. He had suffered back injuries in a motor vehicle accident before engaging employment with the business involved in this case and was continuing under chiropractic care at the time of the alleged injury. Claimant was advised at the end of the day on a Friday that he was terminated from employment and was handed a check representing wages due. Claimant cleaned out his desk and then went to confront his former employer about an alleged shortage of wages. The employer noticed that claimant had taken documents with the employer's letterhead on them. The employer determined to retrieve the documents. Claimant described a prolonged scuffle which included claimant having been thrown down on the floor against a desk. Other witnesses did not corroborate claimant's story.

Claimant did not seek medical attention until the following Monday at a Veterans' Administration Hospital. The following Tuesday claimant went to his chiropractor and related approximately the same story he related in his testimony. The VA hospital and the treating chiropractor repeated claimant's version of the incident in their reports without comment.

The Referee found claimant was not sufficiently credible to establish that he had been injured on the premises of the employer and upheld the denial. The reports of the VA hospital and the treating chiropractor depend entirely on claimant's story to establish any causal connection between the employment situation and claimant's condition. We agree with the Referee that claimant was not sufficiently credible as a witness to afford much weight to his testimony. Moe v. Ceiling Systems, 44 Or App 429 (1980). Because we find that claimant was not sufficiently credible to establish that he was in fact injured as a result of the confrontation with his ex-employer, we affirm the Referee's order.

ORDER

The Referee's order dated May 1, 1985 is affirmed.

STEVE KRAJACIC, Claimant
Robert J. Guarrasi, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-02476
September 30, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Daron's order that: (1) found that claimant had failed to perfect an aggravation claim within the statutory time period; and (2) awarded claimant's attorney $500 for prevailing on a denied claim for out-of-state chiropractic services. Claimant requests a greater attorney fee award. The SAIF Corporation cross-requests review of that portion of the order that found claimant to be entitled to out-of-state chiropractic treatment. The issues on review are the perfection of claimant's aggravation claim, the attorney fee and claimant's entitlement to out-of-state medical services.

Claimant has requested that the Board hear oral arguments before issuing its order in this case. We normally do not entertain oral arguments. OAR 438-11-010(1); Frank R. Roberts, 37 Van Natta 730 (1985). We find no compelling reason to entertain them here. Claimant's request is denied.

With regard to claimant's aggravation claim, we agree with the Referee that claimant failed to perfect his claim within the period allowed by the statute. We, therefore, affirm that portion of the Referee's order.

On the issue of entitlement to out-of-state treatment, we reverse. Claimant was compensably injured in Oregon in 1977. In October of 1983, he relocated to California. He was treated by a chiropractor there and submitted the billing to SAIF. SAIF responded that it would pay for the billing submitted but would not pay for subsequent out-of-state treatments unless claimant secured prior authorization.

In January of 1984 claimant contacted SAIF, informed SAIF that he was relocating to the state of Washington and asked for a list of chiropractors in that state. SAIF informed claimant that it would not pay for out-of-state chiropractic treatment, but that it would accept billings from orthopedists. Despite SAIF's warning, claimant was treated by two chiropractors in Washington and submitted their billings to SAIF. SAIF denied payment. Claimant requested a hearing on the denial.

The Referee overturned the denial, holding that by refusing to pay for any out-of-state chiropractic services, SAIF was effectively precluding claimant from an entire mode of treatment to which he was entitled by way of ORS 656.245(1).

The Referee cited, but did not discuss, Rivers v. SAIF, 45 Or App 1105 (1980), a case we find to be directly on point and dispositive of the present case. In Rivers, the claimant was injured in Oregon, moved to Washington state and was treated by a chiropractor there. SAIF informed claimant that it would not pay for chiropractic treatment, but would accept billings from orthopedists. Claimant proceeded with the chiropractic treatment, submitted the billings to SAIF, and SAIF denied payment. Claimant appealed.

The court held for SAIF. In doing so it specifically noted that the effect of the Oregon statutes and rules pertaining to out-of-state treatment is to preclude claimants seeking those out-of-state services from choosing either their doctor or their mode of treatment without prior authorization from the insurer. The constitutionality of the statutes and rules was challenged by the claimant, but the court held that there had been no violation of equal protection. Rivers, supra, 45 Or App at 1108.

We find that the effect of Rivers is to give insurers the absolute right to determine out-of-state treatment for Oregon claimants. Rivers was limited somewhat by Mogliotti v. Reynolds Metals, 67 Or App 142 (1984), in which the court held that if the insurer gives the claimant a reasonable basis to believe that it will in fact pay for out-of-state services, the insurer will be estopped from later denying payment. See also Lorri K. Day, 36 Van Natta 1096 (1984). In the present case, however, SAIF gave claimant no reason to believe that it would accept billings from his out-of-state chiropractor. In fact, the insurer repeatedly informed him that it would not. Mogliotti and Day are inapplicable. Rivers controls.

Because we find that claimant is not entitled to payment for out-of-state medical services, the issue of the attorney fee award for prevailing on that issue at hearing is moot. Claimant's attorney shall take no fee at hearing nor on Board review.

ORDER

The Referee's order dated March 20, 1985 is reversed in part and affirmed in part. That portion of the order that found claimant to be entitled to payment for out-of-state chiropractic treatment is reversed and the SAIF Corporation's denial is reinstated. The remainder of the order is affirmed.

DALE A. MIKOLAS, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-00698
September 30, 1985
Order on Reconsideration

Claimant requested reconsideration of our Order on Review issued January 21, 1985. We abated our order so that we could receive response from the SAIF Corporation. The request for reconsideration is allowed. On reconsideration, we adhere to our former disposition of this case.

In our Order on Review we ruled that the SAIF Corporation is required to repay to claimant the sum of $397.89 unilaterally offset by SAIF in reliance on the administrative rule subsequently invalidated by Forney v. Western States Plywood, 66 Or App 155 (1983). However, we affirmed that portion of the Referee's order that authorized SAIF to offset all overpayments, which total $2,535.50, against future awards of compensation, if any. Claimant asserts that his attorney is entitled to a fee equal to 25% of the $397.89 we ordered repaid.

Ordinarily, a claimant's attorney is entitled to up to 25% of any increased compensation gained for the claimant at this level as a reasonable attorney fee. OAR 438-47-010(1)(b). In this case, however, we conclude that there was actually no increase in compensation. Although we ordered SAIF to pay claimant $397.89, we also authorized SAIF to take that payment back should claimant

become entitled to future compensation, thus making any "increased compensation" illusory at best. We also note that what we ordered was a repayment, not a payment in the first instance. In no event is claimant receiving any more than he ever had, and if an attorney fee was authorized, he would in fact receive less.

The request for reconsideration is allowed. On reconsideration, we republish our former Order on Review effective this date.

IT IS SO ORDERED.

JAMES D. NIX, Claimant
Osborne & Spencer, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-05083
September 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Brown's order that awarded "interim" compensation and a penalty and associated attorney fee for failure to pay "interim" compensation. The issues are entitlement to "interim" compensation, penalties and attorney fees.

On February 20, 1984 claimant was hired to drive a truck carrying wood chips. He was to be paid by the load. After having worked for four hours, and before completing delivery of his first load of chips, claimant was involved in an accident in which the truck was wrecked. Claimant's employer came upon the accident shortly after it had occurred. Both the employer and the employer's wife encouraged claimant to seek medical attention, at a minimum to be "checked out." Claimant did so at a hospital in Bend, Oregon. The hospital emergency record shows a diagnosis of multiple soft tissue injuries and a possible rib fracture. Claimant was not hospitalized.

Although claimant did not submit a Form 801 until May 7, 1984, he and his wife both testified that a major reason for the delay was that neither claimant nor his wife knew how to reach the employer. It was ultimately claimant's attorney who succeeded in getting the claim form forwarded to the proper party for processing. SAIF accepted the claim as one for a nondisabling injury on May 30, 1984. The Referee found, however, that the employer had notice of the claim as of the date of the accident, February 20, 1984, because of his presence at the accident scene, and that the employer knew or should have known that claimant required medical services, largely because of the employer's encouragement that claimant seek medical assessment.

The employer had a duty under ORS 656.262(3) to notify its insurer, SAIF, of the accident and its potential for a claim "immediately and not less than five days . . ." after the accident. It did not do so. SAIF was not notified until the employer forwarded the completed Form 801 on May 17, 1985. Failure to timely report the accident to SAIF "subjects the employer to a charge for reimbursing the insurer for any penalty the insurer is required to pay under [ORS 656.262(10)] because of such failure." We conclude, however, that the facts of this case do not warrant a penalty.

The Referee acknowledged that under Bono v. SAIF, 298 Or 405 (1984), claimant would be entitled to temporary total disability benefits as "interim" compensation only if he left work as that phrase is used in ORS 656.210(3). Evidence regarding claimant's "leaving work" came from the employer's testimony that claimant was "let go" immediately after the accident because the only truck available for claimant to drive had just been wrecked, and from claimant's and his wife's testimony that claimant was physically unable to work for two weeks after the accident, because of his injuries. Therefore, the only information that claimant "left work" as that phrase is used in ORS 656.210(3), i.e. was unable to work because of his injury, was not known to SAIF until the hearing. SAIF accepted claimant's claim as nondisabling 13 days after it received notice of the claim, thus its obligation to pay "interim" compensation did not mature, ORS 656.262(4), unless, as claimant argues, the obligation to pay "interim" compensation matured 14 days after the accident.

We agree that claimant became entitled to "interim" compensation commencing 14 days after the February 20, 1984 accident. However, because there was no indication to anyone, until the hearing, that claimant's injury was anything other than nondisabling, we conclude that failure to pay temporary disability compensation was not unreasonable. We, therefore, set aside that portion of the Referee's order that awarded a penalty and attorney fee.

We also modify the Referee's award of "interim" compensation. The only evidence of inability to work on account of the injury came from the testimony of claimant and his wife. That evidence was that claimant was unable to work for two weeks. The fact that claimant was not working thereafter had nothing to do with his injury. See Bono v. SAIF, supra, 298 Or at 410. We find that claimant is entitled to temporary total disability benefits during the period February 20, 1984 through March 6, 1984, inclusive.

ORDER

The Referee's order dated January 25, 1985 is modified in part and reversed in part. That portion of the order that awarded temporary disability compensation as "interim' compensation is modified to award temporary total disability benefits during the period February 20, 1984 through March 6, 1984, inclusive. Claimant's attorney is allowed a reasonable fee of 25% of the compensation awarded by this order, not to exceed $750. That portion of the Referee's order that awarded a penalty and attorney fee is reversed.

WILLIAM B. RICE, Claimant
Helm, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Phillip A. Mendiguren, Attorney

WCB 83-10556
September 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The alleged employer, Arthur Bronson, requests review of Referee Cronan's order which found: (1) that he was a noncomplying employer and that claimant was a subject worker; (2) that claimant's back injury claim was not barred for untimeliness; and (3) that the claim was compensable. On review, the alleged employer contends: (1) claimant was an independent contractor;

or, alternatively, (2) that the claim should be barred as untimely; or (3) that the claim is not compensable.

Following our de novo review of the record, we are persuaded that Mr. Bronson was a noncomplying employer and that claimant was a subject worker. Accordingly, we affirm that portion of the Referee's order which found that Mr. Bronson and claimant were subject to the Workers' Compensation Act.

We also affirm that portion of the order which found that the claim was not barred for untimeliness. However, we conclude that the claim should not be barred for reasons different than those expressed by the Referee.

The preponderance of the persuasive evidence suggests that while claimant was cutting and piling timber for the noncomplying employer, a work horse fell on him. This accident occurred on July 29, 1982, but claimant did not seek medical treatment for his ailing back until October 5, 1982. Mr. Bronson learned of the accident on or about August 26, 1982, the day after the parties' work relationship terminated. On that date Mr. Bronson recalled that claimant told him: "Your horse fell on me and damned near killed me." Mr. Bronson "kinda doubted" claimant's statement because claimant had not mentioned the horse accident while accompanying Mr. Bronson on a 900-mile round trip truck ride a few days after the alleged accident. During the entire ride to Sutherlin, Oregon, where Mr. Bronson coincidentally purchased a horse, claimant did not complain of back problems nor did he take any medication. Mr. Bronson was unaware that claimant contended he injured his back in the horse incident until sometime in the spring of 1983, when Mr. Bronson learned of claimant's intention to seek workers' compensation benefits. Claimant eventually filed his claim on July 18, 1983.

ORS 656.265(1) requires a worker or dependent to submit a written notice of an accident resulting in an injury to the employer within 30 days of the accident. Failure to comply with this statute bars a claim unless one of the exceptions of ORS 656.265(4) is satisfied. One of the exceptions to the 30-day written notice requirement is a situation in which the employer had knowledge of the injury. ORS 656.265(4)(a). To establish employer knowledge a claimant need not prove that the employer knew of the claim, only that the employer knew of the injury, even if the employer had good reason to believe that no claim would be filed. Hayes-Godt v. Scott Wetzel Services, 71 Or App 175 (1984); Baldwin v. Thatcher Construction, 49 Or App 421 (1980). If the employer had knowledge of the injury, the claim is not barred, even if the employer was prejudiced by a late filing. Hayes-Godt, supra.; Baldwin, supra.

We conclude that the claim is not barred for untimeliness because the employer had knowledge of the injury. The operative facts contained in Baldwin are analogous to the present case. In Baldwin a worker advised his employer that a wall section had landed on him the previous day, injuring his shoulder. Rather than filing a claim, the worker requested lighter work. Relying on ORS 656.265(4)(a), the Baldwin court held that the subsequent claim, filed approximately 21 months after the accident, was not barred because the employer had knowledge of the injury. Just as the employer in Baldwin, Mr. Bronson doubted whether a claim would be filed stemming from claimant's accident. However, the evidence

preponderates that Mr. Bronson knew of the possibility of an injury at least by the termination of their relationship when claimant advised him of the horse accident. Mr. Bronson's reservations concerning claimant's credibility do not detract from the fact that Mr. Bronson knew of the alleged injury-producing accident.

The Referee found that the claim was not barred because Mr. Bronson failed to produce convincing evidence of prejudice due to the late filing. Although Mr. Bronson asserted the passage of time, dimmed memories, and the inability to locate a witness to the accident as reasons for prejudice, the Referee concluded that none of these assertions were substantiated. Since we have found that the claim is not barred due to employer knowledge of the injury, we need not reach the issue of employer prejudice. However, if the employer had no knowledge of the injury and had we reached the "prejudice" issue, we would have found that the claim was barred. Specific indications of prejudice are unnecessary where the existence of prejudice is apparent from the record as a whole. See Vandre v. Weyerhaeuser Co., 42 Or App 705 (1979). We are persuaded that the following factors would have combined to establish prejudice to the employer as a result of the claim's late filing: (1) the approximately one year lapse of time between the accident and the claim; (2) the inability to locate a witness to the accident, the only witness not related to claimant; (3) the lack of a prompt investigation, immediate medical treatment, and an independent medical examination; and (4) claimant's back surgery during this interim period.

Finally, following our de novo review of the medical and lay evidence we are persuaded that claimant sustained an injury stemming from an accident at work for which he subsequently sought medical services. Consequently, we find that claimant suffered a compensable injury. See ORS 656.005(8)(a). Accordingly, we affirm that portion of the Referee's order which set aside the SAIF Corporation's denial on behalf of the putative employer.

ORDER

The Referee's order dated June 18, 1984, as supplemented herein, is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation, as processing agent for the noncomplying employer.

HERBERT D. RUSTRUM, Claimant
SAIF Corp Legal, Defense Attorney

WCB 84-05483
September 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Leahy's order upholding the SAIF Corporation's denial of claimant's occupational disease claim for mental stress and hypertension. In the alternative, claimant requests remand. Claimant also contends that the Referee erred in excluding certain evidence offered by claimant.

We first consider claimant's contention that evidence was improperly excluded. Claimant contends that the mental pressures of his employment as president of a manufacturing corporation were the major contributing cause of his high blood pressure and

alleged mental condition. He contends that harassment by various bureaucratic entities concerning such matters as toxic waste disposal and plant safety substantially contributed to the stress of his employment. On November 13, 1984 the Hearings Division received from claimant a seven inch thick package of papers, along with a cover letter indicating that they would be offered as evidence in this proceeding. The Referee wrote claimant on November 21, 1984 as follows:

> "Per ORS 656.310 and 656.287 and OAR 438-05-005 to 438-09-010 among other authority I must abide by, the documents sent by claimant do not appear to be legally admissible."

Claimant offered the materials for admission at the November 27, 1984 hearing, explaining that they were being submitted to substantiate his testimony regarding the stressors of his job. The Referee refused to admit the evidence. The following reasons for exclusion were offered: (1) no evidence can be received in a workers' compensation hearing except medical reports, vocational reports and possibly a narrow range of other documents directly related to the case; (2) the materials are hearsay; (3) the materials are not properly numbered and indexed; and (4) the Referee lacks the time to consider the materials. We consider each objection in turn.

In furtherance of the legislative objective of providing 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 compensation proceedings to the greatest extent practicable, ORS 656.012(2)(b), statutes have been enacted to facilitate the introduction of those types of documentary evidence most commonly relied on in workers' compensation proceedings. ORS 656.310(2) provides that the contents of medical, surgical and hospital reports shall be considered prima facie evidence as to the matters contained therein, provided the doctor consents to submit to cross-examination, if requested. ORS 656.287 contains similar provisions relating to vocational reports. In the interest of maintaining fair and efficient proceedings, the Board has promulgated rules regarding the admission of evidence. OAR 438-07-005 et seq. However, neither the pertinent statutes nor the Board's rules limit the scope of admissible exhibits in workers' compensation proceedings to the types of documents referred to in ORS 656.287 and 656.310(2).

Second, we consider the hearsay nature of the submission. Technical hearsay objections have no place in workers' compensation hearings, however, under certain circumstances admitting a document without affording an opportunity for cross-examination of the author can be inconsistent with the statutory obligation to conduct hearings in a manner that will achieve substantial justice. Marion R. Webb, 37 Van Natta 660, aff'd on recon., 37 Van Natta 750 (1985); ORS 656.283(6). Claimant's submission was offered merely to objectively substantiate his testimony regarding the nature and extent of the controversies to which the papers relate. Considering the limited purpose for which the materials were submitted, claimant's availability for cross-examination was sufficient to insure substantial justice.

Third, we share the Referee's concern regarding the disorganized state in which the materials were submitted. OAR 438-07-005(3)(b) requires that claimants number and index documentary evidence. The unrepresented injured worker is not expected to have familiarity with the Board's rules, however, and is not to be held strictly accountable for failures to follow them. OAR 438-05-035. After the hearing claimant indexed certain of the materials contained in his pre-hearing submission in his written closing argument, and he attached copies of the referenced exhibits. Under the circumstances of this case, the post-hearing submission was sufficient to satisfy the indexing and numbering requirement as to the exhibits listed therein.

We find the indexing and numbering requirement inapplicable to claimant's pre-hearing submission. The seven inch thick stack of materials was offered as part of the instrumentality allegedly responsible for claimant's condition. The materials could have been admitted as a single exhibit of physical evidence.

Finally, we recognize the time that would have been required to review and consider claimant's submission. Administrative economy is properly an important concern, however, our fundamental responsibility is to see that each and every proceeding is conducted in a manner that will achieve substantial justice. See ORS 656.283(6). The Referee erred in failing to admit and consider the material submitted by claimant.

Claimant also requests that the case be remanded to the Hearings Division for further development of the evidentiary record. Where the Board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee, it has discretion to remand the case for further evidence taking, correction or other necessary action. ORS 656.295(5). The Board has a restrictive policy regarding remands. Casimer Witkowski, 35 Van Natta 1661 (1983).

Although evidence was improperly excluded, the unadmitted materials are in the record. The Board need not remand to admit evidence in the record that was excluded by the Referee. Edward Morgan, 34 Van Natta 1590 (1982). Although claimant contends that since the hearing he has been hospitalized for the allegedly compensable condition and that it has become more serious, he has not submitted copies of additional medical reports or made specific reference to any other evidence that he would seek to have admitted on remand. We find no sufficient showing that remand is appropriate. Compare Robert A. Barnett, 31 Van Natta 172 (1981) with Bailey v. SAIF, 296 Or 41 (1983); Catherine C. Bailey, 36 Van Natta 280 (1984) and Egge v. Nu-Steel, 57 Or App 327, review denied, 293 Or 456 (1982).

On the merits, the Board affirms the order of the Referee.

ORDER

The Referee's order dated January 4, 1985 is affirmed.

WILLIAM A. SCHULTS, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-08347
September 30, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Brown's order that granted claimant an award of 16° for 5% unscheduled permanent partial disability for injury to the low back in addition to the the 48° for 15% awarded by stipulation. Claimant asserts that he is entitled to an unscheduled disability award in the 40% to 60% range.

On de novo review of the record as a whole, we conclude that claimant is entitled to an increased award of disability, but not to the extent he asserts. Claimant's present awards total 64° (20%) unscheduled disability. Dr. Kho, claimant's treating neurologist, opines that claimant's physical impairment is in the mild, or 10% to 20% of the whole person, category. Claimant is 39 years of age and has an eighth grade education. The bulk of his work experience involves driving tanker and tow trucks and working in the woods at various medium to heavy unskilled occupations. We conclude that claimant previously performed work requiring mostly medium strength and now is confined to light work, however, claimant's present work capacity is limited by factors other than strength.

We conclude that the 20% award does not adequately take into account social and vocational factors affecting claimant's earning capacity. Based upon claimant's impairment and the other relevant social and vocational factors, we find that claimant will be most appropriately compensated by an award of 32° for 10% additional unscheduled permanent partial disablity for injury to his low back.

ORDER

The Referee's order dated November 19, 1984 is modified. Claimant is awarded an additional 32° for 10% unscheduled permanent partial disability, for a total award of 96° for 30% unscheduled permanent partial disability for injury to his low back. Claimant's attorney is allowed a reasonable fee of 25% of the increased compensation awarded by this order, not to exceed $750, payable out of and not in addition to claimant's compensation.

STONEWALL TRUSTY, JR., Claimant
Emmons, et al., Claimant's Attorneys
Mitchell, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-07499 & 84-01716
September 30, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Argonaut Insurance Company requests review of those portions of Referee Nichols' order which upheld the denial of the SAIF Corporation and which recommended reopening of the claim by Argonaut on the Board's own motion under ORS 656.278. Claimant cross-requests review on the issue of responsibility and makes alternative arguments against both insurers. The issue on review is responsibility.

Claimant injured his low back in 1971 while working for Argonaut's insured. The claim was closed without permanent

disability in 1972. Claimant alleged a new low back injury while employed by SAIF's insured in November 1983. Surgery was performed in February 1984 for a bulging disc at L4-5. The only medical opinions on causation were claimant's attending physician's and the surgeon's. The doctors agreed that claimant's disc condition was related to his industrial injury in 1971. The Referee found that claimant's testimony was insufficiently credible to be persuasive that claimant suffered a new injury which contributed to his disability.

The Board affirms the Referee's order. Grable v. Weyerhaeuser Company, 291 Or 387 (1981); Linn Care Center v. Cannon, 74 Or App 707 (1985). The claim will be remanded to Argonaut for processing by the companion order issued this date pursuant to claimant's request under the Board's own motion authority.

ORDER

The Referee's order dated April 2, 1985 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by Argonaut Insurance Company.

FLOYD L. WIEBE, Claimant
Aitchison, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-07791
September 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of that portion of Referee Knapp's order that set aside its denial of claimant's claim of entitlement to vitamin and mineral therapy as a medical service under ORS 656.245(1). Claimant cross-requests review of that portion of the order that affirmed the Determination Order granting claimant 64° for 20% unscheduled permanent partial disability. The issues on review are entitlement to vitamin and mineral therapy and extent of unscheduled permanent partial disability.

We adopt and draw from the Referee's recitation of the facts. Claimant sustained compensable injuries to his left leg, left arm and right shoulder in August of 1982 when he was assaulted on his employer's premises. He was thereafter conservatively treated by chiropractor Dr. Cowan. Upon a referral from Dr. Cowan to Dr. Wilson, an orthopedist, claimant was diagnosed as having suffered a right shoulder separation with a nondisplaced fracture of the distal clavicle. Continued conservative care was recommended.

In March 1983 Dr. Wilson again examined claimant and found his right shoulder to exhibit limited extension and internal rotation. Claimant complained of pain. Dr. Wilson felt that claimant had 90 percent use of his shoulder with normal strength. He felt that claimant should not do overhead work with heavy weight.

In November of 1983 Dr. Cowan opined that claimant was medically stationary with a residual lifting capacity in the light range due to restricted range of motion and reduced strength. A December 29, 1983 Determination Order granted 64° for 20% unscheduled permanent partial disability.

By letter of February 5, 1985 Dr. Cowan reported that claimant had developed muscle atrophy due to abnormal right shoulder movements. He further opined that claimant was

moderately impaired due to reduced range of motion and reduced strength. He felt that claimant could occasionally lift and carry up to 50 pounds and occasionally reach above the shoulder level. Dr. Cowan stated that the vitamins and calcium supplements he prescribed for claimant were necessary to the continued healing of claimant's right shoulder.

Claimant testified that his right shoulder aches and catches when he lifts his arm to mid-chest level. He alleged a loss of strength that has restricted his ability to do some of the work he previously did for his employer. Claimant related that he spends up to $50 per month on the vitamins prescribed by his chiropractor.

I.

On the issue of extent, the Referee found that claimant had been adequately compensated by the 20% unscheduled disability awarded by the Determination Order. On review, claimant asserts entitlement to an increased award. We agree that claimant is entitled to a small increase. At the time of the hearing, claimant was 56 years old. He has an eighth grade education. Although Dr. Cowan rated claimant's impairment as "moderate," we agree with the Referee that claimant's impairment is no greater than "mild." Claimant was capable of heavy work before his injury but is now capable of only medium work.

After reviewing the record, we find that claimant is entitled to an increased award of 32° for 10% unscheduled permanent partial disability, bringing claimant's total unscheduled award to 96° for 30%, which shall be in lieu of all prior awards.

II.

The remaining issue is claimant's entitlement to vitamin and mineral therapy. ORS 656.245(1) provides that for any compensable injury, claimant is entitled to medical services for conditions resulting from the injury for such period as the nature of the injury or the process of recovery requires. The Director of the Workers' Compensation Department, pursuant to his statutory authority, ORS 656.726(3); 656.708(5), has promulgated a rule restricting the compensability of dietary supplements. OAR 436-69-201(6) (renumbered OAR 436-10-040, May 1, 1985), provides in pertinent part:

> "Dietary supplements -- such as minerals and vitamins are not reimbursable unless a specific dietary deficiency has been clinically established in the injured worker. . ."

There is no evidence that claimant suffers from a dietary deficiency. His treating chiropractor, however, has stated that vitamin therapy is necessary to claimant's recovery. At hearing, claimant argued that insofar as the Department's rule limits the provision of what he asserts to be necessary medical services, the rule is invalid.

The Referee held that because the medical evidence was uncontroverted regarding claimant's need for vitamin therapy, the therapy was compensable under ORS 656.245. Although the Referee made no finding regarding the validity of former OAR 436-69-201(6), he noted that in promulgating rules, the Department must act in a way that is consistent with the delegation of authority granted by statute.

On review, the insurer offers alternative arguments: (1) that the administrative rule limiting vitamin therapy was validly promulgated under the Department's statutory authority, and (2) even if the rule is invalid, claimant has failed to prove that vitamin therapy is "reasonable and necessary" to the process of his recovery.

We need not address the validity of the rule, for we find that claimant has failed to prove that vitamin therapy is reasonable and necessary to his process of recovery. We note that the only medical evidence favorable to claimant's claim is the conclusory opinion of his chiropractor that claimant needs vitamins and minerals. The chiropractor has offered no explanation regarding why the therapy is needed or the mechanism by which it will actually aid in claimant's healing process.

We find this absence of explanation important. As noted, the administrative rule governing dietary supplements limits therapy to instances in which a vitamin deficiency is diagnosed. We note that in promulgating the rule, the Department had the benefit of the participation of an Advisory Committee on Medical Care. OAR 436-69-003(2) (renumbered OAR 436-10-001, May 1, 1985). We infer that the Committee took an active role in helping the Department to determine when vitamin therapy is reasonable and necessary.

While the Department's rule is not binding on us, we find it useful in that it suggests that vitamin therapy is not necessary absent a clinical finding that claimant suffers from a specific vitamin deficiency. After considering the rule, we find that if claimant, who suffers from no documented deficiency, is to prove the compensability of vitamin therapy, he must produce persuasive evidence that it is, in fact, necessary for his recovery. The proof in this case requires an analysis of why therapy is required for a condition other than the one recognized by the rule. The chiropractor's conclusory opinion in this case is not sufficient. Claimant has failed to prove that vitamin therapy is a reasonable and necessary medical service under ORS 656.245.

ORDER

The Referee's order dated Febraury 26, 1985 is modified in part, reversed in part and affirmed in part. That portion of the order that affirmed the Determination Order granting 64° for 20% unscheduled permanent partial disability is modified. In lieu of all prior awards, claimant is awarded 96° for 30% unscheduled permanent partial disability. That portion of the order that set aside the insurer's denial of claimant's vitamin therapy is reversed and the denial is reinstated. The remainder of the order is affirmed. Claimant's attorney is allowed a fee equal to 25% of the increased compensation granted by this order, not to exceed $3,000.

MILDRED M. DeROUSSE, Claimant
Flaxel, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-01184
September 20, 1985
Order of Abatement

The Board has received claimant's request for reconsideration of our Order on Review dated August 29, 1985.

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 within ten days.

IT IS SO ORDERED.

RICHARD J. GUERRERO, Claimant
Samuel A. Hall, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 84-03856 & 84-04470
September 23, 1985
Order of Abatement

The Board has received EBI Companies' request for abatement and reconsideration of our Order on Review dated August 29, 1985.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant and the SAIF Corporation are requested to file a response to the motion within ten days.

IT IS SO ORDERED.

RICHARD L. MANLEY, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-11309
September 20, 1985
Order of Abatement

The Board has received the insurer's request that we reconsider our Order on Review dated August 29, 1985.

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.

DARYL G. RICHMOND, Claimant
Phillip H. Garrow, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-08780
September 23, 1985
Order of Abatement

The Board has received the SAIF Corporation's motion to reconsider our Order on Review dated August 30, 1985

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.

EVA L. (DONER) STALEY, Claimant
Pozzi, et al., Claimant's Attorneys
Keith Skelton, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 83-07726 & 83-09071
July 10, 1985
Order of Abatement

The Board has received Crawford and Company's motion to reconsider our Order on Review dated June 24, 1985.

In order to allow sufficient time to consider the motion, the above-noted Board order is abated. Claimant, Liberty Northwest Insurance Corporation and Ingersoll-Rand Company are requested to file responses to the motion within ten days.

The Board defers ruling on Crawford and Company's motion for oral argument pending receipt of the responses from the other parties.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the U.S. Court of Appeals, Ninth Circuit:

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

CROSBY,
Appellant,
v.
SAIF CORPORATION et al,
Respondents.
(A8210-06682; CA A32642)

Appeal from Circuit Court, Multnomah County.

Robert P. Jones, Clifford B. Olsen and Charles S. Crookham, Judges.

Argued and submitted March 4, 1985.

Robert K. Udziela, Portland, argued the cause for appellant. With him on the brief were John S. Stone, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Philip Schradle, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Anna M. Moran, Portland, argued the cause for respondent W. G. Moe & Sons, Inc. With her on the brief was Breathouwer & Gilman, Portland.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

RICHARDSON, P. J.

Reversed and remanded.

RICHARDSON, P. J.

Plaintiff suffered an on-the-job injury while he was employed by defendant W. G. Moe & Sons, Inc., and, as a result, he was entitled to workers' compensation benefits from defendant SAIF. Plaintiff alleges that

> "* * * representatives of the two defendants met and agreed that defendant Moe would create a light duty job for the plaintiff so that workers' compensation benefits would no longer be payable to the plaintiff. The defendants further agreed that after the plaintiff commenced his light duty job he would be discharged from his employment."

Plaintiff pleaded three claims: First, that both defendants engaged in a civil conspiracy against him; second, that SAIF interfered with his contractual relationship with Moe; and, third, that the conduct of both defendants was outrageous. The trial court dismissed the complaint as to SAIF on the ground "that plaintiff has failed to state a claim for relief." The court dismissed the action as to Moe on the ground "that plaintiff's sole and exclusive remedy for the acts alleged to have been performed by defendant Moe are *[sic]* set forth within ORS Chapter 659." Plaintiff appeals, and we reverse.

Both defendants argue that plaintiff's action was properly dismissed, because the gravamen of his complaint is that he was discharged for filing a workers' compensation claim, *see* ORS 659.410, 659.415, and that ORS chapter 659 provides either his exclusive remedy or a remedy that precludes the specific claims in his complaint. Defendants' argument is adversely answered by *Holien v. Sears, Roebuck and Co.*, 298 Or 76, 689 P2d 1292 (1984), and *Carsner v. Freightliner Corp.*, 69 Or App 666, 688 P2d 398, *rev den* 298 Or 334 (1984). SAIF concedes in its brief that under *Holien* "plaintiff's claims are not totally precluded because of remedies available to plaintiff under ORS Ch. 656 and ORS Ch. 659." SAIF nevertheless argues that,

> "* * * to the extent that plaintiff's claims are based on any allegations that plaintiff was *discharged because* he filed a Workers' Compensation claim, then plaintiff's remedies exist solely under ORS Ch. 659 even under the reasoning of [Holien]." (Emphasis SAIF's.)

We disagree with that understanding of the allegations. Plaintiff does not plead that he was terminated

because he filed a claim; he alleges that defendants conspired to divest him unlawfully of his right to workers' compensation benefits and to terminate him. We do not suggest that plaintiff *could not* have pursued a remedy under ORS 659.121 for a violation of ORS 659.410 on the basis of the facts alleged. However, the unlawful conduct for which he *does* seek relief goes beyond the conduct that ORS 659.410 proscribes. *See Carsner v. Freightliner Corp., supra,* 69 Or App at 672-74.

SAIF argues that there are a number of alternative bases for sustaining the trial court's orders.[1] It contends, first, that plaintiff does not adequately allege that he gave SAIF the tort claim notice required by ORS 30.275. Plaintiff alleged:

> "Prior to the commencement of this action, the plaintiff has advised defendant SAIF of his claim in the manner prescribed by Oregon law."

Assuming that the allegation is insufficient, SAIF's motion pertaining to *that* allegation asked that it be made more definite and certain, not that the action be dismissed because of it. SAIF made the appropriate motion, but, for that reason, it is wrong now in contending that any defect in the notice allegation is a basis for dismissing the action.[2] *See Shaughnessy v. Spray,* 55 Or App 42, 50-51, 637 P2d 182 (1981), *rev den* 292 Or 589 (1982).

SAIF contends next that its alleged acts are discretionary governmental acts and that it is therefore immune from suit under ORS 30.265(3)(c). SAIF reasons:

> "* * * [T]he purportedly tortious conduct alleged by plaintiff is that SAIF Corporation worked with plaintiff's employer to make a light duty work position for plaintiff. SAIF was created for the purpose of transacting workers' compensation insurance and reinsurance business. ORS 656.752(1). One of SAIF's functions is to 'receive and handle and process the

[1] Moe does not join in SAIF's alternative arguments.

[2] The parties do not advise us how the trial court resolved the motion against the notice allegation. The court may well have regarded a ruling superfluous in view of the fact that it dismissed the action on other grounds.

claims of workers.' ORS 656.752(2)(b). Oregon Administrative Rules 436-61-010(3)(g)(A) and 436-61-050(8) provide for insurers at their discretion to work with the employer of an injured worker in the creation or modification of jobs to provide a sheltered atmosphere for the injured worker to

return to 'light work.' Although plaintiff would consider it desirable that he receive Workers' Compensation benefits without working, even assuming plaintiff's allegations to be true, SAIF made a policy decision to encourage plaintiff's employer to create a light duty job for plaintiff. * * *

"Plaintiff, of course, further alleges that SAIF Corporation and defendant W.G. Moe & Sons, Inc., agreed that, after plaintiff commenced his light duty job, plaintiff would be discharged. However, it is axiomatic that plaintiff's employer was the party which made hiring and firing decisions regarding plaintiff and plaintiff has not alleged any facts which show that SAIF Corporation did have or even could have affectuated plaintiff's termination from employment with defendant W.G. Moe & Sons, Inc."

SAIF again misses the thrust of the allegations. The fact that Moe had the hiring and firing authority is irrelevant to whether SAIF conspired with Moe to exercise that power for an unlawful purpose. Whether or not we would agree with SAIF that its working with employers to find job placements for injured employes is immune as discretionary, we conclude that SAIF's conspiring with an employer, *inter alia,* to eliminate a worker's entitlement to benefits is not a matter of discretion. Whether SAIF did only what it says it did or did what plaintiff alleges is a jury question. For purposes of reviewing the dismissal of the complaint, we must assume the truth of plaintiff's allegations. SAIF cites no authority for the proposition that intentional torts that involve unlawful conduct can be immune under ORS 30.265(3)(c). We hold that the torts alleged here are not insulated by discretionary acts immunity.

SAIF's next argument is that plaintiff did not state a claim for relief for civil conspiracy because

"* * * civil conspiracy is not itself an independent tort, and plaintiff has not pled the violation of any statute by SAIF Corporation or the violation by SAIF Corporation of any common-law duty owed to plaintiff. Plaintiff's complaint, as discussed above, does not state how plaintiff's discharge was in any way unlawful. Moreover, any alleged agreement between SAIF Corporation and plaintiff's employer to create a 'light duty' position for plaintiff is completely authorized by statute and regulation and is eminently proper. * * *"

SAIF relies on *Bonds v. Landers,* 279 Or 169, 566 P2d 513 (1977). The reliance is misplaced. Although *Bonds* does state

that "[a] civil conspiracy is not an independent tort, in the absence of a statute or unusual circumstances," the opinion goes on to explain that "[t]he damage in a civil conspiracy flows from the overt acts and not from the conspiracy." 279 Or at 175. We do not share SAIF's understanding that a conspiracy, the overt acts of which *have* produced damage, is not actionable. SAIF makes a number of other points in support of its argument that the civil conspiracy claim was properly dismissed. We do not find any of them meritorious.

SAIF cites *Top Service Body Shop v. Allstate Ins. Co.*, 283 Or 201, 582 P2d 1365 (1978), as authority for its next argument, that plaintiff failed to state a claim against SAIF for intentional interference with contract. The court stated in *Top Service Body Shop:*

> "* * * [A] claim is made out when interference resulting in injury to another is wrongful by some measure beyond the fact of the interference itself. Defendant's liability may arise from improper motives or from the use of improper means. They may be wrongful by reason of a statute or other regulation, or a recognized rule of common law, or perhaps an established standard of a trade or profession. * * *" 283 Or at 209-10. (Footnote omitted.)

The operative allegations in the interference with contractual relationship claim are that "plaintiff was hired by Moe," "SAIF * * * intentionally interfered with the plaintiff's employment contract for the purpose of eliminating [its] responsibility to pay workers' compensation benefits" and, as a result, "plaintiff was terminated by his employer" and suffered damages. We do see how those allegations can be read as not satisfying the "improper motives" test of *Top Service Body Shop.*

SAIF also states:

> "Plaintiff's complaint under [the] second cause of action nowhere states how SAIF Corporation allegedly interfered with plaintiff's employment contract which purportedly exists between plaintiff and plaintiff's employer. Plaintiff's failure to plead how SAIF Corporation allegedly interfered with plaintiff's contractual relationship defeats entirely plaintiff's claims under this cause of action. Plaintiff alleges no facts which would constitute any interference. * * *
>
> "* * * * *

> "* * * [P]laintiff's complaint does not even allege the existence of an employment contract between defendant W. G. Moe & Sons, Inc. and plaintiff or between SAIF Corporation and plaintiff. Plaintiff's complaint certainly does not state the type of employment contract, if any, which plaintiff may have had with defendant W. G. Moe & Sons, Inc. The type of employment contract involved would be of great import to this case, because the contract, if one exists, may contain language which makes plaintiff an employe terminable at the will of the employer. In fact, absent statutory or contractual rights to the contract, an employer generally may discharge an employe at any time with or without cause. * * *"

In our view, SAIF is simply mistaken in its contention that *no* employment contract was pleaded. The remaining points it makes either fault the complaint for failing to plead evidence or deal with matters that might be subject to a motion to make more definite and certain. SAIF's argument does not provide a basis for affirming the dismissal of the claim.

SAIF's final argument is that the complaint does not state a claim for outrageous conduct. Many of the points relate to the specificity of the complaint or duplicate points SAIF makes in connection with its other arguments. For reasons similar to those we have noted earlier, we find them unpersuasive as grounds for dismissal.

SAIF also asserts that plaintiff has not alleged that a "special relationship" exists between it and plaintiff sufficient to support a claim for outrageous conduct. *See Bodewig v. K-Mart, Inc.*, 54 Or App 480, 485-87, 635 P2d 657 (1981), *rev den* 292 Or 450 (1982), and authorities there cited. We disagree. Plaintiff has alleged that SAIF is the workers' compensation carrier responsible for the payment of plaintiff's benefits. If a special relationship is necessary to support a finding of outrageous conduct here, *compare Brewer v. Erwin*, 287 Or 435, 458, 600 P2d 398 (1979), and *Rockhill v. Pollard*, 259 Or 54, 485 P2d 28 (1971), with *Turman v. Central Billing Bureau*, 279 Or 443, 568 P2d 1382 (1977), we hold that there can be a special relationship between a workers' compensation insurer and a person entitled to benefits from the insurer. *See* ORS 656.012(2).[3]

Reversed and remanded.

[3] The Supreme Court recently noted in *Humphers v. First Interstate Bank*, 298 Or 706, 709, n 1, 696 P2d 527 (1985):

> "This court has attempted, so far unsuccessfully, to discourage the idea that there is a general tort of 'outrageous conduct,' partly because the phrase misleadingly suggests potential recovery of damages whenever someone's conduct could be said to deserve this epithet. *See Hall v. The May Dept. Stores*, 292 Or 131, 134-37, 637 P2d 126 (1981); *Brewer v. Erwin*, 287 Or 435, 454-57, 600 P2d 398 (1979); and see *id.* at n 13, citing the court's dissatisfaction with the epithets in *Rockhill v. Pollard*, 259 Or 54, 60, 485 P2d 28 (1971). Plaintiff in this case actually alleged the factual elements of intentional or reckless infliction of severe emotional distress as well as 'outrageous' conduct."

We do not understand that footnote to support or require the dismissal of claims simply because the complaint *describes* them as being for "outrageous conduct."

No. 333 July 3, 1985 195

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Peter F. McCabe, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Petitioner,

v.

McCABE,
Respondent.

(82-01704; CA A32445)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 17, 1984.

Richard D. Wasserman, Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Robert K. Udziela, Portland, argued the cause for respondent. With him on the brief were Dan O'Leary, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

SAIF petitions for review of an order of the Workers' Compensation Board affirming the referee's decision that claimant's disability is compensable as either an occupational disease or an occupational injury. Claimant's disability resulted from a ruptured cerebral aneurysm. We hold that claimant has established a compensable occupational disease.

SAIF does not contest the facts leading up to claimant's disability, including the condition of his employment. The principal dispute revolves around the medical explanation of the cause of the disability and involves two conflicting medical opinions.

Claimant was elected the chief executive officer of the Amalgamated Transit Workers Union in Portland in May, 1979, when he was 29. He had no previous experience as a union official. His job as chief executive officer involved a considerable amount of stress. After his election, he found that the executive board of the union was antagonistic toward him and uncooperative in assisting him in union business, and he began to assume much of the work that ordinarily would have been done by the executive board. Six and seven day work weeks were not unusual, and he often received phone calls at home concerning union matters. He rarely worked fewer than eight hours per day and frequently worked sixteen. He was involved in collective bargaining on the union's behalf. He sometimes traveled away from home overnight two days per week when contract negotiations were not in session; he traveled more often when they were.

In the fall of 1980, claimant learned of the possibility of financial irregularities occurring in the union. This greatly distressed him, and he became obsessed with investigating the matter. A lawyer advised him that the best course of action was to file a lawsuit against the executive board and other union officers. Claimant realized that that action would be the final break between him and the executive board and that he would likely lose his job if the allegations of financial irregularities were proven. He spent a great deal of time brooding over this matter in the summer of 1981.

During that time, claimant's personal habits, attitudes, demeanor and personality began to change significantly. His cigarette consumption increased to two and

one-half packs per day, and he began to drink heavily. He exhibited impaired mental acuity, often forgetting matters related to the union's business. For example, he occasionally questioned subordinates about why they were taking certain actions, only to learn that he himself had instructed that those actions be taken. He frequently complained of headaches. Finally, he uncharacteristically erupted in outbursts of anger towards his associates and his children.

In December, 1980, after having been diagnosed as having high blood pressure, claimant began treatment with Dr. Fleming, a clinical psychologist, for anxiety and hypertension. The treatments continued until June, 1981. Dr. Fleming concluded that claimant's problems were caused by the stress associated with his employment and recommended, on a number of occasions, that he resign. Claimant agreed that he should quit his job and told Dr. Fleming that he would do so after the national convention in the fall.

On the evening of September 25, 1981, claimant was in Eugene for a union meeting. After it concluded, at about 10:15 p.m., he called the managing director of the city transit district. That call upset him, and he became very angry about it. He joined several union members in a hotel lounge and described the woman with whom he had spoken in very derogatory terms, which was uncharacteristic of his normal behavior. Shortly afterwards, he repeated the entire conversation again, as if the first had never taken place. He later left the lounge and went to his hotel room. There, while engaged in sexual intercourse, he suffered a ruptured cerebral aneurysm. He was rushed to the emergency room. The ruptured aneurysm and the resulting complications left claimant severely disabled.

SAIF denied claimant's claim for benefits. He requested a hearing, and the referee decided that the claim was compensable as either an occupational disease or an injury. The Board adopted and affirmed the referee's decision, one member dissenting.

We need not address the issue of whether the claim is compensable as an injury, because we hold that it is compensable as an occupational disease. The medical evidence indicates that claimant's aneurysm was congenital. To establish

an occupational disease claim relating to a preexisting condition, a claimant must prove that work conditions caused a worsening of the underlying condition producing disability or the need for medical services. *Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979). Additionally, he must establish that the work conditions were the major contributing cause of the worsening of the preexisting condition. *Dethlefs v. Hyster Co.*, 295 Or 298, 667 P2d 487 (1983); *SAIF v. Gygi*, 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982).

Two doctors, neither of whom examined claimant, testified at the hearing. They disagreed over the cause of the ruptured aneurysm. The parties have devoted a substantial portion of their briefs to a discussion of which doctor was more qualified to express an opinion. We find both well qualified.

Dr. Uhland testified in claimant's behalf. He is a board-certified specialist in internal medicine and has had considerable experience with cardiovascular medicine. His testimony indicates that work stress was the major contributing cause of the disability. He stated that claimant was probably born with the aneurysm and that the enormous amount of work stress and the intermittent rise in blood pressure exhibited in the months preceding the rupture caused a thinning of the walls of the aneurysm. The walls became so

thin that small amounts of blood leaked out. That leakage, he testified, would explain the headaches, memory lapses and personality changes that claimant suffered. He agreed that the act of sexual intercourse was the precipitating event causing the rupture but stated that work stress contributed "in a major way" to claimant's disability by weakening the wall of the aneurysm. He testified that, in his opinion, the aneurysm would not have ruptured as soon as it did without the weakening of the arterial wall caused by the work stress induced rise in blood pressure.

Dr. Raaf, board certified in neurosurgery, testified for SAIF. In a report before the hearing, he stated that the aneurysm was the result of a defect in the arterial wall and that claimant's work was not a factor in the cause of the aneurysm or its rupture. At the time he wrote the report he had not read some of the relevant medical reports discussing claimant's personality change and showing his elevated blood pressure. At the hearing, however, he stated in response to a

hypothetical question that included claimant's work history that his opinion was unchanged by those additional facts. His opinion was that the aneurysm was a congenital defect which naturally weakened with age and that the sexual intercourse caused an increase in blood pressure, causing the aneurysm to rupture. He stated that the act of sexual intercourse was the major contributing cause of claimant's disability. He testified that he was aware of no scientific information that intermittent rises in blood pressure cause an aneurysm to weaken.

Dr. Mundall was one of the physicians who treated claimant in the emergency room. He stated in a letter to SAIF that claimant's condition "was not likely 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."

We are confronted with two opposing theories. On *de novo* review, we are free to choose which medical hypothesis is correct, *Coday v. Willamette Tug & Barge,* 250 Or 39, 49, 440 P2d 224 (1968), and we find Dr. Uhland's more persuasive. Unlike Dr. Raaf, he had examined all of the medical reports before the hearing and was therefore apparently better acquainted with claimant's medical history. His testimony was well-reasoned. Dr. Raaf's answers were not as well-explained as Dr. Uhland's. Dr. Mundall's letter supports Dr. Raaf's theory, but it does not explain why work was not a major factor in claimant's disability or whether he was even aware of the amount of stress involved in claimant's work. In short, we find Dr. Uhland's theory more persuasive.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marilyn Cogswell, Claimant.

COGSWELL,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(83-05552; CA A31557)

Judicial review from the Workers' Compensation Board.

Argued and submitted December 17, 1984.

Howard R. Nielsen, Salem, argued the cause for petitioner. With him on the brief were Allen & Vick, Salem.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

WARDEN, J.

Affirmed.

WARDEN, J.

Claimant petitions for review of an order of the Worker's Compensation Board affirming the referee's dismissal of her claim because she failed to establish good cause for not requesting a hearing within 60 days of the date she was notified that the claim had been denied. ORS 656.319(1).[1] We affirm.

In 1982 claimant was employed at Agripac, Inc., on the production belt. The work required repetitive movements of the arms and shoulders. On October 15, she began experiencing symptoms in her neck and shoulders and, after consulting with a physician, Dr. Buell, she filed a claim alleging a compensable occupational disease for bilateral bursitis of the shoulders. SAIF denied compensability on March 18, 1983. In bold-faced type the letter informed claimant that she had 60 days within which to file a request for hearing on the denial. The letter was signed by Lisa Wilch, a claims representative. Claimant received the letter on March 21.

[1] ORS 656.319 provides:

"(1) With respect to objection by claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A Request for Hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The Request is filed not later than the 180th day after notification of the denial and the claimant establishes at a hearing that there was good cause for failure to file the Request by the 60th day after notification of denial."

Dr. Buell referred claimant to Dr. Stewart, who examined her on April 11. After hearing Dr. Stewart's diagnosis, claimant called Wilch on April 26. Wilch told claimant that SAIF would review Dr. Stewart's reports when they were received. SAIF received the reports on April 29, and Wilch received them on May 16. On May 17, claimant called Wilch, who told claimant that she would get back to her that day. Wilch then consulted her supervisor, who reviewed the file and decided that the denial should stand. Wilch tried to telephone claimant about 4:30 p.m. on that day and again on the afternoon of May 19 and on May 20. There was no answer to any of the calls, and on May 23 Wilch wrote claimant a letter advising her that SAIF's denial of March 18 would stand. Claimant received the letter on May 24. About three

weeks later, she sought legal advice, and a request for hearing was filed on June 14, more than 60 days after she had first been notified that her claim was denied. In affirming the denial, the referee found:

> "The primary reason that claimant did not file a timely appeal, consistent with her testimony, appears to be (1) the time slipped by, (2) claimant was concerned about the health of one of her relatives, and (3) claimant did not have the matter of the denial and that matter of an appeal from the denial in her head, notwithstanding the action of SAIF Corporation."

The Board agreed and affirmed the referee's order.

Claimant has the burden to establish good cause for failure to file within the statutory time. *See Wamsher v. Brooks Products,* 26 Or App 835, 554 P2d 573 (1976). Claimant argues that she has provided a reasonable explanation for her inaction which, under the broad remedial policy of the Workers' Compensation Law, should establish good cause.

On *de novo* review, we hold that claimant has not met her burden. She herself testified that she did not believe Wilch had the authority to accept her claim, that SAIF did not tell her that she would have more than 60 days to file a claim or that she ever discussed her appeal rights with Wilch. It is clear that SAIF did not attempt to mislead claimant into thinking that her claim would remain open after the statutory time for appeal had passed. Apart from a concern about a sister who was ill, the record shows no event or occurrence which could have interfered with claimant's timely filing a request for hearing. *See Wamsher v. Brooks Products, supra.* As claimant testified:

> "This whole thing, like I said, has not been up front in my mind. If I would have been thinking about time and essence of everything, I probably would have went sooner. I probably would have went a whole lot sooner."

Claimant's lack of diligence does not constitute good cause.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Frederick G. West, Claimant.

WEST,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(83-01504; CA A32903)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 1, 1985.

Howard R. Nielsen, Salem, argued the cause for petitioner. With him on the brief were Gary Allen, and Allen and Vick, Salem.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Reversed and remanded for payment of medical expenses.

VAN HOOMISSEN, J.

Claimant petitions for judicial review of a Workers' Compensation Board order that affirmed a referee's order upholding SAIF's refusal to pay some of claimant's medical expenses. The issues are whether all of claimant's chiropractic treatments were reasonable and necessary and whether SAIF must pay a consulting physician for his examination of claimant. On *de novo* review, we reverse and remand.

Claimant compensably injured his back in 1979. He saw Dr. Kelley, a chiropractor, who reported that chiropractic care would enable claimant to continue working and that he would come in for a treatment whenever he felt it was necessary. Claimant was examined by Orthopaedic Consultants which prescribed an exercise regimen. He attempted to exercise but he stopped on Kelley's advice, because the exercise was exacerbating his back pain. He was examined by other physicians, who recommended that he lose weight to reduce the pressure on his spine. He lost about 50 pounds. In 1980, he was awarded 20 percent unscheduled permanent partial disability.

In February, 1983, SAIF notified Kelley that it would not pay for more than four treatments per month. In April, 1983, Kelley told SAIF that he was referring claimant to Dr.

Moore for consultation on April 29. SAIF responded that it had not received Kelley's referral notice until April 29 and that it would not pay for the consultation, because it had not been "appropriately notified."

Claimant testified at his hearing that he was almost continuously in pain and that chiropractic treatments enabled him to work. The referee found that the treatments were related to claimant's industrial injury but that they were too frequent. The Board agreed.

Claimant argues that he is entitled to payment for more than the four monthly treatments permitted by OAR 436-69-201(2)(a) and that SAIF must pay Moore, because Kelley notified SAIF pursuant to OAR 436-69-101(8). SAIF argues that claimant is not entitled to treatments, because he has unreasonably failed to mitigate his injury by exercise and weight loss, *see Nelson v. EBI Companies*, 296 Or 246, 674 P2d

596 (1984), and that it need not pay for an examination which SAIF contends was conducted for purposes of litigation.

ORS 656.245 requires provision of 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."

At the time of the hearing, OAR 436-69-201(2)(a) provided in relevant part:

> "The usual range of the utilization of medical services does not exceed twenty-four office visits by any and all attending physicians in the first sixty days from the date of treatment, and four 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 required."

We examined this rule in *Kemp v. Workers' Comp. Dept.*, 65 Or App 659, 672 P2d 1343 (1984), *modified on other grounds* 67 Or App 270, 677 P2d 725 (1984), and stated:

> "We find nothing in this or any other statute that authorizes any limitations on the number of treatments that a claimant can receive. If this Administrative Rule actually permits a limitation of the treatment which a claimant can receive, it is not authorized by the statute."

We concluded that the rule was valid insofar as it only required submission of a report justifying more than four treatments a month. *Kemp v. Workers' Comp. Dept., supra,* 65 Or App at 663. However, to the extent that SAIF relied on the rule to deny payment for services here, such reliance was impermissible. ORS 656.245 mandates provision of medical services, regardless of frequency, so long as they are reasonable and necessary. In *Wetzel v. Goodwin Brothers,* 50 Or App 101, 108, 622 P2d 750 (1981), we held:

> "Medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in the treatment of an injury for which permanent partial disability has been awarded."

SAIF does not argue that claimant does not need

chiropractic treatments; it only objects to their frequency. Claimant testified that the treatments reduce his pain and

enable him to work; when he stopped the treatments, the pain became almost unbearable. He received treatments only when needed. *See Milbradt v. SAIF,* 62 Or App 530, 661 P2d 584 (1983). The record contains no evidence of functional overlay or that claimant is malingering. There is evidence that he has reasonably attempted the recommended exercise and weight-loss programs. *See Nelson v. EBI Companies, supra.* We conclude that claimant has established that his chiropractic treatments are reasonable and necessary to relieve him of severe pain and to permit him to work. *See Milbradt v. SAIF, supra,* 62 Or App at 533.

We conclude that the purpose of claimant's examination by Moore was to aid Kelley in treating claimant's disability. The record does not support SAIF's argument that the consultation was solely for the purpose of litigation. Kelley's notice to SAIF complied with the applicable administrative rule. SAIF must pay for Moore's examination. ORS 656.245.

Reversed and remanded for payment of medical expenses.

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388 July 17, 1985 No. 369

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Charlene V. Devereaux, Claimant.

DEVEREAUX,
Petitioner,

v.

NORTH PACIFIC INSURANCE CO.,
Respondent.

(83-03330; CA A32542)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 15, 1985.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Associates, Eugene.

Mark A. Anderson, Portland, argued the cause for respondent. With him on the brief were Donald P. Bourgeois, and Miller, Nash, Wiener, Hager & Carlsen, Portland.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

RICHARDSON, P. J.

Reversed on issue of compensability and remanded with instructions to accept the claim; otherwise affirmed.

RICHARDSON, P. J.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee's decision that her carpal tunnel syndrome condition is compensable and that she is entitled to penalties for the insurer's unreasonable denial of her claim. In addition to a reversal on those issues, she seeks a modification of the Board's order with respect to her entitlement to interim compensation and penalties for the insurer's failure timely to pay her the full amount of that compensation.

We turn first to the issue of compensability. Claimant, age 38 at the time of the hearing, began to work for the employer in October or November, 1982. Her work involved two tasks: sorting and stacking wooden blocks after taking them off a conveyor belt and operating a saw. She sought treatment for pain in both hands and forearms from Dr. Wichser, on February 16, 1983. He initially diagnosed probable bilateral carpal tunnel syndrome and later confirmed that diagnosis. The insurer denied the claim on the ground that claimant's condition preexisted her employment.

Claimant had first experienced problems with her left forearm in 1974 or 1975 while working for a different employer. That job involved sorting flowers on a conveyor belt. She testified that a pinched nerve under her collar bone caused pain and numbness from her elbow to her hand and caused the forearm and hand to fall asleep. The pain, which particularly bothered her at night, subsided with treatment.

In 1981, she injured her left forearm and hand in a roller skating accident, causing pain and numbness from her elbow to her fingers. The pain was different than before and apparently was worse. A physician's assistant in Dr. Wichser's office treated her, and the pain subsided in approximately two weeks. The assistant noted on the chart of October 6, 1981, that claimant had had a numb left wrist and pain in her left forearm for three months and that it was especially bad at night through early morning. The assistant made a tentative diagnosis of carpal tunnel syndrome.

Some time before she began to work for employer, claimant had problems with her hands while assisting a friend, Davis, to erect a pool cover. Her hands became numb while

holding a heavy pole above her head for approximately 20 minutes. The feeling returned to them when she lowered her arms.

Davis, who became her supervisor at the employer, testified that, before claimant began to work, she had complained of the same problems of which she now complains. He believed that she had made those complaints in the summer of 1982 but admitted that he was not certain and that it may have been earlier. He could not recall whether she had complained of pain in one or both hands. The chart notes of Dr. Wichser, who regularly treated claimant for unrelated problems resulting from a May, 1982, car accident, contain no

indication of such complaints between May 21, 1982, and February 16, 1983, when claimant first sought treatment for her current problems.

If claimant's condition preexisted her employment, to establish her claim she must prove by a preponderance of the evidence that her work activities caused a worsening of her underlying condition resulting in an increase in pain to the extent that it caused disability or required medical services. *Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979). The work activities must be the major contributing cause of that worsening. *See SAIF v. Gygi,* 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982). If the condition was not preexisting, she must prove that her work activities were the major contributing cause of the condition itself. *SAIF v. Gygi, supra.*

The insurer based its denial on the October 6, 1981, chart notes and a letter from Dr. Teal, to whom claimant had been referred by the insurer. Dr. Teal stated that, based on the history provided by Dr. Wichser, "it sounds like the symptoms pre-existed her employment" and that her job "aggravated her symptoms but did not cause the carpal tunnel syndrome." After the insurer's denial, he changed his opinion after reading a letter from Dr. Wichser protesting the denial. In that letter, Dr. Wichser noted that the October 6, 1981, tentative diagnosis was not made by a qualified physician and was never confirmed, that claimant had told him that she had been asymptomatic from the time of the roller skating accident until early 1983, that his chart notes corroborated her story and that, in any event, there was no history of problems in her right hand or forearm. He concluded that claimant was

without symptomatology related to carpal tunnel syndrome for a considerable period of time before she began work and that the insurer's denial was therefore improper. On that basis, Dr. Teal changed his earlier opinion and stated:

> "* * * Dr. Wichser's letter * * * established that this was not a condition which preexisted her employment * * *. Even if her symptoms had occurred in the past prior to her employment, this appears to be a fairly clear cut case of aggravation of a carpal tunnel syndrome by her work. In either case, it appears to me that the indemnity carrier has responsibility for covering her claim. * * *"

The evidence does not establish that claimant's carpal tunnel syndrome preexisted her employment. Although she had experienced symptoms in 1974-75 similar to those of which she now complains, that problem resolved with treatment. There is no medical evidence that the problem was related to carpal tunnel syndrome. With respect to the injury suffered in the skating accident, as Dr. Wichser noted, the tentative diagnosis of carpal tunnel syndrome was not made by a qualified physician and was never confirmed. That injury apparently also resolved with treatment in a short time. The pool cover incident is of little significance. Feeling returned to claimant's hands immediately after she lowered them, and she sought no medical treatment. Davis' testimony is not persuasive enough to establish that claimant's condition preexisted her employment in the absence of any medical evidence to corroborate his testimony. Finally, claimant's problems

with her right hand and forearm commenced only after she began to work for the employer. The evidence did not show that her condition preexisted her employment. We conclude that her claim is compensable, because both Dr. Wichser and Dr. Teal relate her condition to the repetitive movements related to her work.

The next issue is whether the insurer's denial was unreasonable. If it was, claimant is entitled to penalties under ORS 656.262(10):

> "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."

See Nelson v. SAIF, 49 Or App 111, 118, 634 P2d 245 (1980); *Mavis v. SAIF,* 45 Or App 1059, 1062-63, 609 P2d 1318 (1980). When it issued the denial, the insurer had before it the October 6, 1981, chart note with the diagnosis of probable carpal tunnel syndrome and Dr. Teal's letter stating that claimant's work merely caused the symptoms of her preexisting condition to become symptomatic. Dr. Teal later changed that opinion, but that was after the insurer had denied the claim. On the information available at the time of its denial, the insurer could have had a reasonable doubt as to the compensability of the claim, and its denial was therefore not unreasonable. *Nelson v. SAIF, supra.* Claimant is not entitled to penalties for the denial.

The next issue is claimant's entitlement to interim compensation and penalties for insurer's failure timely to pay her the full amount to which she argues she was entitled. When claimant visited Dr. Wichser on February 16, he released her for light duty work. She returned to work and worked until March 8. During that period, she performed the second and less rigorous of the two tasks she normally performed, operating the saw. The insurer did not pay the first instalment of compensation until April 8. That payment covered the period from March 9, the day after claimant left work, to April 8.

Under ORS 656.262(4), the first instalment of compensation due a claimant "shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim." Claimant argues that she was entitled to interim compensation beginning February 16, the date Dr. Wichser sent his "First Medical Report For Workers' Compensation Claims" to the insurer, and that, because the insurer's first payment was not made within 14 days of that date, she is entitled to penalties under ORS 656.262(10). The referee agreed. The Board modified the referee's decision. It held that claimant was entitled to interim compensation beginning on February 22, the day the insurer received notice of the claim,[1] and that, therefore, the penalties assessed should be based on the compensation due during the period commencing with that date.

[1] Employer received notice of the claim that same day.

Claimant urges this court to modify the Board's order and reinstate the referee's decision. The insurer argues that the award of penalties should be completely stricken from the Board's order because, under *Bono v. SAIF,* 298 Or 405, 692 P2d 606 (1984), claimant was not entitled to interim compensation between February 16 and March 8, because she was working during that time. In *Bono,* the court held that interim compensation need not be paid to a worker who has not demonstrated an absence from work during the time period for which such compensation is sought. Under *Bono,* claimant was not entitled to interim compensation between February 16 and March 8.[2] Thus, her argument that penalties should be based on an amount of interim compensation beginning February 16 fails. However, because the insurer did not cross-petition, we decline to strike the award of penalties. A respondent who has not cross-appealed cannot recover a more favorable judgment from the appellate court than was entered below. *Booras v. Uyeda,* 295 Or 181, 188-89, 666 P2d 791 (1983); *R. A. Gray & Co. v. McKenzie,* 57 Or App 426, 645 P2d 30, *rev den* 293 Or 340 (1982). We must affirm the Board's order on this issue.

Finally, the insurer argues that the Board erred in upholding the referee's decision that claimant was entitled to penalties for the insurer's failure to accept or deny the claim within 60 days as required by ORS 656.262(6). The insurer's failure to cross-petition also precludes our review of that decision. *Booras v. Uyeda, supra; R. A. Gray & Co. v. McKenzie, supra.*

Reversed on issue of compensability and remanded with instructions to accept the claim; otherwise affirmed.

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[2] In *Bono,* the court stated that the claimant was not entitled to interim compensation, because he did not establish "that he had been absent from work *or that his earning power was diminished.*" 298 Or at 410. (Emphasis supplied.) Claimant did not raise the issue of whether she was entitled to interim compensation because she was released only for light duty work and therefore suffered a diminished earning capacity. There is no evidence that she earned less than her regular pay when she returned to work. Furthermore, when she did return, she performed a task that was normally part of her job.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael R. Fischer, Claimant.

HOWARD COOPER CORPORATION,
Petitioner,

v.

FISCHER,
Respondent.

(81-10100; CA A30550)

Judicial Review from Workers' Compensation Board.

Submitted on record and briefs January 25, 1985.

David O. Horne, Beaverton, filed the brief for petitioner.

Rick W. Roll, and Roll, Westmoreland and Lavis, P.C., Tillamook, filed the brief for respondent. On July 11, 1984, Rick W. Roll withdrew as counsel for respondent.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

The issue in this workers' compensation case is whether the insurer is liable for payment for claimant's October 6, 1981, back surgery under ORS 656.245(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."

The referee and the Workers' Compensation Board held that the insurer was liable. We affirm.

Claimant suffered compensable injuries to his low back in 1967 and 1968. As a result, Dr. Groth performed a fusion from L5 to the sacrum on August 5, 1969. Claimant continued to experience back pain, pain and numbness in his legs and headaches. Over the years, he consulted several doctors, none of whom recommended further surgery. There is medical evidence of a psychological component of his problems. In April, 1981, Dr. Berselli began to treat claimant, and in September, 1981, he reported that there was evidence of spinal stenosis at the L3-4 level associated with a mild degree

of disc bulging. He stated that claimant's complaints and physical findings were sequelae of his original injury. He performed a lumbar laminectomy at the L3-4 level on October 6, 1981. The insurer denied responsibility for payment for that operation.

Dr. Berselli relates the need for the laminectomy to trauma induced during the 1969 fusion operation. He testified that it was probable that the exposure of the lamina at the L3-4 level during the 1969 operation caused the thickening of the lamina and the resulting stenosis present in 1981. There is no medical evidence refuting his opinion. The insurer relies heavily upon Dr. Groth's surgical note of the 1969 operation in attempting to undermine Dr. Berselli's opinion. In the note, Dr. Groth stated that, during that operation, the "incision was

made on the right side, carried down exposing the transverse process of L5 and the sacrum" and that a "similar incision was made on the opposite side." The insurer argues that that statement establishes that only the L5-sacrum level was exposed and that the L3-4 level was not. SAIF's analysis of the chart note does not necessarily follow from the words used. Although the note states that the L5-sacrum level was exposed, it does not state that the higher L3-4 level was not also exposed. Dr. Berselli testified that, even though the fusion occurred at the lower level, the excision must be made at a higher level to reach the bone at the L5 level.

Claimant has sustained his burden of proving that the laminectomy was performed for a condition resulting from his compensable injuries. It is more probable than not that the need for the laminectomy resulted from complications arising out of the 1969 fusion, which in turn was necessitated by his compensable injuries.

Affirmed.

No. 391 July 17, 1985 557

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation
of Darlene L. Birtch, Claimant,
and Joyce L. DePew, Claimant, (Deceased).
DEPEW et al,
Petitioners,

v.

SAIF CORPORATION,
Respondent.

(83-01758; 83-01928; CA A33020)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 5, 1985.

William H. Schultz, Portland, argued the cause for petitioner DePew. With him on the brief were Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Michael N. Gutzler, Salem, argued the cause for petitioner Birtch. On the brief were Howard R. Nielsen, and Allen & Vick, Salem.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Affirmed.

VAN HOOMISSEN, J.

Petitioners seek judicial review of a Workers' Compensation Board order upholding SAIF's denial of their claims on the ground that petitioners are not "subject workers."[1] ORS 656.027. We affirm.

Birtch and DePew were employed by Wert at a private club in Clackamas County. The club was primarily an illegal gambling establishment. Birtch worked as a shift manager. She dealt cards, made sure other card dealers were available, answered the door, handled the money and waited on customers. DePew worked as a card dealer and waitress. Both worked the 2 a.m. to 10 a.m. shift. They were paid in cash from gambling receipts at the end of each shift. In September, 1982, the club was robbed. After ordering Birtch and DePew to lie on the floor, the robber shot both of them in the back. Birtch was seriously injured; DePew was killed.

Claims filed by Birtch and on behalf of DePew's child were referred to SAIF, because Wert had no coverage. *See* ORS 656.054(1). SAIF denied the claims on the ground that petitioners' contracts of employment called for the performance of criminal acts. After a consolidated hearing, the referee agreed with SAIF that petitioners were engaged in criminal activities. *See* ORS 167.117 to 167.162. Nevertheless, he concluded that Wert was a subject employer and that petitioners were subject employes. The Board disagreed. It concluded that petitioners were not subject workers and that it would violate both the purpose of the Workers' Compensation Act and public policy to allow compensation. Accordingly, the Board reinstated and affirmed SAIF's denials.

Petitioners argue that we should interpret the Workers' Compensation Act liberally in favor of injured workers, *see Holden v. Willamette Industries,* 28 Or App 613, 618, 560 P2d 298 (1977), and that had the legislature intended to exclude from coverage workers engaged in criminal activities, it would have said so specifically in ORS 656.027.

ORS 656.027 provides that all workers are subject to the Workers' Compensation Act, except sixteen types of workers and work activities that the legislature has chosen specifically to exclude from coverage. Nowhere in ORS 656.027, or anywhere else in the act, is there an exclusion based on a contract of employment that calls for the perform-

[1] Separate briefs have been filed on behalf of petitioner Birtch and on behalf of the minor child of DePew.

ance of criminal acts. Therefore, if we were to look no further, the statute would appear to cover petitioners.

The legislative policy statement contained in ORS 656.012 provides:

> "(1) The Legislative Assembly finds that:
>
> "(a) The performance of various industrial enterprises necessary to the enrichment and economic well-being of all the citizens of this state will inevitably involve injury to some of the workers employed in those enterprises; and * * *."

Clearly, *illegal* gambling is not an enterprise "necessary to the enrichment and economic well-being" of our citizens. Neither is criminal activity within the spirit of the statute. In *Johnson v. Star Machinery Co.*, 270 Or 694, 703-706, 530 P2d 53 (1974), the Supreme Court stated:

> "[T]he rule requiring the court to follow the plain meaning of seemingly unambiguous language is not inflexible and not without exceptions. Hence, if the literal import of the words is so at variance with the apparent policy of the legislation as a whole as to bring about an unreasonable result the literal interpretations must give way and the court must look beyond the words of the act.
>
> "* * * * *
>
> "'* * * [A] thing may be within the letter of the statute and yet not within the statute because not within its spirit, nor within the intention of its makers * * *,' *Holy Trinity Church v. United States*, 143 US 457, 459, 12 S Ct 511, 36 L Ed 226 (1892) * * *."

See Fox v. Galloway, 174 Or 339, 346, 148 P2d 922 (1944). The issue is not, as petitioners appear to argue, that they should not be punished; the issue is whether they were subject workers within the meaning of the act. We conclude that both the statutory language and the public policy implicit in the Workers' Compensation Act prohibit an award of compensation for injuries suffered by a worker employed under a contract to engage in criminal activities.[2]

Professor Larson would agree with this formulation:

> "Although it could be argued technically that a requirement of a 'contract of hire' can be satisfied only by showing a legal contract, the cases have generally drawn a distinction between contracts that are illegal in the sense that the making of the contract itself violates some prohibition, and contracts that call for the performance of acts that are themselves violations of penal laws. The former will ordinarily support an award of compensation; the latter will not." 1C Larson, *Workers' Compensation Law*, § 47.51, 8-291, 292 (8th ed 1982).

Affirmed.

[2] Petitioners rely on *Boyd v. Francis Ford, Inc.*, 12 Or App 26, 504 P2d 1387 (1973). In that case, the claimants' decedent was killed in a one-car accident on his way home after a business meeting. He was intoxicated at the time of his death. The issue was whether the decedent, a subject worker, was acting within the course and scope of his employment. We held that he was, and that his drinking before the accident, which was a question of negligence, was not enough to deny coverage. The present case does not concern the course and scope of employment, but rather whether petitioners were subject workers, an issue not addressed in *Boyd*.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Katherine E. Casteel, Claimant.
STATE ACCIDENT INSURANCE FUND
CORP.,
Petitioner,
v.
CASTEEL,
Respondent.
(82-03575 and 82-03576; CA A31893)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 22, 1985.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Dave Frohnmayer, Attorney General, James E. Mountain, Jr., Solicitor General, and Donna Parton Garaventa, Assistant Attorney General, Salem.

Diana Craine, Portland, argued the cause for respondent. Robert K. Udziela, and Pozzi, Wilson, Atchison, O'Leary and Conboy, Portland, filed the brief for respondent.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

Van Hoomissen, J., dissenting.

YOUNG, J.

Claimant compensably injured her back and hip. A referee awarded permanent total disability. SAIF requested Board review, and the Board reduced the award to 10 percent unscheduled permanent partial disability. Claimant requested review by this court, and we modified the Board's order and granted claimant an award of 50 percent unscheduled permanent partial disability. *Casteel v. SAIF,* 55 Or App 474, 638 P2d 1165 (1982). The issue is whether SAIF is entitled to credit the amounts paid pursuant to the referee's award of permanent total disability against the final award of 50 percent unscheduled permanent partial disability. The Board held that ORS 656.313(2) prohibits recovery, by offset or other means, of amounts paid pending review.

ORS 656.313 provides:

"(1) Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant.

"(2) If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to *repay* any such compensation which was paid pending the review or appeal." (Emphasis supplied.)

OAR 436-54-320 governed the recovery of overpayments of benefits:[1]

> "Insurers and self insured employers may recover over payment of benefits paid to worker on an accepted claim from benefits which are or may become payable on that claim. *Payment of benefits paid during appeal pursuant to ORS 656.313 shall not be recoverable under this section."* (Emphasis supplied.)

In *Bekins Moving and Storage Co. v. Jordan,* 68 Or App 57, 680 P2d 392 (1984), we affirmed, *per curiam,* the Board's denial of the employer's request to offset permanent total disability benefits paid claimant pending Board review against the permanent partial disability benefits awarded.

The authority for our decision was *Hutchison v. Louisiana Pacific,* 67 Or App 577, 679 P2d 338 (1984), where we held that, under ORS 656.313, the claimant was entitled to payment of temporary partial disability from the time of the referee's order and that the insurer was not entitled to an offset even if the referee's order was later reversed. SAIF's argument relies entirely on a distinction between "repayment" under ORS 656.313 and an "offset" or "credit." In *Hutchison, supra,* and *Bekins, supra,* we refused to distinguish "offsets" from "repayment" under ORS 656.313(2). We agree with the Board that the legislature, in enacting ORS 656.313, has placed the burden of erroneously ordered compensation paid pending review or appeal on the employer and its insurer. SAIF is not entitled to an offset.

Affirmed.

[1] The administrative rule was in effect at the times relevant to this appeal. The current administrative rule is renumbered OAR 436-60-170 and the quoted language has been deleted.

VAN HOOMISSEN, J., dissenting.

I would hold that SAIF is entitled to credit amounts paid, pending the appeal, on the permanent total disbility awarded by the referee against the final award of 50 percent permanent partial disability. Therefore, I respectfully dissent.

This case involves a single claim and a single final award of permanent disability. The referee awarded claimant permanent total disability. SAIF requested review. Pending review, SAIF paid benefits. ORS 656.313(1). By the time this court finally fixed the permanent disability award at 50 percent, SAIF had paid less than the 50 percent which we awarded. SAIF seeks *credit* for that amount.[1] SAIF argues that, because it has not paid an amount equal to the award of 50 percent permanent partial disability, claimant is entitled only to the balance of that award. That makes sense to me. To hold otherwise is to give claimant a windfall that, in my view, is not mandated by the authorities cited in the majority's opinion.

I see a clear distinction between requiring a claimant to *give back* benefits already received and allowing a carrier to have a *credit* for benefits paid. The former takes money out of a claimant's pocket—money that the claimant has probably

[1] SAIF concedes that, had it already paid more than the 50 percent finally awarded, it would not have been able to recoup the excess payments. ORS 656.313(2).

already spent and, therefore, does not have to give back. The latter merely recognizes that the claimant is entitled to an award and has already received partial payment of that award. Thus, the claimant gets everything to which she is entitled. That is fair and does no violence to the intent of ORS 656.313(2), which only addresses *repayment* of benefits paid pending appeal.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dawn Mellis, Claimant.

MELLIS,
Petitioner,
v.
McEWEN, HANNA, GISVOLD, RANKIN & VAN KOTEN et al,
Respondents.

(83-00058; CA A31485)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 8, 1985.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief were Pozzi, Wilson, Atchison, O'Leary and Conboy, Portland.

Thomas J. Mortland, Portland, argued the cause for respondents. With him on the brief were Breathouwer and Gilman, Portland.

Before Joseph, Chief Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Reversed and remanded with instructions to accept the claim.

YOUNG, J.

Claimant seeks review of an order of the Board, which reversed a referee's opinion and order and reinstated the employer's denial of compensability. The issue is whether claimant's injury is work related. We reverse and remand for acceptance of the claim.

Claimant is a salaried paralegal employed by a law firm. She is expected to document at least fifteen hundred billable hours per year. The law firm is located on the fourteenth floor of a Portland office building, which has a third floor cafeteria primarily maintained for, and patronized by, the building's tenants. Although claimant is not required to keep a set work schedule, she customarily works 8 a.m. to 5

p.m., with an hour off for lunch. The lunch hour is unpaid. Claimant usually goes home for lunch.

On November 17, 1982, she arrived at work at 9:30 a.m., delayed by a personal errand. She ate an apple at her desk during her usual lunch hour. At 2:15 p.m., she left her office and went to the cafeteria. She testified that she had reviewed a new file, realized that it was going to be a two or three hour job and decided to go downstairs to the cafeteria for a quick break to clear her mind before she got involved in a long session of calculations.

In the cafeteria she ate a small salad. After about 15 minutes, she arose to return to her office. She became entangled in the leg of a chair, tripped and fell and fractured the head of the femur of her right leg. She underwent surgery for internal fixation of the hip socket. She has since returned to work after an extended period of treatment. Although the law firm's office suite includes a coffee area, the firm has long acquiesed in its employees' practice of leaving the office for breaks in the cafeteria.

A compensable injury is an "accidental injury * * * arising out of and in the course of employment." ORS 656.005(8)(a). The ultimate inquiry under the statute is whether the relationship between the injury and the employment is sufficient that the injury should be compensable. *Rogers v. SAIF,* 289 Or 633, 642, 616 P2d 485 (1980). In determining whether an injury is work-related, this court has identified the following factors:

> "a. Whether the activity was for the benefit of the employer * * *;
>
> "b. Whether the activity was contemplated by the employer and employe either at the time of hiring or later * * *;
>
> "c. Whether the activity was an ordinary risk of, and incidental to, the employment * * *;
>
> "d. Whether the employee was paid for the activity * * *;
>
> "e. Whether the activity was on the employer's premises * * *;
>
> "f. Whether the activity was directed by or acquiesed in by the employer * * *;
>
> "g. Whether the employe was on a personal mission of his own * * *." *Jordan v. Western Electric,* 1 Or App 441, 443-44, 463 P2d 598 (1970); *see also Halfman v. SAIF,* 49 Or 23, 618 P2d 1294 (1980).

In *Jordan* and *Halfman* we held that injuries that had occurred off premises during coffee breaks were work-related. In this case, after applying the *Jordan* factors, the Board found that claimant's injury was not work-related, in part because the Board did not believe that eating in a public cafeteria can be considered an ordinary risk of or incidental to claimant's employment, particularly when employer provides a lunch room, and in part because claimant, as a salaried employe, was not paid for her time in the cafeteria. The Board considered the most important fact to be that employer maintained no control over claimant while she was on her break.

We disagree with the Board's factual findings that claimant was not paid for her break time. Claimant's lunch period was not paid. However, within her regular 40 hour week it was contemplated that she would take coffee breaks and that the breaks would be included in her regular work day. We find that the 15 minutes that claimant spent in the cafeteria was a "coffee break" rather than a delayed, unpaid lunch period.

We find that the activity was contemplated by both employer and claimant and that the activity was acquiesed in by employer. As to whether claimant was on a personal mission, we find that a 15 minute break is a "typical kind of

coffee break activity that is contemplated by an employer" and that claimant's activity was not a departure from the employment relationship. *See Halfman v. SAIF, supra,* 49 Or App at 29. That the injury occurred off premises is only a factor weighing against the claim, not a decisive one. After weighing all the factors, we conclude that claimant has established that her injury is work related.

Reversed and remanded with instructions to accept the claim.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Willard Ellis, Claimant.

ELLIS,
Petitioner,
v.
CASCADE WOOD PRODUCTS,
Respondent.

(82-10518; CA A32967)

Judicial review from the Workers' Compensation Board.

Argued and submitted March 4, 1985.

Donald M. Pinnock, Ashland, argued the cause for petitioner. With him on the brief were Davis, Ainsworth, Pinnock, Davis & Gilstrap, P.C., Ashland.

Keith D. Skelton, Portland, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

WARDEN, J.

Affirmed.

WARDEN, J.

In this review of an order of the Workers' Compensation Board, we agree with the Board that petitioner's continued chiropractic treatment is not related to his 1973 injury and, therefore, is not compensable.

Claimant fell at work in 1973 and sprained his back, causing him to miss two days' work. He and employer stipulated to an award of 15 percent unscheduled permanent partial disability. Since the injury, claimant, who lives in Ashland, has continued to receive chiropractic treatment, most recently from Dr. Scofield in Eugene, who uses the "Pettibon Method of Spinal Bio-Mechanics and Bio-Engineering." In 1983, the carrier denied responsibility for further treatment. The referee found the treatment to be related to the compensable injury. The Board reversed.

Although claimant has presented the report of a Medford rheumatologist that arthritis in the back is "rare" and that claimant's back problems are due to the injury, we agree with the Board that the contrary opinions and explanations are more persuasive. The medical evidence supports the conclusion that claimant's continued back pain is due to rheumatoid arthritis instead of the 1973 back sprain. Claimant has had arthritis since 1954, and it affected his back as early as 1959. An orthopedist, whom claimant saw on his own initiative, found that the back sprain should have healed three months after the injury and that the present symptoms probably were due to arthritis. That was confirmed by a Portland rheumatologist, the doctor for employer. Additionally, as employer points out, the chiropractor is now treating claimant for upper back problems that are not in the lumbosacral and thoracic areas that were involved in the original injury.[1]

Affirmed.

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[1] Because we find that the treatments are not related to the injury and are not compensable, we do not reach the issue of reimbursement for claimant's expenses in traveling from Ashland to Eugene for the treatments. Our decision makes moot claimant's other assignments of error concerning attorney fees and penalties.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Lee Austin, Claimant.

AUSTIN,
Petitioner,

v.

CONSOLIDATED FREIGHTWAYS,
Respondent.

(82-03002; CA A31798)

Judicial Review from the Workers' Compensation Board.

Argued and submitted February 15, 1985.

Robert E. Nelson, Gresham, argued the cause and filed the brief for petitioner.

Alan M. Muir, Portland, argued the cause for respondent. With him on the brief were Dennis S. Reese, and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed and remanded for determination of penalties and attorney fees.

WARREN, J.

Claimant seeks review of a Board order which affirmed the referee's determination that employer reasonably suspended time loss benefits after learning that claimant was receiving income from self-employment.

Claimant suffered a compensable back injury on December 15, 1981, while working as a truck driver. Although he had not been released for work, on March 3, 1982, he opened a lawn mower repair business, which he had been operating as a hobby out of his home since 1975. On March 18 and 19, 1982, employer's investigators observed claimant lifting, bending and doing his share of the work in the repair shop. The shop was open for business six days per week.

Without first seeking income information, on March 19, 1982, employer notified claimant that he no longer qualified for temporary total disability:

> "Our information reveals that you are and have been employed for some time. You do not qualify for temporary total disability benefits while employed.
>
> "Will you please provide us with a list of earnings, from any source, for the period of December 15, 1981, through the present. We will be entitled to an offset of all income earned.
>
> "If you do not reply within ten days, our attorney has advised us to take whatever action is necessary to obtain this information."

Employer characterizes this notice as a "temporary

suspension letter." Benefits were suspended as of the date of the letter. Immediately thereafter, claimant telephoned employer's claims examiner to advise her that he was not receiving any wages from the mower repair business. The claims examiner asked if she could see claimant's financial records, and he replied that he would provide the records after consulting his attorney. No records were provided until the date of the hearing, despite several requests by employer.

On December 27, 1982, a determination order was issued, awarding claimant temporary total disability benefits from December 16, 1981, through June 28, 1982. No temporary total disability has been paid since March 19, 1982.[1]

The referee and the Board held that the suspension of benefits was reasonable. The Board stated that the suspension should not be viewed as a "termination" of benefits, but as a "calculation" of partial (zero) benefits which the employer is entitled and required to make unilaterally, under OAR 436-54-222(3),[2] after determining that a claimant has post-injury wage earnings. The Board reasoned that, because claimant would not provide wage information, employer could infer that he was earning as much as or more than he did at the time of the injury. The Board considered the situation to be analogous to the presumption allowed by OEC 311(1)(c), that evidence wilfully suppressed is presumed to be adverse to the party suppressing it.

Although such a rule would, as the Board suggests, "put some teeth in the Board's often repeated admonition that claimants have some duty to furnish information necessary to prove their claims," it is not the law. Time loss benefits under ORS 656.212 may be terminated when medical reports indicate that the worker's condition has become medically stationary or when the worker has been released for or has returned to regular work. ORS 656.268; *Jackson v. SAIF,* 7 Or App 109, 490 P2d 507 (1971). Benefits may be terminated unilaterally if it is determined that the employe has returned to work for at least the same hours and wages. *Phillips v. Peco Manufacturing Co.,* 32 Or App 589, 574 P2d 707 (1978). If the attending doctor has not approved the claimant's return to regular employment, the insurer or self-insured employer must continue to make time loss payments until termination is authorized by the Workers' Compensation Department. *See Georgia Pacific v. Awmiller,* 64 Or App 56, 666 P2d 1379 (1983).

An employer has the right to suspend benefits with the consent of the Director of the Workers' Compensation

[1] The determination order was issued while this matter was pending before the hearing referee on the question of whether the employer acted reasonably. The determination order was not before the referee or the Board, and this opinion does not resolve any issues which may arise out of that order.

[2] 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."

Department under ORS 656.325(1) if the claimant refuses to submit to a medical examination or commits injurious or unsanitary practices which tend either to imperil or to retard recovery. If, at any time, a dispute arises, a hearing may be requested. ORS 656.325(6); ORS 656.283(1). As we stated in *Jackson v. SAIF, supra,* there may be other occasions when the employer may wish to stop making payments, but it cannot be done on the employer's own motion. As employer concedes, claimant was not medically stationary and had not been released for work on the date benefits were suspended. Employer did not know whether claimant had returned to work for at least the same wages and hours, because it had not sought income information.

The Board's characterization of employer's letter of March 19, 1982, as a "unilateral calculation" of temporary partial benefits is contrived. It is true that an employer is required under OAR 436-54-222(3) to cease making total disability payments and to calculate and begin making partial payments when it knows that a claimant has returned to work, but to characterize employer's conduct here as a "calculation" is not consistent with the evidence. Employer itself described the letter of March 19, 1982, as a "suspension of benefits" and, before it was sent, it had not sought any information from claimant regarding his income; instead, it suspended benefits as a means of obtaining that information.

Employer argues on appeal that the power to suspend benefits is necessary, because "the statutes, administrative rules, and appellate cases do not assist an employer in obtaining the claimant's post-injury wage rate for the purpose of calculating partial disability." The Worker's Compensation laws provide every employer with the right to request a hearing at any time, ORS 656.283(1); that is the employer's resource for obtaining information if the claimant refuses to provide it. Suspension of time loss benefits was not proper and was unreasonable in the absence of a determination order or evidence that claimant had returned to work for at least the same hours and wages.

Reversed and remanded for determination of penalties and attorney fees.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of James G. Cannon, Claimant.
LINN CARE CENTER et al,
Petitioners,
v.
CANNON,
Respondent.
(83-04539; CA A32964)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 2, 1985.

Jerald P. Keene, Portland, argued the cause for petitioners. On the brief were Craig A. Staples, and Roberts, Reinisch & Klor, P.C., Portland.

Patrick L. Hadlock, Corvallis, argued the cause for respondent. On the brief were S. David Eves, and Ringo, Walton, Eves & Stuber, P.C., Corvallis.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

The issue in this Workers' Compensation case is whether the Board correctly determined that claimant's back surgery was reasonable and necessary. On *de novo* review, we affirm. We write only to address the insurer's contention concerning the application and effect of a Workers' Compensation Department administrative rule.

The surgery in question was elective, and the insurer sought application of OAR 436-69-507, which provides, in part:

> "(3) When elective major orthopedic or neurological surgery is recommended, the insurer may recommend an independent consultation with a physician of insurer's choice. The insurer shall notify the attending physician within 5 days if a consultation is desired. The consultation shall take place within 14 days of the attending surgeon being notified of the intent to obtain the consultation. * * *
>
> "* * * * *
>
> "[4](b) If the surgeon and the consultant disagree about the need for surgery, another opinion may be sought by the insurer from a consultant mutually agreeable to the surgeon and the initial consultant. * * *"

A mutually agreed on consultant, selected pursuant to subsection 4(b) of the rule, recommended against surgery. Claimant's request for surgery was denied by the insurer, and on June 9, 1983, a determination order was issued. In spite of

the denial, claimant underwent surgery on July 19, 1983. The surgeon reported that the surgery was necessary due to claimant's constant pain. A hearing was held, and the referee stated that the provisions of the administrative rule are designed to ensure that surgery be performed only if it is reasonably supported by medical opinion. He found that, considering the administrative rule and pre-surgery medical opinions, the record did not support the compensability of the surgery. The Board reversed and concluded, on the basis of post-surgical findings of a back problem and claimant's testimony of improvement following surgery, that the surgery was reasonable and necessary.

Employer suggests that, when the provisions of OAR 436-69-501 have been invoked and the third medical opinion recommends against surgery, a claimant should not recover

for surgery performed simply because of post-surgical findings that it was beneficial. We disagree. Although based on the pre-surgery evidence, the insurer's refusal to authorize the surgery reasonable, and the insurer was therefore not subject to a penalty, even though the post-surgery evidence supported a conclusion that the surgery was, in fact, needed. The fact that medical treatment is beneficial is an indication that the treatment was reasonable and necessary. Subsequent improvement is relevant and can and should be considered in determining the compensability of medical services. The Board properly considered claimant's post-surgical improvement in determining whether the treatment was reasonable and necessary.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Leslie Colvin, Claimant.

COLVIN,
Petitioner,
v.
INDUSTRIAL INDEMNITY,
Respondent.

(81-03061; CA A31519)

Judicial review from the Workers' Compensation Board.

Argued and submitted February 1, 1985.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

John E. Snarskis, Portland, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, Joseph, Chief Judge and Warden, Judge.

WARDEN, J.

Affirmed.

WARDEN, J.

Claimant seeks judicial review of an order of the Workers' Compensation Board. We affirm.

Claimant worked as a paralegal for a firm of approximately 50 lawyers. In 1978 she suffered a low back injury while attending a firm picnic at the home of one of the firm's partners. The picnic began during working hours and continued until late in the night. The accident took place between 6 p.m. and 7 p.m., after normal working hours. She fell on stairs that had been made slippery by water tracked in from the swimming pool. No one saw her fall, but she told Kreft, the firm's senior paralegal, about her injury shortly after the incident. She also mentioned to Lilly, an associate of the firm, that she had fallen and injured her back at the party.

Claimant missed work the first two days of the week following her fall because of pain and bruising. She suffered recurring symptoms periodically over the next two years. In September, 1980, she experienced a severe recurrence of symptoms while on firm business in another city. She made a claim relating to her low back on October 1, 1980, and another claim relating to her neck on October 27, 1980.

Employer denied the claims on January 14, 1981. The referee reversed the denial of the low back claim and upheld the denial of the neck claim.[1] He based the ruling on findings that claimant was credible, that Kreft and Lilly were claimant's supervisors and that she had informed them of her injury shortly after it occurred, thereby giving employer "knowledge of the injury" for purposes of ORS 656.265(4)(a), and concluded therefrom that her claim was not barred for failure to give timely notice. He further concluded that claimant's injury was sufficiently work related to be compensable. He ordered insurer to accept claimant's low back claim and to pay penalties and attorney's fees, because "[t]he denial was issued more than 60 days after acknowledgment of either claim, significantly longer as to the low back claim."

The Board reversed on the basis that claimant's mention of her injury to Kreft and Lilly did not constitute notice to employer, concluding that the claim was therefore

untimely. The Board further held that, "[e]ven 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."

Claimant first assigns as error the Board's holding that her claim was untimely. We agree with the Board. The opinions of both the Board and the referee, however, confuse the question of who in an employer's organization must *know* of an injury for purposes of the exception to the notice requirement in ORS 656.265(4)(a), with the question of who

[1] Claimant did not request review of the denial of her claim for injury to her neck.

must be *notified* of an injury for purposes of ORS 656.265(3).[2] The Board wrote:

> "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 the 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 notice of claim."

Whether claimant's conversations with Kreft and Lilly constituted "notice of a claim" is not in issue. Claimant concedes that she was not trying to report an injury to her employer when she made her comments to Kreft and Lilly.[3]

Her argument is only that employer had *knowledge* of the injury for purposes of the exception to the notice requirement in ORS 656.265(4)(a). That provision, unlike ORS 656.265(3), does not mention "a foreman or other supervisor of the employer," and it is therefore unnecessary to determine whether Kreft and Lilly were claimant's supervisors.

We think the relevant question in determining whether the employer had knowledge of the injury within the meaning of ORS 656.265(4)(a) is whether the individuals who were aware of the injury also had the apparent authority or a duty to do something about it. In the setting presented here, it would not only have been sufficient if any partner of the firm had known of claimant's injury, but it would also have been sufficient if an employe responsible for handling workers' compensation matters had known of it. Whether that employe was or was not claimant's supervisor would have been irrelevant.

There is no dispute, however, about whether Kreft or Lilly had the apparent authority or any duty to take some action concerning claimant's injury. They did not. Accordingly, we affirm the Board's reinstatement of insurer's denial, without reaching the question whether claimant's injury arose out of and in the course of her employment, which is the focus of claimant's second assignment of error.

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[2] ORS 656.265(3) and (4)(a) provide:

> "(3) Notice shall be given to the employer by mail, addressed to the employer at the last-known place of business of the employer, or by personal delivery to the employer or to a foreman or other supervisor of the employer. If for any reason it is not possible to so notify the employer, notice may be given to the director and referred to the insurer or self-insured employer.
>
> "(4) Failure to give notice as required by this section bars a claim under ORS 656.001 to 656.794 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 * * *."

[3] Although the concession is not clear in claimant's brief, she testified at the hearing that she did not think about reporting her injury, because she thought she would recover fully and because the firm's frequent involvement in insurance defense litigation created an atmosphere that was not conducive to filing workers' compensation claims. During the hearing she responded to argumentative cross-examination by stating, "I did take a risk when I didn't report it, didn't I?"

Claimant's third assignment of error is:

> "The Board erred in granting Claimant 'interim compensation' from the time of the filing of her written claim until its tardy denial, rather than commencing such compensation at the time of Claimant's verbal notice to her employer."

As explained above, claimant's oral report of her injury to Kreft and Lilly was not "notice to her employer." Thus, if she were entitled to interim compensation, it could have begun no earlier than October 1, 1980, the date on which she made her low back claim.[4]

Affirmed.

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[4] After the briefs for this appeal were filed, the Supreme Court held in *Bono v. SAIF*, 298 Or 405, 692 P2d 606 (1984), that interim compensation need not be paid to a worker who has not demonstrated an absence from work during the period for which such compensation is sought. The record does not indicate whether claimant missed work after October 1, 1980. Insurer, however, has not requested that we disturb the Board's award of interim compensation or its award of penalties and attorney's fees for employer's late denial of the claim. Accordingly, we leave those awards in place.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Munzo Mashadda, Claimant.

MASHADDA,
Petitioner,

v.

WESTERN EMPLOYERS INSURANCE et al,
Respondents.

(82-01374; CA A32602)

Judicial review from the Workers' Compensation Board.

Argued and submitted March 25, 1985.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

Bruce L. Byerly, Portland, argued the cause for respondents. With him on the brief were Moscato & Byerly, Portland.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

WARDEN, J.

Reversed and remanded with instructions to accept claim.

WARDEN, J.

Claimant seeks judicial review of a Workers' Compensation Board order that reversed a referee's order setting aside employer's denial of his claim. The parties agree that while claimant was operating a dirt compaction roller on September 2, 1981, the machine tipped over. They dispute, however, whether that incident resulted in a compensable injury to claimant. On *de novo* review, we reverse and remand.

The referee specifically found that claimant was not credible. The Board and we agree. The record is replete with inconsistent testimony by claimant as to the details of the accident and his injuries. The medical evidence shows that claimant was malingering, a conclusion which was confirmed by surveillance of him by employer. The issue, then, is whether the evidence preponderates in favor of a finding of a compensable injury within the meaning of ORS 656.005(8)(a) which provides in part:

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

The referee found the injury compensable on the basis of the testimony of a fellow worker who saw the accident and the initial reports of the treating physician, Dr. Goertz, who examined claimant on the day after the purported injury and treated him thereafter. The referee concluded:

> "As I indicated earlier, I find that an incident did occur on September 2, 1981.
>
> "* * * * *
>
> "The claimant saw Dr. Goertz at 3:15 the following day[.]
>
> "* * * * *
>
> "[T]hat afternoon there are sufficient complaints that Dr. Goertz ordered x-rays of the claimant's wrist and back. Although there are no hard objective findings, there was tenderness present to such a degree apparently that Dr. Goertz diagnosed both back and left wrist sprain. He also kept the claimant off work.
>
> "* * * * *
>
> "But I don't think [claimant] engineered an incident. Although I distrust his testimony, I don't think he expected

> that roller to roll over in the manner it did. And although given the problems with the credibility that I have noted, those problems all occur long after the claimant first sought treatment with Dr. Goertz."

The report filed by Goertz after the initial examination gave as the nature of the injury that the "[p]atient was operating rolling machine, the machine fell over and the patient fell with it." The diagnosis was "sprain, back and left wrist."

The Board found no objective evidence of disability or the need for medical services but only subjective symptoms of injury stated by claimant, who was not credible. The Board apparently found that Goertz retracted his initial diagnosis when he wrote the following in a referral letter of December, 1981:

> "This is in reference to [claimant]. This is a 31 year old man who was on the job one day last September when he reported that his roller turned over, throwing him to the ground. He had some immediate low back pain and was seen the next day at our clinic where other than some upper lumbar tenderness his exam was basically normal. The x-ray was also normal at that time. I assumed it was a simple strain and treated him conservatively with Motrin and rest. His back symptoms initially got better but then worsened again and

have continued basically unchanged, still without any significant objective evidence of strain."

We do not find that language to constitute a retraction of his first diagnosis. That claimant later falsified his symptoms does not mean that the back strain diagnosed the day after the accident was not a legitimate complaint. The Board has interpreted the initial medical examination in the light of claimant's later malingering. We view the malingering as relevant only to the issue of the amount of compensation.

Employer concedes that an accident occurred. From witnesses' accounts of it, it was of sufficient violence to have caused an injury. Goertz' notes of his examinations of September 3, 8 and 15, 1981, all mention lumbar tenderness and spasm, from which he diagnosed a simple strain. Dr. Wilson, the neurologist to whom Goertz referred claimant, also diagnosed a chronic lumbar strain in his examination of January 8, 1982.

On our review of the record, we conclude that the accident, which employer concedes occurred in the course and scope of employment, produced an injury to claimant which required medical services. Claimant's lack of credibility as to the extent of his disability goes to the compensation to be awarded. We are satisfied that the accident resulted at least in the need for medical treatment, and the amount of compensation can be determined on remand.

Reversed and remanded with instructions to accept the claim.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marcile L. Paige, Claimant.

PAIGE,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(82-01727; CA A31785)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 25, 1985.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's decision that her occupational disease claim is not compensable and that she is not entitled to interim compensation or penalties and attorney fees for SAIF's failure to pay interim compensation or for its late denial of her claim. We affirm.

Claimant, 57 at the time of the hearing, worked for the House of Myrtlewood for approximately six or seven years before she filed her occupational disease claim on September 7, 1981. She sanded bowls and other items made from myrtlewood as they revolved on a lathe. She claims that her work caused a worsening of preexisting degenerative arthritis in her shoulders. SAIF denied the claim on January 8, 1982.

To establish her claim, claimant must prove by a preponderance of the evidence that her work activities caused a worsening of her underlying condition, resulting in an increase in pain to the extent that it caused disability or required medical services. *Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979). The work activities must be the major contributing cause of that worsening. *See Dethlefs v. Hyster Co.,* 295 Or 298, 667 P2d 487 (1983); *SAIF v. Gygi,* 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982).

Dr. Whitney, an orthopedic surgeon, treated claimant for her shoulder problems. In three responses to letters from claimant's attorney he offered his opinion on the role work played in her shoulder problems. He stated in the first letter that claimant's work aggravated or worsened her shoulder problems, but it is unclear whether he meant that it worsened the underlying condition or merely caused it to become symptomatic. In the second letter he stated that her work caused "a symptomatic worsening and perhaps some acceleration of the condition" but stated that he could not honestly say whether it was the major contributing cause of a worsening of the condition. In the last letter he stated that several factors affected the degenerative process in claimant's shoulder, including her work, her obesity, the natural aging process and heredity, and that the most significant factor was her work. He added that the chronic straining process involved in her job would cause a worsening of the symptoms and "theoretically" a progression of the degenerative process.

Whitney's letters establish that claimant's work contributed to the underlying conditions becoming symptomatic, but that is not sufficient to establish compensability. *Wheeler v. Boise Cascade,* 298 Or 452, 693 P2d 632 (1985). As to the underlying condition, the letters at best state only that her work possibly caused the condition to worsen. Claimant must prove more than a mere possibility that her work caused a worsening, *Queen v. SAIF,* 61 Or App 702, 706, 658 P2d 563

(1983); *Lenox v. SAIF,* 54 Or App 551, 554, 635 P2d 406 (1981); *Gormley v. SAIF,* 52 Or App 1055, 1061, 630 P2d 407 (1981), and she therefore has failed to sustain her burden of proof. Her claim is not compensable.

The next issue is whether claimant was entitled to interim compensation, payable under ORS 656.262 before a claim is accepted or denied. *See Bono v. SAIF,* 298 Or 405, 692 P2d 606 (1984); *Jones v. Emanuel Hospital,* 280 Or 147, 570 P2d 70 (1977). In *Bono,* the court held that interim compensation need not be paid to a worker who has not demonstrated an absence from work during the period for which compensation is sought. The claimant in *Bono* was not entitled to interim compensation, because he did not establish "that he had been absent from work nor that his earning power was diminished." 298 Or at 410.

After filing her claim on September 7, 1981, claimant missed no time from work until October 1, 1981, when she was injured in a work-related accident. She was unable to work because of that injury until November 17, 1981. She received interim compensation for the October 1 injury, covering the period from October 5, 1981, through November 17, 1981. What happened after November 17 is not clear. She apparently returned to part-time work. The record does not indicate whether she was able to work only part time because of her shoulder condition or because of her injury of October 1. She states at one point in her brief that she worked part time until January 8, 1982, when her shoulder condition forced her to leave work entirely, but at another point she states that she was unable to work between January 4 and January 11, because of that condition. A "Disability Certificate" signed by Whitney states that claimant was unable to work from January 4 through January 11. However, a report by another doctor indicates that she worked January 1, 4, 5 and 6, until she could no longer tolerate the pain, and then she did not work for the

remainder of the month. It is not clear from that report whether she quit working because of the pain from her shoulder condition or the pain from her thrombophlebitis, for which that doctor was treating her. SAIF denied her claim January 8, 1982.

On this record, we hold that claimant was not entitled to interim compensation for her shoulder condition. She was not entitled to such compensation before November 17, 1981, because she had missed no time from work because of that condition. *Bono v. SAIF, supra.* After that date, she may have been entitled to interim compensation in the form of temporary partial disability payments, *see* ORS 656.212, but she has not demonstrated that her inability to work full time was a result of her shoulder condition rather than her October 1 injury. We agree with the Board that no interim compensation was due. Because there was no amount due, no penalty can be assessed against SAIF for its late denial of the claim. *See* ORS 656.262(10).

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Charles S. Haynes, Claimant.

HAYNES,
Petitioner,

v.

WEYERHAEUSER CO.,
Respondent.

(81-09765; CA A33306)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 1, 1985.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Evohl F. Malagon, and Malagon & Associates, Eugene.

J. P. Graff, Portland, argued the cause for respondent. With him on the brief were Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

YOUNG, J.

The issue in this workers' compensation case is whether, in light of the provisions of ORS 656.283(1), the Workers' Compensation Board has jurisdiction to review a dispute between claimant and his self-insured employer over the appropriate amount of payment of a doctor's fee for services in connection with an accepted claim. The Board affirmed the referee's determination that jurisdiction over such disputes is vested in the Director of the Workers' Compensation Department. We agree and affirm.

The present dispute arose when employer refused to pay that portion of the medical fees that exceeded the administrative guidelines.[1]

[1] At the time of claimant's injury in 1980, OAR 436-69-420(7) provided in pertinent part:

> "If an insurer believes a fee may be in excess of the usual, customary, and reasonable standard, he may request an opinion of the Medical Director * * *. If the fee is judged to exceed the standard, a request shall be made that it be reduced. If it is not voluntarily reduced, the Director may order it reduced, in accordance with ORS 656.248(2)."

OAR 436-69-701(4), in effect after March 1982, provided:

> "(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." (Now renumbered OAR 436-10-090(5).)

Claimant argues that employer, in refusing to pay the amount of the medical bill exceeding the 90th percentile, failed to apply the administrative guideline in effect at the time of the injury. Because we determine that this is a medical fee dispute and that the Board correctly determined that it was without jurisdiction, we do not consider the argument.

Subject to timeliness requirements, any party or the Director of the Workers' Compensation Department may request a hearing "on any question concerning a claim." ORS 656.283(1). Claimant submits that the question of whether his doctor is entitled to payment for medical services in the amount billed is a question concerning a claim, because nonpayment would entitle the doctor to deny treatment, which in turn would jeopardize claimant's rights to receive treatment from the medical provider of his choice.

ORS 656.704(3) provides:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, * * *

> matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. *However, such matters do not include any proceeding under ORS 656.248 or any proceeding resulting therefrom.*" (Emphasis supplied.)

Pursuant to ORS 656.704, the Board's authority to conduct hearings is limited to "matters concerning a claim," which does not include proceedings that arise under ORS 656.248, which gives the Director the authority to promulgate administrative rules for medical fee schedules. The administrative rules provide a framework for resolution by the Director of medical fee disputes. We conclude that, pursuant to ORS 656.704(3), a dispute concerning the *amount* of the fee to which the medical service provider is entitled for providing medical services to compensably injured workers is excluded by the terms of the statute from the jurisdiction of the Hearings Division.

Claimant cites *SAIF v. Belcher,* 71 Or App 502, 692 P2d 711 (1984), as authority for his position that *claimant's* interest in the medical fee dispute brings the dispute within the Hearings Division's jurisdiction. In *Belcher,* we adopted the Board's reasoning in *Lloyd C. Dykstra,* 36 Van Natta 26 (1984), in determining that the Hearings Division has jurisdiction to determine a dispute concerning the *frequency* of medical treatment. We held that a claimant has the right to request a hearing pursuant to ORS 656.283(1), despite the Director's jurisdiction to resolve disputes between the insurer and the medical service provider concerning the frequency of medical treatment. The Board noted in *Dykstra:*

> "[O]ur 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* * * *. 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)." 36 Van Natta at 33 (emphasis in the original).

We still agree with the reasoning in *Dykstra* and hold that the Hearings Division and the Board lacked jurisdiction to consider the dispute over medical fees.

Affirmed.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Ralph R. Cutright, Claimant.

CUTRIGHT,
Petitioner on Review,

v.

WEYERHAEUSER COMPANY,
Respondent on Review.

(80-06928; CA A29177)

In the Matter of the Compensation of Agnes J. Brech, Claimant.

BRECH,
Petitioner on Review,

v.

RIVER SHORE MOTEL et al,
Respondents on Review.

(81-00582; CA A29279)
(SC S31315)
(Cases consolidated)

In Banc

On review from the Court of Appeals.*

Argued and submitted March 6, 1985.

Robert K. Udziela, of Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, argued the cause and filed the petition for petitioners on review.

Paul L. Roess, of Foss, Whitty & Roess, Coos Bay, argued the cause for respondent on review Weyerhaeuser Company.

Allan M. Muir, Portland, argued the cause and filed a brief for respondents on review River Shore Motel and Insurance Company of North America. With him on the response to the

petition for review were Schwabe, Williamson, Wyatt, Moore & Roberts, Ridgway K. Foley, Jr., P.C., and Dennis S. Reese, Portland.

Jerald P. Keene, of Roberts, Reinisch & Klor, P.C., Portland, filed an amicus curiae brief on behalf of the Association of Workers' Compensation Defense Attorneys.

JONES, J.

The Court of Appeals is affirmed.

Lent, J., filed a dissenting opinion joined by Campbell, J.

* Judicial review from Workers' Compensation Board. 70 Or App 357, 688 P2d 439 (1985).

JONES, J.

The issue is whether workers' compensation claimants are entitled to temporary total disability[1] benefits for aggravation of their original compensable injuries, where the claimants had voluntarily removed themselves from the labor market, *i.e.*, "retired," at the time of the aggravation of their prior work-related injuries. We hold that the claimants are not entitled to compensation for temporary total disability.

In these consolidated cases, the facts are undisputed. In each case the claimant sustained a disabling compensable injury.[2] In each case the claimant was awarded compensation for both scheduled and unscheduled permanent partial disability. In each case the claimant's condition worsened to the point that surgery was necessary, and the claimant was unable to perform work at a gainful and suitable occupation for at least the period encompassing the surgery. In each case the claimant had voluntarily left the labor force at the time the prior condition worsened and surgery became necessary. In each case the claimant had not left work because of the aggravation of the prior injury. In each case the claimant applied for additional compensation for temporary total disability (TTD) and for medical services because of the worsening. ORS 656.273(1).[3] In each case the employer accepted responsibility for payment of necessary medical services but denied responsibility for the payment of compensation for TTD because the claimant was no longer in the labor market by the time the claimant applied for compensation for TTD.

In each case the claimant requested a hearing on the denial, and the referee ordered the employer to pay compensation for TTD. In each case the employer appealed, and the Workers' Compensation Board reversed the referee's decision.

On judicial review the cases were consolidated pursuant to ORAP 6.30, and the Court of Appeals affirmed *per curiam*. We allowed review to consider the issue posed at the outset of this opinion.

The employers argue that TTD benefits are payable as compensation for the "loss of wages" and one who has retired does not lose wages when his condition worsens to the point of unemployability; therefore, argue the employers, that claimant is not entitled to compensation for TTD.[4] The

[1] The term "temporary total disability" is used in ORS 656.210(3) to describe "the total disability [which] is only temporary" mentioned in ORS 656.210(1).

[2] ORS 656.005(8)(b) provides:

"A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death."

[3] ORS 656.273(1) provides:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury."

[4] The employer of Brech further contends that the case of *Stiennon v. SAIF*, 68 Or App 735, 683 P2d 556, *rev den* 298 Or 238 (1984), presented the identical issue to these cases and, therefore, review in these cases was improvidently granted and this court should not consider them. It should be clear since our decision in *1000 Friends of Oregon v. Bd. of Co. Comm.*, 284 Or 41, 584 P2d 1371 (1978), that our denial of a petition for review carries no indication that this court considers the decision of the Court of Appeals to be correct.

employers argue that our decision in *Bono v. SAIF*, 298 Or 405, 692 P2d 606 (1984), holds that a worker must "leave work" in order to be entitled to compensation for TTD and, therefore, because these claimants were not working when their conditions worsened to the point of unemployability, they are not entitled to compensation for "loss of wages."

The claimants argue that under ORS 656.273(1), because their respective conditions have worsened since their last awards of compensation, they are entitled to additional compensation, and because it is undisputed that their surgeries will result in a period of complete inability to work, they are entitled to compensation for TTD. They assert that the language of ORS 656.210(1) so commands:

> "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation * * *."

The Workers' Compensation Law does not contain a definition of "total disability" or of "temporary total disability." The law does contain a definition of "permanent total disability" in ORS 656.206(1)(a):

> " 'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. * * *"

As part of the explanation of "permanent total disability," ORS 656.206(3) provides:

> "The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

ORS 656.210(1) uses the term "the total disability" but does not specifically instruct the reader where the referent for the term is to be found. The use of the definite article leads us to conclude that the term speaks to "total disability" as used elsewhere in the Workers' Compensation Law.

The present Workers' Compensation Law derives from Oregon Laws 1913, chapter 112, and section 21 thereof fixed the schedule of compensation to be paid under the law. Subsection 21(b) defined "permanent total disability" and the amounts to be paid for such disability. Subsection 21(c) specified that if the worker died during "such period of total disability" beneficiaries were to recover certain compensation. Subsection 21(d) pronounced that when "the total disability" was only temporary, the worker was to receive benefits that were calculated on the basis of the schedule set forth in subsection 21(b) relating to permanent total disability. That history and the continued juxtaposition of these provisions cause us to conclude that the most likely referent is for "the total disability" now to be found in ORS 656.206(1)(a).

We construe "the total disability" used in ORS 656.210(1) to mean the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which incapacitates the worker from regularly performing work at a gainful and suitable occupation. Total

disability describes the extent of disability that a worker may suffer. "Permanent" or "temporary" describes duration, not the extent, of disability. If the total disability is permanent, payment of compensation is made according to ORS 656.206; if the disability is temporary, payment is made according to ORS 656.210. In either case, benefits for total disability are only available where the requisite incapacity to work exists.

The employers argue that *Bono v. SAIF, supra,* holds that to be entitled to compensation for TTD one must leave work. In that case a worker sought "interim compensation"

under ORS 656.262(4)[5] and our decision in *Jones v. Emanuel Hospital,* 280 Or 147, 570 P2d 70 (1977). As noted in *Bono,* the term "interim compensation" is one coined by this court in *Jones. See Bono v. SAIF,* 298 Or at 407 n 1. In *Bono* we observed that interim compensation is related to compensation for TTD in that the rates of compensation are similarly calculated. Noting that ORS 656.210(3)[6] requires that a worker must leave work to trigger payment of compensation, we then stated:

> "* * * The payment of temporary total disability benefits is based in part upon whether the injured worker 'leaves work.' ORS 656.210(3). Interim compensation is based on temporary total disability benefits. Thus, we hold that in order to receive interim compensation, a subject worker must have left work as that phrase is used in ORS 656.210(3). * * *" 298 Or at 410.

The holding in that case is simply that a worker cannot receive interim compensation during a period of time in which the worker is actually working. There is nothing in that holding from which we desire to retreat; there is nothing in that holding which governs the case at bar.

The entire scheme of Workers' Compensation Law is to compensate *workers,* who are active in the labor market, for wages lost because of inability (or reduced capacity) to work as a result of a compensable injury and to pay for medical expenses incurred in treatment of injury. The name of the act itself, proclaimed by ORS 656.001, indicates who is to be covered— "workers." "Worker" is defined as

> "* * * any person, including a minor whether lawfully or unlawfully employed, *who engages to furnish services for a*

> *remuneration,* subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any

[5] 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."

[6] 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 inpatient 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."

person whose services are performed as an inmate or ward of a state institution." ORS 656.005(28) (emphasis added).

There is not one word in the statute that refers to a person who no longer engages in furnishing services for remuneration. Certainly, one who retires voluntarily from the work force is no longer a "worker" as defined.

The stated policy of the legislature is set out in ORS 656.012 and includes a declaration of the objectives of the Workers' Compensation Law. ORS 656.012(2) provides:

> "* * * [T]he 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) 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;
>
> "(c) *To restore the injured worker physically and economically to a self-sufficient status* in an expeditious manner and to the greatest extent practicable; and
>
> "(d) To encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents." (Emphasis added.)

The thrust of the act is to restore injured workers to employment status, and the act also provides coverage for those apprenticing or training for work. *See* ORS 656.138(1).[7]

That the legislature intended workers' compensation benefits to provide wage replacement is made clearer by the statutes providing for compensation for injured workers or their beneficiaries. ORS 656.204(2) states that "[i]f death results from the accidental injury, payments * * * shall be paid in an amount equal to 4.35 times 50 percent of the average weekly wage to the surviving spouse until remarriage." Thus, death benefit compensation is based on wage replacement.

Under ORS 656.206(3), the formula for calculating permanent total disability benefits is based on wage replacement:

> "(2)(a) When permanent total disability results from the injury, the worker shall receive during the period of that disability compensation benefits equal to 66-2/3 percent of wages not to exceed 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50, whichever amount is lesser.
>
> "(b) In addition, the worker shall receive $5 per week for each additional beneficiary not to exceed five. * * *"

[7] ORS 656.138(1) states:

> "All persons registered as apprentices or trainees and participating in related instruction classes conducted by a school district, community college district or education service district in accordance with the requirements of ORS chapter 660 or section 50, title 29, United States Code as of September 13, 1975, are considered as workers of the school district, community college district or education service district subject to ORS 656.001 to 656.794."

The calculation of TTD benefits under ORS 656.210(1) is also based upon wage replacement:

> "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages * * *."

ORS 656.268(1), which sets forth the procedure for determining awards for permanent disability, emphasizes that "[o]ne purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker." As we have noted, a worker is one who engages in furnishing services for remuneration.

ORS 656.287(1) provides:

> "Where there is an issue regarding loss of earning capacity, reports from vocational consultants in governmental agencies or private vocational consultants *regarding job opportunities, the fitness of claimant to perform certain jobs, wage levels, or other information relating to claimant's employability* shall be admitted into evidence at compensation hearings * * *." (Emphasis added.)

Additionally, section 2, chapter 535, Oregon Laws 1981, provides:

> "(1) The insurer or self-insured employer of an injured worker shall be responsible for contacting the worker within five days after:
>
> "(a) Receipt of a medical report which indicates that the worker may be unable to return to work for a period of 21 days or longer; or
>
> "(b) The worker has been off work for more than 21 consecutive days since the date of injury,
>
> and *shall assist the worker in returning to the work force* for a gradual, intermittent or immediate return to regular, modified or other available employment. Each insurer and self-insured employer shall maintain records of such contacts and assistance in such manner as the department, by rule, may prescribe.
>
> "(2) the insurer or self-insured employer *shall assist the worker in returning to the worker's previous employment.* If the worker is not able to return to the previous employment, the insurer *or* self-insured employer *shall assist the worker in obtaining similar or suitable employment.*
>
> "(3) Assistance under this section shall include, but not be limited to use of the insurer's or self-insured employer's placement and rehabilitation resources, job search, on-the-job placement and contracting with the Vocational Rehabilitation Division of the Department of Human Resources or with suitable private rehabilitation services for the purpose of reemploying the worker at a position or a wage as close as possible to the worker's occupation or employment at the time of injury. All vocational assistance services provided to injured workers shall be in accordance with rules prescribed by the director." (Emphasis added.)

Although this section was not operative until July 1, 1984, Or Laws 1981, ch 535, § 26(2), its adoption by the 1981 legislature is an indication of the legislature's construction of the act.

Finally, of greatest significance is ORS 656.325(5), which provides:

> "Notwithstanding ORS 656.268, an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 *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." (Emphasis added.)

As applied to aggravation claims, this statute dictates that a worker receiving TTD benefits must not refuse wage earning employment prior to the aggravation claim determination if the worker is capable of working. Thus, a claimant who has retired from the labor market cannot qualify for TTD benefits because of the claimant's decision to refuse further wage earning employment. Further, ORS 656.206(3) requires a worker seeking permanent total disability compensation to prove a willingness to seek regular employment and to make reasonable efforts to obtain such employment. Surely, if a worker claiming permanent total disability status must demonstrate a willingness to work, a claimant seeking compensation for aggravation of a pre-existing injury must similarly prove a willingness to seek work in order to obtain TTD benefits under ORS 656.325(5). Again, we emphasize that "total disability" is an inability to *work,* either temporarily or permanently.

The dissent disagrees with this determination, labeling it "pure *ipse dixit.*" This disagreement is based on the 1948 case of *Lindeman v. State Indus. Acc. Comm.*, 183 Or 245, 192 P2d 732 (1948), in which this court said in *dictum* that under the now defunct Oregon Workmen's Compensation Act "the loss of capacity to earn is the basis upon which compensation should be based." 183 Or at 250. The dissent urges us to bow to the doctrine of *stare decisis* and to decide the present case under the rationale of *Lindeman.* Neither the doctrine of *stare decisis* nor the application of sound legal reasoning supports the dissent's view.

The "loss of earning capacity" referred to in *Lindeman* is only a factor used to measure the extent of disability in the determination of benefits for temporary *partial* disability, ORS 656.212, and permanent *partial* disability, ORS 656.214. ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments

> provided for temporary total disability which his loss of earning power at any kind of work bears to his earning power existing at the time of the occurrence of the injury."

ORS 656.214(5) provides:

> "In all cases of injury resulting in permanent partial disability, * * * the criteria 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 facts as age, education, training, skills and work experience. * * *" (Emphasis added.)

This definiton does not help the claimants. Earning capacity only goes to the extent of disability. Loss of earning capacity can only be determined in the context of the claimant's ability to work; it is not, by itself, an independent kind of injury for which compensation is provided.

"Ipse dixit" is defined in Black's as "a bare assertion resting upon the authority of an individual." Black's Law Dictionary 743 (5th ed 1979). Our decision of the present case relies not upon an assertion of any individual, but upon an examination of the legislative statements made in the Workers' Compensation Law as it applies to the instant cases. We decline the opportunity to rely upon prior language of this court laid out in *dictum* in a case construing a statute which no longer exists. Our present holding that TTD benefits are wage replacement for those persons working or seeking work is based upon our analysis of the pronouncements of the legislature, not upon an engrafting of an earlier questionable pronouncement of this court.

The legislature adopted the present workers' compensation scheme after extensive hearings and testimony by representatives of employes, employers and insurance carriers. This resulted in a "statement * * * by the legislature after an opportunity of the people of this state to present their divers views to the legislature" as is urged by the dissent. Contrary to the view expressed in the dissent, this process has already occurred and the legislation as passed does not provide the relief sought by the present claimants. Comments regarding the wisdom or propriety of that choice, absent any constitutional infirmity, should be addressed to the legislature, not this court. As we have shown, the pronouncements of the

legislature found in the *present* Workers' Compensation Law applicable to the *present* case, are more compelling to our resolution of this case than is *dictum* from a 37-year-old case decided under a now defunct statute.

A claim for temporary total disability benefits in the absence of wage loss seeks a remedy where there is no damage. Non-workers can sustain medical expenses. They cannot lose earnings.

Temporary disability benefits are maintenance benefits intended to provide support and help replace lost income during the healing or recovery process.

Under the circumstances of these consolidated cases, the claimants are not entitled to temporary total disability benefits. The Court of Appeals is affirmed.

LENT, J., dissenting.

I agree with the majority that "total disability" as used in ORS 656.210(1) means

"the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which

incapacitates the worker from regularly performing work at a gainful and suitable occupation."

I further agree that when the loss is permanent the worker is permanently totally disabled and that when the loss is only temporary the worker is temporarily totally disabled. I further agree that our decision in *Bono v. SAIF,* 298 Or 405, 692 P2d 606 (1984), does not govern the case at bar.[1] I also agree that if the total disability is permanent, payment is made according to ORS 656.206 and that if the total disability is temporary, payment is made according to ORS 656.210. I have now listed all that is in the majority opinion with which I can agree.

First, I wish to draw attention to the main theme underlying the majority opinion. The rest of the opinion is nothing but an attempt to find an underpinning for the result

already expressed. The majority states that the "purpose" of temporary total disability compensation is to replace wages lost by a worker who is still in the labor market. One would expect to find some decision of this court, some words of the statute or some legislative history for that statement. One searches the majority opinion in vain for that support. The statement is pure *ipse dixit.* If that is legislative policy, the statement should be made by the legislature after an opportunity of the people of this state to present their divers views to the legislature. It surely cannot be a statement by this court, in its infinite wisdom, on the basis of briefs by none but the parties (and their supporters, linked in interest).

The majority questions the teaching of this court's pronouncement 35 years ago in *Lindeman v. State Indus. Acc. Comm.,* 183 Or 245, 192 P2d 732 (1948), where this court stated:

> "The Oregon Workmen's Compensation Act provides primarily for three types of compensation to be paid to employees covered by the act (or to their beneficiaries or dependents in case of death) for injuries arising out of and in the course of their employment. They are:
>
> "(1) Compensation for disability, dependent as to amount upon whether the injury produces a permanent total, a temporary total, or a temporary partial disability. §§ 102-1756, 102-1758, and 102-1759, O.C.L.A.
>
> "(2) Compensation in stipulated amounts for loss of some part of the body, such as an arm, a leg, or an eye, and 'other cases of injury resulting in permanent partial disability'. § 102-1760, O.C.L.A.
>
> "(3) Compensation for death. §§ 102-1755, 102-1757, and 102-1761, O.C.L.A.
>
> "The statute provides no compensation for physical pain or discomfort. It is limited to the *loss of earning ability. The loss of capacity to earn is the basis upon which compensation should be based. Weber v. American Silk Spinning Co.,* 38 R.I. 309, 95 A. 603, Ann. Cas. 1917E 153; *Gillen v. Ocean Accident & Guarantee Corp.,* 215 Mass. 96, 102 N.E. 346, L.R.A. 1916A 371." (Emphasis added.)

[1]The majority's quoted material at slip op 5 from *Bono v. SAIF,* 298 Or 405, 410, 692 P2d 606 (1984), stops just short of an intendedly significant statement in *Bono.* Immediately following the majority's quotation is the following sentence:

> "Claimant did not establish that he had been absent from work *nor that his earning power was diminished.*" (Emphasis added.)

183 Or at 249-250. Even if it be argued that the quoted material was dictum or the same kind of statement of policy made by the majority in this case, it was a statement that governed the trials of some 17 years of workers' compensation

cases. It was a statement embodied in the charges to juries. It was a statement that purported to interpret the statute. It was a statement accepted as a premise both by those in favor of, and those opposed to, the 1965 revision of the law. Regard for the doctrine of *stare decisis* should persuade the majority to abandon its holding.

In *Lindeman* this court noted that under § 102-1752, OCLA, a worker injured on the job was to be compensated for his disability. That section provided:

> "Every workman subject to this act while employed by an employer subject to this act who, while so employed, sustains personal injury by accident arising out of and in the course of his employment and *resulting in his disability* * * * shall be entitled to receive from the industrial accident fund * * * the sum or sums hereinafter specified * * *." (Emphasis added.)

A related section, § 102-1754, provided:

> "If any workman while he is subject to this act and in the service of an employer * * * shall sustain a personal injury by accident arising out of and in the course of his employment caused by violent or external means, he * * * shall receive compensation as hereinafter provided."

Then followed the sections providing, in order for the calculation of benefits to be paid for death, permanent total disability, death during permanent total disability, temporary total disability, temporary partial disability and permanent partial disability.

The majority states that the "loss of earning capacity," to which *Lindeman* refers, is only a factor with respect to temporary *partial* disability and permanent *partial* disability. I respectfully draw the attention of the majority to the language above quoted from *Lindeman*. The language is not limited to partial disability.

The majority states that the statute to which *Lindeman* spoke "no longer exists" and is "now defunct." I invite the majority to compare ORS 656.202 to 656.214 with the sections of Oregon Compiled Laws Annotated to which *Lindeman* and I have referred, *supra*. ORS 656.202 provides that a subject worker who sustains a "compensable injury"[2] shall

receive compensation as provided in ORS 656.001 to ORS 656.794. Then follows, in order, just as in Oregon Compiled Laws Annotated, the method of calculating benefits to be paid for death, permanent total disability, death during permanent total disability, temporary total disability, temporary partial disability and permanent partial disability.

The majority is considerably taken with the fact that ORS 656.210 bases compensation for temporary total disability on a percentage of wages. Lo and behold! So did that "defunct" statute, § 102-1758, OCLA.

The statutes to which *Lindeman* spoke seem to be alive and well. The present codification is consonant. A worker is compensated for partial or total disability, temporary or permanent. ORS 656.210 provides explicitly that if the worker's total disability is only temporary, the worker is to receive a certain percentage of weekly wage "the worker was receiving at the time of his injury." The majority simply fails to address the fact that both of the workers with whom we are here concerned were actually working at the time of injury and that ORS 656.210 does no more and no less than to say that a worker who is temporarily totally disabled "shall receive" a percentage of the wage being earned at the time of the injury. No statute concerning temporary total disability states that the worker must "still be in the labor market" to receive compensation for that condition of unemployability resulting from industrial injury defined by both the majority and this opinion.

The majority justifies its usurpation of legislative function by resort to ORS 656.206(3), which requires a worker to prove "that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment" in order to prove "permanent total disability status." The majority says that ORS 656.206(3) is an "explanation" of permanent total disability. ORS 656.206(3) is nothing more than a statement by the legislature that a worker must satisfy a certain condition

precedent to achieve a "status" that will allow him to receive the compensation for permanent total disability to which he may be otherwise entitled.

Before turning to the possibility that these workers in the case at bar must satisfy the requirements of ORS 656.206(3), I desire to point out the total want of legislative indication that the subsection is to be considered in connection with compensation for temporary total disability.

The legislature has given some attention to offsetting certain social security benefits against the amount of compensation for permanent total disability to which a worker might be entitled. In ORS 656.209 the legislature has addressed the case of the worker who is receiving "disability" benefits from federal social security. Surely when that legislation was considered in 1977 and 1979, it could not have escaped legislative attention that there should be a similar offset for receipt of old age social security benefits by a worker who was permanently totally disabled, but the legislature did not provide for one to lose all or any part of compensation for permanent total disability because one was receiving old age social security benefits and, therefore, not "still in the labor market."

If the legislature did not see fit to eliminate compensation for permanent total disability for old age "retirement"

[2]ORS 656.005(8) defines "compensable injury."

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

"(b) A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death."

benefits, what suggests that the legislature intended to do so for those entitled to temporary total disability compensation by reason of being incapacitated to the extent mentioned at the outset of this opinion?

Because the majority desires to make ORS 656.206(3) a touchstone for entitlement to compensation for temporary total disability, I believe that the majority must have a longer, harder look at that subsection in order to reach the result that it does here.

That text requires that a worker must show his willingness and his efforts to find employment to gain the "status" of permanent total disability as defined in ORS 656.206(1). When must he show that? He must do so at the time he is seeking adjudgment that he is permanently totally disabled. This court has not addressed this condition precedent. The Court of Appeals has. That court has logically

reasoned that a worker who is so incapacitated that motivation and seeking work would be "futile" need not undertake the fruitless task. *See,* for example, *Brech v. SAIF,* 72 Or App 388, 695 P2d 964 (1985), where the court held:

> "The second basis for the referee's denying permanent total disability is claimant's alleged failure to comply with the requirement of ORS 656.206(3) that a claimant prove 'that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment.' Claimant's failure to seek employment is not unreasonable when, in view of his disabilities, such efforts would be futile. *Hanna v. SAIF,* 65 Or App 649, 654, 672 P2d 67 (1983); *Looper v. SAIF,* 56 Or App 437, 441, 642 P2d 325 (1982). The evidence establishes that claimant cannot perform regular gainful employment; because he is permanently totally disabled from a physical standpoint, it is unnecessary for him to undertake the futile effort of seeking employment."

72 Or App at 391. I find it difficult to believe that the majority would quarrel with the line of decisions that the Court of Appeals has developed in this respect.

The majority would apply ORS 656.206(3) to entitlement to compensation for temporary total disability. Although I do not believe that is the proper course, I invite the majority to carry its desire to the logical result forecast by the Court of Appeals decisions with respect to entitlement to compensation for permanent total disability.

The plain fact of the matter is that both of the claimants at bar will not be able to work at least during the time of surgery. It is during that time that these claimants ask for the compensation for their unemployability. It would be futile indeed for them to seek employment from the hospital bed. That is the time period with which these cases are concerned, not some time either before or after that period in which it is conceded and agreed that they will not be able to work because of worsening of their conditions resulting from their original injuries.

The majority has taken the policy statement contained in ORS 656.012(2), the definition of "worker" in ORS 656.005(28), ORS 656.287(1), an evidentiary section, and a section, ORS 656.340, mandating the employer to do certain things, and from that holds that these claimants are not

entitled to compensation for a period of time during which their worsened conditions will make them totally disabled, as defined, at least temporarily.

As to ORS 656.012(2), I can only again express the idea that a preamble in general terms should not control over explicit textual language found elsewhere in the Workers' Compensation Law.

As to definition of "worker," the definition contained in ORS 656.005(28) is obviously for the purpose of triggering coverage under the law. ORS 656.003 explains that the definitions apply except where the context otherwise requires. The word "worker" is used throughout ORS 656.001 to 656.794 in senses that make it perfectly obvious that it is not used to mean one who is working. I am not going to list them all. Some of the sections with which we are here most closely concerned demonstrate the fact. ORS 656.206(2) to (5) speak to a "worker" who is permanently totally disabled. ORS 656.208 concerns the "worker" who dies during the period of permanent total disability. Even ORS 656.210 provides for a "worker" to receive compensation for temporary total disability. One who is totally disabled, permanently or totally, cannot meet the definition given in ORS 656.005(28).

ORS 656.287(1) does no more than to make admissible certain evidence where there is an issue regarding "loss of earning capacity," something the majority contends is not involved in this case.

ORS 656.340 imposes a variety of duties on an employer or its insurer to assist a "worker," who, incidentally, is obviously not working and, therefore, cannot meet the definition of "worker" in ORS 656.005(28).

The majority finds that "of greatest significance" is ORS 656.325(5), a subsection that entitles an employer to cease paying compensation for temporary total disability and commence paying compensation for temporary partial disability "when an injured worker refuses wage earning employment prior to claim determination" if the worker is capable of performing the employment offered.

This subsection is not applicable at all. Claim determination for these claimants occurred long ago. There is not one bit of evidence in the record that either of these claimants

has been offered, and has refused, wage earning employment. I daresay that no employer of sound mind would offer wage earning employment to one confined to the hospital bed or its equivalent while undergoing or recovering from surgery.

Under statutory text these workers are entitled to the compensation they here seek. It is a mistake to inject into the statutory scheme the views of the majority of this court as to what the law ought to be, but is not.

Campbell, J., joins in this dissenting opinion.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Danny D. Kishpaugh, Claimant.
ZURICH INSURANCE COMPANY,
Respondent on Review,
v.
DIVERSIFIED RISK MANAGEMENT,
Respondent on Review,

KISHPAUGH,
Petitioner on Review,
v.
AMERICAN STREVELL, Employer.
(82-08701, 82-08700; CA A33657; SC S31566)

In Banc

On review from the Court of Appeals.*

Argued and submitted July 9, 1985.

Leo R. Probst, Portland, argued the cause and filed the petition for petitioner on review.

Deborah L. Sather, Portland, argued the cause for respondent on review Zurich Insurance Company. With her on the response to the petition for review was Moscato & Byerly, Portland.

No appearance for respondent on review Diversified Risk Management.

CAMPBELL, J.

The order of the Court of Appeals is affirmed.

* Judicial Review from Workers' Compensation Board Order of September 24, 1984; Court of Appeals Order of January 31, 1985, dismissing claimant's Petition for Judicial Review.

CAMPBELL, J.

The issue in this case is whether the Court of Appeals lacks jurisdiction to hear a workers' compensation appeal if the petitioner fails to give notice to all parties who appeared in the proceedings below. The Court of Appeals dismissed claimant's Petition for Judicial Review (notice of appeal) for lack of jurisdiction after claimant did not serve a copy on a party to the proceeding before the Workers' Compensation Board. We affirm.

Claimant suffered a compensable back injury in 1980. In 1982 his back condition worsened. When filing for compensation he asserted that either he had sustained a new injury or, in the alternative, that the former injury was aggravated. Diversified Risk Management, the authorized insurance carrier in 1980, denied the claim of aggravation. Zurich American Insurance Company, the carrier in 1982, denied that the injury was new. Claimant requested a hearing on each denial

and requested that the claims be consolidated for hearing. The referee held that there was no new injury and allowed the aggravation claim, making Diversified responsible for payment of benefits. The referee also awarded permanent partial disability of 15 percent. Claimant appealed to the Workers' Compensation Board claiming that he was entitled to a greater disability award. Diversified cross-appealed. The Board affirmed the referee's award of permanent partial disability but reversed the referee's decision, holding that there was a new injury rather than an aggravation and that Zurich had the responsibility to pay claimant. Claimant appealed to the Court of Appeals on the issue of the adequacy of the disability. When filing his notice of appeal, he did not serve a copy on Diversified. Zurich moved to dismiss for failure to serve Diversified. Zurich cross-appealed the Board's order holding Zurich as the responsible carrier. The Court of Appeals allowed the motion to dismiss claimant's notice of appeal to that court. Claimant petitioned this court for review challenging the Court of Appeals' dismissal on three grounds: (1) That Diversified is not a party to the appeal; (2) that the statutory requirement of notice to parties, ORS 656.298(3), is not jurisdictional; and (3) that Diversified had actual notice of the appeal. Claimant's first assertion is that notice was sent to all parties whose interest possibly could have been affected. ORS 656.005(19) defines the term "party" as follows:

> " 'Party' means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer."

Claimant contends that because Diversified was absolved of responsibility for claimant's injury and only Zurich and the employer were responsible, all the interested parties were served. That reasoning is not sound. ORS 656.298(6) provides:

> "The review by the Court of Appeals shall be on the entire record forwarded by the board. The court may remand the case to the referee for further evidence taking, correction or other necessary action. However, the court may hear additional evidence concerning disability that was not obtainable at the time of the hearing. The court may affirm, reverse, modify or supplement the order appealed from, and make such disposition of the case as the court determines to be appropriate."

This statute, which gives the Court of Appeals *de novo* review of workers' compensation cases, suggests that the Court of Appeals has the authority to explore, on its own motion, all matters arising from the record in order to arrive at the "appropriate" disposition. That is, the Court of Appeals could reverse the Workers' Compensation Board finding that the injury was a new injury and not an aggravation, thus placing Diversified back on the hook for benefit payments.[1]

It is also clear that claimant considered Diversified a "party" in all the proceedings before the Workers' Compensation referee and the Board. The statute is clear that both Zurich and Diversified are "parties" because they were insurers of the employe and named as parties by claimant.

[1] The Court of Appeals did not dismiss Zurich's cross-appeal with respect to the Board's finding that it was the responsible carrier.

Claimant's next reason for review is that ORS 656.298(3) is not jurisdictional. ORS 656.298(3) provides:

> "The judicial review shall be commenced by serving, by registered or certified mail, a copy of a notice of appeal on the board *and on the parties who appeared in the review proceedings,* and by filing with the clerk of the Court of Appeals the original notice of appeal with proof of service indorsed thereon. * * *" (Emphasis added.)

In *Southwest Forest Industries v. Anders,* 299 Or 205, 219, 701 P2d 432 (1985), we addressed whether the requirement of service on the Board was jurisdictional, stating:

> "The Court of Appeals, *sua sponte,* dismissed this appeal for failure to serve the Board as required by ORS 656.298(3). The same reasoning employed by this court from the time of *Demitro v. State Industrial Acc. Com.,* [110 Or 110, 223 P 238 (1924)], forward, that jurisdiction in the court springs from the statute and that strict compliance with the statute is necessary to the court's jurisdiction, will lead to the affirmance of the Court of Appeals' action on the ground it chose."

The reasoning as to service on the Board applies equally to service "on the parties who appeared in the review proceedings." Without service on the "parties," the Court of Appeals lacks jurisdiction.

Claimant's third assertion is that Diversified had actual notice of the appeal because Zurich's cross-appeal was served on Diversified. In *Stroh v. SAIF,* 261 Or 117, 492 P2d 472 (1972), we held that a copy of a notice of appeal by ordinary mail rather than by registered or certified mail as required by statute still satisfies the notice requirement where notice is actually received within the 30-day time limit of ORS 656.295(8).[2] However, in this case, the Board order was mailed on September 24, claimant's notice of appeal was filed in the Court of Appeals on October 19, and Zurich's cross-appeal was mailed October 24, and received by the Court of Appeals October 25. There is no evidence establishing that Diversified received actual notice of claimant's notice of appeal before October 25 at the earliest. Thus, Diversified did not have actual notice within the 30-day requirement of ORS 656.295(8).

In summary, Diversified was a party as defined by ORS 656.005(19). The requirements of ORS 656.298(3) are jurisdictional and Diversified did not get actual notice or notice by registered or certified mail within 30 days of the mailing of the decision of the Board.

The Court of Appeals is affirmed.

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[2] ORS 656.295(8) reads as follows:

> "An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298. * * *"

J. Kent LLEWELLYN, D.C., P.C., dba Llewellyn Chiropractic Clinic; William J. Cash, D.C., dba AA Chiropractic Clinic; Steve A. Deshaw, D.C., dba Chiropractic Physicians Clinic; Douglas Held, D.C., dba Held Chiropractic Clinic; D.E. Beeson, D.C., dba Beeson Chiropractic Center; John Schmidt, D.C., dba Chiropractic Physicians Clinic; Lyndon McGill, D.C., dba East Salem Chiropractic Clinic; Tom Wright, D.C., dba Wright Chiropractic Clinic; Bruce Ramforth, D.C., dba Jacksonville Chiropractic Offices, Plaintiffs-Appellants,

v.

Morris K. CROTHERS, M.D.; Roy Green, M.D.; and State Action Insurance Fund Corporation, Defendants-Appellees.

Nos. 83-4019, 83-4037.

United States Court of Appeals,
Ninth Circuit.

Argued and Submitted May 10, 1984.

Decided July 8, 1985.

Gary D. Allen, Allen & Vick, Salem, Or., and C. Jacob Ladenheim, Ladenheim & Campbell, Fincastle, Va., for plaintiffs-appellants.

William F. Nessly, Jr., Asst. Atty. Gen., Salem, Or., for Crothers and Green.

James Clark, Spears, Lubersky, Campbell & Bledsce, Portland, Or., for SAIF.

Appeal from the United States District Court for the District of Oregon.

Before KENNEDY and FERGUSON, Circuit Judges, and WILLIAMS,* District Judge.

* Honorable David W. Williams, Senior U.S. District Judge for the Central District of California, sitting by designation.

KENNEDY, Circuit Judge:

Plaintiffs, licensed chiropractors in the State of Oregon, brought this action for damages and injunctive relief based on alleged antitrust, equal protection, and due process violations in the setting of fee guidelines and maximum fee schedules for chiropractic services under the Oregon Workers' Compensation Act (the Act), Or. Rev.Stat. §§ 656.001-656.794 (1983). The principal issue in the case concerns the immunity of the defendants for implementing policies of the state, and, consequently, their identities and governmental capacities are significant. The individual defendants are Dr. Roy L. Green and Dr. Morris K. Crothers, respectively the Director and the Medical Director of the Oregon Workers' Compensation Department (OWCD). The corporate defendant, the State Accident Insurance Fund Corporation (SAIF), is a public corporation created by the Oregon legislature to insure employers' liabilities under the Act.

The district court granted defendants' motions to dismiss the due process claim and their motions for summary judgment. With regard to the antitrust claims, the court found immunity for all defendants under the doctrine of *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943). The court also rejected plaintiffs' equal protection challenge, finding a rational basis for the distinctions drawn between chiropractors and other health care providers. The district court entered final judgment in favor of defendants. We affirm.

Oregon law requires almost all employers to provide medical and income protection for job-related accidents. Or.Rev.Stat. § 656.023 (1983); *see also* Or.Rev.Stat. § 656.027 (1983). The obligation may be satisfied through private insurance, state insurance, or self-insurance. State coverage is provided through SAIF. SAIF's board of directors is appointed by the governor and confirmed by the state senate. Or.Rev.Stat. § 656.751(1) (1983). SAIF issues guarantee contracts to insure employers for their liability under the Act, Or.Rev. Stat. § 656.419(1) (1983), administers claims, and pays benefits to injured workers employed by covered employers. Or. Rev.Stat. §§ 656.245, 656.262(1), 656.-752(2)(b) (1983). It also enforces employers' obligations to insure against their compensation liabilities. Or.Rev.Stat. § 656.-504, 656.566, 656.752(2)(a) (1983).

The administrative and judicial aspects of the workers' compensation program are entrusted to the OWCD, which consists of the board, the Director, and their various assistants and employees. Or.Rev.Stat. § 656.708(1) (1983). The Director, Roy Green, as the administrative head of the OWCD, possesses comprehensive authority to "[m]ake and declare all rules and regulations which are reasonably required in the performance of the director's duties." Or. Rev.Stat. § 656.726(3)(a) (1983). In exercising these duties, the Director is assisted by the Medical Director, Dr. Morris Crothers, who advises the Director on medical matters and prepares medical rules.

The Act specifically authorizes the Director to promulgate reasonable rates to be paid for medical services provided pursuant to the Act. Or.Rev.Stat. § 656.248(1) (1983). It further empowers the Director to adopt formal "medical practice rules" on

the recommendation of the Advisory Committee on Medical Care and in accordance with the Oregon Administrative Procedure Act, Or.Rev.Stat. §§ 183.310–183.550 (1983). Or.Rev.Stat. § 656.794(2)(b) (1983).

Appellants base their Sherman Act claims on three different actions taken by the defendants: (1) the implementation of a de facto fee schedule in 1979; (2) the adoption of a "90th percentile" fee limitation in 1980; and (3) the adoption of a treatment schedule limitation in 1980. We describe each of these matters and occurrences briefly.

In 1979 Crothers used empirical data to determine the normal, average fees charged for various services by health care providers. He obtained from SAIF a sampling of bills from health care providers, computed figures constituting the 90th percentile, and used the results to adjust individual bills pursuant to section 656.248(2). The parties refer to these actions as the de facto rate adoption. In 1981 an OWCD Hearings Referee found the adoption of the de facto rate schedule to be improper because it bypassed the required rulemaking procedures of the Oregon Administrative Procedure Act. The Referee held that Crothers had not exceeded his authority, but rather that he had exercised it in an arbitrary and capricious manner.

In 1980, noting that bills to carriers for medical and chiropractic office visits were excessive, Dr. Crothers prepared fee guidelines for medical doctors and for chiropractors. He computed a level of charges, equal to the fees charged by the lowest 90 percent of billing offices, which he determined was the reasonable fee for the services provided. The guidelines were updated annually for chiropractors.

In 1980, after public hearings, the OWCD adopted an administrative rule which limited both the number and the frequency of treatments available to injured workers. Or.Admin.R. § 436–69–320(2) (1980) (current version at Or.Admin.R. § 436–69–201(2)(a) (1983)). The rule applies to medical doctors as well as chiropractors; however, it has a more severe impact on the latter group because of the nature of their practice.

Reciting the above actions and events, plaintiffs allege Crothers and the codefendants conspired with each other and acted in bad faith to injure the chiropractors. In Count One, plaintiffs contend the conduct violated sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2 (1982). In Count Two, plaintiffs maintain the same conduct constituted a denial of due process and equal protection.

As to the individual defendants, we agree with the district court that their actions are immune from Sherman Act liability under the principle of *Parker v. Brown*, 317 U.S. 341, 352, 63 S.Ct. 307, 314, 87 L.Ed. 315 (1943), as actions of the State of Oregon in its sovereign capacity. *See Hoover v. Ronwin*, — U.S. —, 104 S.Ct. 1989, 1998, 80 L.Ed.2d 590 (1984); *Bates v. State Bar of Arizona*, 433 U.S. 350, 360, 97 S.Ct. 2691, 2697, 53 L.Ed.2d 810 (1977); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 790, 95 S.Ct. 2004, 2014, 44 L.Ed.2d 572 (1975). The acts challenged, though taken by the individual defendants in their administrative capacity, were direct implementations of a precise statutory policy, so the case before us does not present the question whether the executive branch of a state government may formulate and pursue a policy that is within the *Parker* exemption. The Supreme Court has yet to consider this precise issue. *See Ronwin*, 104 S.Ct. at 1995 n. 17. Our court, however, addressed that question in *Deak-Perera Hawaii, Inc. v. Department of Transportation*, 745 F.2d 1281 (9th Cir.1984), *cert. denied*, — U.S. —, 105 S.Ct. 1756, 84 L.Ed.2d 820 (1985), and concluded that *Parker* immunity was applicable; but we need not rely on *Deak-Perera*. The actions by the individual defendants here were done as a routine implementation of a legislative policy, including rulemaking and the exercise of other delegated authority.

[1, 2] With respect to implementation of the de facto fee schedule in 1979, section 656.248 of the Oregon Revised Statutes supports the defendants' actions. The law authorizes the directors to set rates and to adjust individual bills, and as such states an affirmative and express policy to subordinate free competition among health care providers to the need of the state to reduce costs in the area of worker's compensation health care. The fee limitation rule was adopted pursuant to the statute and was actively supervised by the OWCD. Aggrieved parties could obtain further review pursuant to the provisions of the Oregon Administrative Procedure Act. Where the restraint in question is, first, clearly articulated and affirmatively expressed as a matter of state policy, and, second, subject to the active supervision of the state itself, the *Parker* defense is applicable. *California Retail Liquor Dealers Association v. Mid-Cal Aluminum, Inc.*, 445 U.S. 97, 105, 100 S.Ct. 937, 943, 63 L.Ed.2d 233 (1980) (citing *City of Layfayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410, 98 S.Ct. 1123, 1135, 55 L.Ed.2d 364 (1978)). The requisites are met here, and the adoption of the fee limitation is immune from the antitrust laws under *Parker*.

[3] The individual defendants are also immune for use of the treatment frequency schedule, despite its lack of specific statutory authorization. The Director is empowered to make all rules which are reasonably required in the performance of his duties. Or.Rev.Stat. § 656.726(3)(a). The Act also creates an Advisory Committee on Medical Care which is obligated to prepare and submit to the Director appropriate rules governing the furnishing of medical care. Or.Rev.Stat. § 656.794. The Oregon Court of Appeals has validated the frequency limitation schedule as currently enacted. *Kemp v. Workers' Compensation Department*, 65 Or.App. 659, 672 P.2d 1343, 1345–46 (1983), *modified*, 67 Or.App. 270, 677 P.2d 725 (1984). The state court concluded that the regulation was designed to ensure that treatments received are both reasonable and necessary and held the regulation was within the scope of section 656.245 of the Oregon Revised Statutes. The regulation additionally furthers the state's interest in minimizing health care costs. Under *Parker*, immunity is fully applicable.

The adoption of the de facto fee schedule presents some different questions, namely whether action within the intendment of section 656.248 and entitled to *Parker* immunity loses such immunity because taken in a procedurally improper manner. We hold that such action may retain its immune character, and that it does so in this case.

[4] At the outset, we should note that even the constitutional invalidity of the attempted state regulation is not an appropriate basis for disregarding the immunity conferred by *Parker*. *Preferred Communications, Inc. v. City of Los Angeles*, 754 F.2d 1396, 1414 (9th Cir.1985). *Accord*, *Bates v. State Bar of Arizona*, 433 U.S. 350, 97 S.Ct. 2691, 53 L.Ed.2d 810 (1977). From this, it should follow that a procedural irregularity in the adoption of the challenged state regulation does not render *Parker* inapplicable.

Further, the theoretical underpinning for the *Parker* doctrine is the Supreme Court's pronouncement that the Sherman Act was not intended to reach the activities of state governments. A state's antitrust immunity springs from an essential principle of federalism, the necessity to respect a sovereign capacity in the several states. *Ronwin*, 104 S.Ct. at 1995–96. Given this purpose, it follows that actions otherwise immune should not forfeit that protection merely because the state's attempted exercise of its power is imperfect in execution under its own law.

> State laws intended to displace the antitrust laws may delegate to public agencies or officials the power to act, decide, or regulate in order to achieve anticompetitive results. Of course, state law "authorizes" only agency decisions that are substantively and procedurally correct. Errors of fact, law or judgment by the agency are not "authorized," and state tribunals will normally reverse erroneous acts or decisions. If the antitrust court demands unqualified "authority" in this sense, it will inevitably become the standard reviewer of governmental agencies whenever it is alleged that the agency, though possessing the power to engage in the challenged conduct, has exercised its power erroneously.

Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 Harv.L.Rev. 435, 449–50 (1981). **"'Ordinary' errors or abuses in the administration of powers conferred by the state should be left for state tribunals to control." *Id.* at 453. A contrary rule would tempt aggrieved parties to forego available state corrective processes in hopes of obtaining the treble damages remedy conferred by the Sherman Act. Here state corrective processes were available, and the aggrieved parties could resort to them.**

[5] The availability of such processes in this case is evidenced by the invalidation of the fee schedule by the OWCD Hearings Referee. The adoption of the de facto fee schedule is immune from the antitrust laws under the principles we have stated, even though accomplished in violation of applicable rulemaking procedures.

[6] Appellants contend, notwithstanding the foregoing analysis, that *Parker* immunity should be unavailable because of the alleged bad faith motivation of Crothers. The district court found, "[t]here is evidence that neither Crothers [nor] SAIF ... liked chiropractors as a group and that they may have actively sought ways to 'get the chiropractors.'" *Llewellyn v. Crothers*, No. 81–6462–FR, slip op. at 22 (D.Or. Apr. 20, 1983). The availability of *Parker* immunity, however, does not depend on the subjective motivations of the individual actors, but rather on the satisfaction of the objective standards set forth in *Parker* and authorities which interpret it. This must be so if the state action exemption is to remain faithful to its foundations in federalism and state sovereignty. A contrary conclusion would compel the federal courts to intrude upon internal state affairs whenever a plaintiff could present colorable allegations of bad faith on the part of defendants.

[7] In this case, despite the possibility of improper motivation on the part of Crothers, no evidence indicates that his ac-

tions exceeded the scope of his authority. His actions were taken pursuant to an express state policy and were of a kind contemplated by the statutory scheme. The actions were not overruled through the state supervisory process, and we must conclude that Crothers' conduct served the state's best interests. In the context of determining antitrust immunity, further inquiry into the subjective motivations of the Oregon officials is unwarranted.

[8, 9] We turn next to the question whether the defendant SAIF is subject to antitrust challenge for its actions. The district court treated SAIF as a private, nonstate agency party despite its statutory origin and its clear interrelation with the state government. Although that proposition seems dubious to us, for the purposes of this appeal, we may assume its correctness without so holding. Even if regarded as a private party, SAIF has immunity under *Parker v. Brown* for its conduct taken pursuant to the rules and regulations of the OWCD. Those actions were mandated by the statutes, rules, and regulations of Oregon governmental entities. A restraint need not be compelled by the state for immunity to attach; it is sufficient so long as state policy permits the anticompetitive conduct, if other tests for immunity are met. *Southern Motor Carriers Rate Conference, Inc. v. United States*, — U.S. —, 105 S.Ct. 1721, 1728–29, 85 L.Ed.2d 36 (1985). Here the actions in question were mandated by Oregon law and regulations, and antitrust immunity is applicable. *See Mid-Cal Aluminum*, 445 U.S. at 105, 100 S.Ct. at 943; *Knudsen Corp v. Nevada State Dairy Commission*, 676 F.2d 374, 379 (9th Cir.1982); *Turf Paradise, Inc. v. Arizona Downs*, 670 F.2d 813, 822 (9th Cir.), *cert. denied*, 456 U.S. 1011, 102 S.Ct. 2308, 73 L.Ed.2d 1308 (1982). The assumed private party did no more than comply with the requirements of a state scheme that itself was exempt from antitrust attack.

[10, 11] Appellants allege that SAIF violated antitrust laws in lobbying the OWCD to take the governmental actions here in question. SAIF and its actions in this regard may have been outside the scope of *Parker* immunity, but this aspect of the complaint fails nevertheless under the *Noerr-Pennington* doctrine. Under the Sherman Act, it is not impermissible for two or more persons to associate together in an attempt to persuade the legislature or the executive to take particular action with respect to a law that would produce a restraint or a monopoly. *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 136, 81 S.Ct. 523, 528, 5 L.Ed.2d 464 (1961); *Omni Resource Development Corp. v. Conoco, Inc.*, 739 F.2d 1412, 1413 (9th Cir. 1984); *Avdin Corp. v. Loral Corp.*, 718 F.2d 897, 903 (9th Cir.1983); *Clipper Express v. Rocky Mountain Motor Tariff Bureau, Inc.*, 690 F.2d 1240, 1251 (9th Cir. 1982), *cert. denied*, 459 U.S. 1227, 103 S.Ct. 1234, 75 L.Ed.2d 468 (1983). This is true even when the petitioners act with the intent to urge a restraint of trade, *United Mine Workers v. Pennington*, 381 U.S. 657, 670, 85 S.Ct. 1585, 1593, 14 L.Ed.2d 626 (1965), so long as they harbor a "legitimate expectation that such efforts will in fact induce lawful government action." *Omni Resource Development Corp.*, 739 F.2d at 1413. Since SAIF's lobbying efforts resulted in lawful action by the OWCD, we are presented with a required application of the *Noerr-Pennington* doctrine, and SAIF's conduct is immune from antitrust challenge.

The appellants' allegations regarding conspiracy between the governmental and private defendants do not negate the antitrust exemptions in this case. The conspiracy allegations in the complaint are couched in the most vague and conclusory terms.

> Vague and unsupported conspiracy allegations deserve very little respect from the antitrust court, given (1) the temptation for a party before a governmental body to claim an antitrust conspiracy whenever the decision is disappointing, (2) the modest likelihood that bad faith or corruption can be proved, and (3) the potential chilling effect antitrust proceedings might have on the operations of government.

Areeda, *supra*, at 452. The conspiracy allegations do not overcome the fundamental immunities we have here defined and discussed.

[12] The district court was also correct in granting summary judgment on appellants' equal protection claim. The state has broad authority and discretion in the regulation of economic affairs. *See generally, Williamson v. Lee Optical, Inc.*, 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955). No suspect classification or other basis for applying heightened scrutiny has been established, and it has not been shown that the classification used here bears no rational relation to a legitimate governmental purpose. *See San Antonio Independent School District v. Rodriguez*, 411 U.S. 1, 40, 93 S.Ct. 1278, 1300, 36 L.Ed.2d 16 (1973); *Dandridge v. Williams*, 397 U.S. 471, 485, 90 S.Ct. 1153, 1161, 25 L.Ed.2d 491 (1970); *Parks v. Watson*, 716 F.2d 646, 654 (9th Cir.1983).

[13] There is a rational basis to distinguish between chiropractors and other health care providers in setting reasonable rates of reimbursement for their services. Each profession has its own distinctive qualifications and licensing requirements. The State of Oregon places special limitations on the licensing and practice of chiropractors. Or.Rev.Stat. §§ 684.010–684.990 (1983). In light of the differences between chiropractors and other health care providers in training, licensing, practice, and treatment, the Director had a rational basis for the classifications used. *See Aasum v. Good Samaritan Hospital*, 542 F.2d 792, 796 (9th Cir.1976). No equal protection violation was established.

The judgment of the district court is AFFIRMED.

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VAN NATTA CITATIONS

Name	Citation	Pages
Joyce F. Adair	35 Van Natta 203 (1982)	227
Robert L. Akins	35 Van Natta 231 (1983)	706
Claude Allen	34 Van Natta 769 (1982)	194
Juan Alonzo	37 Van Natta 57 (1985)	1160
Robert E. Alvarez	35 Van Natta 1822 (1983)	202
Patricia A. Anderson	35 Van Natta 1057 (1983)	1146
Carl W. Andrews	35 Van Natta 1685 (1983)	998
Earl W. Andrews	35 Van Natta 1582 (1983)	256
Arnold Androes	35 Van Natta 1619 (1983)	3,39,641
Juan Anfilofieff	37 Van Natta 257 (1985)	552
James B. Arndt	36 Van Natta 4 (1984)	1160
Kenneth E. Awmiller	34 Van Natta 1123 (1982)	1275
Dick L. Babcock	35 Van Natta 325 (1983)	1102
Erwin L. Bacon	37 Van Natta 205 (1985)	981
Warren C. Bacon	35 Van Natta 1694 (1983)	39
Anita A. Bade	36 Van Natta 1093 (1984)	501,641,937,1052
Zelda M. Bahler	33 Van Natta 478 (1981)	84,458,508,544,692,973
Catherine C. Bailey	36 Van Natta 280 (1984)	1291
Elmer W. Baird	34 Van Natta 965 (1982)	30
Faye L. Ballweber	36 Van Natta 303 (1984)	440
Rasool Bambechi	35 Van Natta 1060 (1983)	964
Clarice Banks	34 Van Natta 689 (1982)	484,1192
John M. Barbour	36 Van Natta 304 (1984)	65
Jeffrey Barnett	36 Van Natta 1636 (1984)	115,194,218
Robert A. Barnett	31 Van Natta 172 (1981)	164,767,956,1073,1291
Gloria J. Bas	36 Van Natta 175 (1984)	427
Robert E. Becker	36 Van Natta 782 (1984)	501
George Bedsaul	35 Van Natta 695 (1983)	711
Dewey R. Begley	36 Van Natta 1078 (1984)	769
Ralph Bencoach	36 Van Natta 681 (1984)	1282
Kevin Bethel	36 Van Natta 1060 (1984)	29,556
Roy L. Bier	35 Van Natta 1825 (1983)	276
William M. Bird	36 Van Natta 1571 (1984)	3
Thomas Black	35 Van Natta 1193 (1983)	1162
Arnold C. Blondell	36 Van Natta 818 (1984)	1134
Derry D. Blouin	35 Van Natta 570 (1983)	483
Darryl W. Bodle	37 Van Natta 751 (1985)	1055
Anthony A. Bono	37 Van Natta 956 (1985)	1134
Anthony A. Bono	35 Van Natta 1 (1983)	756
Thomas H. Bowen	37 Van Natta 434 (1985)	729
Leighton J. Bowman	37 Van Natta 420 (1985)	1102
Neva W. Brehmer	36 Van Natta 1603 (1984)	942
Ronald R. Brenneman	36 Van Natta 965 (1982)	29
Eldon Britt	31 Van Natta 141 (1981)	256
Robert W. Brown	36 Van Natta 1627 (1984)	749
Theodore P. Brown	36 Van Natta 51 (1984)	1205
Van M. Brown	36 Van Natta 1109 (1984)	115
John B. Bruce	37 Van Natta 135 (1985)	745,927,1211
Wilma Kim Buhman	34 Van Natta 252 (1982)	526
William Bunce	33 Van Natta 546 (1981)	692
Steve W. Burke	37 Van Natta 1018 (1985)	1055
Milton O. Burson	36 Van Natta 282 (1984)	163,415,547

VAN NATTA CITATIONS

Name	Citation	Pages
Joe E. Cain	37 Van Natta 9 (1985)	1012
Pirfil Cam (Employer	34 Van Natta 676 (1982)	257
Donald T. Campbell	35 Van Natta 1622 (1983)	3,39
Robin L. Campbell	37 Van Natta 61 (1985)	75
Larry Campuzano	34 Van Natta 734 (1982)	124
Daniel J. Cannon	35 Van Natta 1181 & 1623	248,284
Edwin R. Cantrell	36 Van Natta 312 (1984)	21,65
Darrel W. Carr	36 Van Natta 16,164	42,475,522,652,923,956
Gracia A. Carter	36 Van Natta 1604 (1984)	743
Dwayne G. Cary	36 Van Natta 265 (1984)	694
Linda L. Cates	36 Van Natta 1696 (1984)	1042
Donald K. Chambers	37 Van Natta 148 (1985)	729
Sharon C. Chase	37 Van Natta 415 (1985)	1171
David Cheney	35 Van Natta 21 (1983)	62,284,427
Kenneth E. Choquette	37 Van Natta 927 (1985)	1041
Gary L. Clark	35 Van Natta 117 (1983)	522,715
Mary Lou Claypool	34 Van Natta 943 (1982)	1018,1055
Charlotte A. Clemmer	36 Van Natta 753 (1984)	1012
Michael Cochran	35 Van Natta 1726 (1983)	460
Leslie Colvin	36 Van Natta 315 (1984)	964
Garland Combs	37 Van Natta 756 (1985)	982,1021,1051,1229
Ralph W. Compton	36 Van Natta 1707 (1984)	767
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Betty L. Counts	35 Van Natta 1356 (1983)	581
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Thomas D. Craft	36 Van Natta 1649 (1984)	681,1242
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Kenneth N. Crocker	36 Van Natta 1505 (1984)	3
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Robert R. Delugach	37 Van Natta 63 (1985)	762
John Denton	34 Van Natta 1598 (1982)	39
Charlene Devereaux	36 Van Natta 911 (1984)	118,494,715
Tom E. Dobbs	35 Van Natta 1332 (1983)	605
Dale Donaldson	34 Van Natta 1154 (1982)	210,675
Douglas Dooley	35 Van Natta 125 (1983)	181,243,515
Vanessa Dortch	37 Van Natta 1207 (1985)	1209,1210,1211
Harold L. Dotson	37 Van Natta 759 (1985)	776,951,982
Mary A. Downey	37 Van Natta 455 (1985)	642,1088
Lloyd C. Dykstra	36 Van Natta 26 (1984)	425,1339
Kenneth L. Elliott	36 Van Natta 1141 (1984)	115,218,415,446,1033
Richard F. Erzen	36 Van Natta 218 (1984)	501,552
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Earl Freeman	34 Van Natta 1284 (1982)	1042
Gary A. Freier	34 Van Natta 543 (1982)	154,194
Judy M. Friedrich	36 Van Natta 1210 (1984)	481,605,729,759
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Tony Giuriolo	34 Van Natta 1615 (1982)	1174
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Robert G. Perkins	36 Van Natta 1050 (1984)	12,271,759,951
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George N. Roth	14 Van Natta 202 (1975)	164
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Lucine Schaffer	33 Van Natta 511 (1981)	1042,1171
Richard A. Scharbach	37 Van Natta 598 (1985)	1002,1033,1064,1202,1246
Anna M. Scheidemante	35 Van Natta 740 (1983)	958
Henry A. Schmidt	34 Van Natta 582 (1982)	1189,1192
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Bloomfield, Michael I., 83-12121 (3/85)
Bodenhamer, Paul H., 82-10525 (4/85)
Bonney, Terry L., 84-04259 etc. (7/85)
Bowen, Coy F., 83-11642 (8/85)
Boydston, Erma L., 84-06429 (3/85)
Branom, Samuel L., 83-09531 etc. (1/85)
Briggs, Michael R., 83-09701 (4/85)
Bright, Delores M., 84-03421 (3/85)
Britton, Paul W., 83-08680 (7/85)
Brown (Church), Sherry, 83-06132 (5/85)
Brown, Darlene M., 84-00928 (6/85)
Brown, Evelyn Appel, 84-05843 (7/85)
Brown, Marvin L., 81-09489 etc. (2/85)
Brown, Rodney F., 83-05801 (5/85)
Brueckner, Anna, 84-10723 (9/85)
Buckmaster, Gerald J., 84-08735 (4/85)
Burns, Robert T., 83-03151 etc. (5/85)
Bustamante, Joan, 84-00134 etc. (8/85)
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Butler, Linda, 83-12251 (4/85)
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Cahan, Shirley G., 83-03651 (2/85)
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Calkins, Kathy K., 84-02419 (7/85)
Callahan, Tommie D., 84-00721 (8/85)
Carlson, James E., 84-02203 (2/85)
Carr, William E., 83-05764 etc. (8/85)
Carter, David J., 83-09917 (3/85)
Case, William H., 83-12174 (1/85)
Cave, Bonnie B., 84-07084 (7/85)
Cayo, Phillis, 82-09451 (4/85)
Chan, Sangauth, 84-06968 (7/85)

Chapman, Rosa (Gillette),80-10362 (2,4/85)
Chatterson, Arliss M., 84-02959 (3/85)
Choquette, Kenneth E., 83-07556 (6/85)
Christensen, Richard, 84-03279 etc. (8/85)
Claflin, Betty J., 83-11524 etc. (3/85)
Clark, Tommy E., 83-08836 (1/85)
Cloney, Brenda, 84-03855 (5,7/85)
Cogburn, Sandra, 83-02287 etc. (2/85)
Colcleaser, Everette D., 84-00845 (8/85)
Cole, Donna M., 83-06975 (2/85)
Colombo, Richard J., 84-05050 (5/85)
Comstock, Dickie A., 84-04120 (9/85)
Conaway, James C., 82-01640 etc. (6/85)
Cooper, Ray K., 84-02674 (3/85)
Copeland, Ernest M., 83-10623 (3/85)
Cornelius, Irene L., 83-06841 (4/85)
Costello, Guy L., 83-09435 etc. (1/85)
Cox, Fred A., 84-05161 (3/85)
Cox, Randall C., 84-02326 (5/85)
Coxey, Harry A., 83-08923 etc. (6/85)
Coy, James P., 83-03556 (1/85)
Craig, Curtis E., 77-01874 (8/85)
Crain, Joyce I., 84-01120 (2/85)
Cross, Clarence E., 83-08906 (4/85)
Crowder, Hobert E., 83-09809 (1/85)
Crumble, Wendy R., 83-09104 (3/85)
Crump, Orson K., 84-06426 (5/85)
Culley, Timothy D., 83-11044 (4/85)
Cupps, Sandra K., 84-02908 etc. (4/85)
Curry, Kenneth D., 84-06095 etc. (5/85)
Curtis, Margaret J., 83-03641 (1/85)
Curtis, Wendy C., 83-11912 (2/85)
Daly, James S., 84-07571 (9/85)
Daniels, Robin E., 83-11931 (1/85)
Dass, John J., 83-02753 (6/85)
Daugherty, Eldred D., 83-10075 etc. (7/85)
Davenport, Jack A., 83-08678 etc. (8/85)
Davila, Epifanio C., 85-00739 (8/85)
Davis, Anna R., 84-01911 (9/85)
Davis, Bobby L., 84-06494 (5/85)
Davis, Jefferson L., 84-01795 (7/85)
Davis, Jewell, 84-03395 etc. (7/85)
Davis, Raymond R., 84-03395 etc. (7/85)
De La Rose, Simon, 84-04262 (5/85)
Delfs, Rick L., 84-12431 (8/85)
DeLisle, Brian, 84-07022 (5/85)
Depew, Carmon L., 84-10377 (9/85)
Dickens, Douglas B., 84-03801 etc. (8/85)
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Dill, Jimmy H., 83-10170 (7/85)
Dimatteo, Joe W., 84-09381 (9/85)
Dime-In-Bull, Inc., 84-03416 (7/85)
Dittman, John R., 84-09010 (8/85)
Dolinar, Henry J., 82-11180 etc. (2/85)
Donovan, William A., 83-12093 (4/85)
Dorsey, Terry E., 84-04641 (9/85)
Driggers, Roger A., 84-03514 (5/85)
Duckett, James E., 83-07023 etc. (9/85)
Duncan, Debra L., 84-04540 (4/85)
Durflinger, Rick L., 84-08799 (6/85)
Duval, Ronald K., 83-00739 etc. (5/85)
Eaggleston, Richard, 82-08904 (3/85)
Earley, Robert F., 84-10617 (8/85)
Ehlin, Norman E., 84-05571 (7/85)
Ellingson, Steve, 82-06605 (1/85)
Evans, Mary K., 84-01025 (7/85)
Fahlgren, Dorothy A., 84-01154 (3/85)
Ferguson, Tace C., 84-09189 (8/85)
Ferry, Barbara & Harlan (9/85)
Finley, Orin G., 83-10167 etc. (8/85)
Fisher, Deryl E., 80-07170 (1/85)
Flanary, Susanne, 83-05078 etc. (9/85)
Foss, Jerry H., 84-05731 etc. (9/85)
Foster, Barbara K., 84-00412 (2/85)
Fowke, Ernest H., 83-03357 etc. (7/85)
Fox, James E., 84-04174 (8/85)
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Free, Sharon D., 84-03485 (6/85)
French, Sharon A., 83-10099 (4/85)
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Fuson, Darrell W., 83-08946 (3/85)
Gallegos, Margaret, 83-02336 (7/85)
Gallegos, Samuel, 83-02336 (7/85)
Garcia, Ruben M., 82-05143 (1/85)
Gardner, Robert J., 84-02617 (7/85)
Gheer, Walter G., 83-07891 (1/85)
Gibson, Rex D., 81-09211 (1/85)
Gilbert, David A., 83-07374 etc. (2/85)
Gillar, Bohuslav J., 84-10261 (9/85)
Gilliam, Bobby L., 83-05629 (2/85)
Glickert, George B., 84-00646 (1/85)
Gobble, Ernest S., 84-12704 (9/85)
Gonzales, Julio L., 84-08101 (9/85)
Gonzalez, Abran G., 84-01449 (6/85)
Goodpaster, Thomas W., 84-01290 (5/85)
Gordon, Theodore C., 83-03961 (2/85)
Gotchall, Karin K., 83-04581 (2/85)
Graves, Patsy J., 84-06069 (7/85)
Green, Danny R., 84-00841 (4/85)
Green, Teri A., 84-02535 (4/85)
Greenwell, Richard K., 84-01442 (6/85)
Gregg, Charles L., 84-10197 (6/85)

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Gullett, Betty J., 84-01785 (5/85)
Haga, Catherine M., 84-05765 (3/85)
Hager, Walt N., 84-03939 (1/85)
Hagnas, John S., 84-08253 (7/85)
Haines, Garry L., 84-04950 (6/85)
Hall, Rodney W., 84-01737 (5/85)
Halseth, Diane L., 84-00948 (1/85)
Halverson, Jan T., 83-09826 (2/85)
Hancock, James E., 83-04285 etc. (1/85)
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Harris, Ralph R., 83-06921 (4/85)
Harvey, Virginia M., 84-08662 (9/85)
Hatton, Yvonne M., 83-10917 (7/85)
Hawtry, Fred W., 83-10311 (9/85)
Hedlund, Robert K., 81-08777 (5/85)
Helmick, Donald L., 84-07919 (4/85)
Hermann, Paul H., 85-02059 (9/85)
Hernandes, Francisco M., 84-10186 (9/85)
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Herrington, Cecelia H., 84-05254 (9/85)
Herrington, Gerald, 82-08603 (3/85)
Hester, Harry V., 80-08473 (1/85)
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Hilkey, Dana, 84-04157 (7/85)
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Hinkle, Lawrence W., 84-00690 (2/85)
Hoeffer, Floyd K., Sr.,83-09837 etc.(5/85)
Holland, Judith, 83-10688 (3/85)
Hollenbeck, William E., 84-07329 (5/85)
Hollingsworth, Nettie R., 84-00173 (9/85)
Hooker, Melvin J., 84-03754 (5/85)
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Horton, Warren C., 84-04793 (6/85)
Hovelsrud, Raymond A., 83-11712 (2/85)
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Huff, Michael P. (Emp.), 84-06095 (5/85)
Hume, Raymond S., 82-05533 (5/85)
Hunt, Evalee, 84-04003 (4/85)
Hutcheson, Earl B., 83-01750 (6/85)
Hutson, Cari D., 84-01832 (6/85)
Isabell, Tim W., 84-03078 (2/85)
Ivanoff, George S., 83-06862 (2/85)
Jackson, Shirley A., 84-07469 (9/85)
Jarrett, Bonnie J., 84-01893 (4/85)
Jaskoski, Michael R., 84-05033 etc. (9/85)
Jenkins, Richard H., 83-09211 (9/85)
Jensen, Anita R., 84-06246 etc. (5/85)
Jensen, Leonard J., 84-01121 (7/85)
Jensen, Madeline, 83-04443 (3/85)
Jiminez, Celice J., 84-04892 (9/85)
Johnson, Fred D., 84-00194 (2/85)
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Johnson, Joanne K., 84-01418 (4/85)
Johnson, Margaret, 84-04567 etc. (3/85)
Johnston, Michael J., 84-01395 (6/85)
Jones, Charles L., 83-02497 (6/85)
Jones, Charles R., 81-07141 (1/85)
Karr, William E., 84-07920 (6/85)
Kelley, Milton H., 80-04840 (2/85)
Kelly, Billie L., 83-08828 (2/85)
Kelly, Donald D., 84-02576 (1/85)
Kelly, Patrick J., 83-07200 (7/85)
Kidd, Arthur W., 82-07593 (6/85)
King, Willie, 82-03810 (1/85)
Kirby, Nancy L., 84-01984 (2/85)
Kiser, Harold J., 83-08684 (2/85)
Knephoff, John J., 83-10609 (4/85)
Knodel, Lonnie R., 84-03685 (5/85)
Knotts, Richard C., 84-09930 (7/85)
Koch, William R., 83-07513 (2/85)
Kohler, Gary L., 84-00984 (1/85)
Korbulic, Paul, 84-00668 (3/85)
Koronaois, George J., 83-08930 (5/85)
Kunst, James R., 82-10956 (9/85)
Lacy, George L., 83-07622 (2/85)
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Laing, George J., 83-11024 (4/85)
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Lambert, Alan C., 84-00134 etc. (8/85)
Lamotte, Ronald G., 83-02836 (9/85)
Lamunyon, Cashius C., 84-08721 (9/85)
Lane, Lynnda J., 83-06103 (2/85)
Lanpheare, Paul D., 84-08769 (7/85)
Larsen, Frances A., 84-02204 (2/85)
Lavine, Jesse B., 84-03050 (3/85)
Lee, Albert N., 82-00045 (2/85)
Lee, Yvonnda M., 84-09449 (9/85)
Leigh, Doreen, 83-03919 (4/85)
Lendgren, Leland C., 84-03543 (6/85)
Lewis, Lisa M., 83-10390 (1/85)
Linday, Jeffrey L., 84-06636 (7/85)
Lindland, Barbara (Noble), 83-07474 (6/85)
Lloyd, Chester M., 84-04091 (6/85)
Lloyd, Debbie K., 84-07577 (9/85)
Lockhart, Howard B., 83-03851 (2/85)
Long, Jere L., 83-08035 (3/85)
Longhenry, Judy A., 84-05600 etc. (8/85)
Loomis, Carolyn J., 81-08410 (5/85)
Lowery, John D., 83-02029 (5/85)
Lundberg, Neil E., 84-01733 (2/85)
Lunsford, Shirley D., 84-07566 (9/85)
Luthy, Mark R., 84-13075 (6/85)
Macaitis, Robert B., 84-04090 (4/85)
Mahoney, Dennis W., 84-03593 (4/85)
Marlow, Roylee W., 84-09584 (6/85)
Martin, Stephen R., 83-05921 (3/85)
Martina, David A., 80-02691 (1/85)
Mashia, Eric W., 83-10341 (1/85)
Mathis, Agnes J., 84-10361 (7/85)
Maughan, Rex D., 83-10885 (1/85)
Mayes-Kerns, Francis E., 84-00082 (7/85)
McBride, Betty L., 84-08233 etc. (4/85)
McClendon, Bonnie J., 83-09074 (1/85)

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McCoy, Jimmie D., 84-06658 (7/85)
McDonald, Donald J., 83-12170 (2/85)
McGougan, James A., 84-00639 etc. (4/85)
McKay, Chawn K., 84-02781 (5/85)
McKenzie, Clarence E., 84-00955 (5/85)
McLoughlin, Carl M., 83-08697 (3/85)
McMurtry, Larry D., 83-11855 (2/85)
McSwane, John E., 84-00392 (1/85)
Mealer, James A., 83-04725 (4/85)
Meola, Jerry J., 80-09459 (1/85)
Metcalf, Leilia H., 84-03501 (5/85)
Midwood, James D., 83-10915 (4/85)
Miles, James C., 83-11420 (5/85)
Mingus, Melvin J., 84-00601 (7,8/85)
Mirich, Michael D., 84-00644 (7/85)
Mitchell, James R., 84-02037 (1/85)
Mitchell, Robin, 81-05553 (2/85)
Monroe, Nancy A., 83-06040 (9/85)
Moore, Lorrena M., 84-07232 (7/85)
Morelatos, Vasiliki, 84-07965 (9/85)
Morgan, Glenellen D., 83-10846 (2/85)
Morgan, Howard D., 84-03645 (9/85)
Morris, John W., 84-02591 (6/85)
Mosley, Donald P., Jr., 84-06885 (6,6/85)
Mulkey, Frank A., 83-02226 (9/85)
Nelson, Ronald A., 84-05256 (7/85)
Nesbitt, Mara L., 83-08868 etc. (4/85)
Neth, Jack H., 84-02165 (7/85)
Netterwald, John D., 84-02941 etc. (4/85)
Ninneman, Elmer A., 84-02469 (7/85)
Noffsinger, Marvin L., 84-05413 etc.(6/85)
Nolan, Terry E., 84-06088 (6/85)
O'Brien, Janet F., 84-01045 (1/85)
Offutt, Mary L., 84-02971 (5/85)
Olson, Paul, 82-00609 (1/85)
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Opoka, Arlene, 84-03416 (7/85)
Osorio, Martha O., 84-00858 (2/85)
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Pantley, Richard L., 82-11501 (8/85)
Peacher, Hanni L., 83-11850 (1/85)
Pepperling, Earl L., 84-01520 etc. (7/85)
Perry, Edward C., Sr., 84-08260 (6/85)
Pipkin, Jan M., 83-08899 (5/85)
Poelwijk, James A., 84-00300 (9/85)
Poole, Susan, 83-07452 (2/85)
Porras, Maria R., 83-01780 (9/85)
Porter, Lenny C., 83-03584 (2/85)
Portillo, R.J., 84-06552 (8/85)
Post, Joseph C., 79-10059 (2/85)
Potter, Robert P., 83-07212 (2/85)
Praegitzer, Michael B., 82-01622 (5/85)
Prater, Charlotte, 83-00227 (5/85)
Preuitt, Harry P., 84-06988 (9/85)
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Qualls, Elbert E., 84-07846 etc. (9/85)
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Ramberg, Rhea A., 83-00575 (6/85)
Rasmussen, Paul D., 83-09373 (3/85)
Reed, Kenneth L., 83-06139 (3/85)
Reel, Edward J., 84-00293 (7/85)
Rencehausen, Myron, 84-00103 etc. (3/85)
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Reynolds, Beulah P., 84-03420 (2/85)
Richesin, Jess W., 84-10576 (7/85)
Richter, Evelyne L., 83-04450 (1/85)
Rickard, Danny P., 84-00038 (2/85)
Rickerd, Melody A., 84-00136 (5/85)
Rightbower, Robert C., 84-10746 (9/85)
Riley, Edward W., 83-03918 (2/85)
Robertson, John A., 84-09450 (9/85)
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Robirts, George F., 84-08730 etc. (7/85)
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Robles, Grace V., 84-07537 (9/85)
Rogers, Dorothy J., 84-02651 (5/85)
Rolfe, George M., 84-09436 (6/85)
Rose, William R., 83-03291 (3/85)
Rosenberg, Aloha J., 83-11817 (7,8/85)
Rosenberger, Margaret D., 84-08605 (6/85)
Row, Rayford E., 84-00291 (5/85)
Rudolfi, Thomas A., 83-11457 (6/85)
Ruhr, Rose M., 84-01642 (4/85)
Ruiz, Felix G., 83-01664 (7/85)
Russell, James G., 84-01230 (2/85)
Salinas, Mario P., 84-07160 (7/85)
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Scholl, Mary V., 83-07840 (2/85)
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Seaton, Harold, 84-06171 (9/85)
Semonius, Robert F., 84-13644 (9/85)
Shaffer, Larry A., 84-02396 (9/85)
Shepherd, Donald P., 84-04127 (4/85)
Sherburne, Ruth A., 83-10495 (9/85)
Sherman, William L., 83-09890 (1/85)
Sherwood, Steven H., 83-10203 (9/85)
Shipman, Orville D., 76-02789 (6/85)
Shipp, Joseph R., 84-02713 (4/85)
Shorb, Guy M., 83-04404 (9/85)
Shroyer, Susan M., 83-09002 (2/85)
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Siladic, Maria, 84-05252 (6/85)
Simi, Randy G., 84-10210 (8/85)
Sisk, Gordon L., 83-09606 (8/85)
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Smith, David R., 84-07188 (9/85)
Smith, Don L., 84-08577 (9/85)
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Smith, Jay R., 83-07297 (9/85)
Smith, Kathryn D., 84-03578 etc. (4/85)
Smith, Russell E., 82-06363 (2/85)
Smith, William A., 84-03753 (3/85)
Smith, William R., 84-09649 etc. (5/85)
Spady, Bonnie M., 84-04882 (6/85)
Spalding, Rita M., 83-09642 (2/85)
Staggs, Charles H., 84-04188 etc. (7/85)
Stallings, Russell I., 84-00207 (4/85)
Standley, Everett S., 84-06089 etc. (9/85)
Steffens, Catherine L., 84-00596 (9/85)
Stephan, Herman E., 84-00046 (2/85)
Strange, Mark D., 84-08073 (4/85)
Stratton, Judy C., 83-12237 (6/85)
Swanberg, Max S., 83-10524 etc. (9/85)
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Teague, Donnie R., 83-08658 (3/85)
Terry, Elva J., 83-06885 (1/85)
Tevepaugh, Marvin, 84-05351 (4/85)
Tevepaugh, Ruby, 84-05351 (4/85)
Thompson, Sylvester, 84-00960 (7/85)
Thornbrugh, John E., 83-09980 (2/85)
Tieger, Milton, 82-05441 (2/85)
Truong, Nhah V., 84-02248 (4/85)
Turcott, Adele, 84-10196 (7/85)
Turner, Betty S., 83-08233 (2/85)
Turner, Herbert C., 84-04433 (9/85)
Turner, Joyce M., 82-01328 etc. (8/85)
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Van Dinter, Donald M., 84-00265 etc.(8/85)
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VanMeter, Richard H., 83-11939 (9/85)
Venegas, Johnnie, 84-01006 (3/85)
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Vreeland, Roger W., 84-03391 (8/85)
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Walton, Robert C., 84-01954 (5/85)
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Wehde, Clar, 84-04051 (9/85)
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West, Frederick G., 84-03171 (2/85)
Wheatley, William G., 84-02571 (7/85)
Whisenant, Sharon M., 84-05234 (5/85)
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Wiedmaier, Heidi K., 83-10080 (4/85)
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Wiley, Ricky L., 85-02025 (9/85)
Wilken, Sondra L., 84-00970 (2/85)
Wilkinson, Mary A., 84-08887 (7/85)
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Wisely, Kyle T., 83-08118 (1/85)
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Womack, Charles W., 84-00895 etc. (6/85)
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Woods, Harold D., 83-09770 etc. (3/85)
Woodward, Thomas E., 82-10288 (1/85)
Woodward, Thomas E., 84-08962 (9/85)
Wright, Joanne M., 84-01840 etc. (7/85)
Wroe, Lawton W., 84-00779 (5,6/85)
Wurster, Judith K., 84-01068 (7/85)
Wyland, Colleen, 84-04772 (7/85)
Wynia, Wanda (Thrasher),82-06565 (5/85)
Yager, Marvin C., 84-00708 (9/85)
Yurkovich, Joseph K., 84-01537 (3/85)
Zakit, Patricia A., 84-07094 (5/85)
Zeulner, Roberta L., 84-05378 (5/85)
Zurbrugg, Clifford B., 84-04585 (9/85)
Zysett, Merle, 81-09902 (9/85)

The following decisions under Own Motion Jurisdiction are not published in this volume. They may be ordered from the Workers' Compensation Board using the numbers provided.

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)

Adams, Finis O., 85-0419M (8/85)
Adams, Logan A., 84-0487M (7/85)
Adams, Wayne D., Sr., 84-0565M (6/85)
Aderton, Frances L., 85-0400M (8/85)
Alderson, James W., 85-0501M (9/85)
Aldous, Edward T., 85-0294M (5/85)
Alvarez, Richard C., 85-0366M (7/85)
Amend, Theodore S., 85-0485M (9/85)
Anderson, Donald L., 85-0141M (3/85)
Anderson, Eldon G., 85-0276M (5/85)
Anderson, Esther M., 85-0098M (6,7/85)
Anderson, Joseph A., 83-0160M (8/85)
Appling, Charles R., 85-0376M (8/85)
Arveson, Elmer S., 81-0293M (7/85)
Arvidson, George L., 84-0581M (1,3/85)
Bailey, Claude, 85-0030M (4/85)
Baker, Ben W., 85-0522M (9/85)
Baker, Janice M., 85-0414M (9/85)
Baldock, Jo Ann, 84-0069M (5,8/85)
Baldwin, Gerald A., 85-0433M (9/85)
Barber, Vivian I., 85-0116M (8/85)
Barkemeyer, Lloyd, 85-0046M (1/85)
Barnett, Tom L., 85-0038M (2/85)
Barton, Kenneth, 85-0012M (1/85)
Bates, Harold W., 83-0200M (7/85)
Batori, Michael C., 85-0055M etc. (7,8/85)
Bautista, Barbara K., 84-0456M (6/85)
Beadle, Charles R., 85-0492M (9/85)
Beaty, Howard V., 84-0182M (2,3/85)
Becker, Dennis W., 84-0426M (6/85)
Beedle, David H., 85-0369M etc. (7/85)
Benedict, Mitchell A., 84-0200M (6/85)
Benintendi, Cecil L., 84-0371M (2,5/85)
Bennett, Joseph M., 85-0483M (9/85)
Benson, Kathy L., 84-0612M (4/85)
Bentley, Wayne E., 85-0130M (5/85)
Berg, Dale V., 84-0234M (8/85)
Berg, Dale V., 85-0172M (4/85)
Berger, Carl P., 85-0273M (5/85)
Bernard, Ronald V., 84-0560M (4,5,6/85)
Bessich, Bruno, 85-0174M (4/85)
Bidwell, Marilyn, 84-0480M (2,4/85)
Bigelow, Audrey J., 84-0520M (6/85)
Billups, Terry L., 85-0271M (6/85)
Bilyeu, Bertha B., 85-0049M (2/85)
Bird, Wesley E., 84-0549M (6/85)
Bishop, Monica M., 85-0222M (4/85)
Blake, Myra L., 81-0200M (6/85)
Blake, Myron E., 85-0260M (7/85)
Blakely, Bobbie J., 85-0177M (8/85)
Blasier, Frank L., 85-0183M (4/85)
Blasier, Frank L., 85-0183M (8/85)
Bojarsky, Anton, 85-0351M (7/85)
Bolling, Douglas E., 85-0300M (5/85)
Booker, Arbon J., 83-0273M (3/85)
Borisoff, Henry T., 84-0482M (5,7/85)
Bostrom, Bradford L., 84-0108M (5/85)
Bostwick, Harry R., 84-0590M (5/85)
Bott, Katherine J., 84-0329M (5/85)
Bowers, George K., 85-0083M (2/85)
Bowers, James P., 83-0392M (3,7/85)
Boyce, Lloyd, Jr., 84-0242M (1/85)
Bozarth, John I., 85-0058M (2/85)
Bracht, Neil R., 85-0241M (5/85)
Brakefield, Juanita J., 85-0143M (7/85)
Bratton, John R., 85-0218M (4/85)
Bray, Bruce D., 84-0011M (5/85)
Breihof, Daniel P., 84-0617M (2/85)
Brenner, John R., 85-0090M (5/85)
Brieger, Donald N., 85-0252M (5/85)
Briggs, Arthur L., 85-0381M (7/85)
Briley, Carroll L., 85-0270M (7/85)
Brill, Guy A., 84-0073M (3/85)
Brooks, Clarence L., Sr.,84-0328M (5,8/85)
Brooks, Ida E., 85-0152M (6/85)
Brown, Dale C., 85-0251M (6/85)
Brown, Gary O., 84-0266M (5/85)
Brown, James H., 85-0253M (5,5/85)
Brown, Lois R., 83-0276M (9/85)
Brown, Margaret I., 85-0099M (4/85)
Brown, Mark D., 85-0114M (3,8/85)
Brundage, Samuel C., 85-0062M (6/85)
Bryant, Kenneth E., 82-0143M (8/85)
Bugni, James, 84-0534M (1/85)
Bult, Richard A., 85-0373M (8/85)
Burke, Walter, 84-0327M (1/85)
Burrington, Rod L., 85-0448M (8/85)
Bush, Dale A., 85-0025M (1/85)
Calawa, Glenn T., 84-0134M (8/85)
Calhoun, Emmett N., 85-0387M (8/85)
Calkins, Charles R., 85-0127M (7/85)
Calkins, Kenneth W., 85-0059M (6/85)
Calwhite, Robert G., 85-0436M (8/85)
Campbell, Betty J., 83-0235M (7/85)
Campbell, James M., 84-0468M (8/85)
Carmien, James D., 84-0004M (1,5,6,8/85)
Carter, Roger A., 85-0237M (5/85)
Caul, Russell M., 85-0207M (5/85)
Cerkoney, Patricia, 85-0117M (5/85)
Chaffee, Ronald D., 84-0450M (6/85)
Charles, Ronald W., 84-0472M (5/85)
Chavez, Walter C., 84-0445M (6/85)
Childers, Larry L., 85-0180M (4/85)
Christian, Harry S., 84-0609M (1/85)
Clark, Bryan J., 85-0278M (5/85)
Clark, Donald H., 85-0333M (7/85)
Clevenger, Junior Ray, 85-0239M (5/85)
Clough, Robert L., 85-0329M (8/85)

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)
Clouse, Ken J., 85-0163M (6/85)
Clover, Mary A., 85-0066M (2/85)
Cobb, Charles E., 85-0213M (7,8/85)
Coble, Steven, 84-0577M (1/85)
Collier, James D., Jr., 85-0245M (5/85)
Collins, Donna L., 85-0154M (6/85)
Collins-Roberts, Laura, 85-0115M (4/85)
Coon, Emelie R., 84-0510M (1,6/85)
Cooper, Charles, 84-0338M (3/85)
Cooper, Edmund J., 85-0028M (6/85)
Corbett, Gary Lee, 84-0031M (1,5/85)
Corry, David B., 85-0128M (3/85)
Cosgrove, Pamela I., 85-0499M (9/85)
Counts, Theodore W., 84-0055M (2/85)
Crawley, Danny W., 84-0409M (7,8/85)
Cremin, John J., 84-0325M (6/85)
Crow, Lanny M., 85-0077M (6/85)
Crow, Virgil E., 85-0226M (6,8/85)
Daining, David C., 85-0122M (4/85)
Daly, Steve, 85-0068M (2,8/85)
Daniel, Frederick G., 84-0312M (1/85)
Darlington, Michael W., 84-0270M (9/85)
Davenport, Jack A., 84-0226M (8/85)
David, Charlie E., 85-0170M (4/85)
Davis (Knowles), Denise, 85-0204M (5/85)
Davis, Maxine L., 85-0320M (6/85)
Davis, Phyllis J., 84-0594M (2,3,5/85)
Davis, Wallace J., 85-0449M (8/85)
Deaton, Orville, 85-00014M (1,6/85)
DeGraff, Clara J., 85-0372M (7/85)
Delacruz, Joe H., 85-0363M (7/85)
Dennis, Daniel, 84-0289M etc. (5/85)
DeRoss, Willie, 83-0328M (6/85)
Desmarais, Dennis J., 85-0230M (5/85)
Dickerson, Ruby L., 85-0070M (8/85)
Dickson, Richard V., 84-0606M (1/85)
Dickson, Ronald V., 84-0584M (2/85)
Dilworth, William C., 85-0050M (4,6/85)
Dishner, Elwin D., 85-0103M (3/85)
Doane, Sara E., 85-0048M (6/85)
Dobranski, Michael, 85-0321M (6/85)
Dodge, Helen L., 85-0190M (4/85)
Dodrill, Donald L., 85-0410M (8,9/85)
Dodson, Earnest D., 85-0195M (4/85)
Donovan, Debra K., 84-0592M (6/85)
Dorgan, John F., 85-0403M (8/85)
Dorsey, Terry E., 84-0372M (3,6/85)
Doster, Milton, 85-0313M (7/85)
Douglas, Frank M., 85-0264M (5/85)
Douglas, Frank M., 85-0264M (7/85)
Dowell, Carol Ann, 85-0258M (5/85)
Downey, Thomas C., 85-0420M (8/85)
Downing, Robert D., 84-0316M (7/85)
Dragnoff, Michael R., 85-0265M (6/85)
Drew, Dorothy J., 84-0276M (5/85)
Dunn, Raymond, 85-0088M (5/85)
Durlam, Eugene D., 85-0124M (3/85)

Name, WCB Number (Month/Year)
Durst, Leroy H., 85-0015M (1/85)
Duval, Roger A., 84-0042M (6/85)
Earl, Ronald C., 84-0550M (9/85)
Eckstein, Harold A., 85-0238M (6/85)
Ednie, Steven H., 84-0491M (5,8/85)
Edwell, William E., 85-0360M (7,8/85)
Eells, Dencel R., 85-0291M (9/85)
Ellis, Gary P., 84-0466M (5,7/85)
Elmore, Michael E., 85-0096M (2/85)
Elsey, James E., 84-0575M (1/85)
Endicott, Robert W., 85-0118M (3/85)
Ensminger, Harvey J., 85-0315M (6/85)
Enze, Edward, 84-0420M (6/85)
Erdahl, Charles L., 85-0456M (9/85)
Erlacher, Connie J., 84-0601M (4,9/85)
Essy, Frank M., 84-0508M (7/85)
Ezell, Ruth M., 84-0521M (1/85)
Faas, Eugene G., 84-0500M (3/85)
Fandrich, Frank S., 85-0153M (3/85)
Farley, Mary E., 84-0423M (1,3/85)
Farnsworth, Harold D., 85-0415M (8/85)
Feasel, Virgil M., 84-0049M (5/85)
Feldt, Darold J., 85-0135M (4/85)
Ferguson, Donald, 82-0248M (1/85)
Ficker, Joseph, 83-0367M (5/85)
Finley, John D., 85-0528M (9/85)
Finney, George E., 85-0101M (4,6/85)
Fischer, John T., 85-0200M (9/85)
Fitch, Ronald M., 85-0444M (8/85)
Flescher, James A., 85-0166M (6,8/85)
Flory, Terry L., 84-0393M (6/85)
Fortenberry, Phillip G., 84-0492M (6/85)
Fowler, Charles O., 84-0053M (9/85)
Fraley, Lewis, 83-0381M (1/85)
France, Roger G., 85-0310M (8/85)
Freamon, Robbin K., 85-0176M (4/85)
Freeman, Nadine M., 84-0247M (3/85)
Fucci, Deborah C., 84-0481M (2,3/85)
Fuestman, Beatrice, 85-0024M (1/85)
Fuhrmann, Kyong S., 84-0411M (4,5/85)
Fuller, Gary E., 85-0132M (4/85)
Gairson, Mark, 84-0019M (7/85)
Galego, Arthur C., 85-0451M (8/85)
Garbe, Erna, 85-0086M (3,4/85)
Garcia, Jose A., 85-0340M (7,9/85)
Gardner, Leland R., 85-0140M (6/85)
Gaustad, Verona G., 84-0373M (2/85)
Gay, Walter A., 84-0136M (5/85)
Gentry, Alice M., 84-0210M (1/85)
Gentry, Wayne N., 85-0347M (7/85)
George, Donald G., 84-0517M (3,7/85)
Geving, Snowden A., 85-0311M (6/85)
Gilbert, Randy V., 84-0546M (1,6,9/85)
Gilcrist, Sharon W., 85-0319M (6,7/85)
Gilge, Kenneth, 84-0488M (1/85)
Goodman, Thomas J., 85-0281M (6/85)
Goodrich, Delmar R., 85-0047M (7,8/85)

Name, WCB Number (Month/Year)
Goodridge, David, 84-0195M (1/85)
Gorecki, Thaddeus J., 85-0292M (5/85)
Gorringe, Philip, 85-0475M (9/85)
Grant, David D., 85-0293M (7/85)
Graves, Peggy J., 84-0518M (6/85)
Gray, Delbert D., 85-0039M (2,5/85)
Gray, Robert K., 85-0279M (5/85)
Greene, David R., 84-0543M (6,8/85)
Greer, Annie Jo, 85-0290M (6/85)
Gregor, Robert L., 84-0429M (3/85)
Gregory, Daniel G., 85-0407M (8/85)
Grenbemer, David L., 85-0244M (5/85)
Griffiths, Happy J., 85-0227M (4,5/85)
Grizzle, Robert H., 85-0064M (2,2/85)
Groom, Roswitha A., 85-0094M (2/85)
Groth, Melvin L., 85-0107M (6/85)
Grove, Gerald E., 85-0361M (9/85)
Gunderson, Lenora L., 85-0314M (5/85)
Haas, Edward R., 84-0539M (7/85)
Hafdahl, Walter A., 85-0232M (8/85)
Hafemann, Diana M., 85-0005M (6/85)
Hagen, James D., 85-0201M (4/85)
Hagger, Danny G., 85-0515M (9/85)
Haley, Dolores F., 83-0359M (4,8/85)
Haley, Dolores F., 85-0391M (8/85)
Hall, Kenneth D., 85-0254M (6,7/85)
Hamilton, Lloyd L., 84-0582M (1,6/85)
Hamlett, Mark C., 85-0307M (5/85)
Hance, William J., 85-0389M (7/85)
Hanson, David A., 85-0457M (8/85)
Hargand, Charles H., 84-0260M (1/85)
Harris, Joann L., 85-0075M (2/85)
Harris, Thomas, 85-0211M (4/85)
Harrison, Donald E., 85-0503M (9/85)
Hartlerode, William A., 85-0468M (8/85)
Hartsock, Elaine M., 85-0053M (1,8/85)
Harvey, Loren R., 84-0614M (1/85)
Hawthorne, Charlotte D., 84-0191M (9/85)
Hay, Kenneth A., 84-0239M (6/85)
Helmer, Hazel, 85-0431M (9/85)
Hendershott, Clifton H., 85-0286M (5/85)
Henderson, Arnold M., 85-0312M (7/85)
Hendrix, Melvin E., 84-0277M (1/85)
Henley, Ira Don, 85-0019M (1/85)
Hernandez, Isabel David, 84-0369M (4,5/85)
Hetrick, Gregory A., 85-0168M (3/85)
Hickey, Elmer N., 85-0337M (7/85)
Hidy, Jack A., 85-0072M (6/85)
Hight, Liddie B., 84-0265M (3,6/85)
Hiles, Charles E., 85-0338M (6/85)
Hill, Cynthia, 84-0504M (8/85)
Hilton, Alice L., 85-0051M (6/85)
Hilts, Thomas F., 85-0157M (3/85)
Hing, Leonard, 84-0593M (1/85)
Hinton, Larry, Jr., 85-0439M (8/85)
Holaday, Merl A., 85-0121M (4/85)
Hollenbeck, William E., 84-0218M (7/85)

Name, WCB Number (Month/Year)
Holly, Willard H., 84-0352M (5/85)
Holmes, Loren, 85-0013M (2,5/85)
Holt, Earnest P., 84-0545M (6/85)
Hookland, Richard S., 85-0151M (3,8/85)
Hopkins, Mike A., 85-0447M (8/85)
Hornberger, Julia M., 85-0137M (3,5/85)
Howard, Gerald B., 84-0172M (4/85)
Howard, Wesley L., 84-0394M (6/85)
Howell, Michael L., 85-0469M (8/85)
Howerton, Clifford D., 85-0196M (6,6/85)
Hudspeth, William R., 85-0150M (3/85)
Huffman, Milford W., 84-0461M (1,3/85)
Huffman, Robert D., 85-0388M (7/85)
Huggins, Weldon N., 85-0052M (1/85)
Hulbert, David, 85-0343M (8/85)
Hunter, George A., 85-0194M (6/85)
Huntsucker, Clifford, 84-0081M (9/85)
Hutchens, Judith A., 85-0065M (2,5/85)
Hutcheson, Orvilla J., 85-0438M (8/85)
Hutchins, Francis, 83-0331M (1/85)
Hutchinson, James W., 84-0602M (6/85)
Hutchinson, Joseph O., 83-0393M (4,5,9/85)
Idlewine, James R., 85-0109M (5,7/85)
Imbler, George L., 85-0486M (9/85)
Ismert, Arthur J., 85-0384M (7/85)
Jackson, Billie G., 85-0138M (5/85)
Jackson, Rickey J., 84-0430M (2,6/85)
Jackson, Robert D., 83-0025M (4,6/85)
Jackson, Robert D., 85-0004M (6/85)
Jager, Norman E., 82-0209M (6/85)
James, Ronald L., 84-0341M (8/85)
Jewell, Alan B., 85-0518M (9/85)
Johnson, Allen E., 84-0516M (6/85)
Johnson, Dorothy L., 84-0215M (6,6/85)
Johnson, Elroy B., 84-0559M (8/85)
Johnson, Leon, 84-0471M (8/85)
Johnson, Minnie B., 85-0289M (6/85)
Johnson, Stella, 85-0011M (4/85)
Johnstone, Michael C., 84-0571M (1/85)
Jones, Billy Joe, 85-0399M (7/85)
Jones, Dennis J., 84-05603 etc. (7/85)
Jones, Johnnie E., 83-0284M etc. (8/85)
Jones, Johnnie E., 85-0027M (2/85)
Jones, Tim L., 85-0462M (8/85)
Juhola, Eunice E., 84-0308M (6/85)
Karn, Ernest W., 85-0216M (6/85)
Keen, Gwendolyn E., 85-0095M (2/85)
Keeney, Wayne W., 84-0528M (5/85)
Keeton, John W., 85-0474M (9/85)
Kelley, Charles, 84-0574M (1/85)
Kellogg, Lawrence L., 84-0615M (6,8/85)
Kemp, Joseph C., 85-0519M (9/85)
Kendell, Chris W., 85-0165M (3,6/85)
Kent, Larry M., 85-0036M (1,3,6/85)
Kephart, Archie F., 81-0173M (1,4,8/85)
Keyser, John P., 82-0191M (5/85)
Kinaman, Jerry W., 85-0078M (8/85)

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)

King, Hazel J., 85-0284M (5/85)
King, Janice M., 84-0622M (1/85)
Kinney, Bert A., 84-0469M (6/85)
Kirchhoff, Rex S., 85-0235M (5/85)
Kitterman, Jane L., 85-0037M (6/85)
Kluchesky, Roy N., 84-0509M (9/85)
Knigge, Robert A., 85-0089M (2,3/85)
Knupp, Patricia M., 83-0304M (5/85)
Kociemba, LeRoy, 85-0324M (6/85)
Kreinheder, Terry, 84-0439M (6/85)
Krieger, Delton A., 85-0188M (4/85)
Kuehmichel, Richard, 84-0350M (3/85)
Kurtz, Judy E., 84-0012M (1/85)
Labahn, Arthur J., 85-0334M (6/85)
Laing, George J., 83-0219M (4/85)
Lakey, John, 85-0413M (8/85)
Lamb, Raymond L., 85-0093M (8/85)
Langley, Billey L., 84-0192M (8,9/85)
Larson, James L., 84-0620M (6/85)
Larson, James L., 84-0620M (9/85)
Laukkanen, Mikko E., 85-0490M (9/85)
Layton, John G., 85-0233M (7/85)
Lee, Ralph R., 85-0354M (8/85)
Lemmon, Marvin L., 85-0368M (8/85)
Lewis, Albert E., 85-0262M (5/85)
Lian, Leonard R., 85-0417M (9/85)
Lincoln, James F., 85-0377M (8/85)
Lind, Richard E., 85-0002M (1/85)
Lindsay, Mamie I., 85-0160M (6/85)
Littleton, Robert S., 85-0247M (5/85)
Lloyd, Audley, Jr., 83-0182M (1/85)
Logan, Eugene A., 84-0197M (3/85)
Long, Larry, 83-0115M (1/85)
Lovato, Richard H., 84-0099M (6/85)
Lowe, Perry D., 84-0131M (7/85)
Lozano, Antonio, 85-0280M (8/85)
Lunsford, Paul O., 84-0570M (7/85)
Lycett, Lori (Davis), 85-0018M (5,6/85)
Macauley, Ayisha, 84-0598M (7,7/85)
Maddox, Gary L., 85-0380M (7/85)
Maine, Keith M., 85-0304M (8/85)
Manchester, Earl E., 85-0189M (8,8,9/85)
Manes, Boyd E., 85-0008M (1,6/85)
Maples, Georgia, 85-0509M (9/85)
Marks, Norman, 84-0310M (1/85)
Marr, Gene A., 84-0547M (3,4/85)
Marrs, Charlotte, 84-0462M (1/85)
Martin, Melvin L., 84-0531M (1/85)
Martin, Ralph B., 85-0081M (6/85)
Martin, Ronald D., 85-0209M (5/85)
Martinez, Armando H., 84-0561M (5,7/85)
Martinez, Jose, 85-0221M (4/85)
Martushev, Daniel, 85-0306M (5,7,9/85)
Mather, Donald W., 85-0256M (6/85)
Matthews, Billie G., 85-0214M (4/85)
Maynard, James W., 85-0325M (6/85)
McAllaster, John E., 85-0326M (7/85)

Name, WCB Number (Month/Year)

McArthur, Charles G., 85-0308M (5/85)
McClendon, William G., 83-0375M (1/85)
McConnell, Richard B., 85-0437M (8/85)
McKnight, Wayne C., 85-0148M (6/85)
McManus, A.B., 85-0136M (8/85)
McMullen, Flora, 84-0214M (6/85)
McUne, D. Stephen, 84-0587M (7,8,9/85)
Meade, Donna M., 85-0429M (8/85)
Meek, Stevan P., 85-0341M (6/85)
Melampy, Diane V., 85-0267M (6/85)
Melhorn, Thomas, 85-0441M (8/85)
Mercier, Darrel L., 85-0181M (4,6/85)
Meredith, Joseph W., 85-0149M (3/85)
Messer, George R., 85-0179M (7/85)
Metcalf, William B., 85-0339M (6/85)
Meter, Charles, 85-0395M (7/85)
Mickelson, Roger M., 84-0208M (9/85)
Middleton, Paul L., 84-0389M (1,9/85)
Milich, Forrest D., 84-0386M (3,8/85)
Miller, Beverly L., 84-0281M (4/85)
Miller, Bruce A., 85-0378M (7/85)
Miller, Donald K., 85-0033M (3/85)
Miller, Raymond I., 85-0301M (6/85)
Miller, Sheila A., 84-0618M (2/85)
Miller, Steven D., 85-0010M (3/85)
Mills, Chester L., 85-0198M (4/85)
Millsap, Lawrence, 85-0461M (8/85)
Mitchell, James R., 85-0142M (3,8/85)
Mitchell, Sharon, 84-0599M (1/85)
Mix, Anthony C., 84-0607M (8/85)
Monroe, Dean C., 85-0375M (8/85)
Monroe, Jack G., 85-0155M (3/85)
Monteith, Norris, 84-0287M (5/85)
Mooney, Clarence T., 85-0003M (1/85)
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